NHS
Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
13.00, Thursday 14 April 2022
Cabinet Suite, Shire Hall, Westgate Street, Gloucester, GL1 2TG
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			13.00
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 10 March 2022**	Approval	Enc 1	13.05
5	**Matters arising from Board meeting held on 10 March 2022**	Assurance		
6	**Patient Story** *Katie Parker-Roberts, Head of Quality*	Information	Presentation	13.10
7	**Chief Executive's Briefing** *Deborah Lee, Chief Executive Officer*	Information	Enc 2	13.40
8	**Trust Risk Register** *Mark Pietroni, Medical Director*	Assurance	Enc 3	14.00
9	**Quality Report** *Matt Holdaway, Chief Nurse and Director of Quality, Mark Pietroni, Medical Director, and Qadar Zada, Chief Operating Officer*	Assurance	Enc 4	14.15
10	**Learning from Deaths Report** *Mark Pietroni, Medical Director*	Assurance	Enc 5	14.35
	Break (14.45-14.55)			
11	**Finance Report** *Karen Johnson, Director of Finance*	Assurance	Enc 6	14.55
12	**Digital Programme Report** *Mark Hutchinson, Chief Digital and Information Officer*	Assurance	Enc 7	15.15
13	**Assurance Reports:** • **Quality and Performance Committee** *Alison Moon, Non-Executive Director* • **Finance and Digital Committee** *Robert Graves, Non-Executive Director* • **Audit and Assurance Committee** *Claire Feehily, Non-Executive Director* • **Estates and Facilities Committee** *Mike Napier, Non-Executive Director*	Assurance	Encs 8-11	15.30
14	**Any other business**		None	15.35
15	**Questions/Comments from Governors**			
	Close by 15.45			

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 10 March 2022, 12.30, Quayside House, Shire Hall			
Chair	Peter Lachecki	PL	Chair
Present	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Robert Graves	RG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	Matt Holdaway	MHo	Chief Nurse and Director of Quality
	Mark Hutchinson	MH	Executive Chief Digital and Information Officer
	Karen Johnson	KJ	Director of Finance
	Simon Lanceley	SL	Director of Strategy and Transformation
	Deborah Lee	DL	Chief Executive Officer
	Alison Moon	AM	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Deputy for Safety, Deputy Chief Executive
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director of People
	Roy Shubhabrata	RS	Associate Non-Executive Director
	Elaine Warwicker	EW	Non-Executive Director
	Qadar Zada	QZ	Chief Operating Officer
Attending	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Mike Ellis	ME	Public Governor
	Andrea Holder	AH	Public Governor
	Katie Parker-Roberts	KPR	Head of Quality (item 2 only)
	Maggie Powell	MP	Appointed Governor
	Lisa Stephens	LS	Head of Midwifery (item 2 only)
	Hannah Wingfield	HW	Patient (item 2 only)

Ref	Item
1	**Chair's Welcome and Introduction** The Chair welcomed everyone to the meeting.
2	**Apologies for absence** Mike Napier, Non-Executive Director
3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 10 February 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 10 February 2022** None.
6	**Patient Story** The Board heard from HW, a patient of maternity services at Gloucester Royal Hospital. A powerful poem written by HW raised themes of worry and fear, being alone, and not being listened to.

	LS informed the Board of plans in place for continued improvements to maternity services, including practical things such as equipment improvements to bays and keys for all midwives, and strategic improvements including psychology support for midwifery advocates and leaders, quarterly meetings with the Head of Midwifery Services, communication plans, and the implementation of a holistic approach which would include a Birth Reflections service that would be offered to patients at different points in their journeys; this was also being discussed with the Local Maternity and Neonatal Service (LMNS). The Board was also informed that work was underway to review induction and transitional care areas and how these points in the journey can be smoother. The Board was advised that the Trust's midwives were very dedicated and were fully committed to improving the service. Recruitment had improved, and vacancies had reduced, but some challenges remained in relation to levels of covid absence and maternity leave. HW informed the Board that she was involved with the Maternity Voices Partnership and was in discussions with the Trust about improvements. HW felt secure and confident in the care that the Trust provided, with the improvements that have been put in place. The Board reflected on the story, and discussed how patient feedback can be used to further service improvement and how patient stories were useful to hear at Board meetings as a way of holding the Trust to account. KJ considered what success would look like for maternity services in twelve months' time and asked the team what it would look like for them. LS reflected that a shared understanding of safety, patient experience, staff experience, and how dashboard data could be used to inform improvements would be markers of success. DL reflected that the experience had shocked her and the approach as described had demonstrated a lack of basic kindness and compassion, and that improvements in the culture of the service were also a significant priority.
7	**Chief Executive's Briefing** DL provided a briefing to the Board on the following key points: • The Trust was closely linked to the national effort to provide aid for the Ukraine situation. The Board was advised that the Trust was willing to enter into mutual aid arrangements if required. All contracts for drugs and medical supplies had been reviewed to determine whether there were any arrangements with Russia or Belarus with the intention to recommend to Board that they be terminated. However, there were none identified. • The Board was advised that the Trust was implementing as much flexibility as possible to ease current operational pressures within the organisation. • The numbers of patients with No Criteria to Reside (NCTR) had peaked and remained a significant focus with a number of new actions in place to improve this, including increased use of volunteers and adapting the model of care to the changing situation within the Emergency Department. • The Board heard that people within the organisation remained positive and still found ways to be kind and compassionate every day despite the pressures, but the levels of fatigue and frustration were considerable and impacting on staff in unparalleled ways. • The Board was advised that a new Chair had been appointed; Deborah Evans was due to join the Trust in May. • The Trust continued to do a lot of teaching and research work, which contributed towards its ambition for university hospital status. A Professor of Nursing post had recently been appointed to and the first intake of medical students to the new Three Counties Medical School would commence this year with students coming on placement with the Trust. • The Board noted that the overseas nursing and medical recruitment programme was going well.

	• DL advised the Board that the Trust's Green Plan continued to be rolled out across the Trust; the Green Council was particularly inspiring in its work throughout the organisation. DL took the opportunity to thank the communications team for its work on the Plan and more generally on how complex information was made so accessible. • The Board discussed the rise in the cost of living and energy prices and was concerned about how staff within the Trust would be affected. DL informed the Board that the Wellbeing Hub had not yet seen an increase in contacts about financial health, however the Trust was promoting to staff the financial wellbeing support package which was considerable and included access to salary advances, loans from "trusted" sources, signposting to benefits advice, and debt management.
8	**Trust Risk Register** The report showed no changes from the previous month. The Board was informed that all risks had a review date, which would be updated for the next iteration. Operational and safety risks were regularly reviewed, with Datix reports also reviewed for themes which contributed towards early interventions. The Board discussed the progress of system risks, particularly in relation to patient flow; the Board was advised that the Trust was linking in to the processes that had been established at system level.
9	**Quality Report** The Board received the report and noted key points as follows: • The Board was advised of continued significant pressure in urgent care, which included increases in ambulance handover delays and resulting deterioration of ambulance response times in the community, alongside poor-quality care within the Emergency Department at times. A number of interventions were in place around offload and cohort areas, but the challenge remained. • Twelve-hour breaches were also a significant challenge for the Trust. The number of NCTR patients continued to be challenging, with domiciliary and care home capacity significantly reduced due to workforce challenges and covid outbreaks. • Cancer performance was good, although the Trust had not met the two-week wait target in January due to staffing impact of the Omicron variant. However, the Board was assured that performance in this area had recovered in February. • The Trust's elective referral to treatment performance was currently at 70%, which the Board was advised was one of the best in the South West. The Board noted that there were no immediate risks around elective recovery. • Patients waiting 52 weeks and over continued to reduce on a weekly basis with the implementation of a range of actions including weekend working, patient risk assessments, and improved recording. The Board was informed that work to improve communication with patients on the waiting list was underway, including a new text messaging service encouraging patients to take part in a survey about waiting times and patient experience. • One MRSA infection had been reported; this was under investigation and the review would include any missed care opportunities. • Incidents of pressure ulcers were increasing, and there had been four falls resulting in harm, which was attributed to delays in care, workload pressures on wards, staffing challenges and the number of moves patients were sometimes exposed to. A review of bed moves was taking place across the organisation to improve experience and outcomes for patients. • PALS contacts continued to increase, with some challenging complexities. A recruitment plan was in place and continued to go well; bank administrative support was in place to manage the increase in contacts.

	The Board acknowledged the significant operational pressures that the Trust was under, and although the work ongoing to address the issues was noted, assurance could not be taken that improvements would be made at the pace they were required.
10	**Maternity Reports** ***Ockenden Review of Maternity Services*** The report detailed the progress on the Trust's delivery of the seven immediate and essential actions from the Ockenden Report. Following NHSEI review of the Trust's position, the Local Maternity and Neonatal System had reviewed and confirmed the current position. The Trust was fully compliant in three areas, with an agreed set of actions in place to achieve full compliance in the other four areas. The Board asked if the area related to listening to women and their families, although fully compliant, was challenging enough for the Trust. The Board noted that the updates were specifically against compliance targets and that stretch targets were monitored through the Maternity Delivery Group and captured in the Journey to Outstanding reports. ***Midwifery Staffing Report*** The report provided assurance that there were effective workforce planning tools in place to review current establishments. The report described the urgent action being taken to tackle staff shortages and the increased pressures on staff, which had been exacerbated by the pandemic. Workforce shortages were regularly monitored on a shift-by-shift basis, with colleague wellbeing initiatives available to all staff. RG asked about additional challenges that would be brought with the implementation of Continuity of Carer and the staffing implications it would have as the programme was rolled out. MH highlighted that the service only needed a further seven whole time equivalent staff to reach establishment, and that the key staffing challenge currently was high levels of maternity leave. A number of actions were in place to offer student midwives jobs within the Trust, and further work around retention was underway to support staffing levels. RS raised the number of red flag events within the report, and was assured that these were reviewed with more rigour under new leadership. AM informed the Board that themed clusters of low-level incidents would be reviewed at Quality and Performance Committee to fully understand basic levels of care that had not been provided, and the impact.
11	**Gender Pay Gap Report** The Board received the report, noting that the Trust's pay gap can be objectively explained through the application of terms and conditions of the agenda for change framework, the length of service of a number of senior male doctors, and trends around the Clinical Excellence Awards. The Board was advised of the work ongoing to remove barriers around flexible working and progression into senior roles. Additional analysis was showing that the number of females, both entering the medical workforce and existing staff, would reverse the pay gap in future years. The Board **approved** the report for publication.
12	**Finance Report** ***Finance*** • The Trust was reporting a year-to-date surplus of £271k, which was on plan. • There was a deficit of £133k in month, which was on plan. A small deficit each month was planned for the rest of the financial year to achieve the current forecast outturn of £6k surplus at year end.

	• There were a number of risks to the forecast, which were in line with last month's report. The main drivers continued to be the Trust's ability to spend non-recurrent funding due to workforce constraints, and the level of elective demand being lower than anticipated. • The Trust continued to explore investment opportunities to maximise patient care, replace ageing equipment and support staff wellbeing. • Planning guidance for 2022-23 continued to be worked through with system partners. • A draft Operational Plan 2022-23 was due to be submitted by 17 March, with final submissions due by 28 April. It was expected that the first submission would reflect a system deficit which was in line with most other systems in the South West. ***Capital*** • The Trust's forecast capital envelope was currently at £68m. To date, the Trust had delivered goods, completed works, or received services to the value of £39.1m. A financial monitoring return had been submitted to NHSEI reflecting the current funding available. • A significant challenge remained to deliver £28.9m by the end of the financial year. • There had been no material levels of slippage reported, however significant concerns remained around the volume of projects due to be completed in the last two months of the year although a similar scale of spend had been achieved in the last two months of the prior year. • The programme continued to be monitored and mitigations continued to be explored for any potential slippage that may arise. • The Board was advised that a five-year capital programme was in place to enable greater longer-term planning.
13	**Digital Programme Report** The Board received the report, noting that nursing documentation had been rolled out and doctor documentation went live on 23 February 2021. The Board was advised that staff had appreciated the 24/7 support that had been available, with feedback received that the Electronic Patient Record (EPR) had already made a positive impact on patient care and colleague communication. The Board asked that doctors not currently engaged with the programme were included; the Board was pleased to note that regular audits of the system showed that all staff had engaged. Fifty thousand records had been accessed by the ten most prolific users of the system already. The Board reflected that other areas of the Trust could learn from the success of the implementation of the digital programme.
14	**Committee Assurance Reports** The Board noted the reports for information.
15	**Any other business** The Board considered its compassionate culture and how Board members would reflect on this and display compassionate behaviours every day, particularly during this period of operational pressures.
16	**Questions/Comments from Governors** • Governors continued to be impressed by the humanity of the Trust. • Governors were pleased that the current economic situation had been recognised and discussed. • Governors felt that the Board continued to ask the right and good questions.
Close	

Unconfirmed

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Gender Pay Gap Report	The Board approved the report for publication.		

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD APRIL 2022
CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 It is five and half years since I wrote my Chief Executive's report welcoming Peter Lachecki as our new Trust Chair; his final Board meeting today feels equally significant. Peter joined the Trust at a time of great challenge and has skilfully navigated the organisation through some very turbulent times resulting in its exit from Financial Special Measures, removal of Regulatory Undertakings relating to performance and financial governance and the highlight of achieving a Care Quality Commission Good rating for the first time in the Trust's history.

1.2 Peter's legacy will be rich and deep; for me he will stand out for the way in which he has created a Board that is truly patient centred, open and transparent in all its dealings and one where everyone's contribution is valued. Quite simply, I would not be standing had it not been for the unrelenting support and care he has shown me during his tenure – a heartfelt thank you from me doesn't do his contribution justice but I offer it in any event.

Operational Context

2.1 Operationally, the Trust remains extremely busy with ambulance services in particular reporting increased demand throughout the Region. Unfortunately, our inability to discharge patients in a timely way means that our Emergency Departments (ED) continue to be congested as a result of being unable to flow patients quickly through the ED. Of particular concern is the impact that this has on patients conveyed to hospital by ambulance, who are often required to queue pending their transfer into the Department. Additionally, the impact of these delays on the ability of crews to respond to urgent patients in the community is of particular concern and has rightly attracted national attention. Extensive work is in hand to address both the root causes of poor flow and to mitigate the risks until such time the pressures are eased. This includes the agreement of Standard Operating Procedures to ensure the immediate release of crews to respond to emergency ambulance calls, where no other crews are available and exploring alternative models to reduce the time ambulance crews are delayed awaiting handover of their patient. System working involving all partners remains strong and a number of improvements to flow have been achieved but in a context of ongoing high demand for supported discharge. However, fundamentally and without doubt we need to reduce the numbers of patients in our hospital for discharge is the next step in their pathway which means a focus on both our back door but also our front door to ensure that we do not admit frail patients to hospital unless there is no alternative, given the likelihood that these patients will have a protracted length of stay with all the associated consequences.

2.2 Reflecting the importance and critical nature of these services on overall operational pressures, care quality and staff morale, a Chief Executive led Urgent and Emergency Care Improvement Board has been established to provide assurance to the Board. The purpose of this Board is to ensure that all the opportunities for improvement, which are in the Trust's remit to deliver, are being appropriately prioritised and resources directed to support delivery. This mirrors the successful approach adopted to Elective Recovery.

2.2 Whilst the focus on COVID infections has lessened in recent weeks, Gloucestershire continues to experience higher numbers of community COVID cases compared to both national and South West levels. It is predicted that these rates will plateau and begin to decline in the next week or so. Whilst the majority of patients in our hospitals have "incidental" COVID, the operational impact of managing this situation remains very significant and, most notably, staff absences have been at their highest levels for many months. For example, in maternity services, a combination of high COVID absences, staff sickness and maternity leave in early April resulted in absences peaking at 25% of the available workforce, requiring temporary service changes to enable safe staffing to be maintained.

2.5 On Wednesday the Trust received an unannounced targeted inspection of its maternity services by the Care Quality Commission (CQC). The formal report will be published in due course but early feedback from inspectors describes staff to have been welcoming and engaged but, unsurprisingly, services and staff morale were found to have been impacted by poor staffing levels and high workload in recent times. The informal and formal feedback will be presented to the Trust's Quality and Performance Committee in keeping with our usual approach before being presented to public board in due course.

2.6 In addition, the CQC has confirmed that they will be undertaking a Comprehensive Well-Led Review of the Trust in the coming weeks, including a three-day onsite inspection scheduled to take place from the 3rd to 5th May 2022. Whilst the focus of this inspection will be the Trust's governance and leadership arrangements, the Well-led Review will also incorporate one additional unannounced inspection of a core service in the weeks preceding the Well-led inspection. I look forward to welcoming inspectors on site and showcasing the work we have been doing since their last Well-led inspection in 2018.

2.7 The Trust's elective and diagnostic performance remains strong; cancer performance is strong relative to the regional position but improving 62 cancer waiting performance remains a huge priority including the continued work to improve histopathology turnaround times – positively the risk relating to the introduction of the Trust's new laboratory system has been closed. A snap shot of elective performance relative to other systems in the Region is provided below.

27 February 2022

		Elective											
		RTT				Diag				Cancellations		Cancer	
		%>52 week	No over 78 weeks	No. of 104 weeks	Total Incomplete	All Diag %>6 week	Endoscopy % >6 weeks	Imaging % >6 weeks	Physiological Measurement % >6 weeks	Cancelled OPs P1-2	Cancelled OPs P3-4	%>62days	No. of 104 days*
BNSSG	N Bristol	7.77%	544	187	29508	43.1%	70.4%	23.5%	64.9%	7	2	17.4%	192
	UHB and Weston												
	UHB	7.98%	847	379	46517	39.1%	65.2%	28.9%	54.6%	13	29	11.5%	82
	Weston												
BSW	Great Western	2.22%	53	0	28962	46.2%	51.2%	47.3%	30.0%	1	9	8.9%	50
	RUH	4.04%	96	8	31614	34.2%	37.7%	31.4%	62.8%	3	4	9.1%	63
	Salisbury	3.55%	113	7	18102	5.2%	13.2%	3.0%	14.2%	1	1	8.1%	38
Cornwall	Royal Cornwall	4.02%	247	48	36820	34.9%	3.1%	38.9%	26.9%	5	32	8.9%	25
Devon	Northern Devon	7.15%	138	14	19469	59.4%	30.7%	62.8%	62.5%	2	25	13.2%	50
	Royal Devon & Exeter	9.50%	1920	710	63654	40.8%	44.1%	41.9%	32.1%	36	61	7.5%	69
	Torbay & S Devon	7.90%	651	217	35083	39.2%	54.9%	37.8%	13.6%	19	24	10.8%	32
	Plymouth	7.34%	1260	543	41709	21.2%	14.0%	14.8%	47.1%	14	56	13.5%	34
Dorset	Dorset County	10.26%	530	220	17372	12.8%	20.2%	11.2%	11.7%	3	80	9.3%	33
	UH Dorset												
	Poole	4.93%	887	415	54841	10.8%	36.5%	2.3%	19.9%	24	50	6.8%	34
	Bournemouth												
Glos	GHFT	2.02%	49	1	58857	18.9%	8.0%	0.3%	52.7%	4	27	8.8%	41
Somerset	Somerset	5.44%	417	145	33030	30.2%	11.2%	10.6%	64.8%	12	61	6.8%	37
	Yeovil	6.06%	177	22	11412	17.5%	32.6%	8.9%	42.9%	3	25	10.4%	29

Weekly RTT PTL	Weekly Activty Return	UEC Daily Sitrep	Weekly Cancer PTL

Where data is reported weekly the actuals for the week ending in C2 are reported.They are then compared with the average of the previous 6 weeks (not including the current reported week).

Weekly Performance is below that of the average of the previous 6 weeks
Weekly Performance is below that of the average of the previous 6 weeks but within 10%
Weekly Performance is above that of the average of the previous 6 weeks

* The formatting of these cells is to show red where values are >5

3 Key Highlights

3.1 Preparations for the Trust's first staff awards since 2019 are in full swing and reached a significant milestone this week with the publication of the shortlist for the individual award categories. This year saw the highest ever (by some margin) number of nominations with 675 individual nominations being received. This year the awards will be run over two evenings to enable us to involve as many staff as possible in what we know is always a hugely popular "feel good" event. Over the course of the two evenings, we will celebrate 20 individual categories including the first ever *One Gloucestershire* Partnership Award. The very popular Patients' Choice Award and the Lifetime Achievement Award will also feature again this year – one on each of the two evenings.

3.2 Sticking with the theme of achievement, I was delighted that last week the Trust's Digital Team won *Most Promising Pilot Award* for a digital innovation in the national Leading Health Care Awards, for their work with private partner Polygiest to use artificial intelligence to predict those patients presenting in the Emergency Department who are at high risk of staying in hospital for more than 21 days. Identifying these patients at the point of admission enables teams to maximise their focus and resources to avoid admission where at all possible. Our Digital Team is a regular contender and winner for awards reflecting the work that they do but also the value they place on celebrating success and prioritising time to put themselves forward.

3.3 Since my last report, the national Staff Survey results have been published. Not surprisingly, given the challenges of the last year, the survey painted a disappointing picture across the NHS and our Trust was no different. Of huge concern was the number of areas where we were below the national average and notably that fewer staff than previously said they would recommend the Trust as a place to receive care. Claire Radley, Director of People and Matt Holdaway, Interim Chief Nurse joined me in this week's Vlog to speak about the survey results and share their early thoughts on what it means for us and, most importantly, our priorities and approach going forward. First and foremost, we remain absolutely committed to listening and acting on what colleagues have told us and making our organisation one where people feel valued, included and a place they would recommend to others as a place to work and receive care. What is very apparent in this year's results is that whilst we can mobilise many initiatives to support staff, to improve their employment experience and support their development ultimately staff come to work to deliver high quality care and when they feel they can't do this it impacts hugely on their sense of purpose and they feel about the organisation.

3.4 To help gauge the organisational "temperature" and track our impact in a more real time way, we'll be participating in the National Quarterly Pulse Survey going forward and, for the first time, also including those staff who work on our nursing and locum doctor bank who are not included in the national annual staff survey. This survey takes place three times a year (excluding the quarter that the national survey occurs in) and asks a core set of the national survey questions. Whilst response rates are typically lower than the annual survey, those organisations who have participated previously described the insights as helpful.

Deborah Lee
Chief Executive Officer

10th April 2022

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Report to Board of Directors

Agenda item:	8	Enclosure Number:	3
Date	14 April 2022		
Title	Trust Risk Register		
Author /Sponsoring Director/Presenter	Lee Troake, Head of Corporate Risk, Health and Safety Mark Pietroni, Medical Director		

Purpose of Report			Tick all that apply ✓
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Purpose

The Trust Risk Register (TRR) enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation.

One risk was added to the TRR, two were downgraded and one risk was closed at Risk Management Group on 6 April 2022.

Key issues to note

NEW RISK ADDED TO TRUST RISK REGISTER (TRR)

C3682 The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.

Scores: Safety C5 x L4 = 20, Quality C4 x L4 = 16, Statutory C4 x L4 = 16, Reputational C3 x L3 = 9

Risk Cause: Poor patient flow in the Emergency department caused a lack of available beds throughout the hospital which in turn is a result of large numbers of medically optimised patients occupying inpatient beds. Medically Optimised for Discharge (MOFD) has reached a 12-month high, having increased by 16% to an average of 265 patients per day who no longer require acute hospital care. Patient demand has also changed, with higher number of mental health patients seen in ED in the last 12 months and the average number of overall attendances at approximately 377 patients a day.

RISK SCORE REDUCED FOR TRR RISK

None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

D&S3562Path The Risk to the quality of pathology service provision due to functionality issues with TCLE during the implementation phase which prevents the timely booking of samples, access to, or visibility of, critical patient results.

Score downgrade: Safety C4 x L3 = 12 reduced to C4 x L2 = 8, Quality C4 x L4 = 16 reduced to C4 x L3 = 12,

Workforce C3 x L5 = 15 reduced to C3 x L3 = 9, Statutory C3 x L3 = 9, Business C3 x L4 = 12, Finance C3 x L2 = 6

Reason for downgrade: Dashboard data indicates all departments have returned to pre-go-live performance; safety and quality scores reduced to reflect this remains of TRR for workforce score. Outcome of clinical harm review awaited but this will take several months as patient needs to conclude treatment for harm to be assessed.

D&S3565Path The risk of reduced service quality in all clinical areas and operational flow due to lack of timely access to pathology reports, test status and results on SUNRISE EPR.

Score downgrade: Safety C4 x L3 = 12 reduced to C4 x L2 = 8, Quality C3 x L4 = 12 reduced to C3 x L3 = 9, Statutory C3 x L3 = 9, Finance C3 x L4 = 12 reduced to C3 x L3 = 9

Reason for downgrade: Dashboard data indicates all departments have returned to pre-go-live performance; scores reduced to reflect this; downgrade to D&S divisional risk register. Outcome of clinical harm review awaited but this will take several months as patient needs to conclude treatment for harm to be assessed.

PROPOSED CLOSURES OF RISKS ON THE TRR

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, Wotton Lodge and Chestnut House

Reason for closure: Risk closed as roof repairs now complete.

Recommendation

The Board is asked to note the report.

Enclosures

- Trust Risk Register

Ref	Inherent Risk	Controls in place	Actions	Division	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead	Strategic Group	Operational Group	Assurance Committee / Board	Risk Review Date	Operational Lead	Risk Register
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	Risk assesment Update busines case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering. implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan arrange replacement valve and acurator for air handling unit TH1	Gloucestershire Managed Services, Surgical	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - Surgery, Estates and Facilities Committee		Quality and Performance Committee, Trust Leadership Team	30/06/2022	Matthews, Alexandra	Trust Risk Register
D&S2404 CHaem	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 Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 -	Develop Business case to meet capacity demand succession planning for consultant retirement Raise with divison to bring recruitment incentive requirements to PODDG Develop a business case for non-medical prescriber to help with clinics Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Diagnostics and Specialties	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	Divisional Board - D & S	OHPCLI Board		07/06/2022	Johny, Asha	Trust Risk Register
D&S2517 Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - D & S	Pathology Management Board		11/05/2022	Lewis, Jonathan	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	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group;	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system To ensure prioritisation of capital managed through the intolerable risks process for 2021/22 to discuss alternative treatment options with upper GI surgeons	Corporate, Gloucestershire Managed Services	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Finance	Divisional Board - Corporate / DOG, Estates and Facilities Committee,	GMS Health and Safety Committee	GMS Board, Trust Leadership Team	08/06/2022	Lanceley, Simon	Trust Risk Register

S3316	The risk of not discharging our statutory duty as a result of the service's inability to see and treat patients within 18 weeks (Non-Cancer) due to a lack of capacity within the GI Physiology Service.	purchase of anopress machine for use by lower GI surgeons to reduce the numbers requiring GI phys Escalation of patients> 52 weeks to Head of GI physiology to review prioritisation Referral outside of Trust	review cost implications and resources for treatment option of bravo capsule Further individual being trained in GI Physiology by Bev Gray. Individual will work 35.5 hours per week total, not all will be GI Physiology, hours TBC. Will increase GI Physiology capacity by >100% Capital application form completed, Candice Tyers presenting to MEF VCPs have been submitted / await outcome of approval	Surgical	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Interim Chief Nurse	Divisional Board - Surgery			06/05/2022	Hendry, Tracey	Trust Risk Register
M3396Emer	The risk to patient safety relating to poorer outcomes and potential harm throughout their hospital stay as a result of spending longer than 8 hours in ED	UEC Improvement plan. Actions from UEC pathways and delivery group. POCT Huddles	UEC improvement plan Audit in department of 100 patients throughout DEc 2020 Reset culture towards zero tolerance of above 8 hour waits	Corporate, Medical, Surgical, Women's and Children's	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	Emergency Care Delivery Group	Emergency Care Operational Group, Unscheduled	Quality and Performance Committee, Trust Board	11/04/2022	Tomlins, Abigail	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	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Digital Care Board, Divisional Board - Corporate /	Clinical Systems Safety Group, Resuscitation and	Quality and Performance Committee, Trust Leadership	25/04/2022	King, Ben	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Falls prevention assessments on EPR 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6. Falls prevention champions on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR Discuss flow sheet for bed rails on EPR at documentation group W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell Review use of slipper socks with N Jordan SIM training to use hoverjack on 7a Following presentation of W168912 N Jordan to attend ward to review completion of falls documentation and required management of patient following assessment by staff Following presenntation of W171436 to PHH N Jordan to forward information to purchase slippers for patients in ED W165353 Nadine Jordan to review with 9a x-ray identifying # and communication of #	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Falls and Pressure Ulcers Group	Quality and Performance Committee, Trust Leadership Team	29/04/2022	Bradley, Craig	Trust Risk Register
			1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions													

C1945NT VN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Proide training to 5b in the use of cavilon advance + Provide training to ward on completion of 1st hour priorities Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed Bespoke training to DCC staff for categorisation of pressure ulcers Bespoke training to ward 4a to include 1st hour priorities produce training document on wound measurements for Rendcomb The provision of RCA support/training for TV issues to be take to pressure ulcer council Work with Knightsbridge to support staff TVN training Bespoke training in management of pressure ulcer [revention on ward 7a TVN to d/w TVN lead regarding use of share care pathway in regards to EPR. Implement training programme in management of patient pressure ulcers in ED Ward 7a W170891 training with HCA's to allow them to assist registered nurses with assessing patient skin and documenting on EPR	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group	Quality and Performance Committee, Trust Leadership Team	29/04/2022	Bradley, Craig	Trust Risk Register
D&S2976 Rad	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Additional clinics covered by current staff. Have reduced screening numbers 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. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are	meeting with HR to progress replacement of staff in Breast screening Arrange meeting to discuss with Lead Executive Develop escalation process for when Breast Radiologist is not available to provide service Discuss the possible set up of national reporting center widen recruitment net to include head hunter agencies using Trust agreed supplier listlist	Diagnostics and Specialties, Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	Quality Delivery Group, Screening Performance Committee, Trust Health and Safety Committee	Radiation Safety Committee	People and OD Committee, Quality and Performance Committee	29/04/2022	Chatzakis, Georgios	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 Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required.	Women's and Children's	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Interim Chief Nurse				29/04/2022	Mortimore, Vivien	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 Service contract with manufacturer includes software only until July 2022 Stockpiled consumables for use and repair	To complete business case for replacement equipment To complete business case for replacement equipment Progress business case	Diagnostics and Specialties	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	Divisional Board - D & S	OHPCLI Board		30/04/2022	Moore, Bridget	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 Project planning governance	Project approach	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	CDIO	Digital Care Delivery Group	Information Management and Technical Leads Delivery Group	Finance and Digital Committee	01/05/2022	Atherton, Andy	Trust Risk Register
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.77wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR New Elearning module in progress to complete bimonthly audit into inpatient care for diabetes	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Medical Director	Divisional Board - Medical, Quality Delivery Group	Medicines Optimisation Committee, Patient Experience Group	Trust Leadership Team	01/05/2022	Macklin, Susan	Trust Risk Register
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks,	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Corporate, Diagnostics and Specialties,	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	Divisional Board - Corporate /	Quality and Safety Systems	Finance and Digital Committee,	07/05/2022	Troake, Lee	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Diagnostics and Specialties	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - D & S, Estates and Facilities Committee	Pathology Management Board	Trust Leadership Team, Trust Board	24/05/2022	Rees, Linford	Trust Risk Register
C3223COVID	The risk to safety from nosocomial COVID-19 infection through transmission between patients and staff leading to an outbreak and of acute respiratory illness or prolonged hospitalisation in unvaccinated individuals.	•2m distancing implemented between beds where this is viable •Perspex screens placed between beds •Clear procedures in place in relation to infection control •COVID-19 actions card / training and support •Planning in relation to increasing green bed capacity to improve patient flow rate •Transmission based precautions in place •NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control •H&S team COVID Secure inspections •Hand hygiene and PPE in place •LFD testing – twice a week •72 hour testing following outbreak •Regular screening of patients •Minimise transfer of patients from ward to ward	CAFF inspections to be progressed	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Interim Chief Nurse	COVID-19 Task and Finish Group, Capital Control Group, Infection Control Committee, Quality Delivery Group, Risk Management Group, Trust Health and Safety Committee	COVID-19 Incident Management Team, Case and Bed Modelling (Bronze COVID Group), Communications (Bronze COVID Group), Elective Business Continuity (Bronze COVID Group), Impact on Elderly and Vulnerable (Bronze COVID Group), Staffing (Bronze COVID Group)	People and OD Committee, Quality and Performance Committee	24/05/2022	Bradley, Craig	Trust Risk Register

C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Infection Control Committee		Quality and Performance Committee	24/05/2022	Bradley, Craig	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	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols.	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Divisional	Safeguarding Adults Operational Group,	Quality and Performance Committee, Trust Board,	24/05/2022	Freebrey, Clare	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel	People and OD Committee, Quality and Performance Committee, Trust Leadership Team	24/05/2022	Holdaway, Matt	Trust Risk Register
C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic.	COVID T&F Group to develop Recovery Plan to minimise harm To resolve outstanding areas of concern	Corporate	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	COO	Divisional Board - Corporate /		Trust Leadership Team, Quality	30/05/2022	Zada, Qadar	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. SBS blocks access to malicious sites MDE prevents malicious activity on devices, complimented by Sophos Central with InterceptX. Users are not permitted to install applications and we have limited numbers of privileged accounts.	Project approach	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Business	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk		Digital Care Delivery Group, Information Governance and Health Records Group	Information Management and Technical Leads Delivery Group	Finance and Digital Committee	30/05/2022	Turner, Thelma	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Modular lab in place from Feb 2021 Maintenance was extended until April 2021 to cover repairs Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab Project manager to resolve concerns regarding other departments phasing of moves to enable works to start	Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	Capital Control Group, Centre of Excellence Delivery Group, Divisional Board -	Medical Devices Group, Medical Equipment Fund	Service Review Meetings	31/05/2022	Mills, Joseph	Trust Risk Register
WC3257Gyn	The risk of not having a dedicated gynaecology bed base staffed by gynaecology nurses to keep women safe from avoidable harm and to provide the right care and treatment.	•Specialist gynae nurses to support in-patient care and nursing staff regardless of patient location during daytime shift •Training provided to 2b staff •Written guidance provided to 2b staff •Set up of emergency gynae assessment unit in out-patient setting- to improve flow through ED •Women attending for SMOM and genetic abnormality STOP pre-operatively seen in	Write a business case to ensure correct staffing write an action plan for changes to 2b to support gynaecology in-patients to rind suitable location for gynaecology in-patient service Identify suitable bed base with correct capacity both short and long term Work with site team to cohort gynaecology patients to identified bed base	Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Interim Director of Quality and Chief Nurse	Quality Delivery Group, Divisional Board - W & C		Quality and Performance Committee, Trust Board, Trust Leadership Team	31/05/2022	Hutchinson, Becky	Trust Risk Register
M3682Emer	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Since October, the ED team has implemented several changes to processes in order to mitigate the impact on the department when there is no admitting capacity. This includes: - Revised roles and responsibilities of key roles in the ED	Please can you review Risk, discuss at Specialty Governance or Escalation to Div Board to review and sign off. Progress VCPs for Flow Coordinator and ED Assistants Increasing funded establishment of clinical workforce in ED to address Trust Risk	Medical	Safety	Catastrophic (5)	Likely - Weekly (4)	20	15 - 25 Extreme risk	Medical Director	Divisional Board - Medical	Unscheduled Care Leaders Group	Quality and Performance Committee, Trust Leadership	06/06/2022	Nagle, Pat	Trust Risk Register

		- Reintroduced Patient Safety Huddles 5 times a day - Reconfigured ED layout, bringing cohort	Ensure meeting to discuss ICS risks is re-established and risk M3682 is discussed with partners										Team			
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.	Monitoring by clinical urgency and prioritisation is in place Additional capacity is being sought for each specialty Weekly review of PTL by the COO Monthly oversight by Improvement Board,	1.RTT and TrakCare plans monitored through the delivery and assurance structures Formally review the Bed modelling and scenarios proposed as part of H2 submission.	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Planned Care Delivery Group	Out Patient Board	Quality and Performance Committee, Trust Leadership Team	07/06/2022	Zada, Qadar	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities.	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog To resolve outstanding areas of concern	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Out Patient Board, Quality Delivery Group		Quality and Performance Committee, Trust Leadership Team	07/06/2022	Zada, Qadar	Trust Risk Register

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	9	Enclosure Number:	4
Date	14 April 2022		
Title	Quality Report		
Author /Sponsoring Director/Presenter	Neil Hardy-Lofaro, Deputy Chief Operating Officer Suzie Cro, Deputy Director of Quality Qadar Zada, Chief Operating Officer Matt Holdaway, Chief Nurse/Director of Quality Mark Pietroni, Medical Director		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	✓

Summary of Report

Purpose

This report summarises the key highlights and exceptions in Trust performance for the February 2022 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

The Gloucestershire system is experiencing exceptional pressure in urgent and emergency care. Very significant ambulance handover delays are creating a risk in the community in relation to response times to Category 2 calls. Prolonged waits in the Emergency Department for admission to a hospital bed and to receive prompt treatment are considerable and associated with harm. The Trust, together with system partners are working to improve a series of quality standards in the ED such as time to triage, time to specialist review, 12-hour waits following decision to admit and responsiveness to sepsis. The wider system focus is on the more than 200 patients that no longer require acute hospital care that are unable to be discharged to onward social care.

Quality

Number of bed days lost due to infection control outbreaks

Covid

During February we had 637 lost bed days 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. Outbreak meetings continue to ensure review of all closed

areas and weekend working for onsite Infection Prevention and Control Nurses continues.

The management of red/ COVID patients was discussed in an extraordinary meeting given the significant number of ward closed due to COVID outbreaks and the decision was made to keep COVID positive patients in single rooms on closed areas, COVID exposed patients were moved to be combined in a closed bay or single closed ward and wards were re-opened to green patients before the 10 day period (after movement of COVID positive patients off the ward and cohorting of amber patients in single bays). Patients who are red recovered (completed isolation after testing positive for COVID) are also moved to closed empty beds to minimise empty closed bed numbers. NHSE/I, system partners, UK HSA were approached to inform them of the outbreak situation and get access to further support to prevent further outbreaks.

Hospital standardised mortality ratio (HSMR)

Slight improvement month on month. If COVID activity is removed then both metrics are in the expected range suggesting the modelling has not accounted for this yet. Monitored at HMG previously Dr Foster (now Telstra) has suggested the modelling will slowly improve and adjust to take account the effects of COVID but we are not seeing this, they are going to look at it further and report back to HMG.

Pressure ulcers acquired as in-patient

We have seen an increase during the winter period in the development of Category 2, deep tissue injuries and unstageable pressure ulcers across different wards in both hospitals. Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now accelerated to monthly to increase throughput.

Falls Update

February 2022 saw a rate of 7.6 falls per 1,000 bed days. This is higher than previous months. When comparing to organisations across the South West that share falls data (currently only 4 Trusts) the Trust is performing better with the average falls rate of the other 3 trusts being 9.82 with each organisation also seeing an increase.

February 2022 saw a high number (10 occurences) of falls resulting in harm, such as fractures and head injuries. Every fall resulting in moderate harm or worse is reviewed in the weekly Preventing Harm Hub where immediate safety actions and learning are rapidly assessed. Two patients subsequently died and were referred for Serious Incident Investigations.

The number of falls in hospital are linked to a range of factors, most acutely to safe staffing levels. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing and prolonged length of stay which is associated with an increased number of ward moves.

% Women with induced labour

There has been an increase in February to 33.09% of women experiencing induced labour. The Obstetricians have reviewed rupture of membranes and are ensuring they are giving maternal choice for induction of labour if

required.

% PALS concerns closed in 5 days

The number of cases closed by PALS is currently at 73%. The team have gone from managing 250 cases per month in 2019/20 to 660 cases per month, and continue to only refer 1.4% of their cases on to the complaints team. They are managing a huge increase in volume and also complexity of cases. There is additional triage support within the team from March to free up capacity within the advisors, and an additional advisor has been recruited who will start in April. A review of the service is being undertaken to see how additional support can be brought in for the team.

Friends and Family Test

Our overall Trust FFT positive score has decreased to 88.6%, with a decrease across inpatient and urgent care survey scores in particular. This is largely due to operational pressures, with a large increase in the comments focussing on wait times. In addition to wait times, there has been an increase in negative comments related to pain, emotional and physical support, hygiene and facilities. The divisions have been asked to review their local comments and improvement plans and provide updates to QDG, and the Patient Experience team will do a deeper dive analysis of the pain comments as this has emerged in particular as a concern.

Performance

During February, the Trust did not meet the national standards for 52 week waits, diagnostics, nor the 12 hour and 4-hour ED standards.

February continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 72.57% to 69.25% compared to the previous month. Ambulance handover delays increased for both delays over 60 minutes. Correcting this negative trend remains a priority for the Trust. The Trust has implemented a number of actions aimed at reducing the number of handover breaches and increasing ambulance availability. These have yet to have had an impact as flow through and out of the hospital are not optimised.

The Trust did not meet the diagnostics standard in February however performance improved on last month from 20.8% to 18.3% this month.

For cancer, in February's submitted data, the Trust met 5 of the 9 CWT metrics and exceeded national performance in 8 out of 9 of the CWT metrics. The Trust met the standard for 2 week wait with performance at 93.9%, with breaches attributed to an increased number of referrals, patient choice or COVID self-isolation factors. The 62-day cancer wait standard was not achieved with an unvalidated position of 64.6%, although this has risen locally to 64.3%, with the addition of further treatments. The submitted data is affected by the current challenges with pathology where treatments are added post submission. >62 and >104-day numbers have been declining over last 6 weeks.

For elective care, the RTT performance did not meet the standard at 71.5% (unvalidated) which is a slight improvement on last month.

Recommendation

The Board is asked to note the current performance figures; note the context in which they arise. The exception reports highlight the initiatives and actions being taken internally and by system partners which are intended to arrest further deterioration of the position. The committee is asked to note the positive comparators against national position (Cancer, RTT and Diagnostics). The operational Plan for 2022/23 will further develop confidence

in recovery of key performance indicators.
Enclosures
• Quality Report

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period *February* 2022

Presented at March 2022 Q&P and April 2022 Trust Board

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Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety 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 February, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4 hour ED standard.

February continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 72.57% to 69.25% compared to the previous month. Ambulance handover delays increased for 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 February however performance improved on last month from 20.8% to 18.3% this month. The total number of patients waiting has increased from 7,373 to 7,795. The overall number of breaches has decreased by 115, if Echo's were to be excluded, performance for all other modalities would be 0.56% with just 31 breaches against 5,490 patients waiting.

For cancer, in January's submitted data, the Trust met 3 of the 9 CWT metrics and exceeded national performance in 9 out of 9 of the CWT metrics. A tough month across the board which is reflective of pressure services experienced across the Trust in urgent and planned care. 2ww performance and ongoing 62 day pathways significantly impacted by covid and patient/staff self-isolation in January. February is showing signs of improvement with the Trust currently meeting the main CWT standards (2ww, 28 day and 31 day new tx), however this is an unvalidated position. The 62 day cancer wait standard will not be achieved with an unvalidated position of 65%, although this will potentially rise as more skin treatments are added. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity.

For elective care, the RTT performance did not meet the standard at 71.8% (unvalidated) which is a slight improvement on last month. The total incompletes has improved again on last month with a further reduction made. With validation ongoing at the time of this report, the Trusts position is 57,203 with a further reductions anticipated prior to submission. The number of 52 week breaches has again been reduced despite the operational challenges with an validated figure of 1,115 breaches in month. This is the lowest figure since July 2020 and the most rapid rate of recovery in the South West region. Focus continues to be placed on patients over 78 weeks, which has again reduced in month, and specifically those patients at risk of breaching 104 weeks in this financial year. Currently the Trust has one P6 patient that has breached 104 weeks. This patient has been cancelled 4 times due to COVID, bed capacity and more recently consultant sickness. Given ongoing sickness this patient's care has now been transferred to another consultant and has a planned TCI of 19th March.

The Elective Care Hub continues to work with several specialties with the most recent having a similar number of requests to be removed from the waiting list, with around 8%. The number of patients escalated with new concerns has dropped considerably, to around 9%, from a previous position of between 18% and 21%. This is likely to be relevant to the type of specialties contacted. In addition the team have been supporting the validation of patients awaiting Echo's. Of the 600 patients contacted 10% asked to be removed and 5% raised new concerns.

Directors Operational Assurance Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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

Indicator		Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	262	362	316	262	253	440	354	500	523	467	446	504	330
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	219	382	237	85	117	475	294	692	752	1074	952	1057	1093
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	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%	69.25%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.36%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%
	Actual	69.44%	69.97%	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	58.61%
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	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.45%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	2640	3061	2657	2263	2016	1724	1554	1598	1590	1492	1430	1273	1120
% 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	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%
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	97.00%	97.10%	94.80%	95.40%	92.80%	91.90%	93.50%	92.00%	93.40%	92.10%	92.30%	87.20%	94.60%
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	97.00%	98.30%	93.60%	96.50%	90.70%	96.60%	93.20%	90.80%	89.80%	88.60%	84.90%	89.70%	93.90%
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	99.20%	99.00%	96.60%	98.30%	98.50%	98.30%	97.10%	95.90%	97.90%	96.30%	95.60%	94.20%	98.40%
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	99.40%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	100.00%	99.40%	99.40%
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%	98.60%	98.10%	97.70%	100.00%	97.50%	98.50%	99.40%	100.00%	97.90%	100.00%	99.40%	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	97.20%	97.60%	90.00%	95.60%	95.80%	94.00%	92.60%	88.10%	91.00%	95.10%	94.40%	88.20%	92.40%
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	87.00%	86.70%	85.30%	90.60%	95.70%	92.00%	82.90%	90.80%	76.50%	81.80%	91.50%	85.50%	79.30%
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	93.30%	76.70%	90.80%	65.40%	70.60%	82.10%	63.60%	72.10%	87.10%	70.60%	73.10%	75.00%	79.30%
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	82.00%	83.40%	82.00%	76.30%	80.30%	77.60%	72.10%	71.00%	69.00%	70.90%	61.90%	65.80%	64.60%

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

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

Measure	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	% growth from previous year: Monthly (Feb)	% growth from previous year: YTD
GP Referrals	7,163	8,955	8,556	8,472	8,958	8,663	7,911	8,303	8,146	8,503	7,137	7,894	7,972	11.3%	17.8%
OP Attendances	46,059	57,846	50,410	51,179	54,944	52,155	47,546	52,906	49,494	56,378	47,546	51,437	48,489	5.3%	18.4%
New OP Attendances	13,532	17,948	15,998	16,328	17,228	16,158	14,662	16,658	15,952	18,284	15,350	16,383	15,892	17.4%	21.8%
FUP OP Attendances	32,527	39,898	34,412	34,851	37,716	35,997	32,884	36,248	33,542	38,094	32,196	35,054	32,597	0.2%	16.8%
Day cases	3,180	4,394	4,195	4,558	4,750	4,801	4,525	4,310	4,187	4,535	3,940	4,114	4,181	31.5%	31.3%
All electives	3,612	5,000	5,045	5,424	5,696	5,830	5,469	5,237	5,218	5,492	4,940	4,783	5,027	39.2%	32.7%
ED Attendances	8,021	10,687	11,063	11,930	11,976	12,295	12,006	13,186	13,044	11,988	10,943	11,433	10,545	31.5%	24.8%
Non Electives	3,381	4,108	4,018	4,398	4,642	4,531	4,333	4,244	3,998	3,868	3,444	3,464	2,960	-12.5%	10.7%

Trust Scorecard - Safe (1)

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

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset - First positive specimen <=2 days after admission	167	129	38	3	7	24	120	134	110	186	121	123	174	143	430	1,145	No target	
COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	29	19	10	1	4	11	14	12	14	17	28	53	64	87	98	305	No target	
COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	8	6	2	0	0	1	5	2	0	1	1	24	21	37	26	92	No target	
COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	6	4	2	0	1	1	4	9	1	9	5	23	31	73	37	157	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	2	Zero	
MRSA bacteraemia - infection rate per 100,000 bed days	0.0	0.0	0.0	0.0	0.0	3.9	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	0.0	.7	Zero	
Number of trust apportioned Clostridium difficile cases per month	75	11	8	3	14	11	10	15	7	4	12	8	3	7	20	95	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	5	3	3	7	7	5	9	4	1	8	5	2	5	13	56	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	6	5	0	7	4	5	6	3	3	4	3	1	2	7	39	<=5	
Clostridium difficile - infection rate per 100,000 bed days	22.7	21.8	30.9	13.5	60.2	42.6	34.9	51.1	23.5	13	40.6	27.3	10.2	25.9	26.8	30.8	<30.2	
Number of MSSA bacteraemia cases	18	2	3	1	2	2	2	5	5	0	2	5	3	3	7	31	<=8	
MSSA - infection rate per 100,000 bed days	6.4	5.9	11.6	4.5	8.6	7.7	7	17	16.8	0.0	6.8	17	10.2	11.1	7.8	10.2	<=12.7	
Number of ecoli cases	30	3	2	4	5	3	2	0	3	5	7	5	5	5	17	44	No target	
Number of pseudomona cases	6	1	1	1	2	0	0	1	1	0	1	0	0	0	1	6	No target	
Number of klebsiella cases	12	0	2	2	1	3	3	3	4	2	2	2	0	0	6	22	No target	
Number of bed days lost due to infection control outbreaks	9		0	0	6	161	15	60	1	93	176	453	444	637	722	2,046	<10	>30

Trust Scorecard - Safe (2)

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	21/22	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	1	1	1	1	0	0	0	1	1			1		Zero	
Number of falls per 1,000 bed days	6.5	7.5	6.6	6.1	6.2	6.2	7.1	7.5	7	6.7	7	6.7	7.3	7.6	6.8	6.9	<=6	
Number of falls resulting in harm (moderate/severe)	18	6	6	4	2	3	9	5	5	5	3	9	5	10	15	58	<=3	
Number of patient safety incidents - severe harm (major/death)	19	3	10	7	2	1	9	3	6	7	10	7	7	10	24	69	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	0	0	2	1	0	1	0	3	4	No target	
Medication error resulting in moderate harm	2	6	4	2	2	1	2	3	2	14	4	6	6	2	24	44	No target	
Medication error resulting in low harm	34	10	11	11	4	13	6	4	7	5	11	3	9	8	19	80	No target	
Number of category 2 pressure ulcers acquired as in-patient	79	19	29	16	22	17	24	27	19	22	41	43	37	40	106	308	<=30	
Number of category 3 pressure ulcers acquired as in-patient	2	1	1	1	0	1	0	3	0	1	2	4	2	1	7	15	<=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	3	1	4	3	4	3	5	1	4	9	9	12	14	22	68	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	22	3	4	1	4	8	9	4	6	1	7	12	13	7	20	72	<=5	
RIDDOR																		
Number of RIDDOR	55	2	4	4	1	3	3	2			3	5			12		SPC	
Safeguarding																		
Number of DoLs applied for		46	29	54	73	57	55	59		53	48	68	64	53			No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	7	3	4	3	8	3	3	7	4	6	1	5	2	2	12	44	No target	
Total attendances for infants aged < 6 months, other serious injury		0	1	1	0	0	0	0	0	0		0	0	1			No target	
Total admissions aged 0-17 with DSH	24	9	15	13	26	15	13	11	18	35	39	18	46	24	92	258	No target	
Total ED attendances aged 0-17 with DSH	143	55	88	62	99	84	65	52	73	102	115	54	125	69	271	900	No target	
Total number of maternity social concerns forms completed		50	62	68	58	77	63	46		58	65	52	67	70			No target	
Total admissions aged 0-17 with an eating disorder									9	11		8	5	7			No target	

Trust Scorecard - Safe (3)

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	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%			70.00%													>=90%	<50%
Serious Incidents																		
Number of never events reported	2	2	0	0	2	0	0	1	0	1	1	2	1	2	4	11	Zero	
Number of serious incidents reported	13	5	4	4	3	2	4	4	6	4	4	4	4	3	12	40	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%	89.2%	92.2%	89.9%	89.8%	89.3%	87.0%	87.1%	92.0%	92.3%	90.7%	90.9%	87.5%	87.1%	91.3%	89.4%	>95%	

Trust Scorecard - Effective (1)

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	21/22	Standard	Threshold
Maternity																		
% of women on a Continuity of Carer pathway	0.60%	0.00%	0.00%		10.40%	9.70%	9.70%	10.80%	10.90%	11.80%	10.30%	9.60%	10.20%	14.70%	9.70%	10.70%	No target	
% C-section rate (planned and emergency)	29.44%	26.79%	31.67%	30.43%	28.88%	33.96%	29.04%	32.02%	30.42%	31.59%	31.63%	32.44%	33.19%	31.45%	31.87%	31.36%	No target	
% emergency C-section rate	15.56%	12.24%	17.71%	16.30%	17.72%	16.77%	15.58%	17.98%	16.76%	17.76%	17.05%	15.61%	17.77%	15.72%	16.84%	16.84%	No target	
% of women booked by 12 weeks gestation	92.8%	93.1%	93.6%	93.2%	91.9%	91.2%	91.9%	91.3%	88.8%	91.0%	91.7%	92.5%	91.1%	89.8%	91.7%	91.3%	>90%	
% of women that have an induced labour	31.42%	30.72%	30.63%	28.05%	27.92%	26.40%	25.90%	28.49%	25.41%	25.00%	25.66%	24.95%	29.42%	33.09%	25.21%	27.15%	<=33%	>30%
% stillbirths as percentage of all pregnancies	0.39%	0.23%	0.62%	0.00%	0.22%	0.42%	0.19%	0.00%	0.00%	0.19%	0.00%	0.00%	0.43%	0.00%	0.06%	0.13%	<0.52%	
% of women smoking at delivery	10.90%	9.24%	10.21%	9.42%	8.23%	9.56%	10.48%	8.19%	10.16%	10.07%	8.80%	11.86%	12.58%	10.78%	10.20%	9.98%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	60.2%	56.7%	54.0%	48.7%	49.0%	51.1%	48.4%	53.9%	48.0%	50.3%	48.1%	47.1%	46.0%	49.1%	49.8%		
% breastfeeding (initiation)	79.9%	83.1%	82.4%	81.0%	75.9%	78.4%	78.5%	79.8%	80.8%	81.1%	79.5%	76.3%	78.8%	76.8%	79.1%	78.9%	>=81%	
% PPH >1.5 litres	4.4%	2.5%	5.2%	5.9%	5.0%	4.2%	5.2%	6.7%	4.9%	4.5%	3.4%	4.9%	3.6%	2.2%	4.3%	4.7%	<=4%	
Number of births less than 27 weeks	19	1	3	2	0	2	0	0	1	2	2	0	1	0	4	10		
Number of births less than 34 weeks	104	7	10	7	15	13	8	11	18	13	9	10	7	4	32	114		
Number of births less than 37 weeks	379	27	29	28	44	34	41	33	47	49	32	44	33	19	125	403		
Number of maternal deaths	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total births	5,570	437	483	463	468	486	526	544	558	546	537	497	471	413	1,580	5,509		
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%	1.9%	2.4%	3.2%	1.7%	1.6%	1.8%		

Trust Scorecard - Effective (2)

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	21/22	Standard	Threshold
Mortality																		
Summary hospital mortality indicator (SHMI) - national data	1.0	1.0	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	108.4	105.2	103.2	104.2	106.2	108.4	108.6	108.3	108.8	106.9					106.9	Dr Foster	
Hospital standardised mortality ratio (HSMR) - weekend	111.7	113.6	107.1	104.6	107.1	109.2	113.4	113.8	113.8	115.6	113.8					113.8	Dr Foster	
Number of inpatient deaths	288	159	129	145	154	146	182	156	163	183	191	189	217	183	563	1,909	No target	
Number of deaths of patients with a learning disability	19	1	0	2	4	0	4	2	2	2	4	1	3	1	7	21	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	7.98%	8.10%	7.90%	7.94%	7.84%	7.78%	8.40%	8.29%	7.80%	7.07%	7.25%	6.87%	7.57%		7.07%	7.71%	<8.25%	>8.75%
Research																		
Research accruals	4,152	110	220	575	240	328	183	192	456	426	236	172	183	151		1,354	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	52.5%	62.5%	54.4%	53.5%	48.9%				47.5%	51.9%	50.0%	45.8%	72.7%	70.0%	48.4%	72.7%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	86.0%	88.4%	90.2%	83.1%	89.3%	91.8%	82.7%	91.8%	84.9%	66.7%	72.7%	75.4%	46.3%			88.2%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	30.70%	38.80%	49.20%	37.00%	44.10%				12.70%	15.10%	16.70%	8.70%	9.10%	75.00%	12.30%	9.10%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	52.30%	74.60%	60.70%	63.20%	67.90%				44.60%	48.80%	40.50%	39.60%	54.50%	75.00%	38.40%	54.50%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	62.9%	61.5%	64.1%	84.4%	52.5%	66.3%	68.2%	60.7%	56.1%	43.5%	50.8%	47.9%	59.4%	43.4%	47.5%	58.0%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	62.93%	61.54%	64.06%	84.44%	52.54%	66.27%	68.18%	59.02%	56.10%	43.55%	50.77%	47.95%	57.97%	41.50%	47.50%	56.30%	>=65%	<55%

Trust Scorecard - Caring (1)

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	89.4%	89.6%	88.3%	90.2%	89.7%	87.0%	85.4%	86.4%	85.0%	88.0%	87.8%	89.1%	87.1%	86.9%	86.5%	>=90%	<86%
ED % positive	81.4%	83.9%	77.5%	76.3%	73.6%	74.8%	62.7%	70.5%	60.9%	66.7%	68.0%	78.8%	78.6%	67.6%	70.9%	67.5%	>=84%	<81%
Maternity % positive	92.9%	92.9%	92.6%	96.2%	93.0%	89.2%	92.9%	84.8%	87.7%	82.4%	89.7%	84.3%	94.1%	91.9%	85.6%	86.3%	>=97%	<94%
Outpatients % positive	94.0%	94.7%	94.5%	94.4%	93.6%	94.3%	93.1%	93.7%	93.2%	93.3%	93.9%	94.7%	94.3%	93.4%	94.1%	93.8%	>=94.5%	<93%
Total % positive	90.7%	92.9%	92.1%	91.5%	91.1%	91.2%	90.7%	88.5%	86.2%	85.4%	89.4%	91.2%	91.0%	88.6%	89.2%	88.1%	>=93%	<91%
Number of PALS concerns logged	2,394	204	262	256	275	191	241	238	264	274	248	230	266	248	754	1,465	No Target	
% of PALS concerns closed in 5 days	79%	86%	83%	82%	85%	90%	85%	82%	76%	65%	78%	71%	65%	73%	73%	83%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	0	1	0	0	0	0	1	0	0	0	0	0	0	0	1	<=10	>=20

Trust Scorecard - Responsive (1)

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	21/22	Standard	Threshold
Cancer																		
Cancer - 28 day FDS (all routes)				79.1%	77.7%	77.3%	79.9%	78.9%	78.3%	83.1%	78.9%	80.8%	77.6%	86.1%	80.9%	79.7%	>=75%	
Cancer - urgent referrals seen in under 2 weeks from GP	97.1%	97.0%	97.1%	94.8%	95.4%	92.8%	91.9%	93.5%	92.0%	93.4%	92.1%	92.3%	87.2%	94.6%	92.6%	92.7%	>=93%	<90%
Cancer - 2 week wait breast symptomatic referrals	97.5%	97.0%	98.3%	93.6%	96.5%	90.7%	96.6%	93.2%	90.8%	89.8%	88.6%	84.9%	89.7%	93.9%	87.7%	91.2%	>=93%	<90%
Cancer - 31 day diagnosis to treatment (first treatments)	99.1%	99.2%	99.0%	96.6%	98.3%	98.5%	98.3%	97.1%	95.9%	97.9%	96.3%	95.6%	94.2%	98.4%	96.6%	97.0%	>=96%	<94%
Cancer - 31 day diagnosis to treatment (subsequent – drug)	99.7%	99.4%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	99.4%	100.0%	99.8%	>=98%	<96%
Cancer - 31 day diagnosis to treatment (subsequent – surgery)	97.4%	97.2%	97.6%	90.0%	95.6%	95.8%	94.0%	92.6%	88.1%	91.0%	95.1%	94.4%	88.2%	92.4%	93.5%	92.3%	>=94%	<92%
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	99.2%	100.0%	98.6%	98.1%	97.7%	100.0%	97.5%	98.5%	99.4%	100.0%	97.9%	100.0%	99.4%	100.0%	99.5%	99.1%	>=94%	<92%
Cancer - 62 day referral to treatment (urgent GP referral)	82.7%	82.0%	83.4%	82.0%	76.3%	80.3%	77.6%	72.1%	71.0%	69.0%	70.9%	61.9%	65.8%	64.6%	67.2%	72.3%	>=85%	<80%
Cancer - 62 day referral to treatment (screenings)	86.8%	87.0%	86.7%	85.3%	90.6%	95.7%	92.0%	82.9%	90.8%	76.5%	81.8%	91.5%	85.5%	79.3%	78.9%	85.9%	>=90%	<85%
Cancer - 62 day referral to treatment (upgrades)	80.5%	93.3%	76.7%	90.8%	65.4%	70.6%	82.1%	63.6%	72.1%	87.1%	70.6%	73.1%	75.0%	79.3%	73.1%	75.2%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	0	0	2	1	2	3	4	9	10	4	3	2	2	17	42	Zero	
Number of patients waiting over 104 days without a TCI date	269	14	12	14	10	11	9	12	18	21	23	25	14	22	69	179	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.60%	18.27%	<=1%	>2%
The number of planned/surveillance endoscopy patients waiting at month end	1,969	1,946	1,919	1,773	1,680	1,527	1,482	1,439	1,435	1,397	1,410	1,422	1,334	1,269	1,410	1,470	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	59.0%	59.3%	58.8%	61.1%	61.4%	62.2%	62.3%	61.1%	61.7%	60.5%	61.4%	58.5%	58.7%		60.2%	61.0%	>=88%	<75%

Trust Scorecard - Responsive (2)

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department - under 4 hours (type 1)	69.74%	69.44%	69.97%	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	58.61%	62.37%	63.16%	>=95%	<90%
ED: % total time in department - under 4 hours (types 1 & 3)	79.49%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%	69.25%	72.87%	73.81%	>=95%	<90%
ED: % total time in department - under 4 hours CGH	99.77%	100.00%	99.62%	99.73%	99.68%	94.75%	84.95%	88.74%	77.05%	83.00%	79.80%	79.03%	79.17%	73.54%	80.72%	84.27%	>=95%	<90%
ED: % total time in department - under 4 hours GRH	69.74%	69.44%	69.97%	64.75%	61.44%	63.34%	53.00%	57.55%	51.82%	52.48%	54.91%	53.96%	55.55%	51.42%	53.74%	56.71%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	168	21	1	0	0	1	10	1	15	53	448	631	653	394	1,132	1,853	Zero	
ED: % of time to initial assessment - under 15 minutes	53.2%	62.4%	46.3%	40.9%	47.3%	43.1%	7.1%	0.0%	22.3%	30.3%	30.3%	37.4%	35.5%	30.0%	32.4%	29.2%	>=95%	<92%
ED: % of time to start of treatment - under 60 minutes	34.0%	44.2%	26.4%	17.5%	15.1%	14.4%	1.9%	100.0%	14.8%	19.1%	24.9%	30.3%	29.5%	24.1%	24.4%	17.1%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	5.00%	8.06%	9.82%	8.61%	6.66%	6.73%	11.91%	9.48%	13.85%	14.55%	14.21%	13.90%	15.56%	13.25%	14.23%	11.50%	<=2.96%	
% of ambulance handovers that are over 60 minutes	3.67%	6.74%	10.36%	6.45%	2.16%	3.11%	12.86%	7.88%	19.16%	20.92%	32.67%	29.68%	32.62%	43.90%	27.53%	17.86%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	76.50%	92.30%	92.00%	87.80%	87.50%	80.95%	89.06%	80.60%	73.75%	74.03%	80.23%	71.60%	93.48%	76.13%	81.58%	>=95%	
Urgent cancelled operations	66	3	3	0	1	13	12	10	1	44	24	1	1	0	69	107	No target	
Number of patients stable for discharge	123	136	110	113	114	123	161	159	180	180	220	213	239	252	204	178	<=70	
Number of stranded patients with a length of stay of greater than 7 days	384	383	384	359	334	416	367	421	472	468	503	499	492	538	490	443	<=380	
Average length of stay (spell)	5.37	5.55	5.23	4.68	4.78	5.14	4.98	4.84	5.32	5.47	6.01	6.02	6.08	6.59	5.82	5.39	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.73	5.92	5.56	5.18	5.25	5.7	5.57	5.39	5.99	6.22	6.97	7	6.72	7.83	6.71	6.08	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.76	2.61	2.88	2.31	2.57	2.64	2.43	2.31	2.25	2.48	2.16	2.46	2.42	2.06	2.37	2.37	<=3.4	>4.5
% day cases of all electives	87.92%	88.01%	87.86%	83.13%	84.02%	83.37%	82.33%	82.72%	82.28%	80.22%	82.56%	79.74%	85.99%	83.15%	80.90%	82.68%	>80%	<70%
Intra-session theatre utilisation rate	87.23%	85.64%	88.24%	90.17%	90.48%	88.03%	89.60%	89.32%	84.99%	87.67%	85.45%	82.84%	85.93%	84.99%	85.40%	87.33%	>85%	<70%

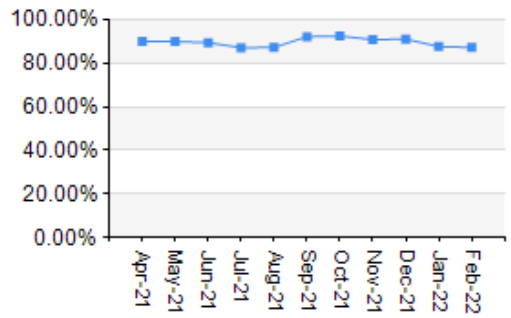
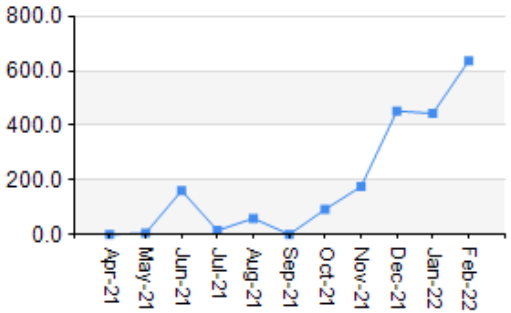
Trust Scorecard - Responsive (3)

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.15	2.23	2.09	2.06	2.02	2.04	2.1	2.13	2	1.93	1.94	1.95	1.94	1.86	1.94	1.99	<=1.9	
Did not attend (DNA) rates	5.74%	5.80%	5.69%	5.89%	6.02%	6.72%	7.05%	7.24%	7.15%	7.20%	7.05%	7.27%	7.67%	7.09%	7.16%	6.94%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.59%	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.45%	71.45%	72.33%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,337	6,415	6,474	6,541	6,426	6,159	5,713	5,582	5,642	5,593	5,642	5,847	5,272	5,187	5,694	5,782	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,881	4,306	3,747	3,572	3,657	3,320	2,854	2,906	2,946	2,935	2,641	2,605	2,292	2,184	2,727	2,901	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,416	2,640	3,061	2,657	2,263	2,016	1,724	1,554	1,598	1,590	1,492	1,430	1,273	1,120	1,504	1,702	Zero	
Referral to treatment ongoing pathway over 70 Weeks (number)	127	304	459	608	667	745	806	611	403	295	228	205	207	190	243	451	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	100.0%	100.0%	100.0%														>=99%	
Percentage of records submitted nationally with valid NHS number	99.9%	99.9%	99.9%														>=99%	

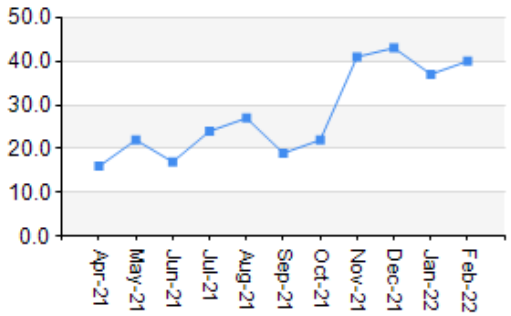
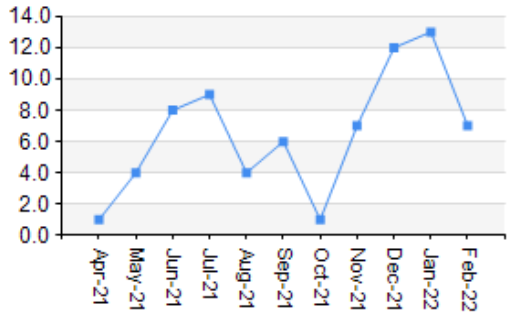
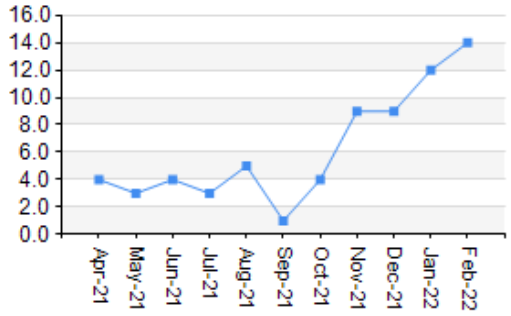
Trust Scorecard - Well Led (1)

	20/21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	21/22 Q3	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	80.0%	83.0%	85.0%	85.0%	84.0%	80.0%	79.0%	78.0%	78.0%	79.0%	80.0%	80.0%	78.0%	80.0%		>=90%	<70%
Trust total % mandatory training compliance	90%	92%	90%	91%	90%	91%	90%	90%	88%	87%	87%	87%	87%	87%	87%		>=90%	<70%
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	94.82%	95.00%	93.10%	98.29%	96.75%	91.64%	96.56%	97.22%	99.61%	97.11%	95.93%	89.16%	85.93%		93.74%	94.41%	>=75%	<70%
% registered nurse day	93.97%	93.14%	90.71%	96.38%	96.05%	90.72%	94.84%	95.11%	98.11%	95.49%	94.07%	87.59%	84.20%		92.07%	92.88%	>=90%	<80%
% unregistered care staff day	104.90%	95.53%	101.28%	106.08%	104.33%	95.67%	100.44%	98.32%	96.58%	95.82%	95.07%	84.77%	83.85%		91.37%	95.72%	>=90%	<80%
% registered nurse night	96.36%	98.22%	97.31%	101.83%	97.99%	93.27%	99.57%	101.09%	102.46%	100.10%	99.31%	91.99%	89.02%		96.78%	97.18%	>=90%	<80%
% unregistered care staff night	113.19%	113.17%	108.91%	111.13%	113.00%	103.77%	109.58%	111.39%	111.67%	105.90%	103.45%	94.98%	95.26%		101.01%	105.58%	>=90%	<80%
Care hours per patient day RN	6	6.2	5.8	5.2	5.5	5.3	5.3	4.7	4.6	5	5.2	5.1	5		5.1	5.1	>=5	
Care hours per patient day HCA	3.8	3.9	3.7	3.7	3.5	3.5	3.5	3.3	3.5	3.2	3.1	3.1	3.1		3.1	3.3	>=3	
Care hours per patient day total	9.8	10.1	9.5	8.9	9	8.7	8.8	8	8.1	8.1	8.3	8.1	8.1		8.2	8.4	>=8	
Vacancy and WTE																		
% total vacancy rate		4.36%	4.75%	4.30%	7.12%		7.00%	7.50%	6.82%	6.39%	7.37%	8.09%	11.16%	10.68%			<=11.5%	>13%
% vacancy rate for doctors		1.83%	0.73%	1.38%	4.15%		9.40%	7.80%	7.41%	6.74%	7.45%	7.05%	8.88%	8.35%			<=5%	>5.5%
% vacancy rate for registered nurses		5.08%	7.92%	7.24%	6.60%		8.50%	9.40%	7.89%	7.87%	8.17%	8.64%	14.46%	14.29%			<=5%	>5.5%
Staff in post FTE		6666.58	6653.99	6678.31	6672.09	6672.85	6680.26	6685.55	6730.66	6718.8	6686.83	6627.94	6648.33	6678.52			No target	
Vacancy FTE		286.96	330.61	298.88	510		505.63	537.29	491.56	457.02	530.17	582.02	834.81	799.75			No target	
Starters FTE		48.84	67.2	86.69	50.85	56.53	36.05	36.53	79.76	42.43	59.94	70.65	77.03	69.31			No target	
Leavers FTE		34.82	45.79	36	57.02	62.03	52.16	78.84	68.51	89.94	66.53	81.1	88.76	47.74			No target	
Workforce Expenditure and Efficiency																		
% turnover		9.5%	9.2%	9.2%	9.5%	10.0%	10.2%	10.7%	11.1%	11.7%	11.7%	12.3%	12.9%	11.8%			<=12.6%	>15%
% turnover rate for nursing		9.83%	9.86%	8.88%	8.96%	9.18%	9.80%	9.77%	9.72%	9.70%	10.52%	10.83%	10.99%	10.69%			<=12.6%	>15%
% sickness rate		3.7%	3.6%	3.7%	3.7%	3.6%	3.6%	3.8%	3.9%	3.8%	3.8%	3.8%	3.9%	4.0%			<=4.05%	>4.5%

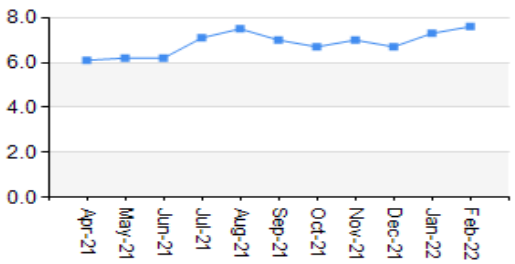
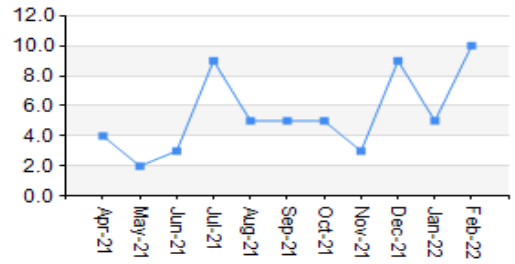
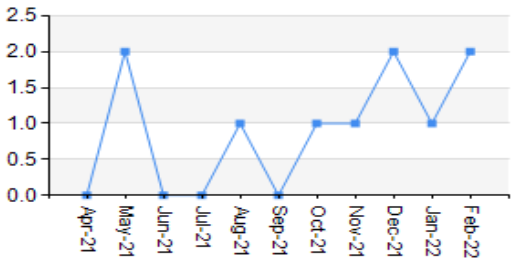
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		The release of the electronic prescribing software is not imminent and will provide more accurate data as previously reported. The VTE committee continue to oversee VTE care	**Quality Improvement & Safety Director**
Number of bed days lost due to infection control outbreaks **Standard: <10**		During February we had 637 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. Outbreak meetings continue to ensure review of all closed areas and weekend working for onsite IPC Nurses continues. The management of red/ COVID patients was discussed in a extraordinary meeting given the significant number of ward closed due to COVID outbreaks and the decision was made to keep COVID positive patients in single rooms on closed areas, COVID exposed patients were moved to be combined in a closed bay or single closed ward and wards were re-opened to green patients before the 10 day period (after movement of COVID positive patients off the ward and cohorting of amber patients in single bays). Patients who are red recovered (completed isolation after testing positive for COVID) are also moved to closed empty beds to minimise empty closed bed numbers. NHSE/I, system partners, UK HSA were approached to inform them of the outbreak situation and get access to further support to prevent further outbreaks.	**Associate Chief Nurse, Director of Infection Prevention & Control**

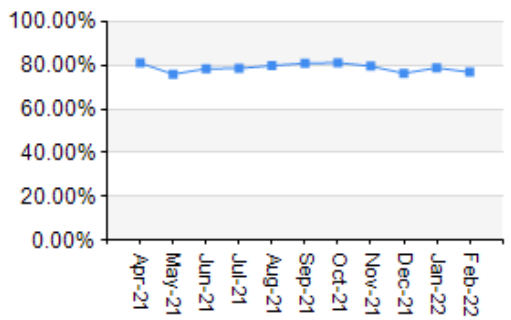
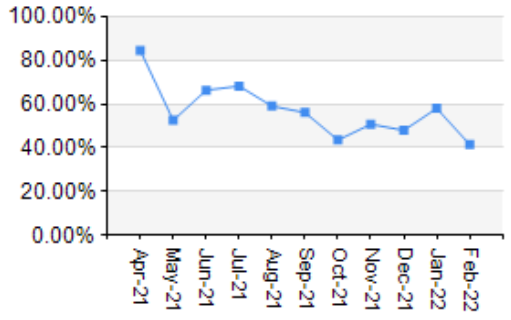
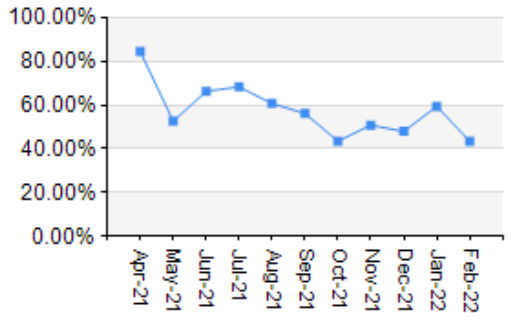
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of category 2 pressure ulcers acquired as in-patient **Standard: <=30**		Patients develop skin and soft tissue damage for multiple reasons in hospital settings. We have seen an increase during the winter period in the development of Category 2, deep tissue injuries and unstageable pressure ulcers across different wards in both hospitals. Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioing. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now accelerated to monthly to increase throughput.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**			
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**			

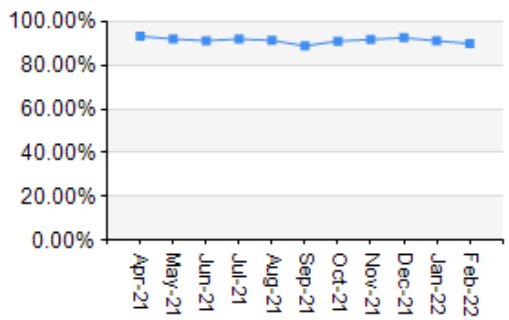
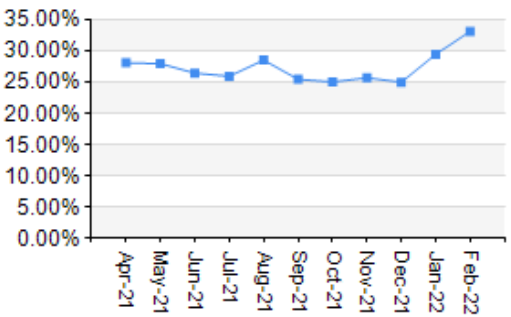
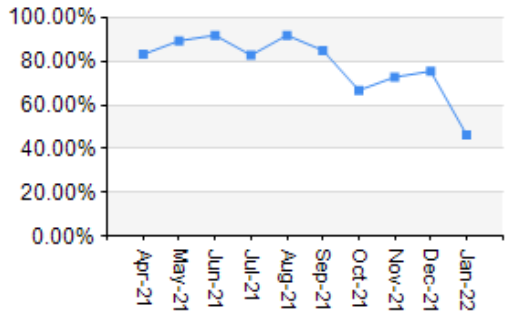
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls per 1,000 bed days **Standard: <=6**		February 2022 saw a rate of 7.6 falls per 1,000 bed days. This is higher than previous months. When comparing to organisations across the South West that share falls data (currently only 4 Trusts) the Trust is performing better with the average falls rate of the other 3 trusts being 9.82 with each organisation also seeing an increase. The number of falls in hospital are linked to a range of factors, most acutely to safe staffing levels. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing and prolonged length of stay which is associated with an increased number of ward moves.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		February 2022 saw a high number of falls resulting in harm, such as fractures and head injuries. There were 10 occurences. Every falls resulting in moderate harm or worse is reviewed in the weekly Preventing Harm Hub where immediate safety actions and learning are rapidly assessed. Two patients subsequently died and were referred for Serious Incident Investigations. The number of falls in hospital are linked to a range of factors, most acutely to safe staffing levels. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing and prolonged length of stay which is associated with an increased number of ward moves.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of never events reported **Standard: Zero**		The incidents will be investigated using a barrier assessment approach. Information is routinely shared the CQC on progress. Immediate safety actions have been identified. To note this is the 10th Never event in the financial year and places the Trust at the top of the NE list nationally.	**Quality Improvement & Safety Director**

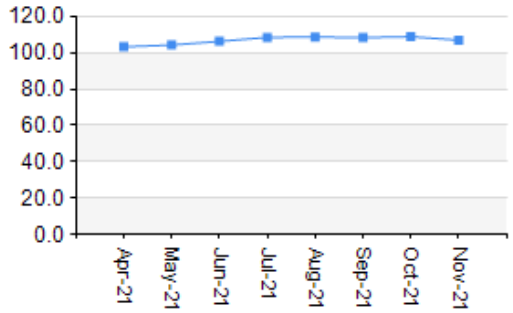
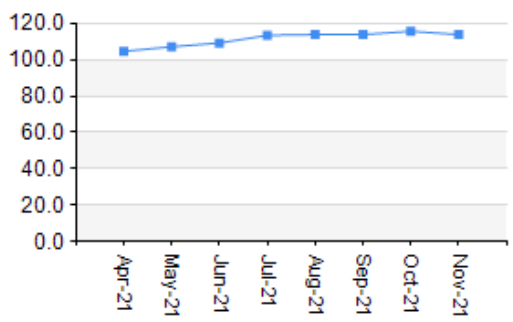
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		Some of this decision is a personal choice element. Due to COVID antenatal classes, where feeding is discussed, is still not face to face, so this is a potential factor. Staff training has now been suspended as a result of COVID, this also includes the multi-professional training between health visitors and midwives. Covid related sickness absence within the team that deliver ongoing breast feeding support has also had an impact.	**Divisional Director of Quality and Nursing and Chief Midwife**
% fractured neck of femur patients meeting best practice criteria **Standard: >=65%**		•55% got to theatre within 36 hrs •45% failed to get to surgery within 36 hours (of which 80% were delayed because of logistical reasons)	**General Manager – Trauma & Orthopaedics**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		We continue to have medical outliers on our wards so patients that require T&O input are outliers on different wards around the hospital. We have ringfenced beds on Mayhill to ensure all daycase procedures are sent through to the right wards which in turn reduces the impact on inpatient capacity.	**General Manager – Trauma & Orthopaedics**

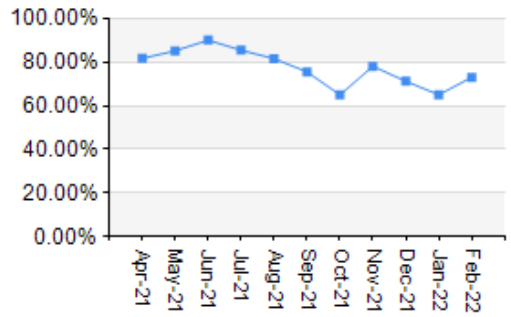
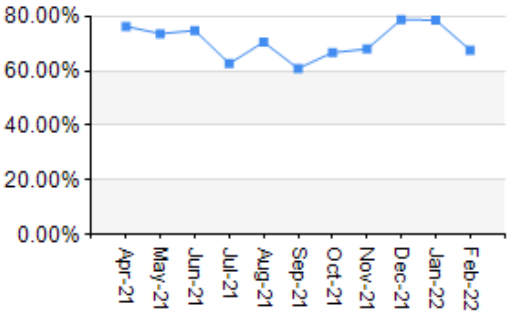
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of women booked by 12 weeks gestation **Standard: >90%**		This is likely due to a combination of a higher number of bookings in February, coupled with staff sickness/Covid within the community team and a higher than usual number of women presenting late. It is also possible that there is an element of late data entry impacting on this metric. There is a data field available on the maternity system for the midwife to record the reason for late booking, but unfortunately this data field is not available in the current data tables. It will, however, be available from the new data warehouse, which is due to go live in April 2022.	**Divisional Director of Quality and Nursing and Chief Midwife**
% of women that have an induced labour **Standard: <=33%**		The Obstetricians have reviewed rupture of membranes and are ensuring they are giving maternal choice for induction of labour if required.	**Divisional Director of Quality and Nursing and Chief Midwife**
Stroke care: percentage of patients spending 90%+ time on stroke unit **Standard: >=85%**		There has been a reduction from previous month and still well below target. Primarily, patients are delayed due to difficulty in maintain a ring fenced bed due to pressures in ED and the availability of HASU beds caused by issues with flow throughout the hospitals. The closure of HASU due to a COVID outbreak has also impacted performance. Other barriers include delays due to an unclear diagnosis leading to further tests before admission and delay in assessment as the Stroke team were not informed by ED.	**General Manager for COTE, Neuro and Stroke**

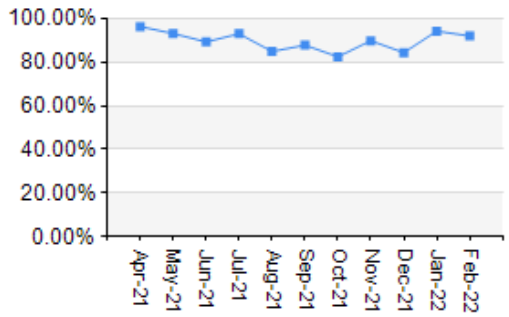
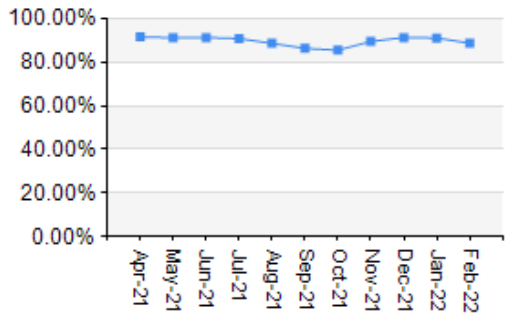
Exception Reports - Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**		Slight improvement month on month. If COVID activity is removed then both metrics are in the expected range suggesting the modelling has not accounted for this yet. Monitored at HMG previously Dr Foster (now Telstra) has suggested the modelling will slowly improve and adjust to take account the effects of COVID but we are not seeing this, they are going to look at it further and report back to HMG.	**Deputy Medical Director**
Hospital standardised mortality ratio (HSMR) - weekend **Standard: Dr Foster**		Slight improvement month on month. If COVID activity is removed then both metrics are in the expected range suggesting the modelling has not accounted for this yet. Monitored at HMG previously Dr Foster (now Telstra) has suggested the modelling will slowly improve and adjust to take account the effects of COVID but we are not seeing this, they are going to look at it further and report back to HMG.	**Deputy Medical Director**

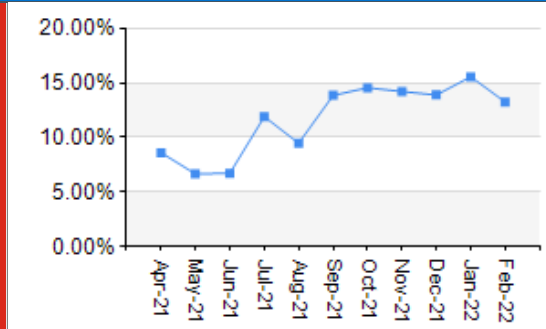
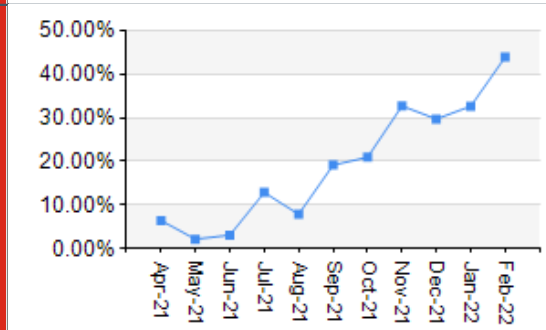
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		The number of cases closed by PALS is currently at 73%. The team have gone from managing 250 cases per month in 2019/20 to 660 cases per month, and continue to only refer 1.4% of their cases on to the complaints team. They are managing a huge increase in volume and also complexity of cases. There is additional triage support within the team from March to free up capacity within the advisors, and an additional advisor has been recruited who will start in April. A review of the service is being undertaken to see how additional support can be brought in for the team	**Head of Quality**
ED % positive **Standard: >=84%**		The ED FFT positive score has decreased this month to 67.6% overall. The comments largely focus on long wait times due to the operational pressures facing the service. The team continue to work on a number of patient experience improvement initiatives, and receive the FFT scores weekly to mitigate any areas of concern arising. Actions having included introducing blanket trolleys, the ED volunteers and the Patient Experience Lead for the area who is focussed on improving communication. Updates are provided on progress monthly at QDG.	**Head of Quality**

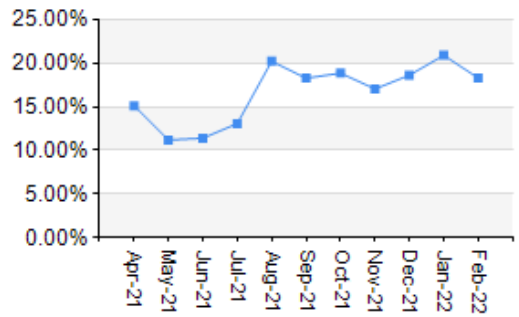
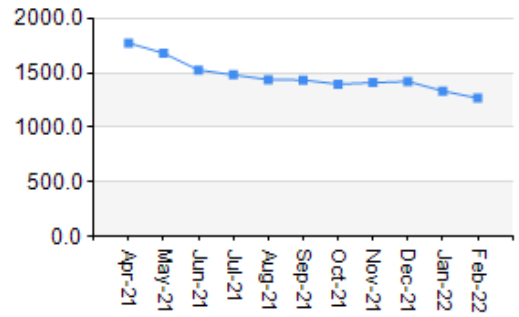
Exception Reports - Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Maternity % positive **Standard: >=97%**		Maternity FFT has remained fairly stable at 91.9%. Further work is ongoing with the Maternity Voices Partnership to look at how we can increase the amount of feedback we receive, and triangulate results with FFT and National survey feedback to inform improvement plans. The Patient Experience workstream in the division is being reviewed, and updates on progress provided at QDG	**Head of Quality**
Total % positive **Standard: >=93%**		Our overall Trust FFT positive score has decreased to 88.6%, with a decrease across inpatient and urgent care survey scores in particular. This is largely due to operational pressures, with a large increase in the comments focussing on wait times. In addition to wait times, there has been an increase in negative comments related to pain, emotional and physical support, hygiene and facilities. The divisions have been asked to review their local comments and improvement plans and provide updates to QDG, and the Patient Experience team will do a deeper dive analysis of the pain comments as this has emerged in particular as a concern.	**Head of Quality**

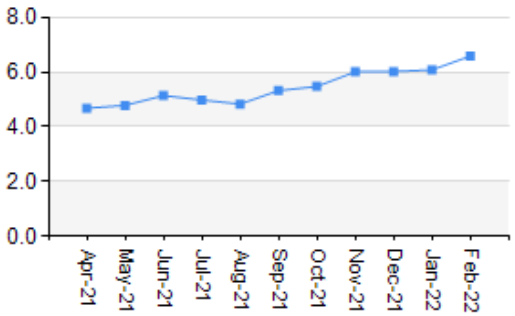
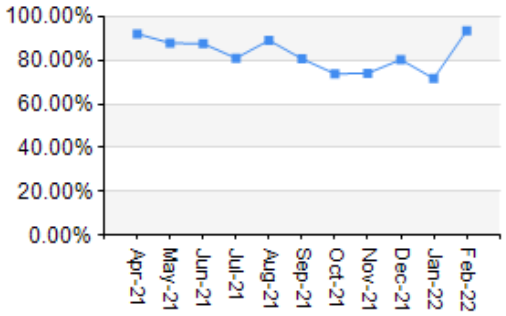
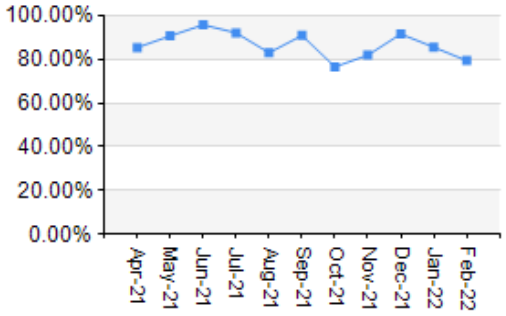
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		As a result of poor flow, there were 1,423 ambulance handover delays >30 minutes in February, an average of 51 breaches per day. Teams in ED have continued to assess patients for alternate pathways on arrival and enact "review & return" to mitigate safety risks and minimise delays.	**General Manager of Unscheduled Care**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		As a result of poor flow, there were a total of 1,093 ambulance handover delays >60 minutes in February, an increase of 5 breaches per day compared to January. Teams in ED have continued to assess patients for alternate pathways on arrival and enact "review & return" to mitigate safety risks and minimise delays.	**General Manager of Unscheduled Care**

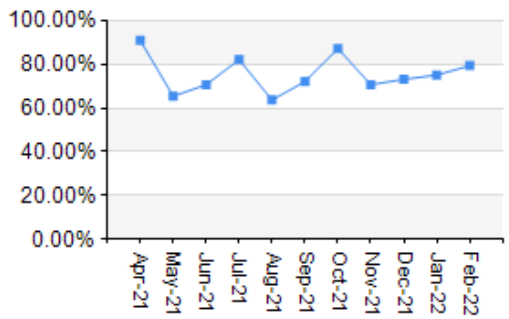
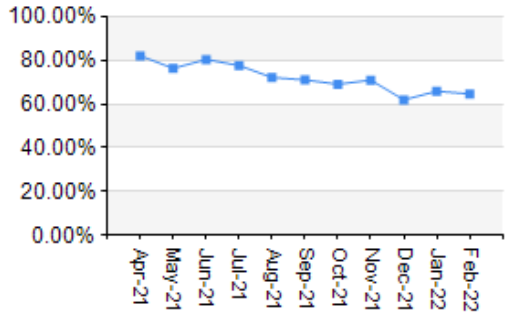
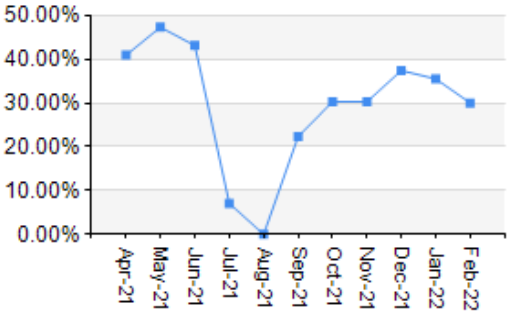
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		An improvement has been seen in month, moving from 20.8% last month to a validated position of 18.27% this month. The total number of patients waiting has increased for successive months from 7,373 to 7,795. The overall number of breaches has decreased by 115 which is attributable to Echos, having decreased from 1,478 last month to 1,393. If Echo's were to be excluded, performance for all other modalities would be 0.56% with just 31 breaches against 5,490 patients waiting.	**Associate Director of Elective Care**
The number of planned/surveillance endoscopy patients waiting at month end **Standard: <=600**		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	**Deputy General Manager of Endoscopy**

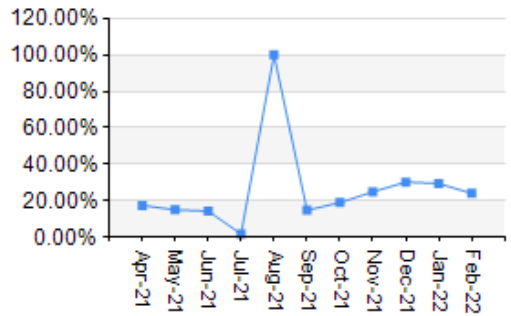
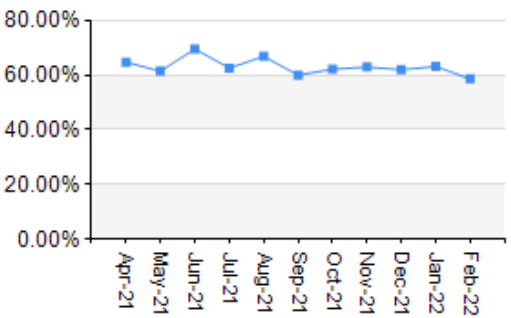
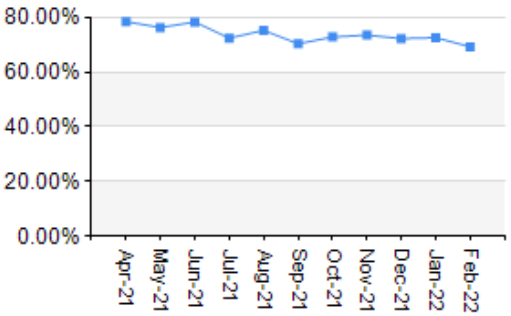
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Average length of stay (spell) **Standard: <=5.06**		Average LOS increased from 6.08 to 6.59, bringing the average to 5.39 during 21/22 vs a target of 5.08. There are provision difficulties within the local residential, nursing and domiciliary care provision sector. The trust are working on the provision pathway teams including challenger clinicians in order to discharge patients earlier and thus meet target. The trust expect that this position will ease when issues in the local care sector are resolved. In the interim, the trust have committed to working innovatively with commissioners, including the use of out of area placements where appropriate.	**Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In January there were just 3 patients cancelled on the day that could not be rescheduled within 28 days. The reasons were, covid sickness, bed capacity, and incorrectly listed – requiring a specialist list.	**Associate Director of Elective Care**
Cancer - 62 day referral to treatment (screenings) **Standard: >=90%**		62 day screening performance (unvalidated) Standard = 90% National = 65% GHFT = 79.3% Treated= 29, Breaches=6	**General Manager - Cancer**

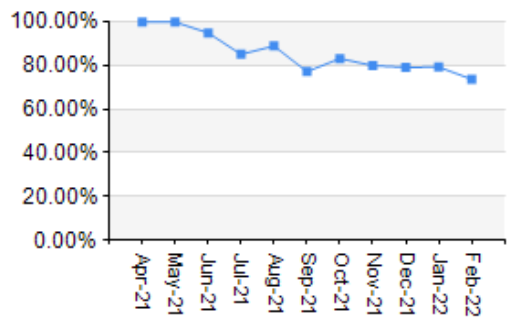
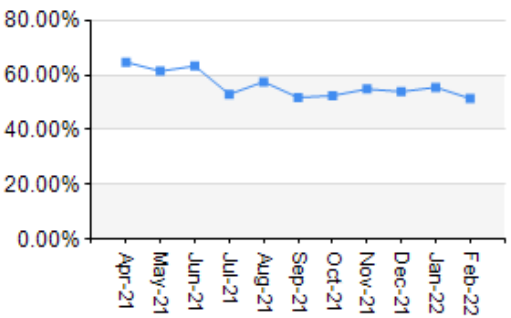
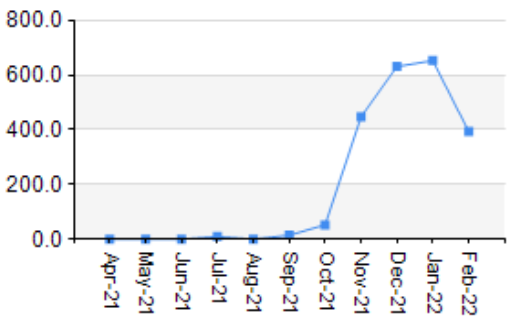
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer - 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated) Standard = N/A National = 76% GHFT = 80.8% Treated= 26, Breaches=5	**General Manager - Cancer**
Cancer - 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) Standard = 85% National = 61% GHFT = 65.5% Treatments = 141.5; Breaches = 49.5; LGI = 12, Urology = 9.5, Gynae = 9, H&N = 3 Reasons for breaches - Prostate pathway and delay to LATP biopsy - Delay to pathology biopsies and radiology reporting - Complex patient pathways - Elective capacity	**General Manager - Cancer**
ED: % of time to initial assessment - under 15 minutes **Standard: >=95%**		The pressure and congestion in ED, resulting from the lack of flow, continues to impact on ambulance offloads, with 15 minute triage performance for ambulance arrivals dropping to 28.8% in February. The ED teams continue to adapt practice, including frequent use of "Review & Return" for patients waiting on ambulances, in order to mitigate risk and progress care pathways. Triage performance for walk-ins dipped to 30.4%, largely owing to stretched nursing rotas and challenges with physical space. The enhanced triage PDSA continues when staffing allows.	**General Manager of Unscheduled Care**

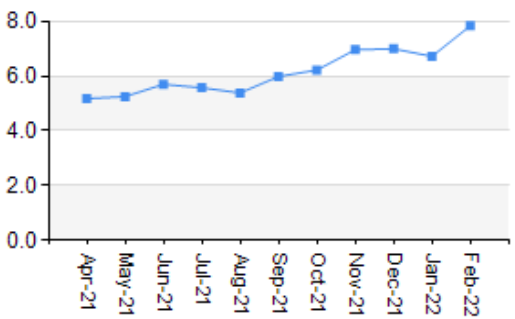
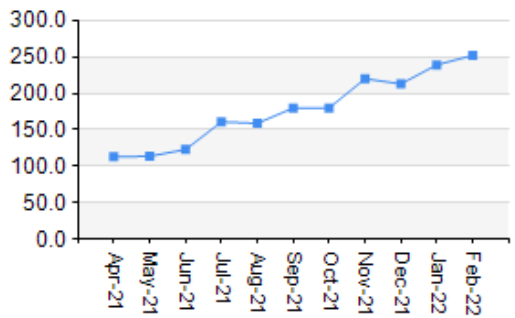
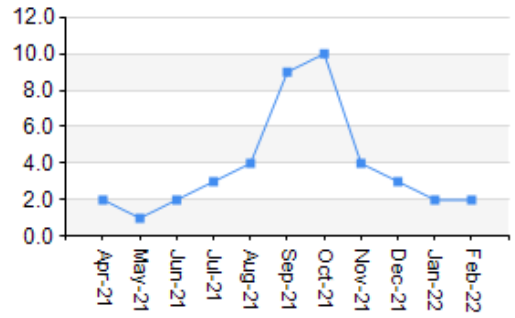
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to start of treatment - under 60 minutes **Standard: >=90%**		Wait to be seen by a clinician in February was, on average, 2 hours and 22 minutes, in part due to sickness absence (Covid). This continues to dip overnight when the department is still crowded and there is typically only one senior decision maker on shift.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (type 1) **Standard: >=95%**		ED 4 hour performance for February averaged 58.74%. This is largely a result of stretched clinical rotas and a congested ED, due to poor flow through and out of the hospital.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (types 1 & 3) **Standard: >=95%**		Average total time in ED for all patients increased by 31% to 6.4 hours. This is skewed by the large numbers of patients waiting in ED for admission, as admitted patients spent an average of 19 hours in ED in February.	**General Manager of Unscheduled Care**

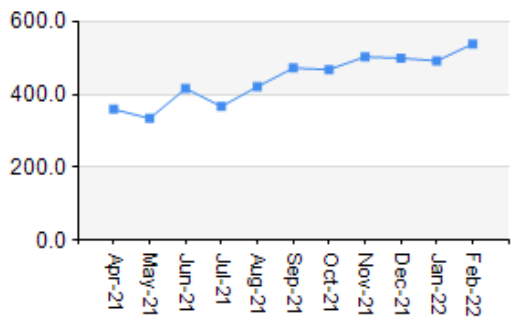
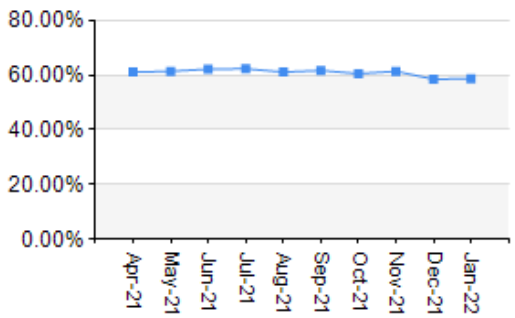
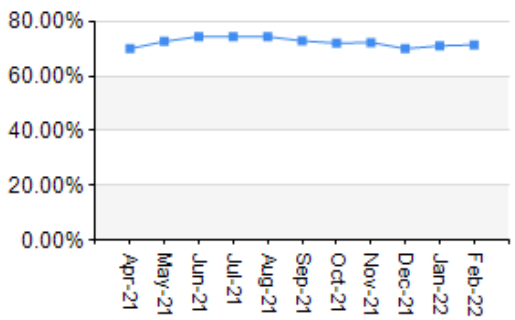
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department - under 4 hours CGH **Standard: >=95%**		ED 4 hour performance for February averaged 58.74%. This is largely a result of stretched clinical rotas and a congested ED, due to poor flow through and out of the hospital.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours GRH **Standard: >=95%**		ED 4 hour performance for February averaged 58.74%. This is largely a result of stretched clinical rotas and a congested ED, due to poor flow through and out of the hospital.	**General Manager of Unscheduled Care**
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		Average total time from DTA to admission in February increased by 34% to 14.6 hours. This is a result of poor flow out of the hospital, which has seen the number of patients who are MOFD rise to 265.	**General Manager of Unscheduled Care**

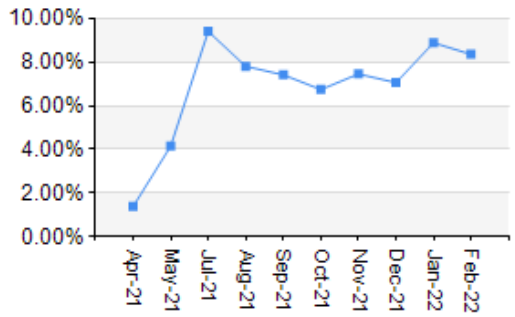
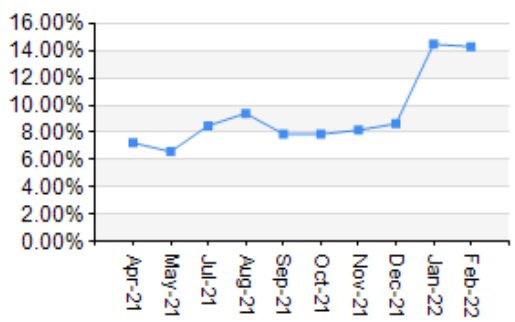
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		Length of stay for general and acute non-elective (occupied bed days) rose from 6.72 to 7.83. There are provision difficulties within the local residential, nursing and domiciliary care provision sector. The trust are working on the provision pathway teams including challenger clinicians in order to discharge patients earlier and thus meet target. The trust expect that this position will ease when issues in the local care sector are resolved.	**Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		Numbers continue to climb despite extensive work for internally and external to the trust. Ongoing challenges around COVID restrictions in care home and dom care carers main factor limiting discharge pathways.	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Number = 2 Upper GI 1 Breast 1	**General Manager - Cancer**

Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		The number of stranded patients with a lengths of seven days rose slightly, from 492 to 538. The 21/22 average stands at 443, which is a 16% variance from target. There are provision difficulties within the local residential, nursing and domiciliary care provision sector. The trust have a robust grip on the position, and have co-ordinated discharge efforts in order to help discharge these patients where possible. The trust have been working with local commissioners to formulate plans which include the provision of discharge budgets, use of Pathway teams targeting stranded patients, speciality inreach to ED and daily ward rounds. These plans are expected to progress at pace.	**Deputy Chief Operating Officer**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Performance remains static as described previously significant change unlikely till discharge summaries migrate to sunrise EPR, this can not be done till EPMA launched later this year.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. RTT performance has improved slightly in month with an anticipated month-end position around 71.7%. GHT remains one of the better performing Trusts within the South West. In addition, RTT performance nationally would appear to around 63% so GHT remains above. As evidenced below, in February, reductions were made in all cohorts of patients – 35, 45, 52 and 70 weeks. This is first time this year, with some of the lowest numbers achieved all year.	**Associate Director of Elective Care**

Exception Reports - Well Led (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors **Standard: <=5%**		Hard to fill medical vacancies continue to be closely managed through Divisions with a particular focus in the coming months on the recruitment of a cohort of overseas doctors to work across Medicine / Unscheduled Care. The workforce plans for 2022/23 will ensure proactive recruitment interventions are in place for both known and forecast vacancies, supported by alternative roles such as SAS Doctors, Physicians Associates and the potential of the new Medical Support Worker role.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses **Standard: <=5%**		The increase in establishment continues to reflect in the registered nurse vacancy position. The Trust's planned pipeline of international registered nurses remains on target in-year. Planning for ongoing overseas recruitment is underway for 2022/23, with plans also to enhance the numbers of newly qualified nurses taking up post in the Trust and also exploring the Return to Practice route.	**Director of Human Resources and Operational Development**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period February 2022

Presented at March 2022 Q&P and April 2022 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals NHS Foundation Trust

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

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

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

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

February continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 72.57% to 69.25% compared to the previous month. Ambulance handover delays increased for 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 February however performance improved on last month from 20.8% to 18.3% this month. The total number of patients waiting has increased from 7,373 to 7,795. The overall number of breaches has decreased by 115, if Echo's were to be excluded, performance for all other modalities would be 0.56% with just 31 breaches against 5,490 patients waiting.

For cancer, in January's submitted data, the Trust met 3 of the 9 CWT metrics and exceeded national performance in 9 out of 9 of the CWT metrics. A tough month across the board which is reflective of pressure services experienced across the Trust in urgent and planned care. 2ww performance and ongoing 62 day pathways significantly impacted by covid and patient/staff self-isolation in January. February is showing signs of improvement with the Trust currently meeting the main CWT standards (2ww, 28 day and 31 day new tx), however this is an unvalidated position. The 62 day cancer wait standard will not be achieved with an unvalidated position of 65%, although this will potentially rise as more skin treatments are added. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity.

For elective care, the RTT performance did not meet the standard at 71.8% (unvalidated) which is a slight improvement on last month. The total incompletes has improved again on last month with a further reduction made. With validation ongoing at the time of this report, the Trusts position is 57,203 with a further reductions anticipated prior to submission. The number of 52 week breaches has again been reduced despite the operational challenges with an validated figure of 1,115 breaches in month. This is the lowest figure since July 2020 and the most rapid rate of recovery in the South West region. Focus continues to be placed on patients over 78 weeks, which has again reduced in month, and specifically those patients at risk of breaching 104 weeks in this financial year. Currently the Trust has one P6 patient that has breached 104 weeks. This patient has been cancelled 4 times due to COVID, bed capacity and more recently consultant sickness. Given ongoing sickness this patient's care has now been transferred to another consultant and has a planned TCI of 19th March.

The Elective Care Hub continues to work with several specialties with the most recent having a similar number of requests to be removed from the waiting list, with around 8%. The number of patients escalated with new concerns has dropped considerably, to around 9%, from a previous position of between 18% and 21%. This is likely to be relevant to the type of specialties contacted. In addition the team have been supporting the validation of patients awaiting Echo's. Of the 600 patients contacted 10% asked to be removed and 5% raised new concerns.

Directors Operational Assurance Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer - 28 day FDS (all routes)	>=75%	Feb-22	86.1%
Cancer	Cancer - urgent referrals seen in under 2 weeks from GP	>=93%	Feb-22	94.6%
Cancer	Cancer - 2 week wait breast symptomatic referrals	>=93%	Feb-22	93.9%
Cancer	Cancer - 31 day diagnosis to treatment (first treatments)	>=96%	Feb-22	98.4%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – drug)	>=98%	Feb-22	99.4%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Feb-22	92.4%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Feb-22	100.0%
Cancer	Cancer - 62 day referral to treatment (urgent GP referral)	>=85%	Feb-22	64.6%
Cancer	Cancer - 62 day referral to treatment (screenings)	>=90%	Feb-22	79.3%
Cancer	Cancer - 62 day referral to treatment (upgrades)	>=90%	Feb-22	79.3%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Feb-22	2
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Feb-22	22
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Feb-22	18.27%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Feb-22	1,269
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Jan-22	58.70%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Feb-22	58.61%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Feb-22	69.25%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Feb-22	73.54%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Feb-22	51.42%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Feb-22	394
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Feb-22	30.0%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Feb-22	24.1%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Feb-22	13.25%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Feb-22	43.90%
Maternity	% of women booked by 12 weeks gestation	>90%	Feb-22	89.8%
Operational Efficiency	Number of patients stable for discharge	<=70	Feb-22	252
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Feb-22	538
Operational Efficiency	Average length of stay (spell)	<=5.06	Feb-22	6.59
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Feb-22	7.833
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Feb-22	2.1
Operational Efficiency	% day cases of all electives	>80%	Feb-22	83.2%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Feb-22	85.0%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Feb-22	93.5%
Operational Efficiency	Urgent cancelled operations	No target	Feb-22	0
Outpatient	Outpatient new to follow up ratio's	<=1.9	Feb-22	1.86
Outpatient	Did not attend (DNA) rates	<=7.6%	Feb-22	7.1%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Jan-22	7.6%
Research	Research accruals	No target	Feb-22	151

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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Key

Assurance

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

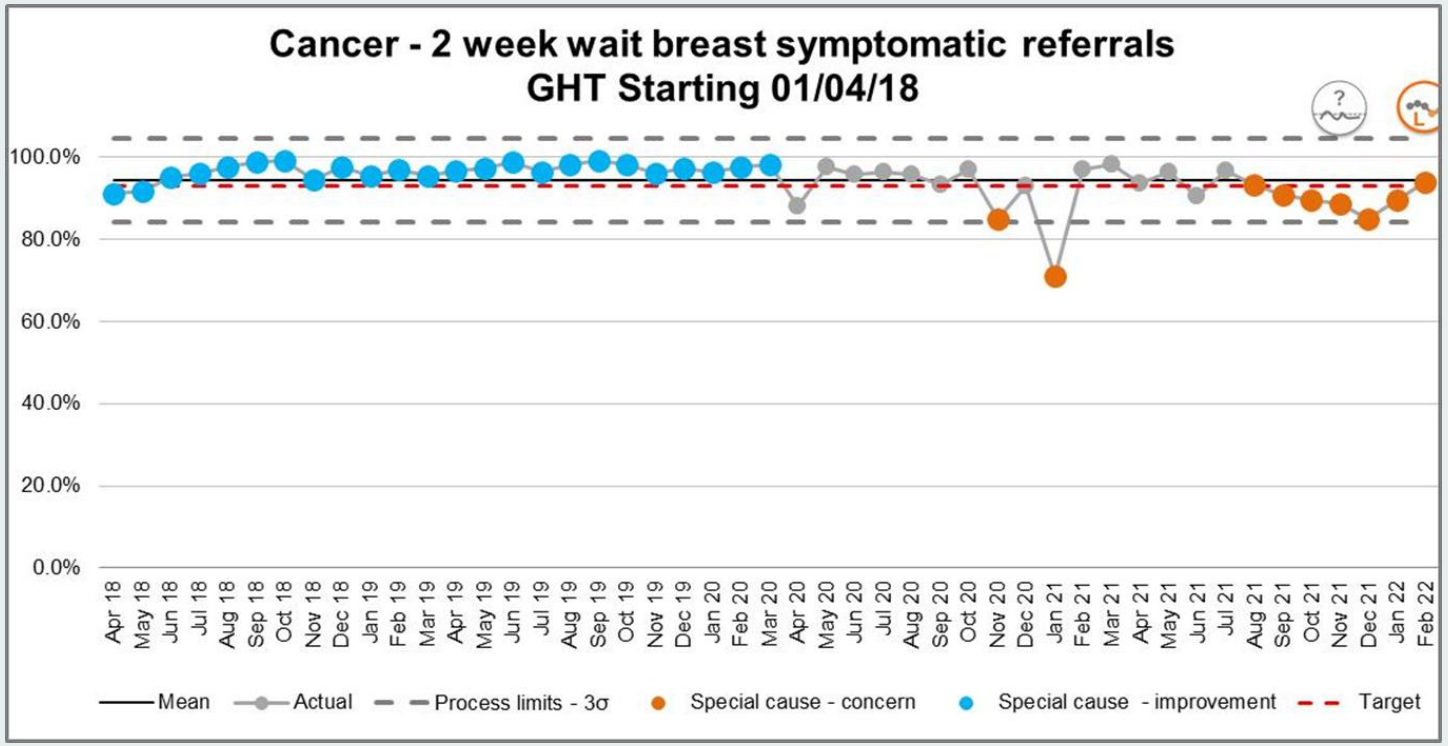
Variation

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Feb-22	71.45%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Feb-22	5,187	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Feb-22	2,184	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Feb-22	1,120	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Feb-22	190	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		Feb-22	70.0%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Jan-22	20.0%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		Feb-22	75.0%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		Feb-22	75.0%	
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%		Feb-22	43.40%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Feb-22	41.5%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

2ww breast symptoms performance (unvalidated) = 93%
National = 49.4%
GHFT performance = 93.9%
Standard = 93%

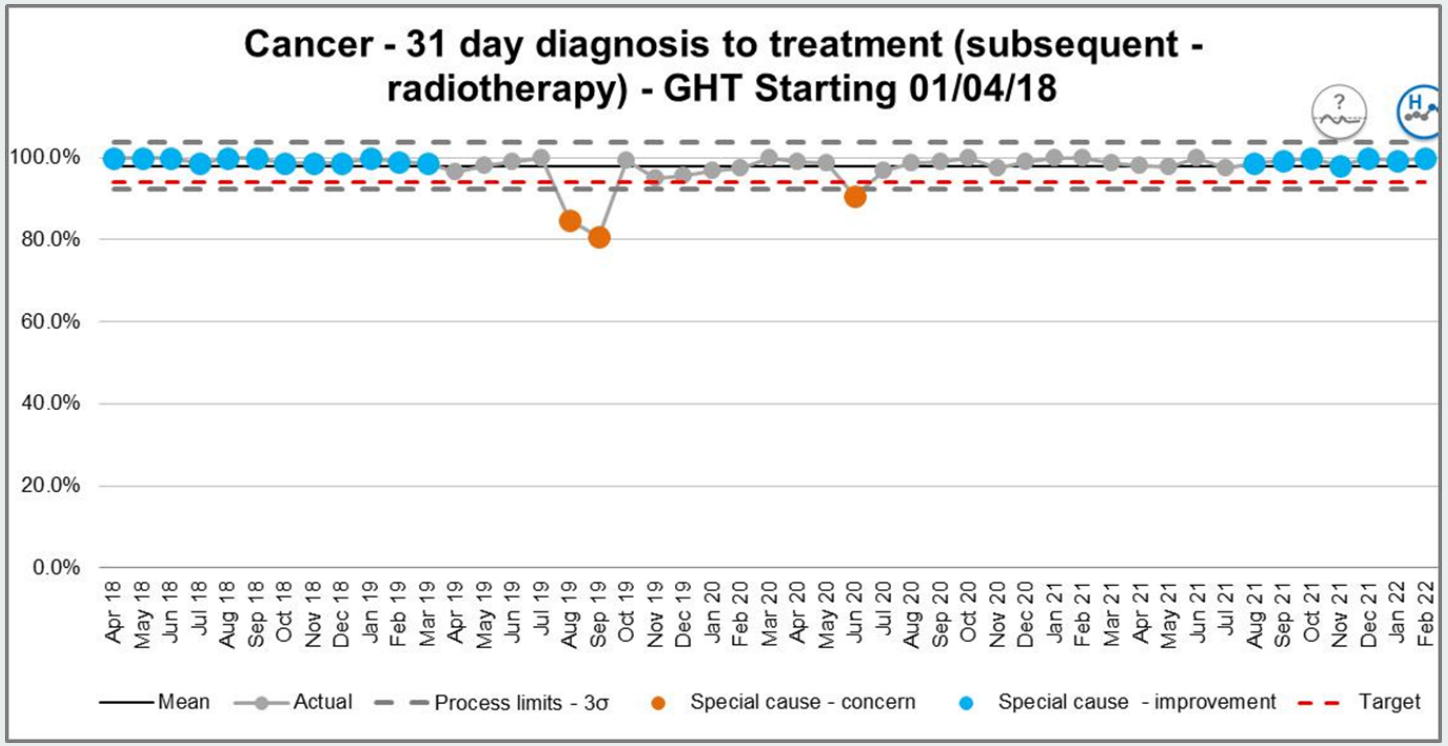
- General Manager - Cancer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day subs radiotherapy performance (unvalidated)
Standard = 94%
National = 91%
GHFT = 98.7%

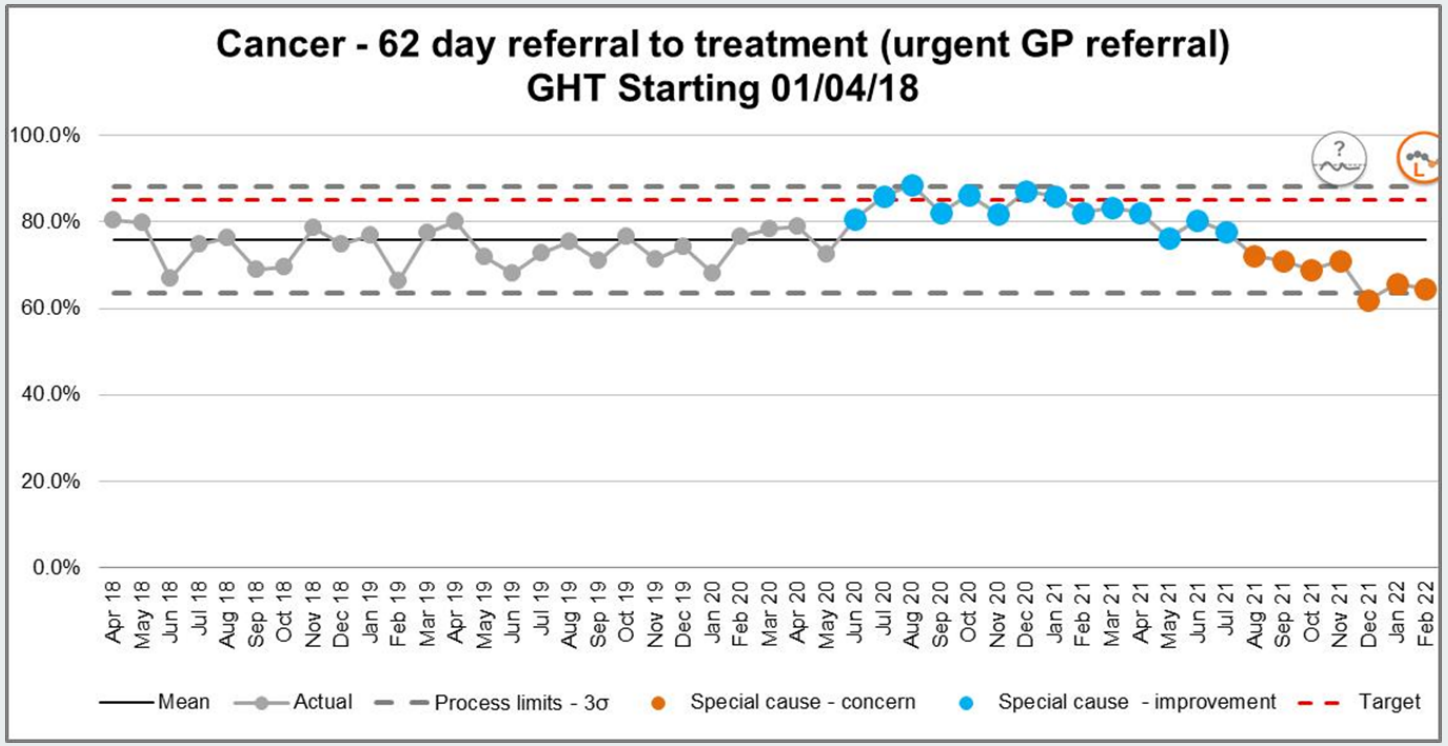
- General Manager - Cancer

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 significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

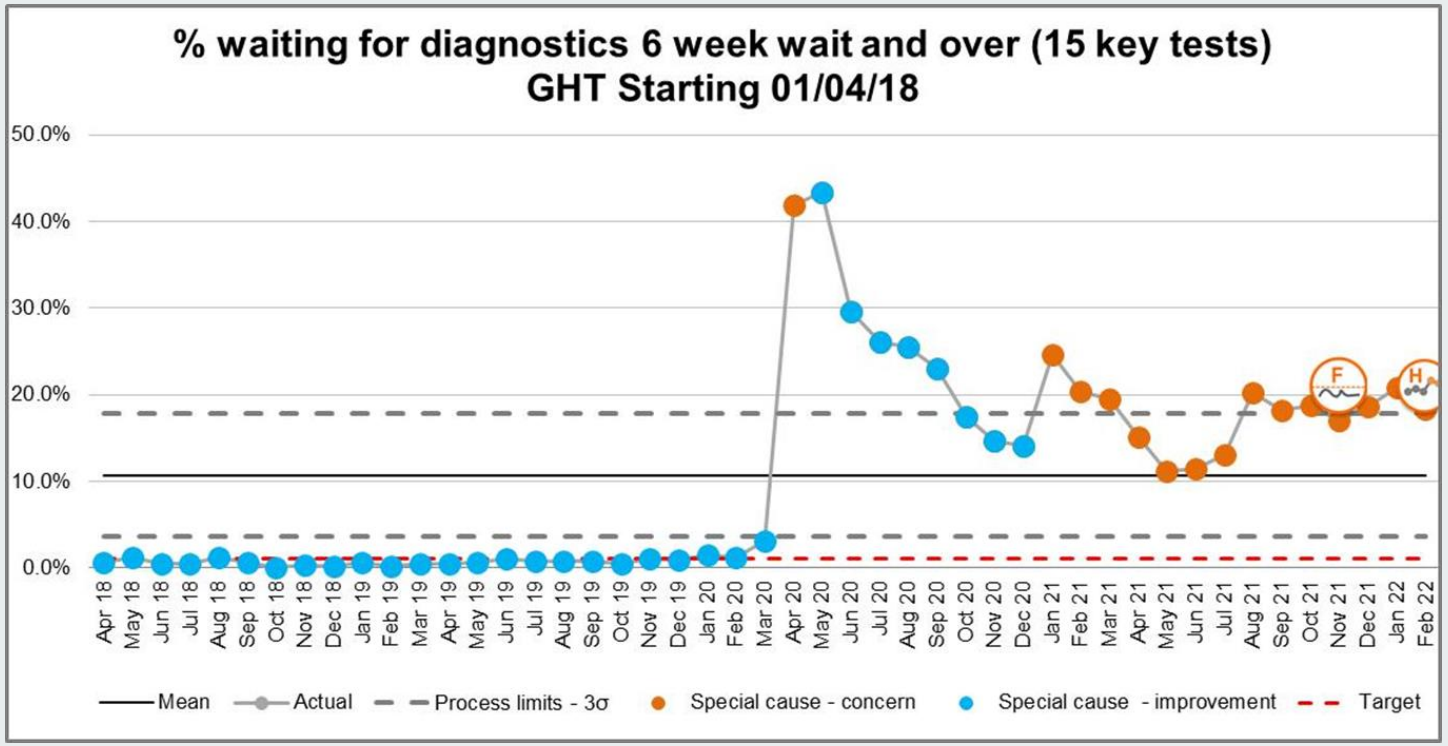
62 day GP performance (unvalidated)
Standard = 85%
National = 61%
GHFT = 65.5%
Treatments = 141.5, Breaches 49.5; LGI = 12, Urology = 9.5, Gynae = 9, H&N = 3
Reasons for breaches: Prostate pathway and delay to LATP biopsy; Delay to pathology biopsies and radiology reporting; Complex patient pathways; Elective capacity
- General Manager - Cancer

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 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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

An improvement has been seen in month, moving from 20.8% last month to a validated position of 18.27% this month. The total number of patients waiting has increased for successive months from 7,373 to 7,795. The overall number of breaches has decreased by 115 which is attributable to Echos, having decreased from 1,478 last month to 1,393.

If Echo's were to be excluded, performance for all other modalities would be 0.56% with just 31 breaches against 5,490 patients waiting.

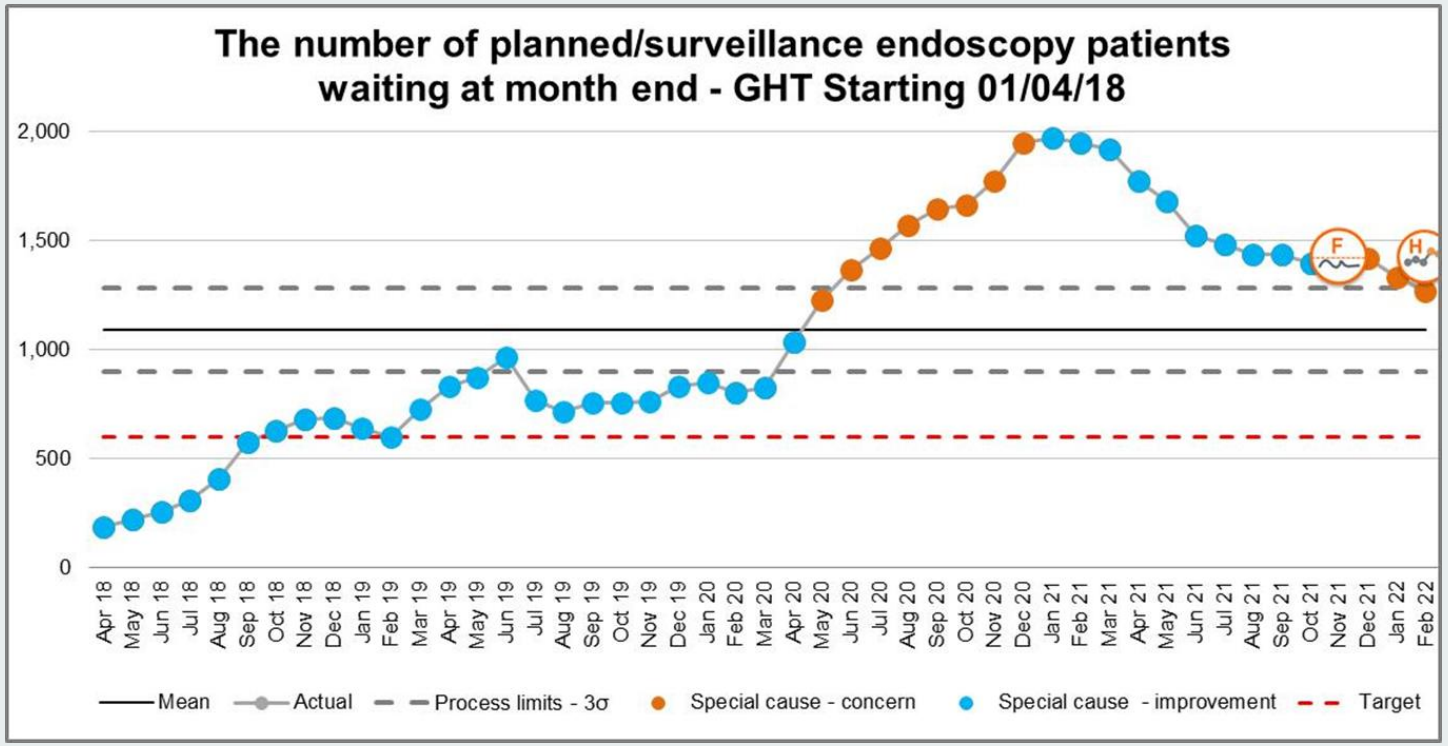
- Associate Director of Elective Care

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 24 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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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.

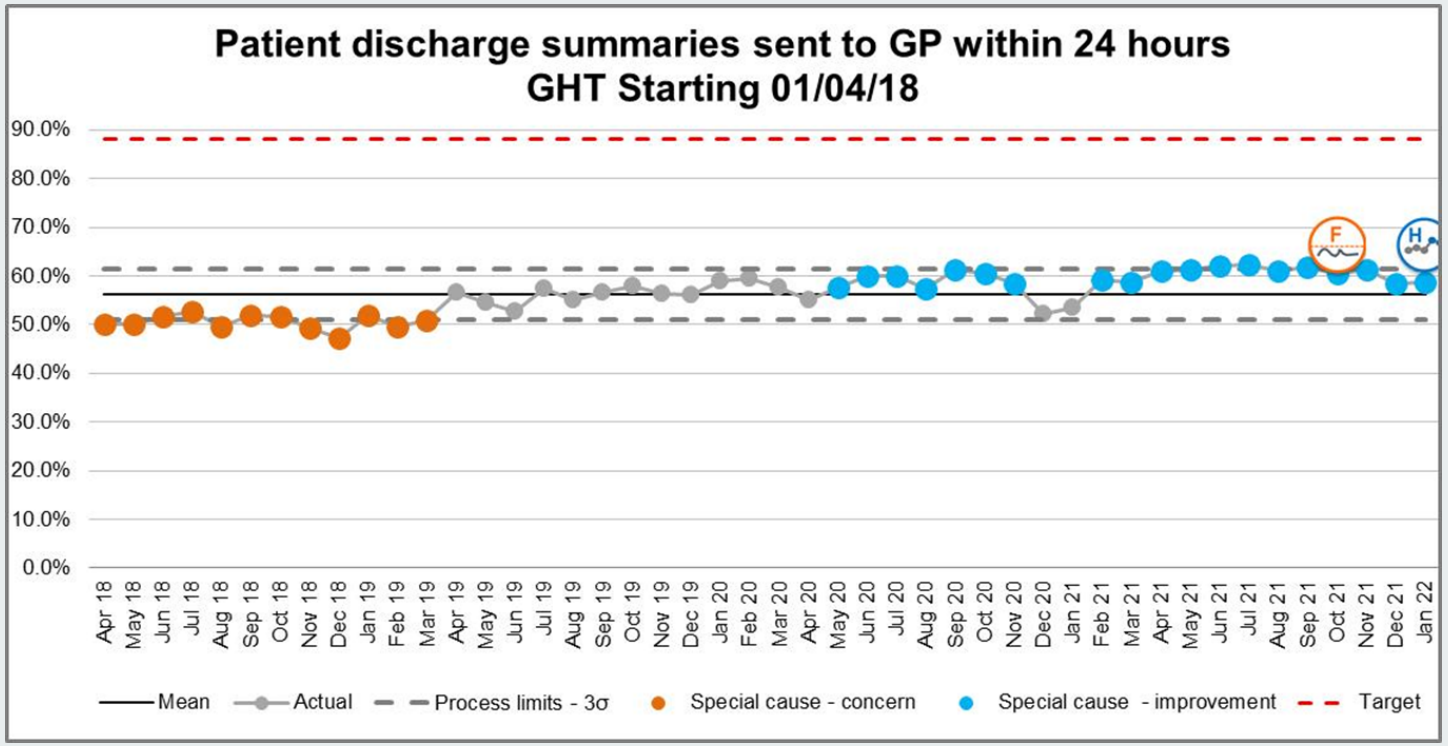
- Deputy General Manager of Endoscopy

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 20 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 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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance remains static as described previously significant change unlikely till discharge summaries migrate to sunrise EPR, this can not be done till EPMA launched later this year.

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

Access:
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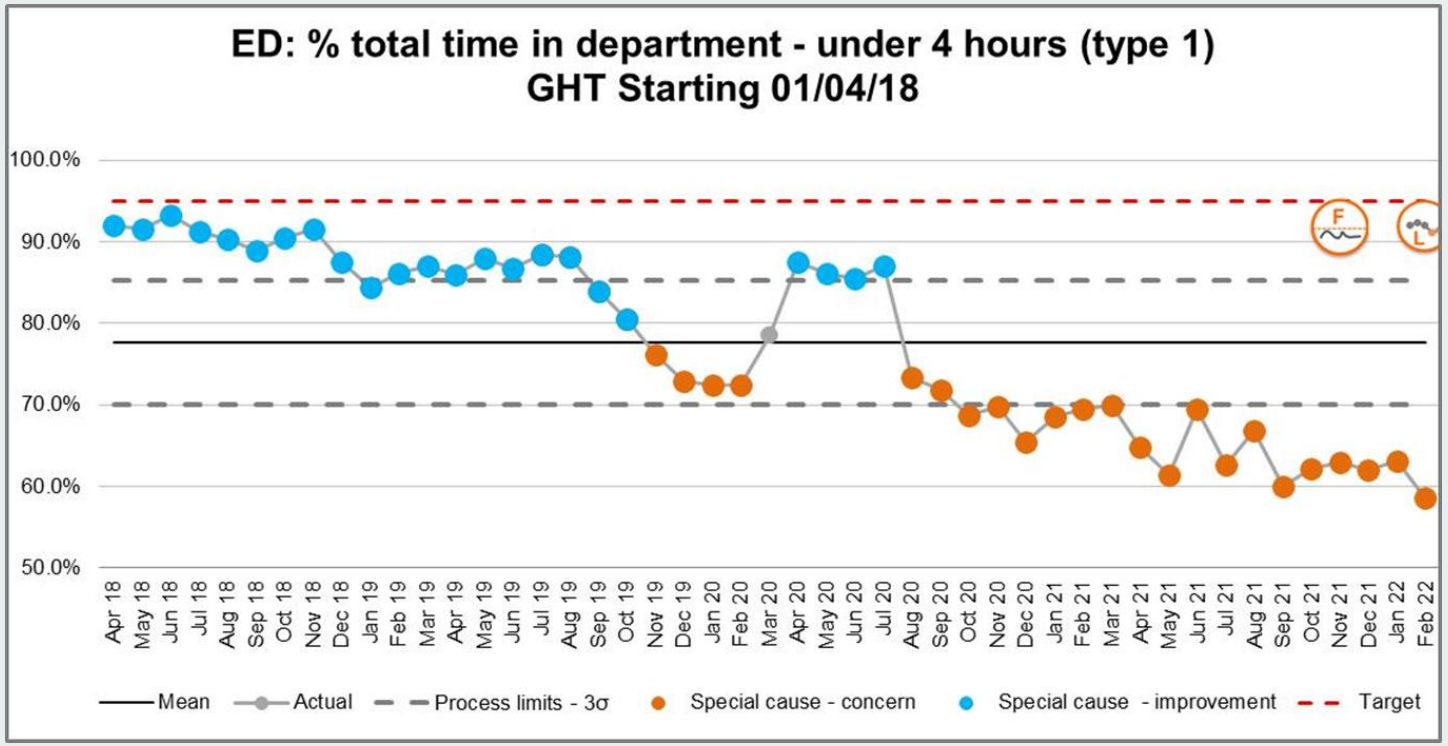
Gloucestershire Hospitals NHS Foundation Trust



Commentary

ED 4 hour performance for February averaged 58.74%. This is largely a result of stretched clinical rotas and a congested ED, due to poor flow through and out of the hospital.

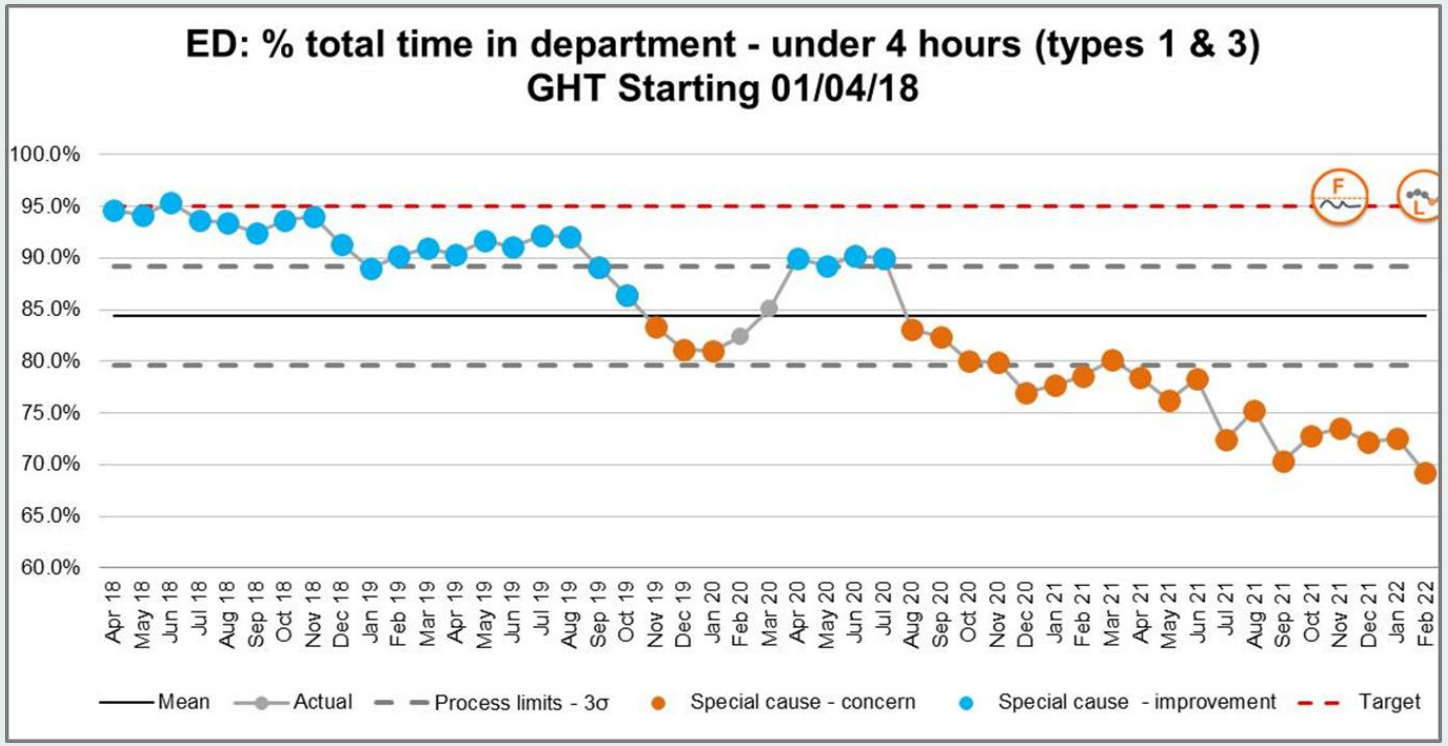
- General Manager of Unscheduled Care

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 20 data points which are above the line. There are 16 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

ED 4 hour performance for February averaged 69.25%. This is largely a result of stretched clinical rotas and a congested ED, due to poor flow through and out of the hospital.

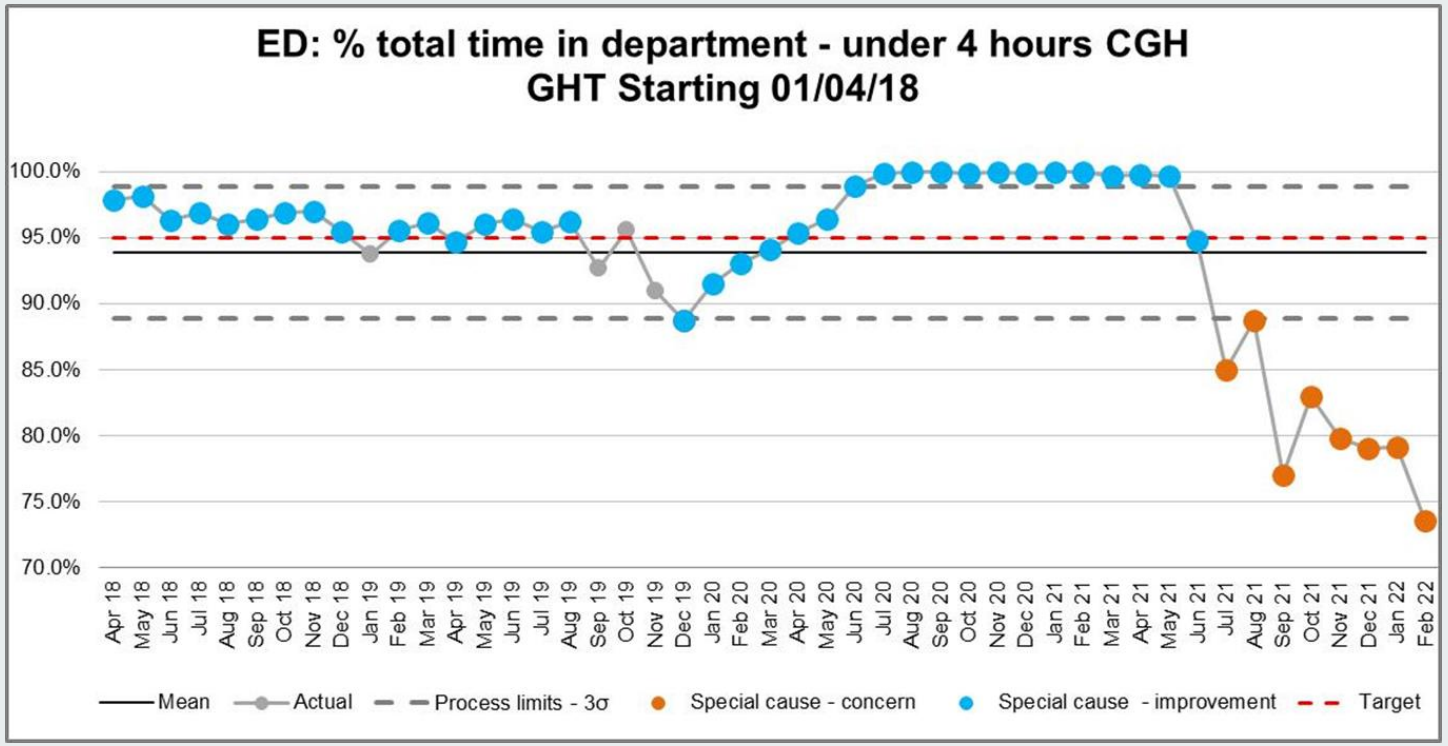
- General Manager of Unscheduled Care

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

ED 4 hour performance for February averaged 73.54%. This is largely a result of stretched clinical rotas and a congested ED, due to poor flow through and out of the hospital.

- General Manager of Unscheduled 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 12 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 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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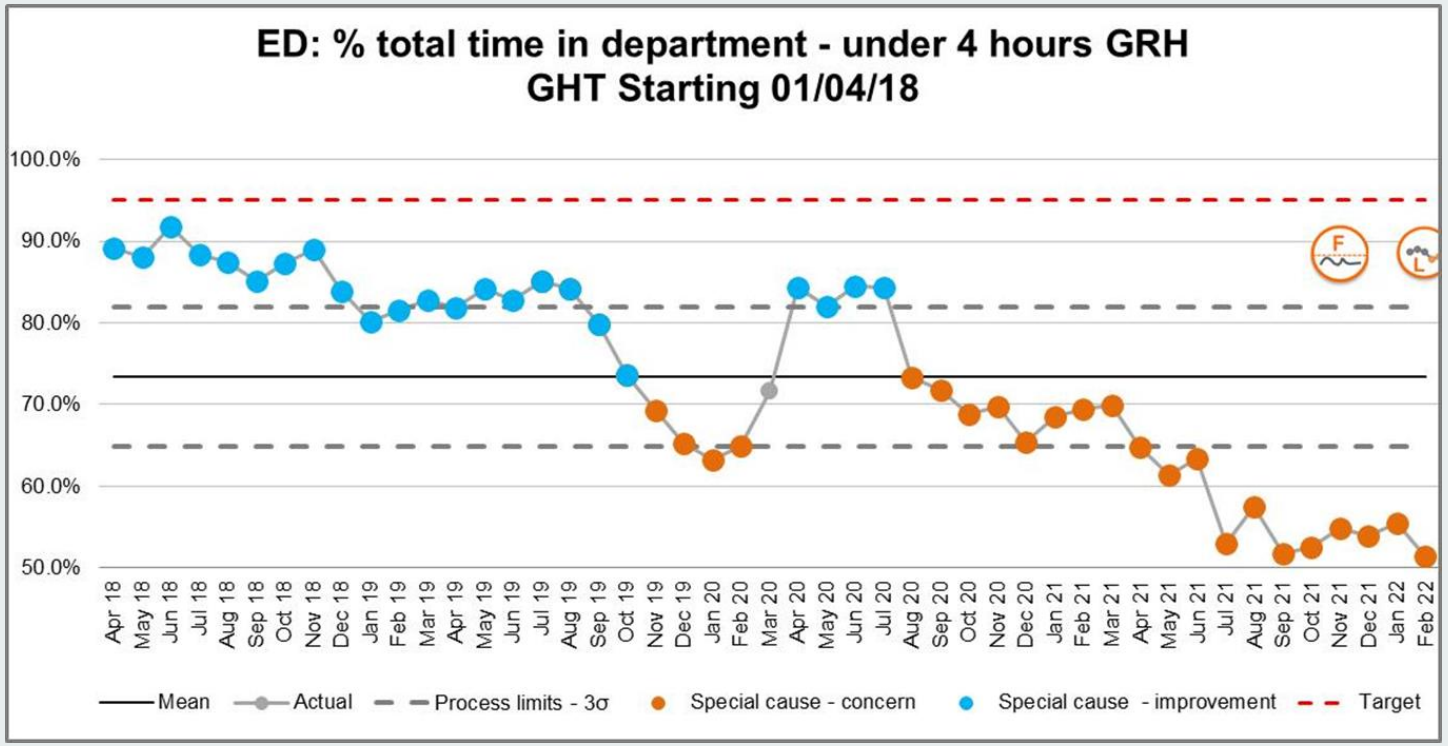
Gloucestershire Hospitals NHS Foundation Trust



Commentary

ED 4 hour performance for February averaged 51.42%. This is largely a result of stretched clinical rotas and a congested ED, due to poor flow through and out of the hospital.

- General Manager of Unscheduled 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 18 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 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

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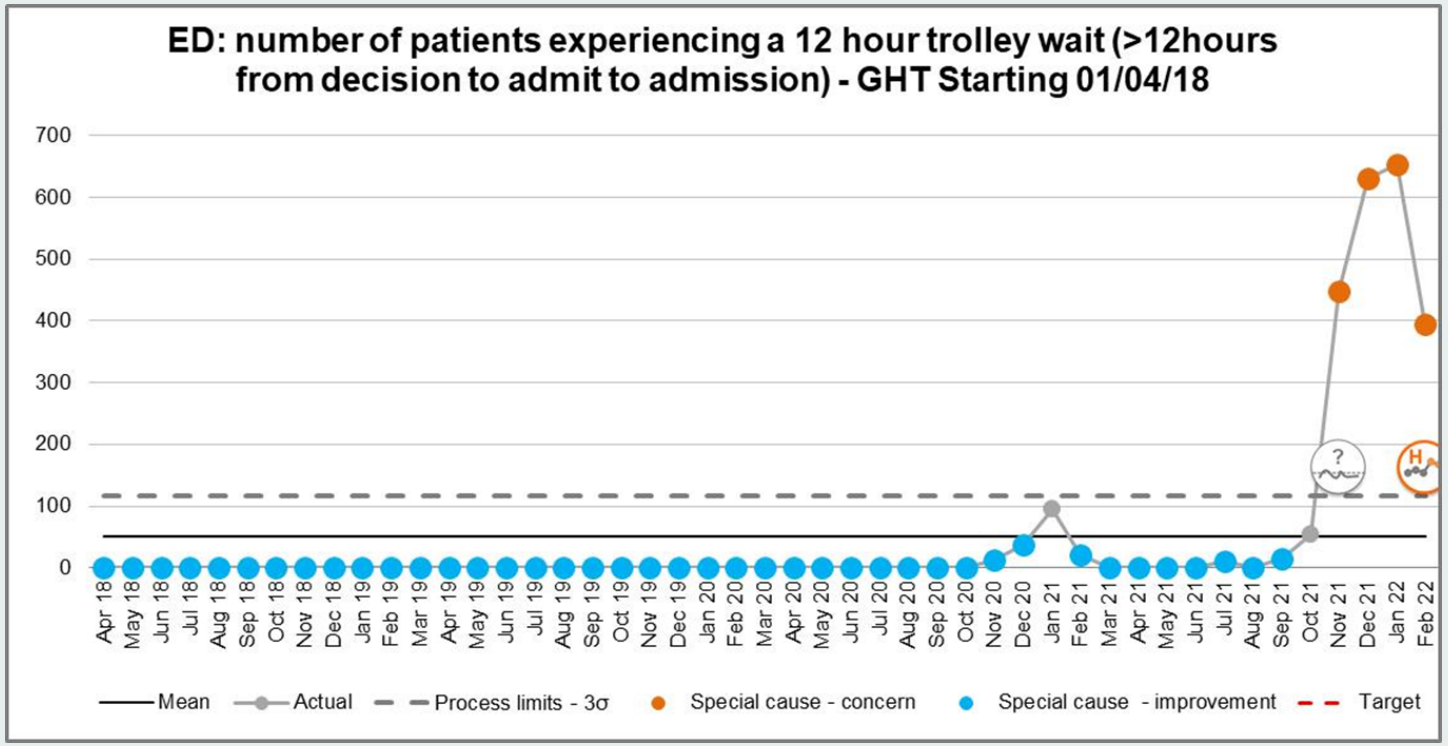


Commentary

Average total time from DTA to admission in February increased by 34% to 14.6 hours. This is a result of poor flow out of the hospital, which has seen the number of patients who are MOFD rise to 265.

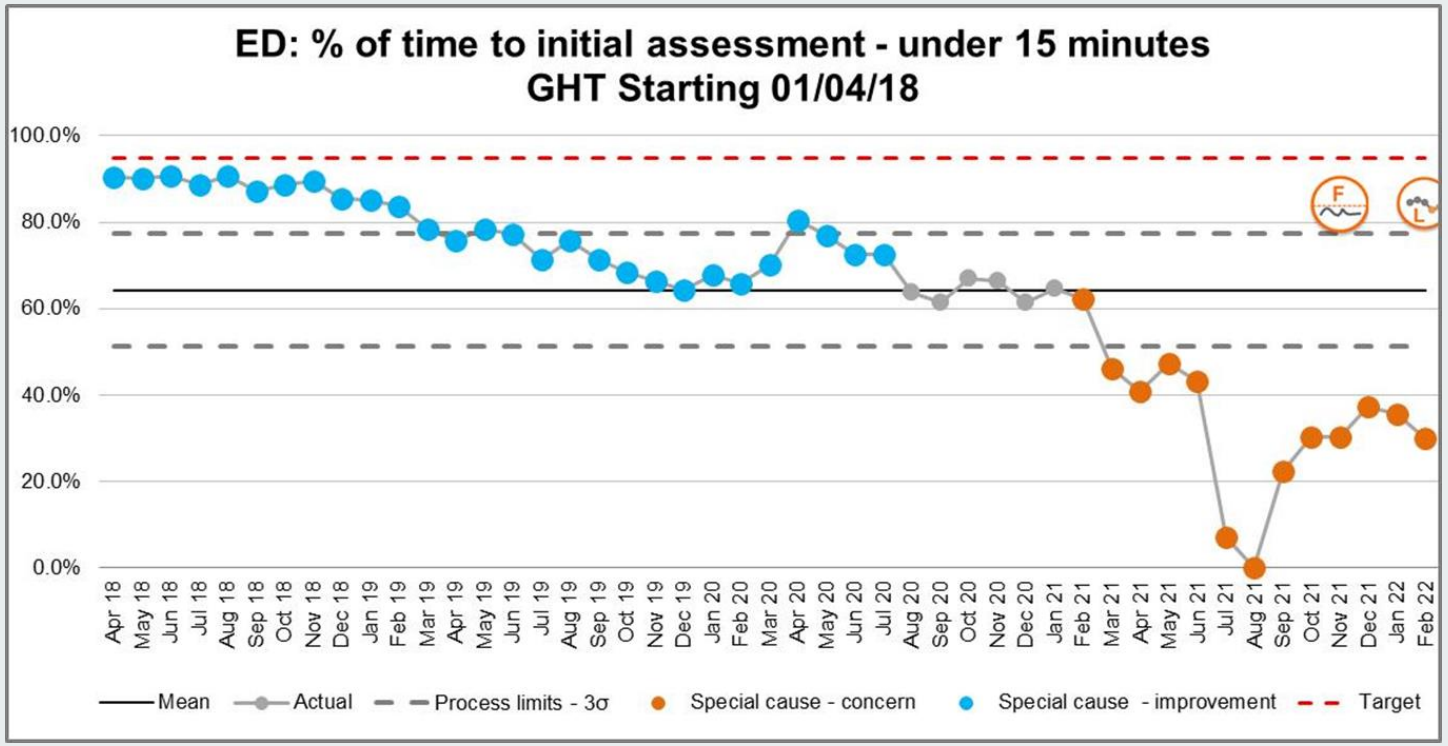
- General Manager of Unscheduled Care

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The pressure and congestion in ED, resulting from the lack of flow, continues to impact on ambulance offloads, with 15 minute triage performance for ambulance arrivals dropping to 28.8% in February. The ED teams continue to adapt practice, including frequent use of "Review & Return" for patients waiting on ambulances, in order to mitigate risk and progress care pathways. Triage performance for walk-ins dipped to 30.4%, largely owing to stretched nursing rotas and challenges with physical space. The enhanced triage PDSA continues when staffing allows.

- General Manager of Unscheduled 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 14 data points which are above the line. There are 12 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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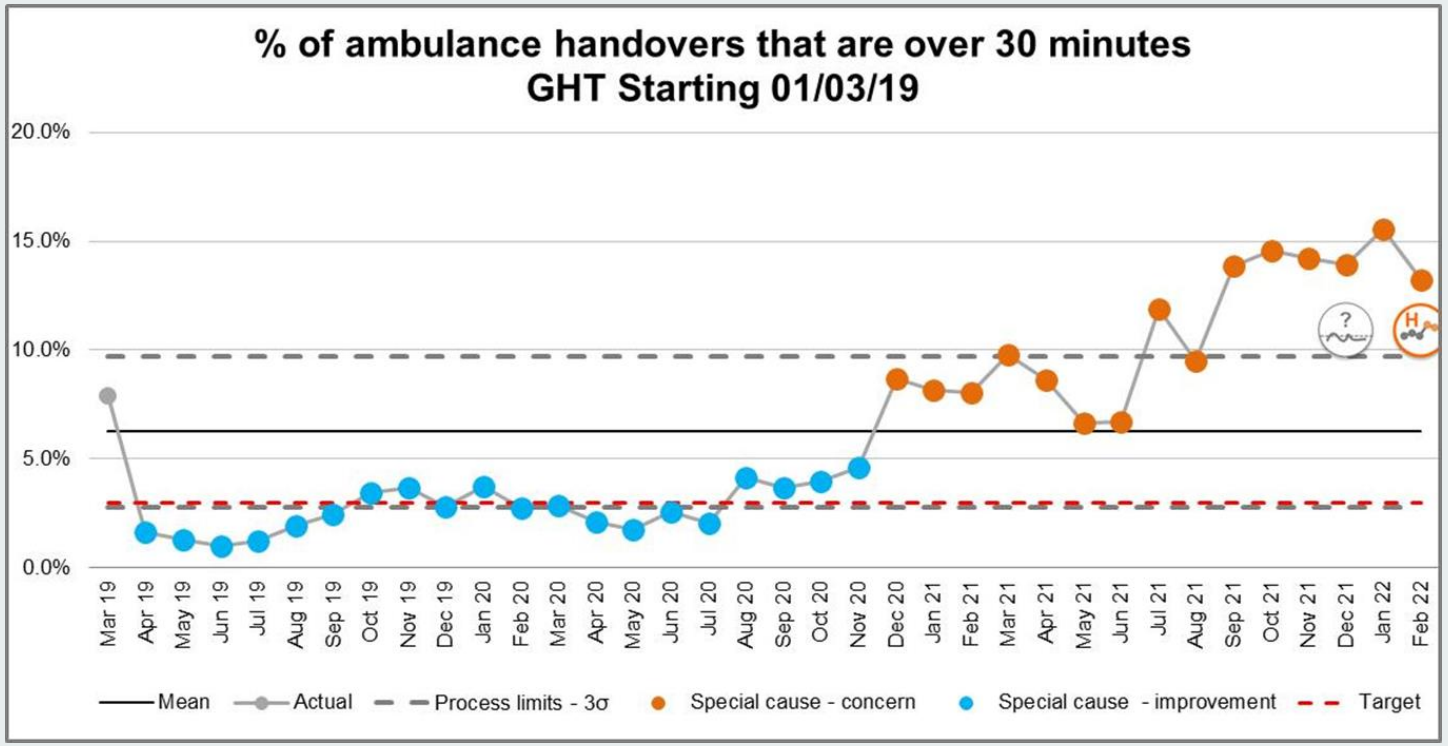

Commentary

As a result of poor flow, there were 1,423 ambulance handover delays >30 minutes in February, an average of 51 breaches per day. Teams in ED have continued to assess patients for alternate pathways on arrival and enact "review & return" to mitigate safety risks and minimise delays.

- General Manager of Unscheduled 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 8 data points which are above the line. There are 11 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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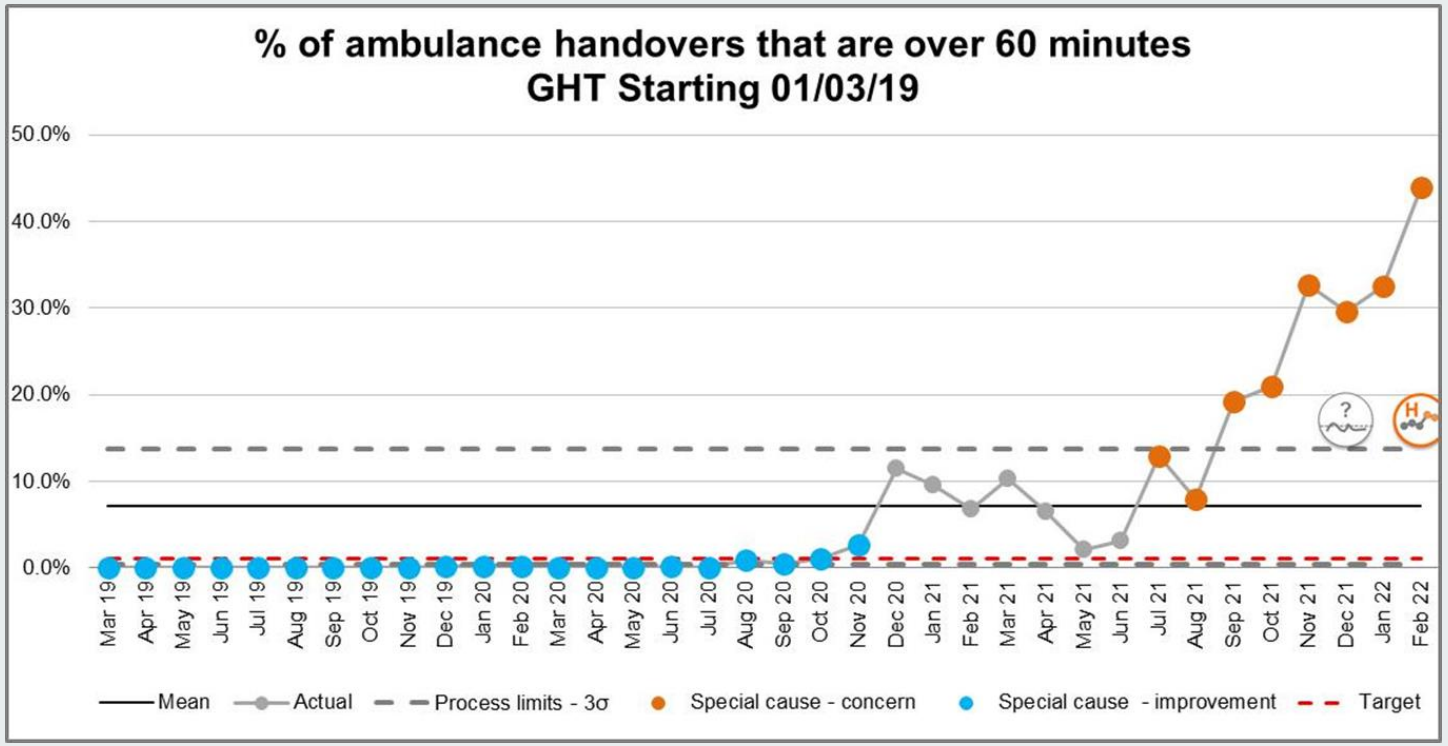

Commentary

As a result of poor flow, there were a total of 1,093 ambulance handover delays >60 minutes in February, an increase of 5 breaches per day compared to January. Teams in ED have continued to assess patients for alternate pathways on arrival and enact "review & return" to mitigate safety risks and minimise delays.

- General Manager of Unscheduled 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 6 data points which are above the line. There are 17 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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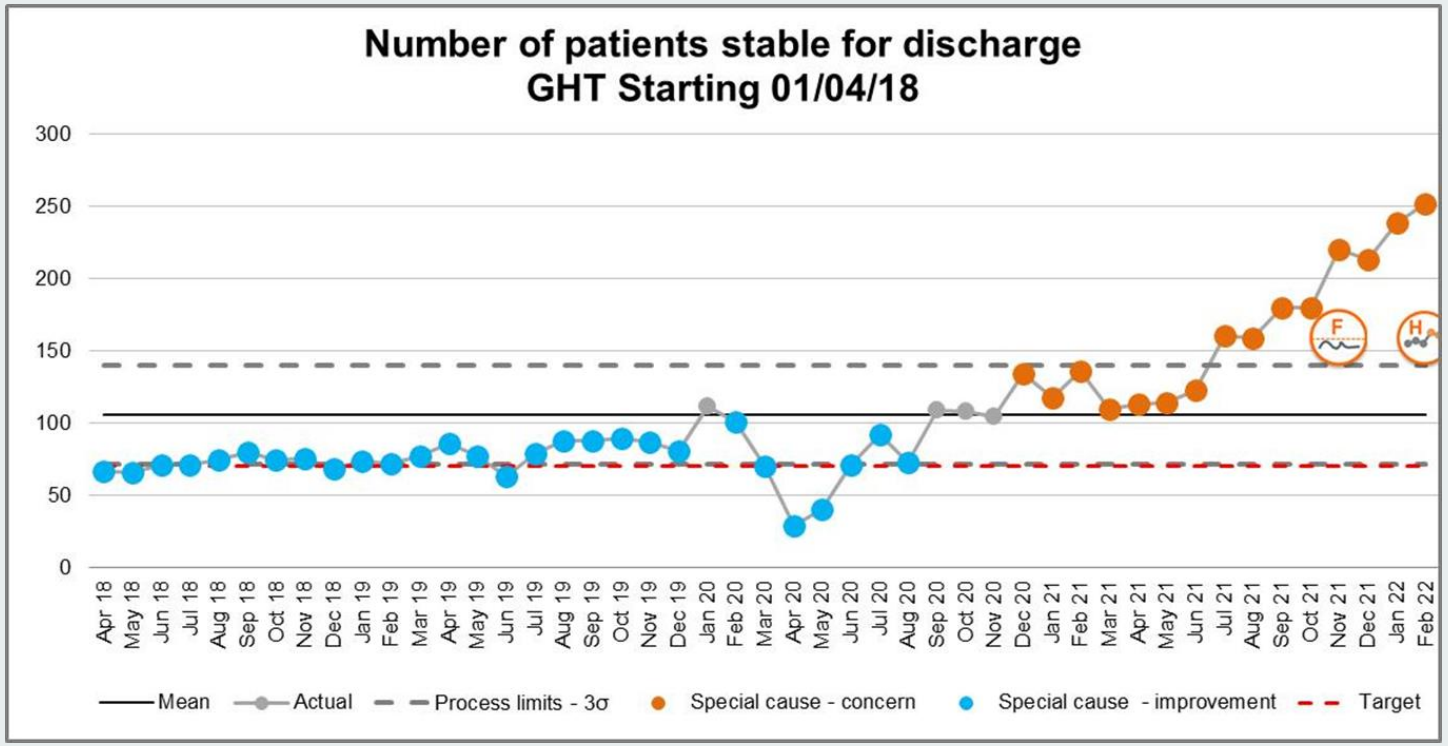

Commentary

Numbers continue to climb despite extensive work for internally and external to the trust. Ongoing challenges around COVID restrictions in care home and dom care carers main factor limiting discharge pathways.

- Head of Therapy & OCT

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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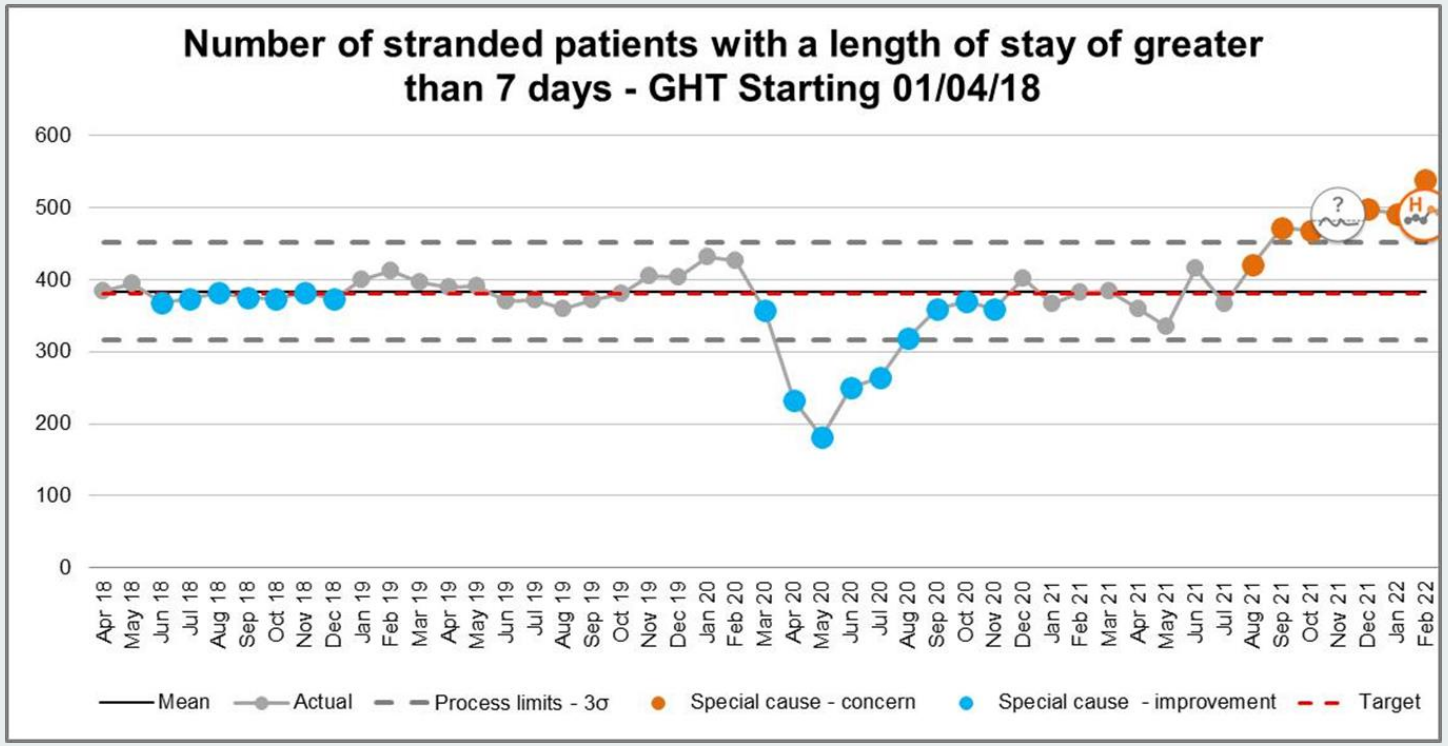

Commentary

The number of stranded patients with a lengths of seven days rose slightly, from 492 to 538. The 21/22 average stands at 443, which is a 16% variance from target. There are provision difficulties within the local residential, nursing and domiciliary care provision sector. The trust have a robust grip on the position, and have co-ordinated discharge efforts in order to help discharge these patients where possible. The trust have been working with local commissioners to formulate plans which include the provision of discharge budgets, use of Pathway teams targeting stranded patients, speciality inreach to ED and daily ward rounds. These plans are expected to progress at pace.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 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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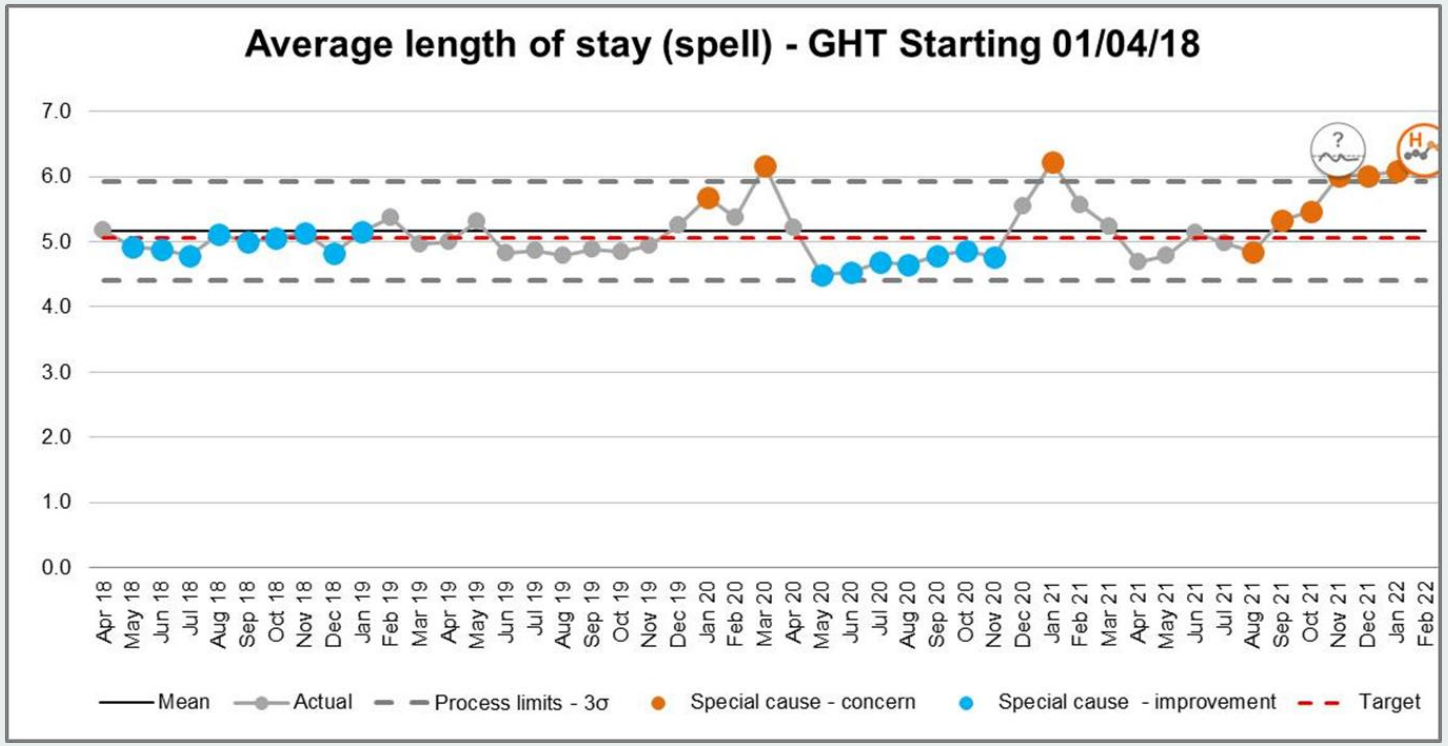

Commentary

Average LOS increased from 6.08 to 6.59, bringing the average to 5.39 during 21/22 vs a target of 5.08. There are provision difficulties within the local residential, nursing and domiciliary care provision sector. The trust are working on the provision pathway teams including challenger clinicians in order to discharge patients earlier and thus meet target. The trust expect that this position will ease when issues in the local care sector are resolved. In the interim, the trust have committed to working innovatively with commissioners, including the use of out of area placements where appropriate.

- Deputy Chief Operating Officer

Data Observations

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

Access:
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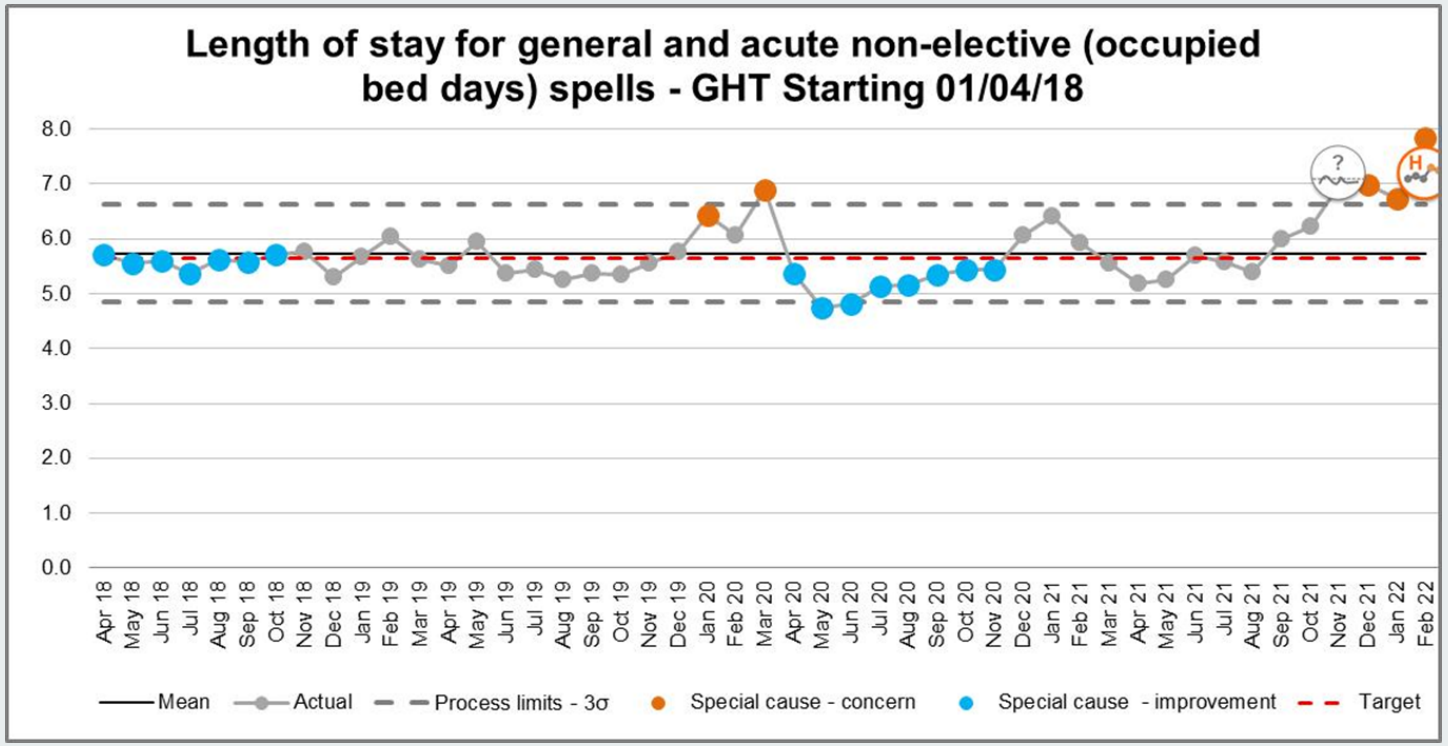
Gloucestershire Hospitals NHS Foundation Trust



Commentary

Length of stay for general and acute non-elective (occupied bed days) rose from 6.72 to 7.83. There are provision difficulties within the local residential, nursing and domiciliary care provision sector. The trust are working on the provision pathway teams including challenger clinicians in order to discharge patients earlier and thus meet target. The trust expect that this position will ease when issues in the local care sector are resolved.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There is 2 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
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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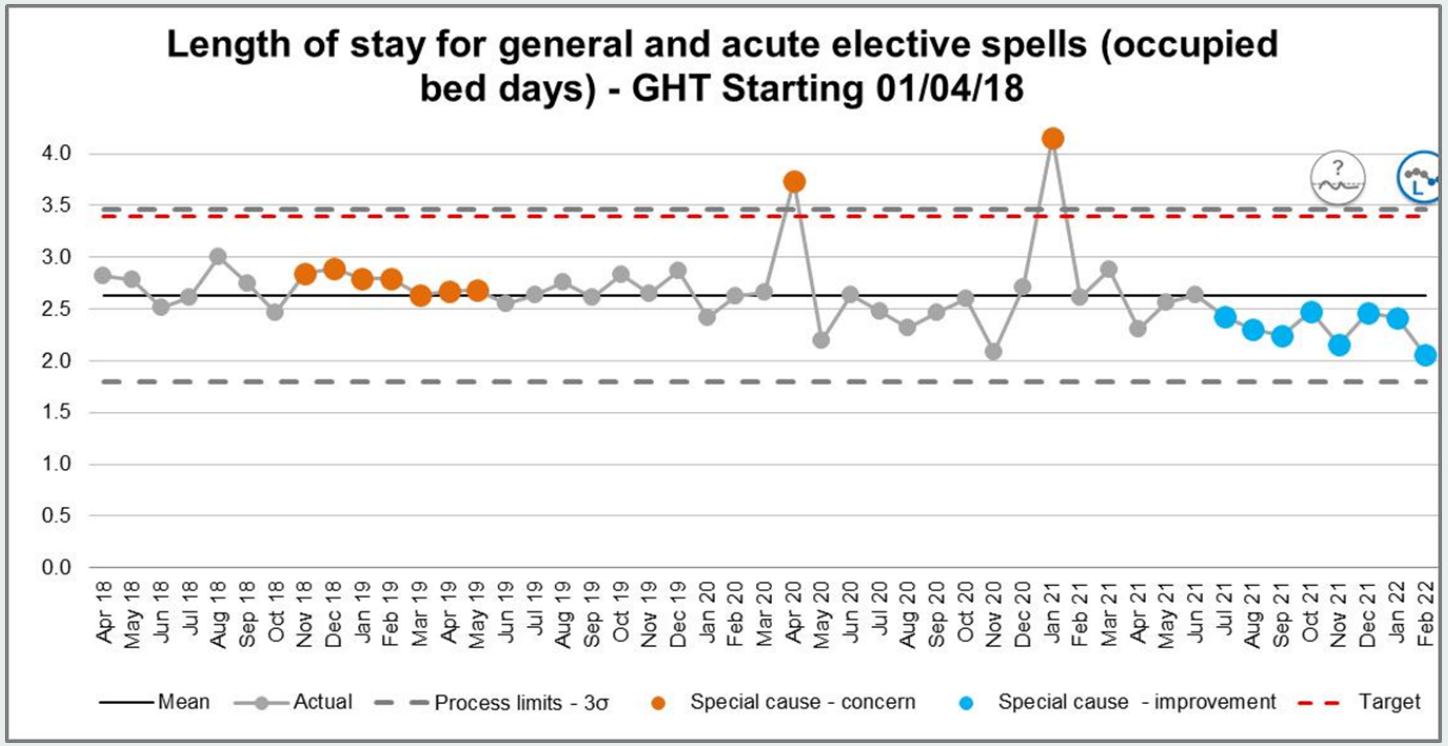
Gloucestershire Hospitals NHS Foundation Trust



Commentary

LOS for general and acute elective spells for occupied bed days improved further to 2.06, versus a target of lower than 3.4. The 21/22 average is 2.37. Elective specialities are functioning excellently and continue to improve.

- 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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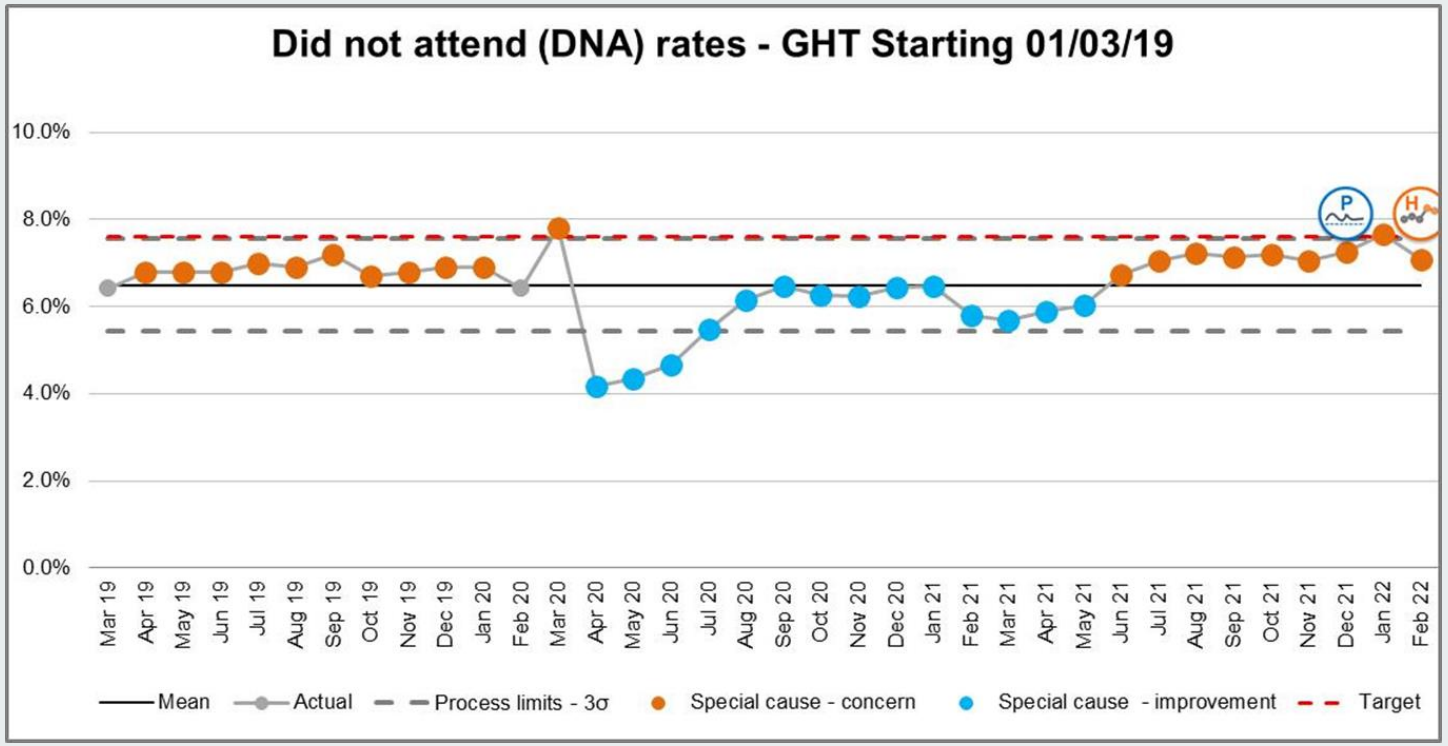

Commentary

The DNA rate is back within target, down to 7.09. With the exception of one month, the DNA rate has been within target all year. Further improvement are expected when the text reminder service is resumed, which is being managed by IT given a number of technical challenges.

- 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 is 2 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

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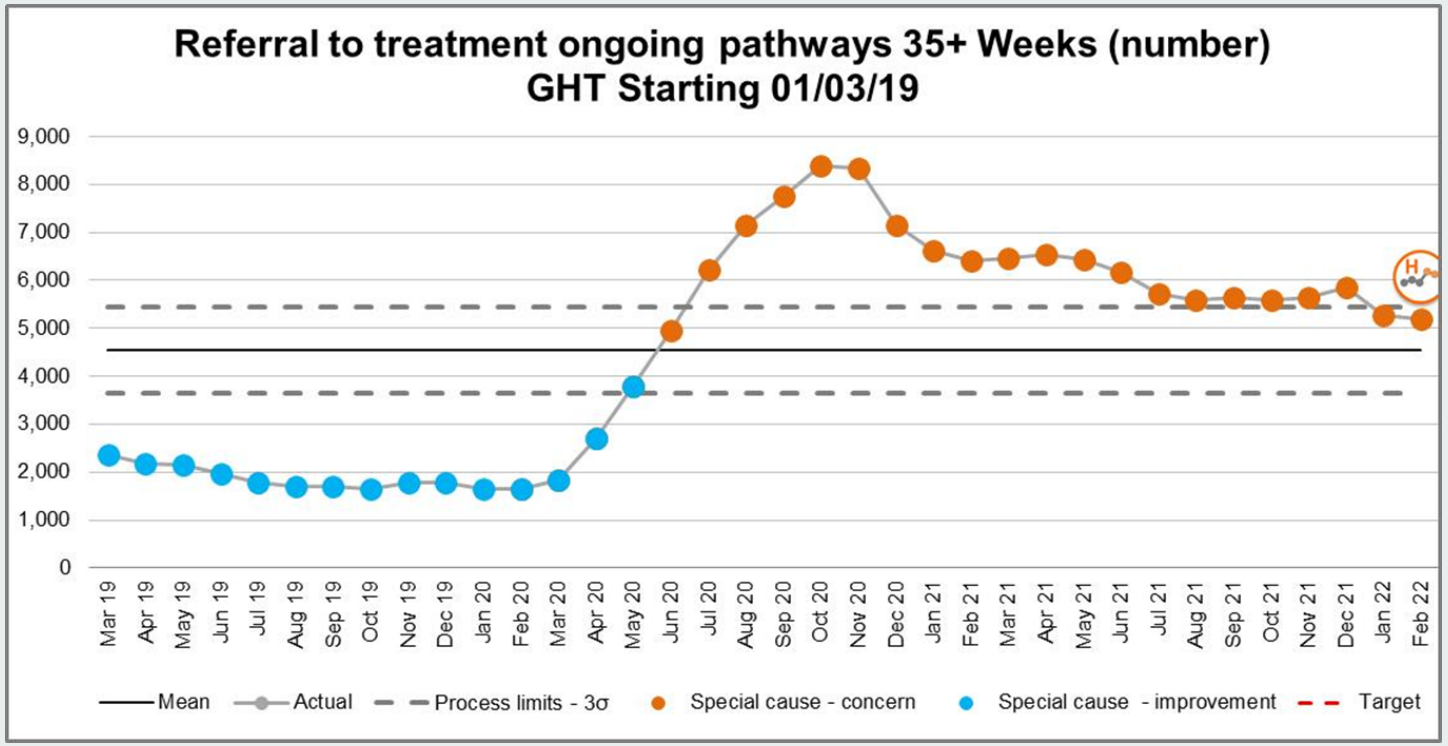

Commentary

A further reduction has been seen with the number of patients waiting greater than 35 weeks. This is now the lowest number achieved all year.

- 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 18 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

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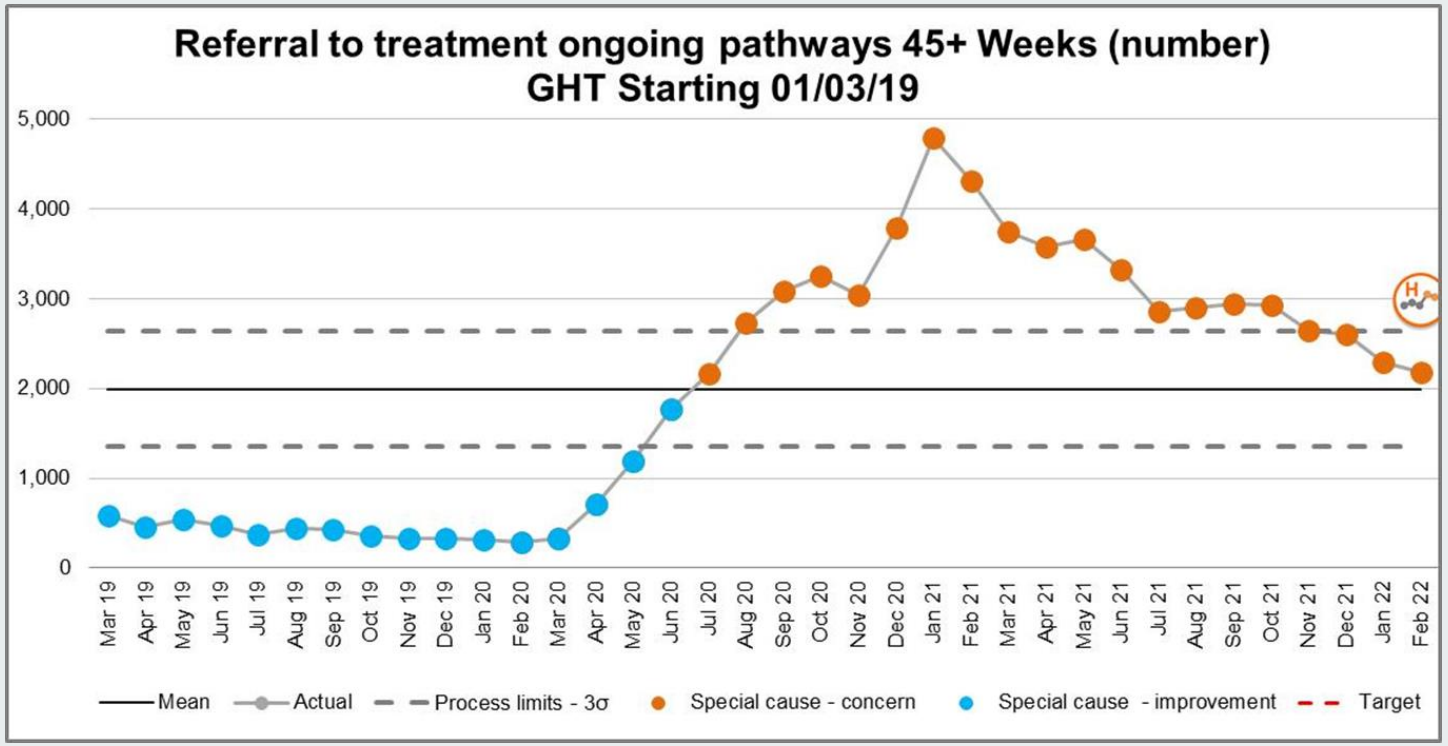
Gloucestershire Hospitals NHS Foundation Trust



Commentary

A further reduction has been made in month, of approximately 100, maintaining the monthly downward trend. This is now the lowest number achieved all year.

- 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 16 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
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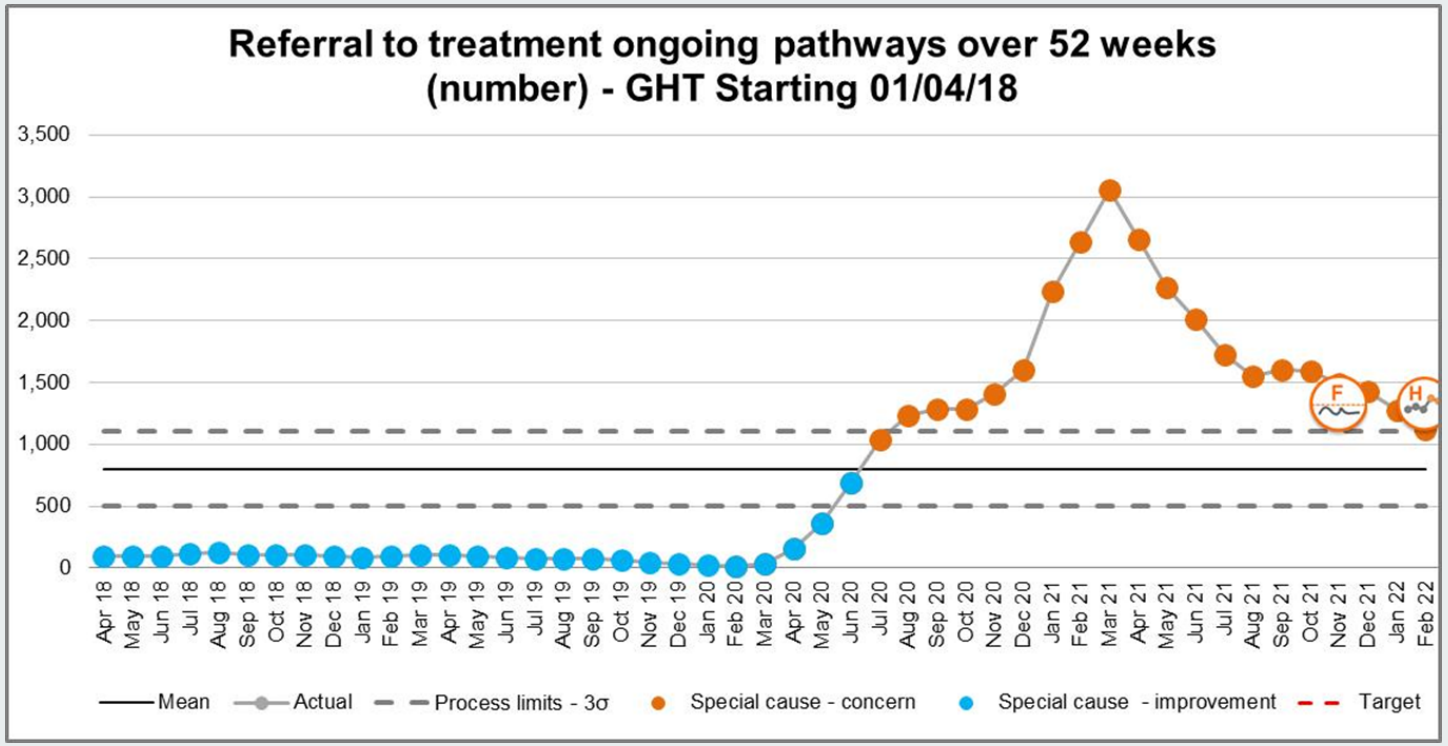

Commentary

See Planned Care Exception report for full details. A further reduction has been made in month, of approximately 150 which is one of the largest monthly gains for some months. Since March 2020, with the exception of just 1 month, gains have consistently been made every month, with this being the lowest number of 52 week waits since July 2020.

- 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 19 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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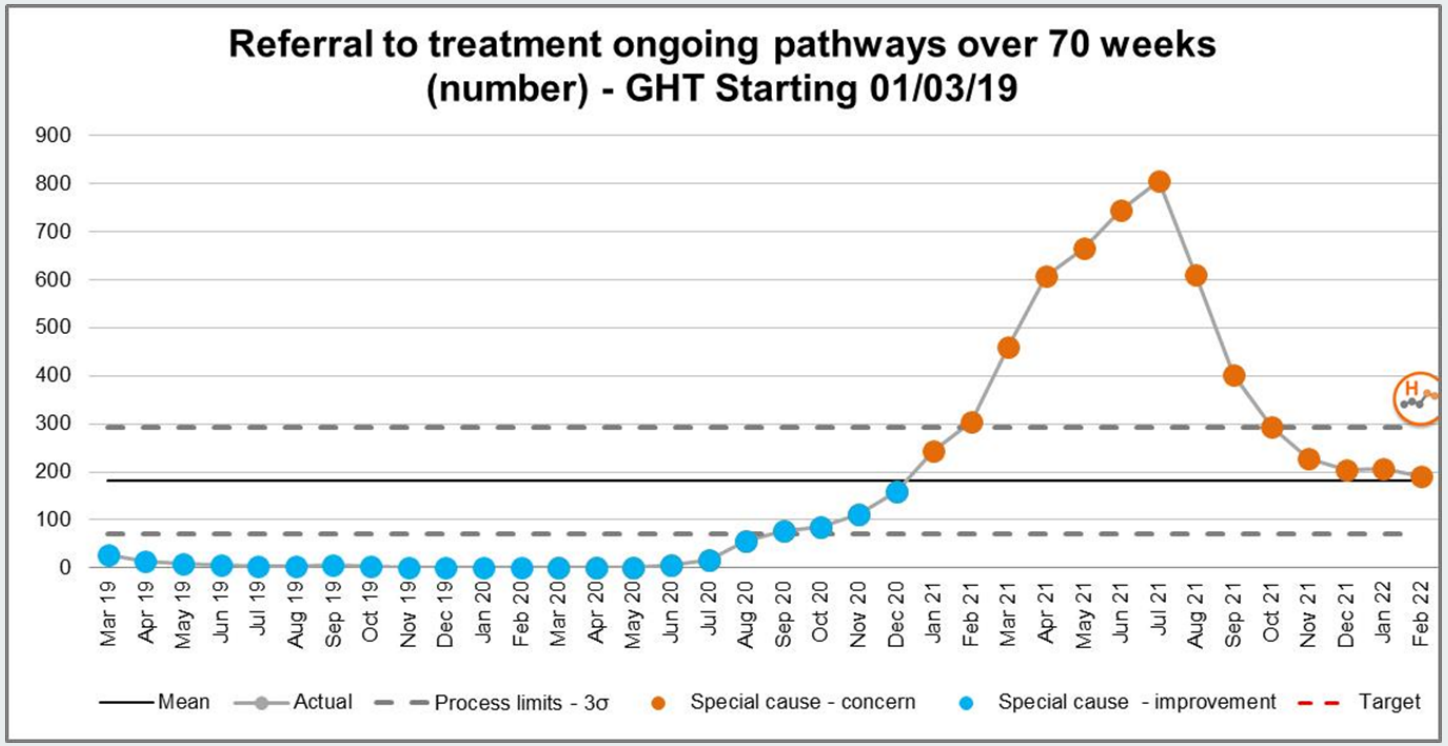

Commentary

The number of patients waiting 70 weeks or more has also reduced in month. This is now the second lowest number achieved all year.

- 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 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

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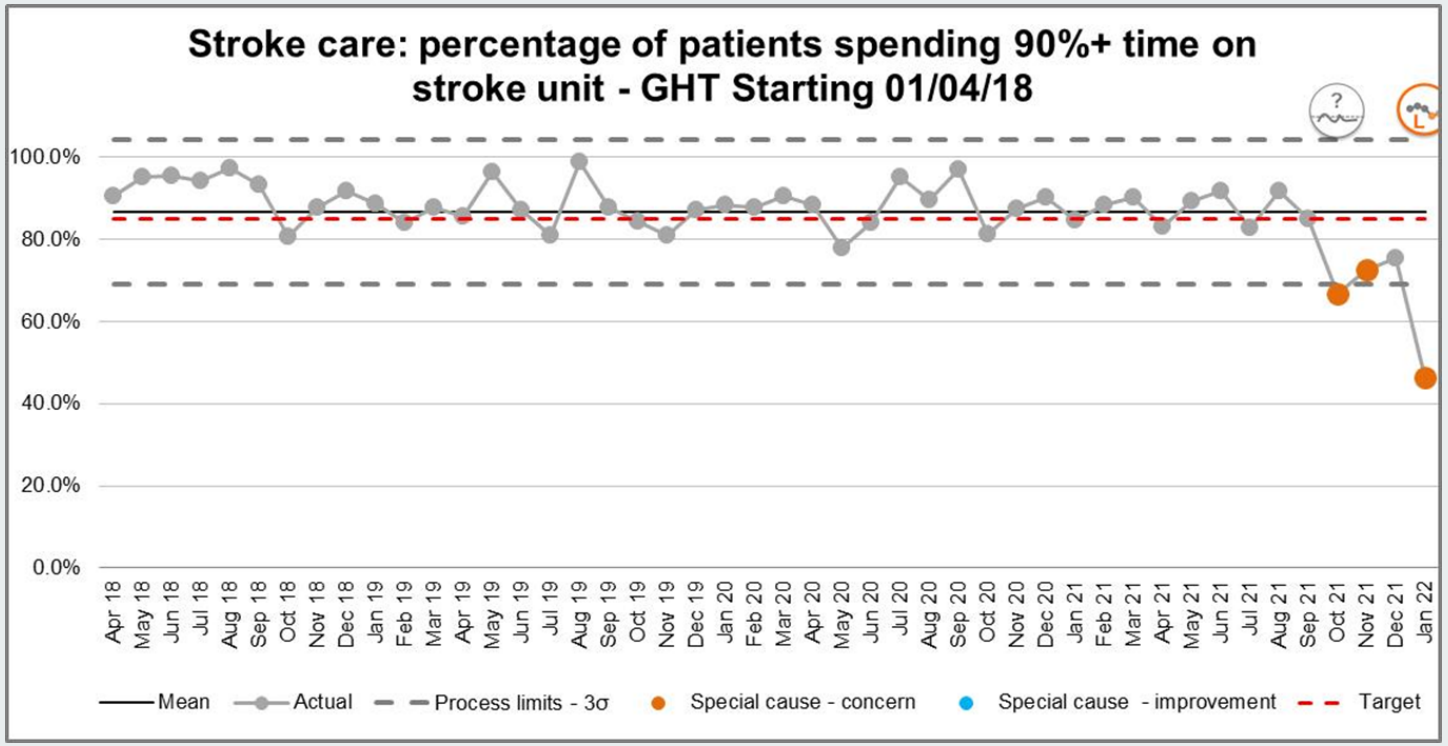

Commentary

There has been a reduction from previous month and still well below target. Primarily, patients are delayed due to difficulty in maintain a ring fenced bed due to pressures in ED and the availability of HASU beds caused by issues with flow throughout the hospitals. The closure of HASU due to a COVID outbreak has also impacted performance. Other barriers include delays due to an unclear diagnosis leading to further tests before admission and delay in assessment as the Stroke team were not informed by ED

- General Manager for COTE, Neuro and Stroke

Data Observations

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

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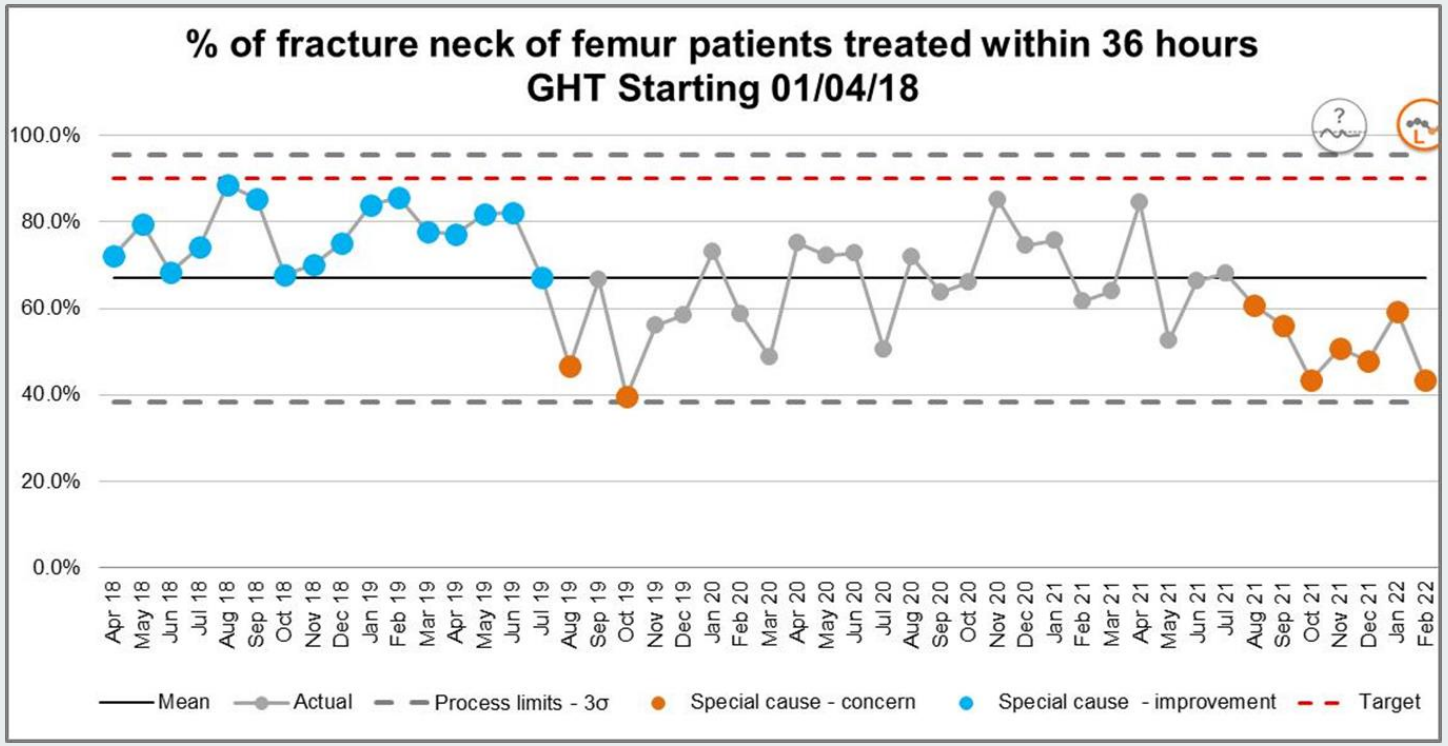
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

We continue to have medical outliers on our wards so patients that require T&O input are outliers on different wards around the hospital. We have ringfenced beds on Mayhill to ensure all daycase procedures are sent through to the right wards which in turn reduces the impact on inpatient capacity.

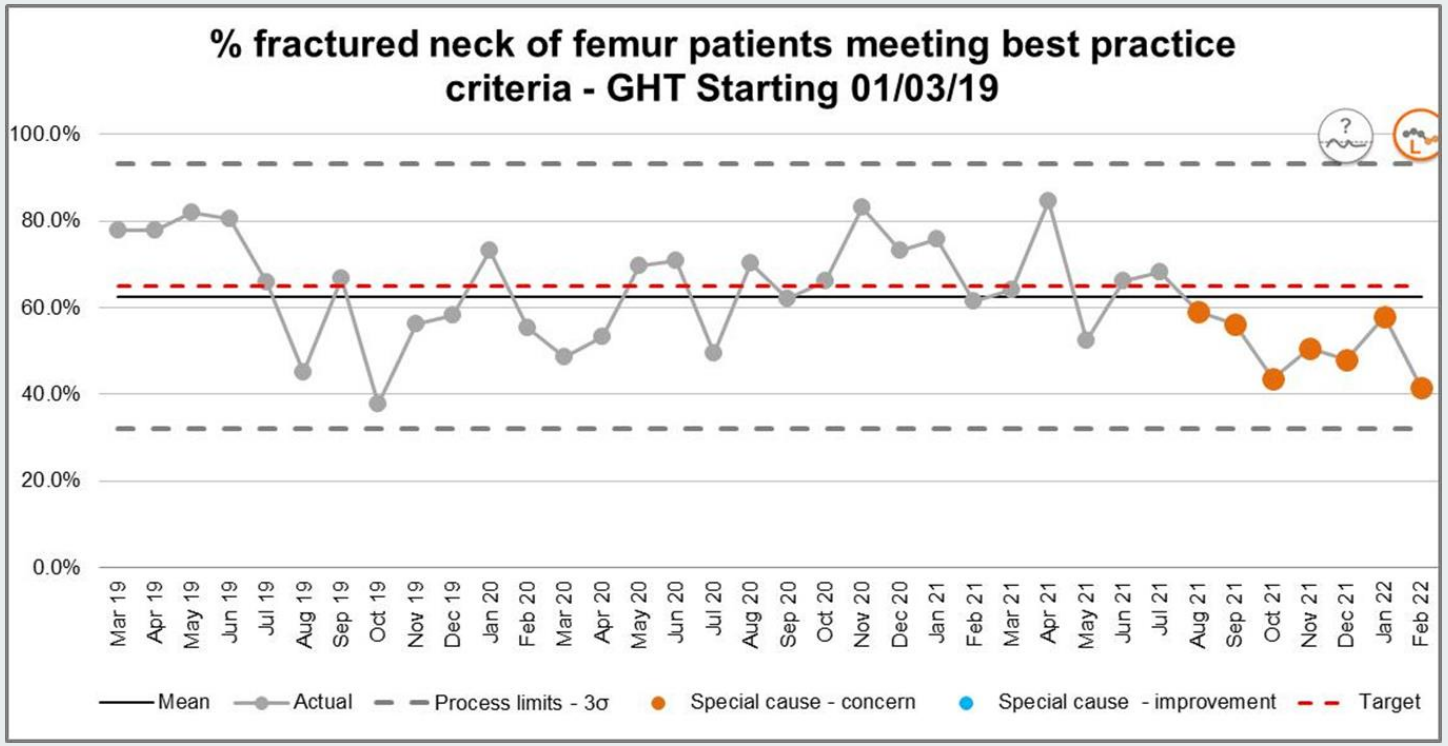
- **General Manager - Trauma & Orthopaedics**

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

- 55% got to theatre within 36 hrs
- 45% failed to get to surgery within 36 hours (of which 80% were delayed because of logistical reasons)

- General Manager - Trauma & Orthopaedics

Data Observations

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

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Friends & Family Test	Inpatients % positive	>=90%	Feb-22	87.1%
Friends & Family Test	ED % positive	>=84%	Feb-22	67.6%
Friends & Family Test	Maternity % positive	>=97%	Feb-22	91.9%
Friends & Family Test	Outpatients % positive	>=94.5%	Feb-22	93.4%
Friends & Family Test	Total % positive	>=93%	Feb-22	88.6%
PALS	Number of PALS concerns logged	No Target	Feb-22	248
PALS	% of PALS concerns closed in 5 days	>=95%	Feb-22	73%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Feb-22	0
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Feb-22	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Feb-22	7
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Feb-22	2
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Feb-22	5
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Feb-22	25.9
Infection Control	Number of MSSA bacteraemia cases	<=8	Feb-22	3
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Feb-22	11.1
Infection Control	Number of ecoli cases	No target	Feb-22	5
Infection Control	Number of pseudomona cases	No target	Feb-22	0
Infection Control	Number of klebsiella cases	No target	Feb-22	0
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Feb-22	637
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	No target	Feb-22	143

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	Feb-22	87
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	No target	Feb-22	37
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	No target	Feb-22	73
Maternity	% C-section rate (planned and emergency)	No target	Feb-22	0
Maternity	% emergency C-section rate	No target	Feb-22	15.7%
Maternity	% of women smoking at delivery	<=14.5%	Feb-22	0
Maternity	% of women that have an induced labour	<=33%	Feb-22	33.1%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Feb-22	0.00%
Maternity	% of women on a Continuity of Carer pathway	No target	Feb-22	14.70%
Maternity	% breastfeeding (initiation)	>=81%	Feb-22	76.8%
Maternity	% PPH >1.5 litres	<=4%	Feb-22	2.2%
Maternity	Number of births less than 27 weeks	NULL	Feb-22	0
Maternity	Number of births less than 34 weeks	NULL	Feb-22	4
Maternity	Number of births less than 37 weeks	NULL	Feb-22	19
Maternity	Number of maternal deaths	NULL	Feb-22	0
Maternity	Total births	NULL	Feb-22	413
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Feb-22	1.69%
Maternity	% breastfeeding (discharge to CMW)	NULL	Feb-22	46.0%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Sep-21	1.0
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Nov-21	106.9
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Nov-21	113.8

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	Feb-22	183	
Mortality	Number of deaths of patients with a learning disability	No target	Feb-22	1	
MSA	Number of breaches of mixed sex accommodation	<=10	Feb-22	0	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Dec-21	1	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Feb-22	7.6	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Feb-22	10	
Patient Safety Incidents	Number of patient safety incidents - severe harm (major/death)	No target	Feb-22	10	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Feb-22	0	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Feb-22	2	
Patient Safety Incidents	Medication error resulting in low harm	No target	Feb-22	8	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Feb-22	40	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Feb-22	1	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Feb-22	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Feb-22	14	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Feb-22	7	
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	Dec-21	5	
Safety Thermometer	Safety thermometer - % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Feb-22	2	
Serious Incidents	Number of serious incidents reported	No target	Feb-22	3	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Serious Incidents	Serious incidents - 72 hour report completed within contract timescale	>90%	Feb-22	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Feb-22	100%	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Feb-22	87.1%	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target	Nov-19	95%	
Safeguarding	Number of DoLs applied for	No target	Feb-22	53	
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target	Feb-22	2	
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	Feb-22	1	
Safeguarding	Total admissions aged 0-17 with DSH	No target	Feb-22	24	
Safeguarding	Total ED attendances aged 0-17 with DSH	No target	Feb-22	69	
Safeguarding	Total admissions aged 0-17 with an eating disorder	No target	Feb-22	7	
Safeguarding	Total number of maternity social concerns forms completed	No target	Feb-22	70	

Quality:
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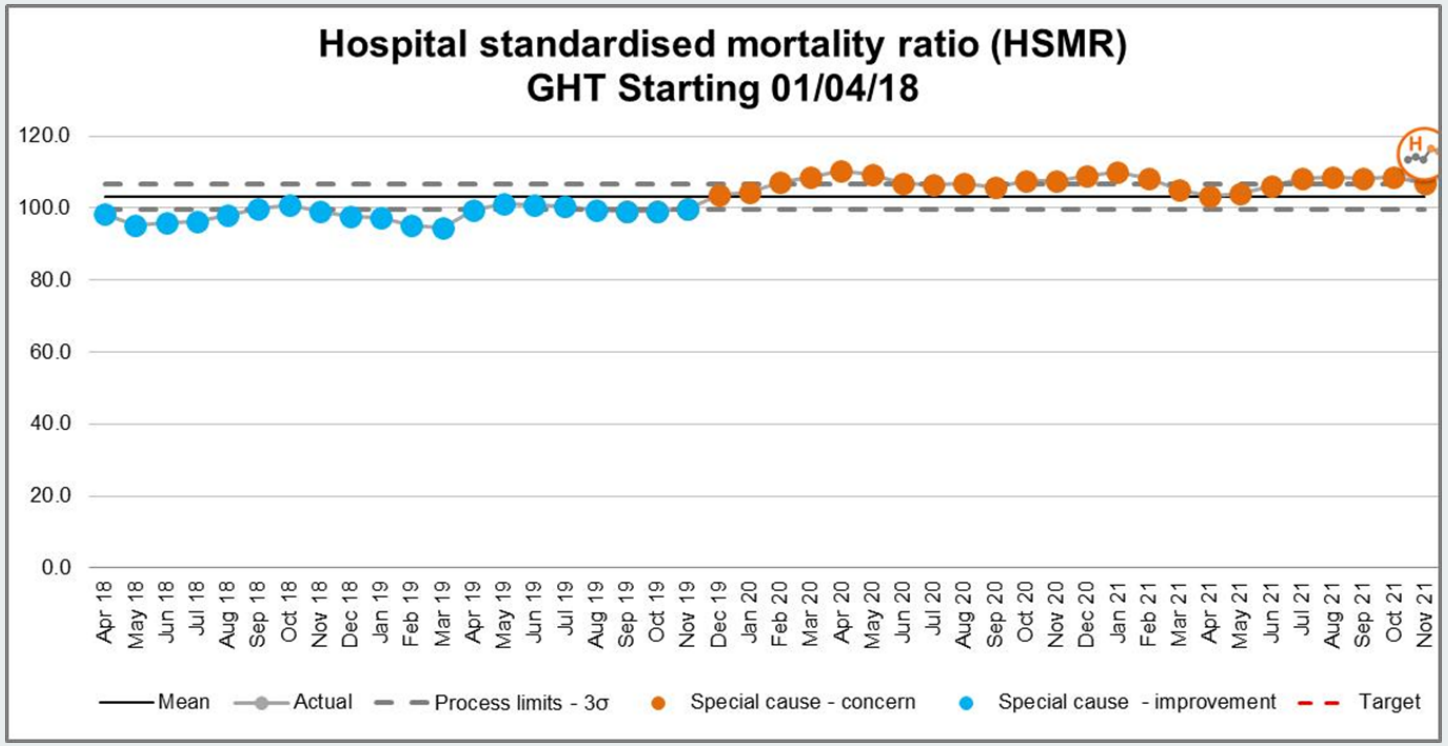


Commentary

Slight improvement month on month. If COVID activity is removed then both metrics are in the expected range suggesting the modelling has not accounted for this yet. Monitored at HMG previously Dr Foster (now Telstra) has suggested the modelling will slowly improve and adjust to take account the effects of COVID but we are not seeing this, they are going to look at it further and report back to HMG.

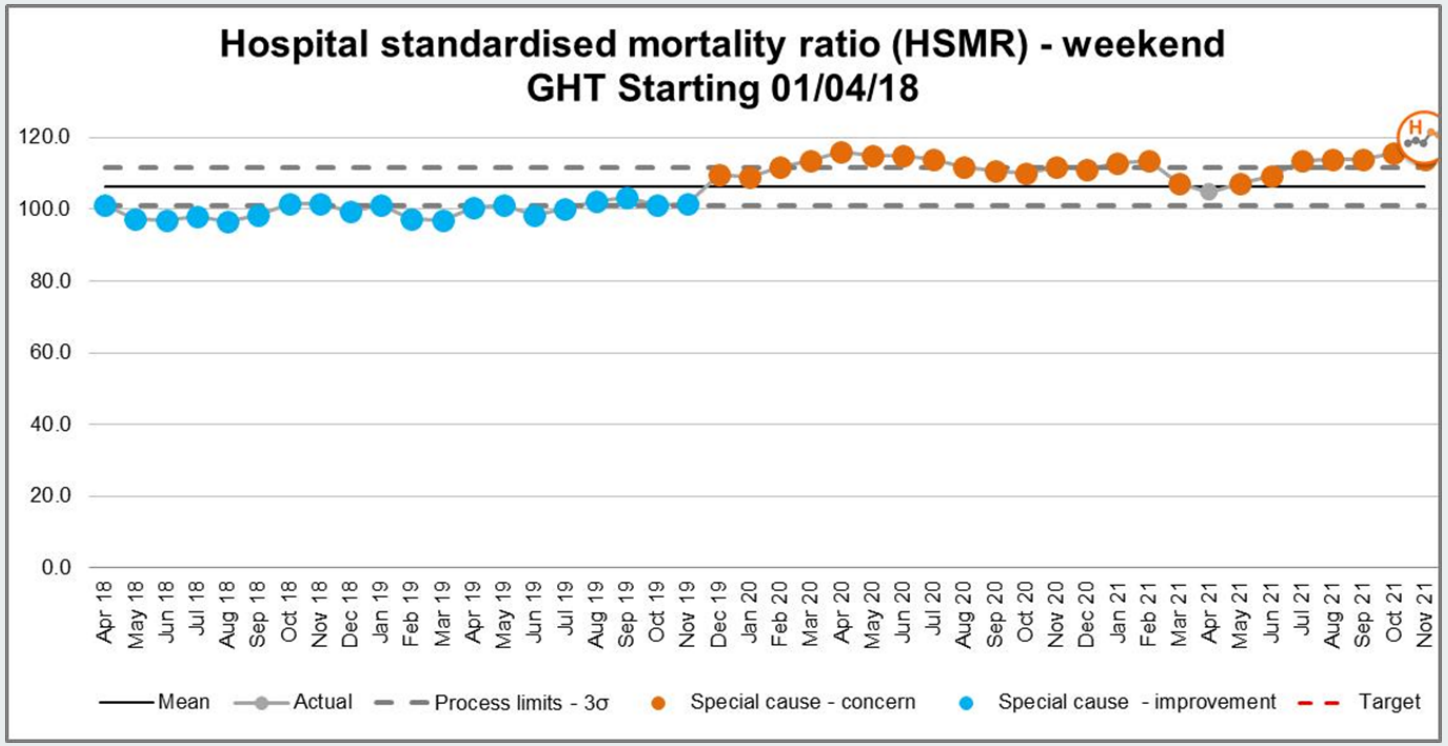
- Deputy Medical Director

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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SPC – Special Cause Variation

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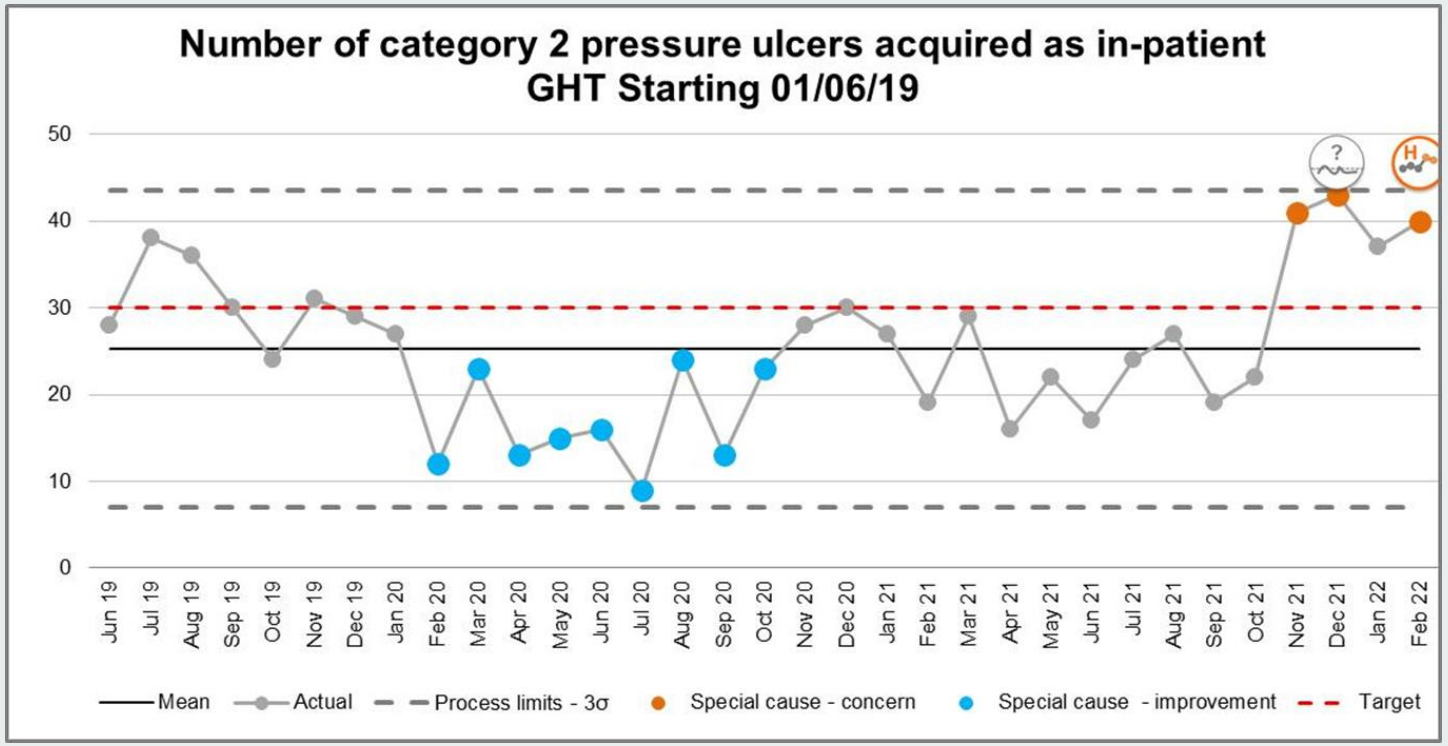

Commentary

Patients develop skin and soft tissue damage for multiple reasons in hospital settings. We have seen an increase during the winter period in the development of Category 2, deep tissue injuries and unstageable pressure ulcers across different wards in both hospitals. Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now accelerated to monthly to increase throughput.

- Associate Chief Nurse, Director of Infection Prevention & Control

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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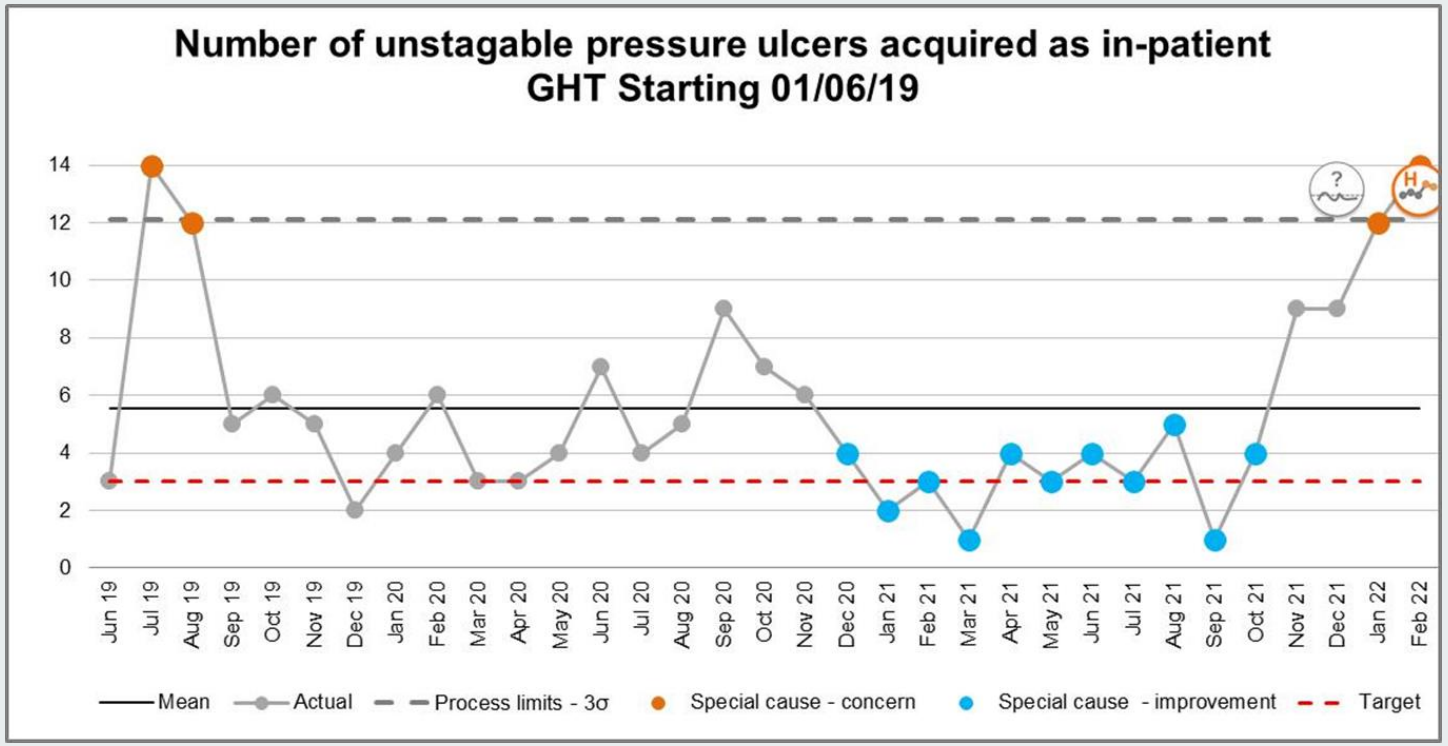
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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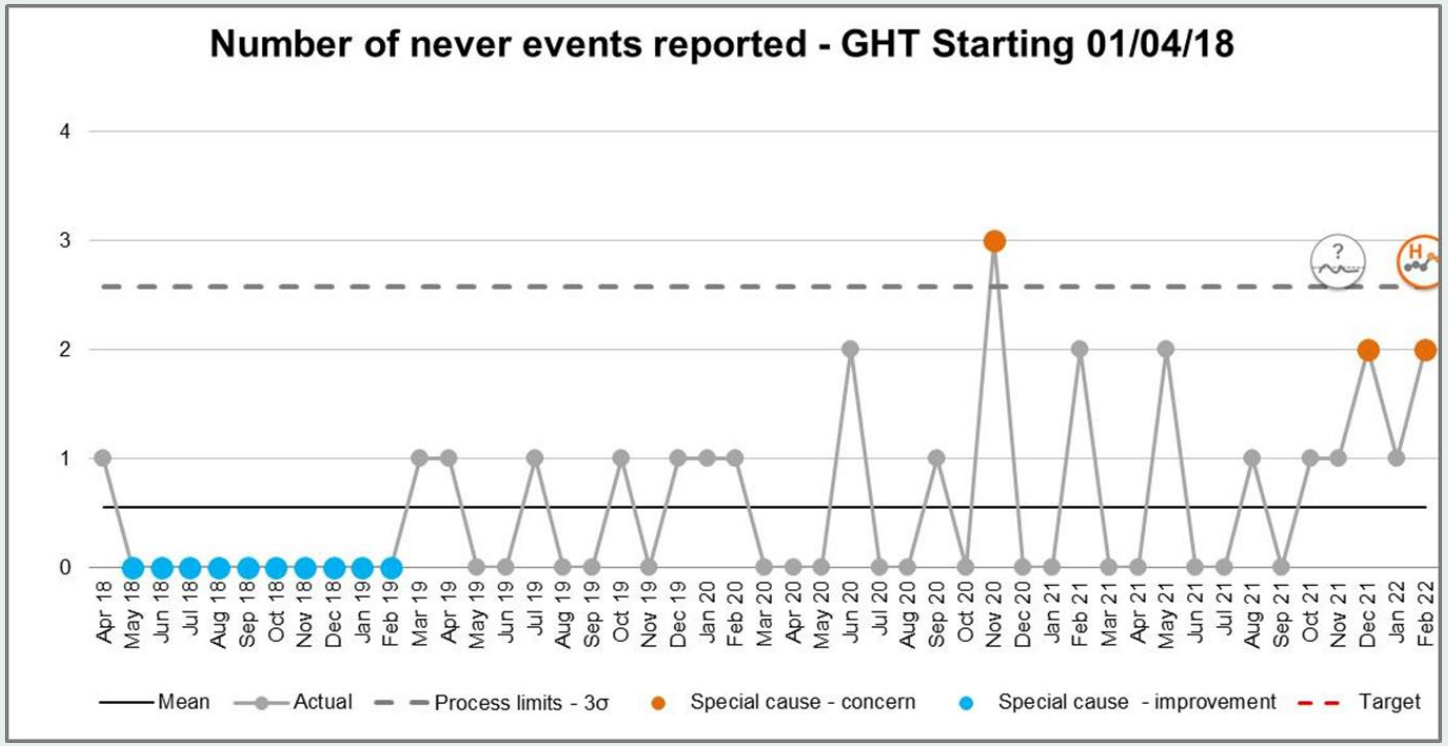
- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The incidents will be investigated using a barrier assessment approach. Information is routinely shared the CQC on progress. Immediate safety actions have been identified. To note this is the 10th Never event in the financial year and places the Trust at the top of the NE list nationally.

- Quality Improvement & Safety Director

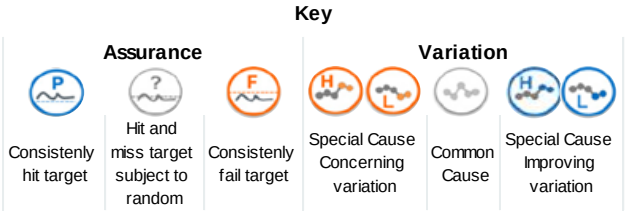
Data Observations

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.
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

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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



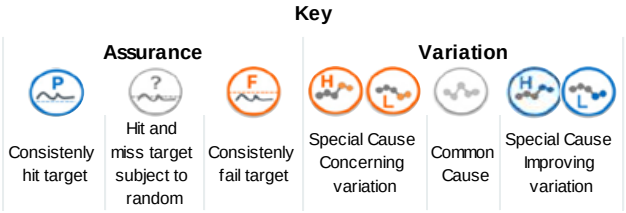
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	
Finance	NHSI Financial Risk Rating		Sep-20	
Finance	Capital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

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

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

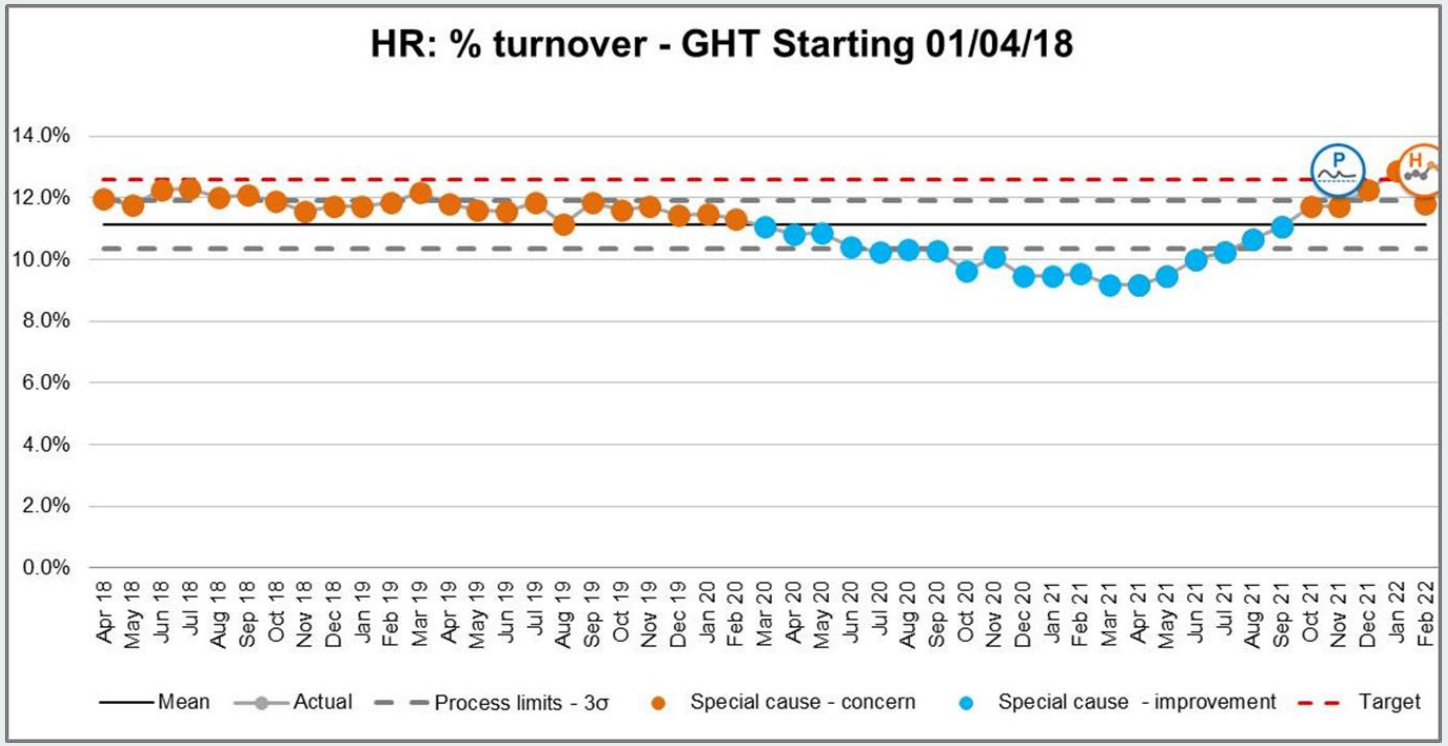
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	Feb-22	78.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	?	Feb-22	87%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	P	Jan-22	85.9%	
Safe Nurse Staffing	% registered nurse day	>=90%	?	Jan-22	84.2%	
Safe Nurse Staffing	% unregistered care staff day	>=90%	P	Jan-22	83.9%	
Safe Nurse Staffing	% registered nurse night	>=90%	?	Jan-22	89.0%	
Safe Nurse Staffing	% unregistered care staff night	>=90%	P	Jan-22	95.3%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Jan-22	5.0	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	P	Jan-22	3.1	
Safe nurse staffing	Care hours per patient day total	>=8		Jan-22	8.1	
Vacancy and WTE	Staff in post FTE	No target		Feb-22	6678.5	
Vacancy and WTE	Vacancy FTE	No target		Feb-22	799.75	
Vacancy and WTE	Starters FTE	No target		Feb-22	69.31	
Vacancy and WTE	Leavers FTE	No target		Feb-22	47.74	
Vacancy and WTE	% total vacancy rate	<=11.5%	P	Feb-22	10.68%	
Vacancy and WTE	% vacancy rate for doctors	<=5%	?	Feb-22	8.35%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	F	Feb-22	14.29%	
Workforce Expenditure	% turnover	<=12.6%	P	Feb-22	11.8%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%	P	Feb-22	10.7%	
Workforce Expenditure	% sickness rate	<=4.05%	P	Feb-22	4.0%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Trust's staff turnover continues to be of key focus across all staff groups, particularly with the ongoing flight risk following the pandemic. Understanding reasons for staff leaving remains a priority in order to support the development of informed retention initiatives. Understanding the outcomes of the Trust's Staff Survey results is also key in the months ahead to ensure there are proactive and responsive actions.

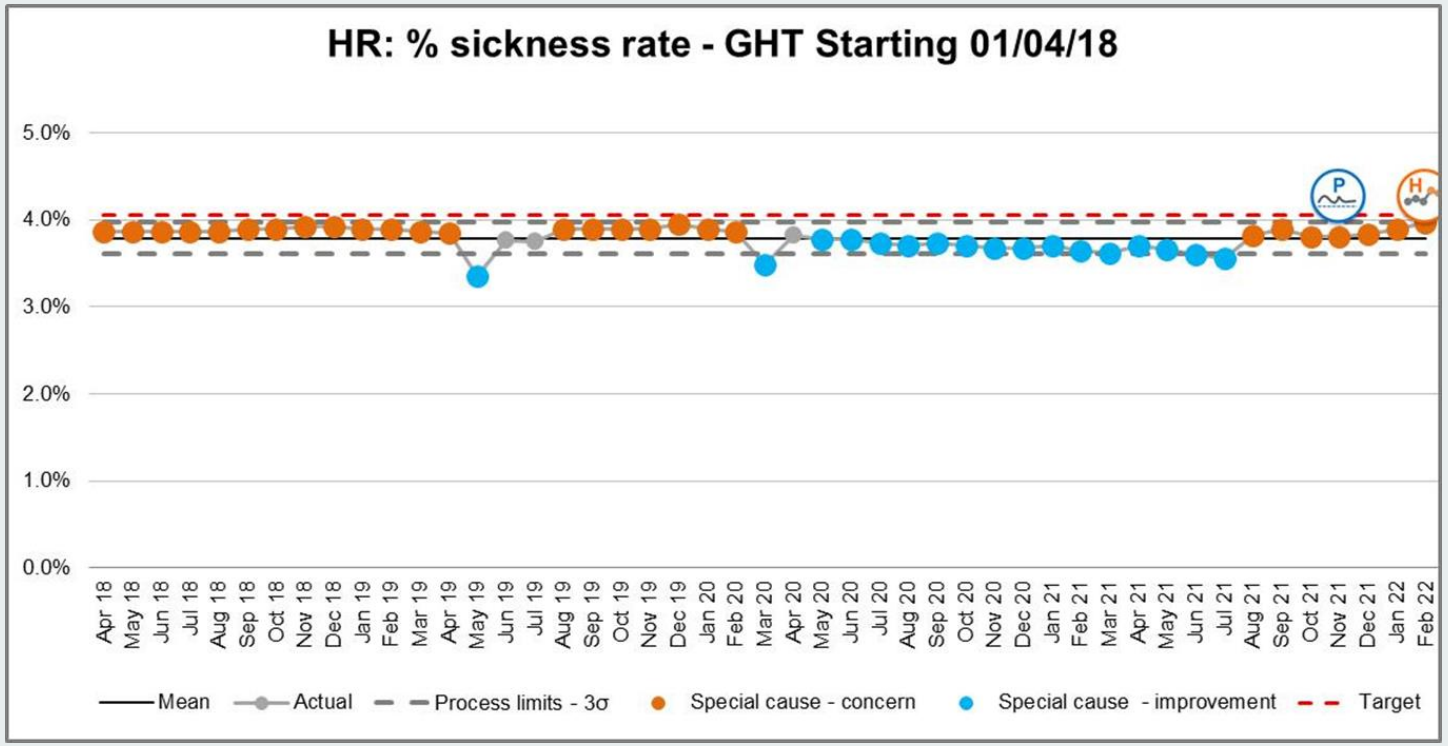
- **Director of Human Resources and Operational Development**

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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Particular focus is currently being given to supporting staff who are suffering from long COVID.

- **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 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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	10	Enclosure Number:	5
Date	14 April 2022		
Title	Learning from Deaths Report Quarter 2		
Author /Sponsoring Director/Presenter	Andrew Seaton, Quality Improvement and Safety Director Mark Pietroni, Medical Director		

Purpose of Report			Tick all that apply ✓
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	✓

Summary of Report

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 communicate 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 around 85%.
- 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 decreased to 53% from 63% which reflects a significantly busy time for the Trust as we moved into winter last year. Each Division have been asked to review their triggers to ensure sufficient deaths are captured for reviews.
- All serious incidents have action plans based on the identified learning which are monitored to completion.
- Mortality statistic for HSMR, SMR have risen to statistically higher than expected with weekend\weekday mortality also higher than the accepted range.The COVID impact on mortality maintains a complex picture but when COVID is removed from these data the Trust remains within normal variation.

- HSMR is now 108.4 from the previous reported position of 101.4
- SMR is now 106.9 from the previous reported position of 99.4

SHIMI for period Sept 2020 - Aug 2021 remains in the expected range at 101.32 from 98.13.

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.

Recommendation

The Board is asked to receive the report as a briefing and source of assurance that the Trust is continually reviewing and learning from deaths.

Enclosures

- Learning from Deaths Report

Gloucestershire Hospitals
NHS Foundation Trust

QUALITY & PERFORMANCE COMMITTEE – FEBRUARY 2022

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 July - September 2021 and 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. (Appendix 2 for Q&PC only).

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 an example is summarised in Appendix 4 (For Q&PC only).

Some areas review all deaths because of small numbers of deaths in the specialty. Several areas are not performing sufficient reviews as they rely on the national triggers, Divisions have been asked to review their triggers in these areas and report back to HMG

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 HSMR and SMR have moved to a higher than expected range from the previous report. SHIMI remains within the expected range. The COVID impact on mortality maintains a complex picture but when COVID is removed from these data the Trust remains within normal variation.

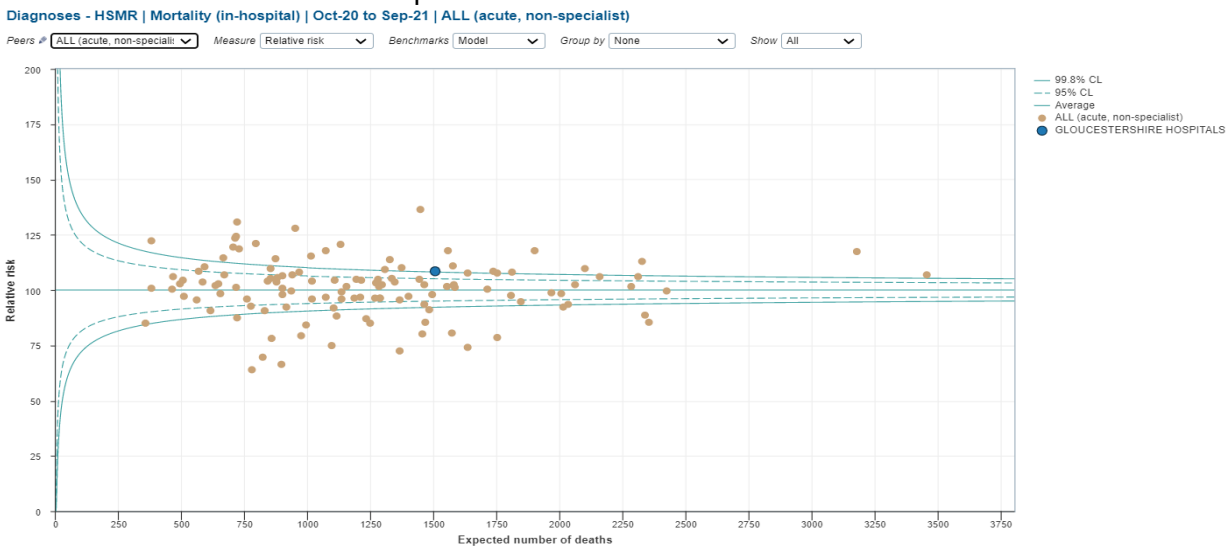
3.2 HSMR &SMR for the period October 2020 – September 2021 is above the expected range:

- HSMR is now 108.4 from the previous reported position of 101.4 but returns to normal limits when COVID activity is removed.

- SMR has now 106.9 increased to from the previous reported position of 99.4 which is statistically significant, but returns to normal limits when COVID activity is removed.

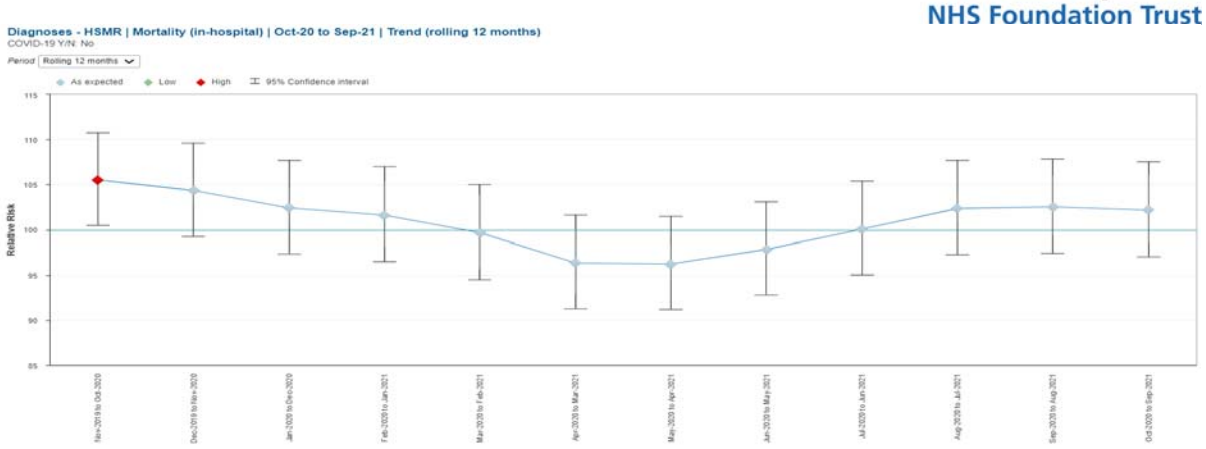
- SHIMI for period Sept 2020 – Aug 2021 remains in the expected range at 101.32 from 98.13. This data has COVID removed before calculation.

3.2 HSMR October 2020 – September 2021



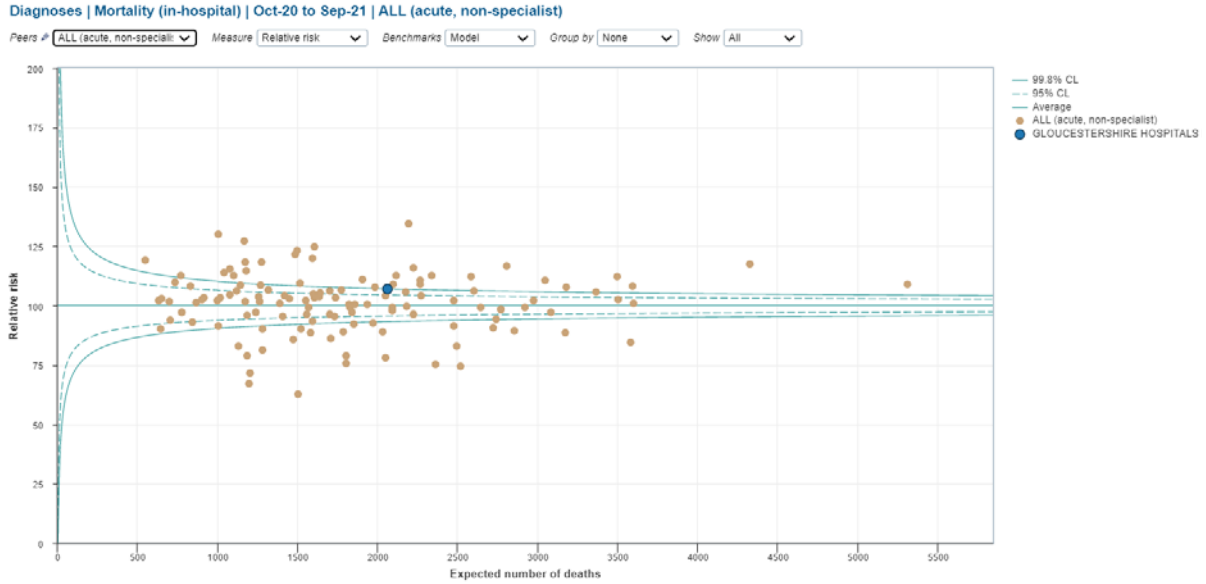
If COVID-19 activity is removed from the HSMR (where it is in a secondary diagnosis position), it reduces to 101.0 (99.5 – 102.5) for the latest 12 month period, this is statistically 'as expected'. The rolling 12 month trend shows a similar trend with an increase noted in April 21.

Fig. 1.2 — Rolling 12 Month Trend in HSMR Excluding COVID-19 Activity

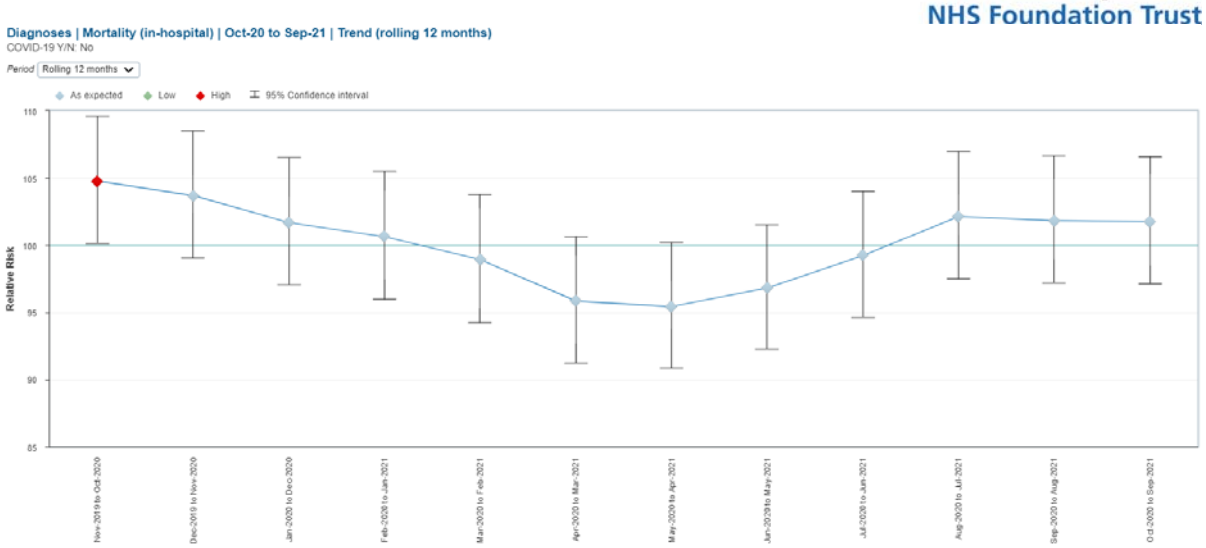


3.3 SMR

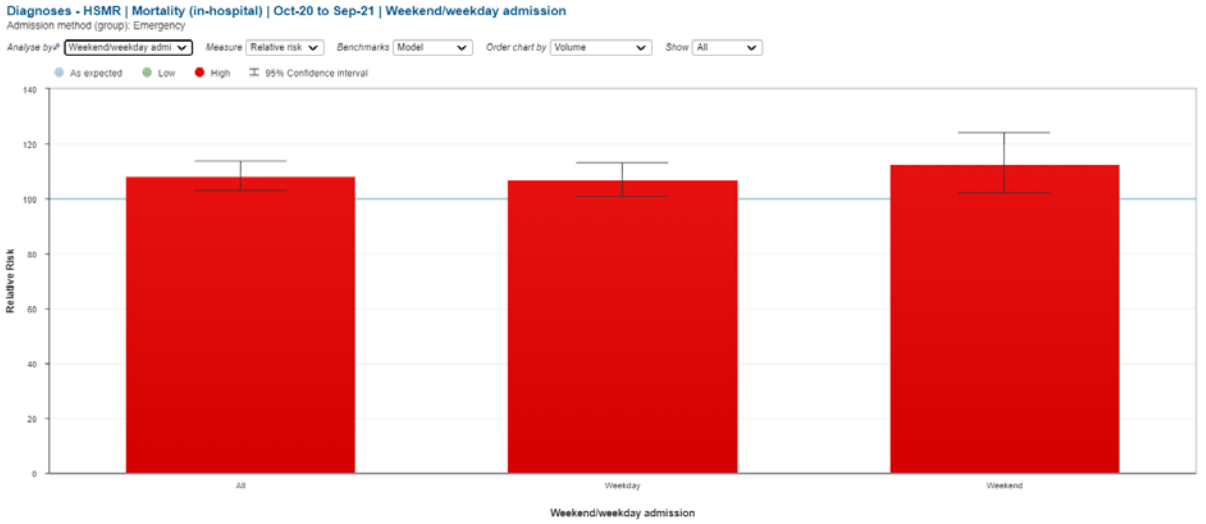
The SMR for the Trust is statistically significantly higher for this period Oct 2020 – Sept 2021.



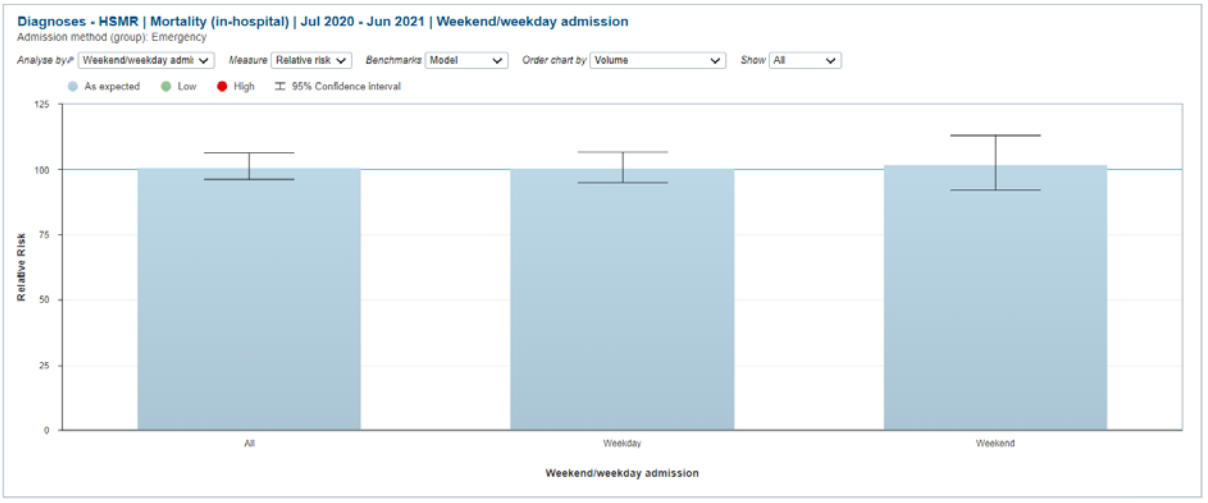
If COVID-19 activity is removed from the SMR (primary or secondary diagnosis position), it reduces to 101.8 (97.1 – 106.6) for the latest 12 month period, this is statistically significantly 'as expected'. The rolling 12 month trend shows a slight increase since April 21.



Both weekday and weekend HSMR for emergency admissions are now higher than expected range. Oct 2020-Sept 2021



Previously reported weekday and weekend HSMR for emergency admissions were within the expected range. July 2020 – June 2021



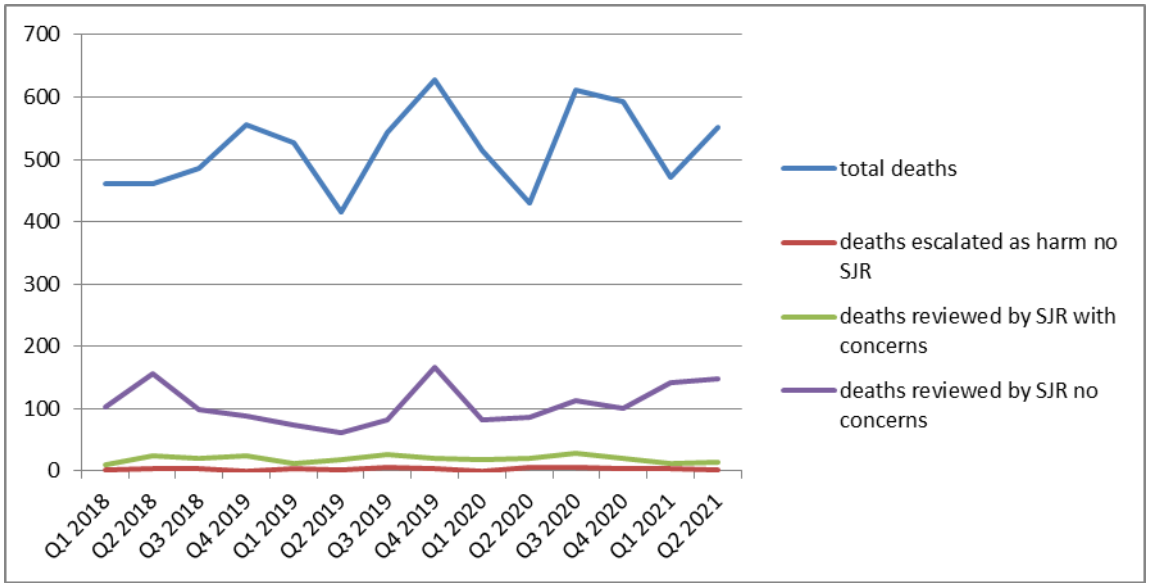
4. Structured Judgement Review Process

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 continue to ensure all deaths are recorded in real time.

4.2 Deaths identified for review (next page)

Mortality Quarterly Dashboard Trust wide: Quarter 2 (July – Sept 2022)

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
552	471	**2**	4	**14**	13	**147**	141	157 (28%)	146(31%)	**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
1023	2150	**6**	15	**27**	89	**288**	382	303 (30%)	454 (21%)	**1**	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	**5**	8	**30**	67	**41**	108	**18**	40	**1**	1

Problems identified in care and care record									
Problem in assessment, investigation or diagnosis		Problem with medication /IV fluids /electrolytes /oxygen		Problem related to treatment/management plan		Problem with infection control		Problem related to operation/ invasive procedure	
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)
1	1	1	1	0	1	0	0	0	0

Problems identified in care and care record							
Problem in clinical monitoring		Problem in resuscitation following a cardiac or respiratory arrest		Other Problem		Quality of Patient Record Poor or very poor	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
1	1	0	0	1	2	1	1

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death (measurement ceased)		Deaths reviewed within 3 months of request (% 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 (19/01/2022) (% of total requiring review)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
Not measured	12 (57%)	**86 (53%)**	Measurement amended	**4 (80%)**	2 (66%)	**54 (34%)**	17 (12%)	**72 (46%)**	24 (16%)
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
Not measured	30 (34%)	**Measurement amended**	Measurement amended	**6 (75%)**	9 (64%)	**71 (23%)**	305 (67%)	**96 (32%)**	8 (2%)

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. Several areas are not performing sufficient reviews as they rely on the national triggers, this area needs a review and the identification of more relevant triggers.

4.4 The Performance against standard tables above illustrates the general performance with 53% a slight drop from an average of around 60% which would reflect the business of the Trust during winter when these reviews would be undertaken for this quarter.

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. These data will be presented at the End

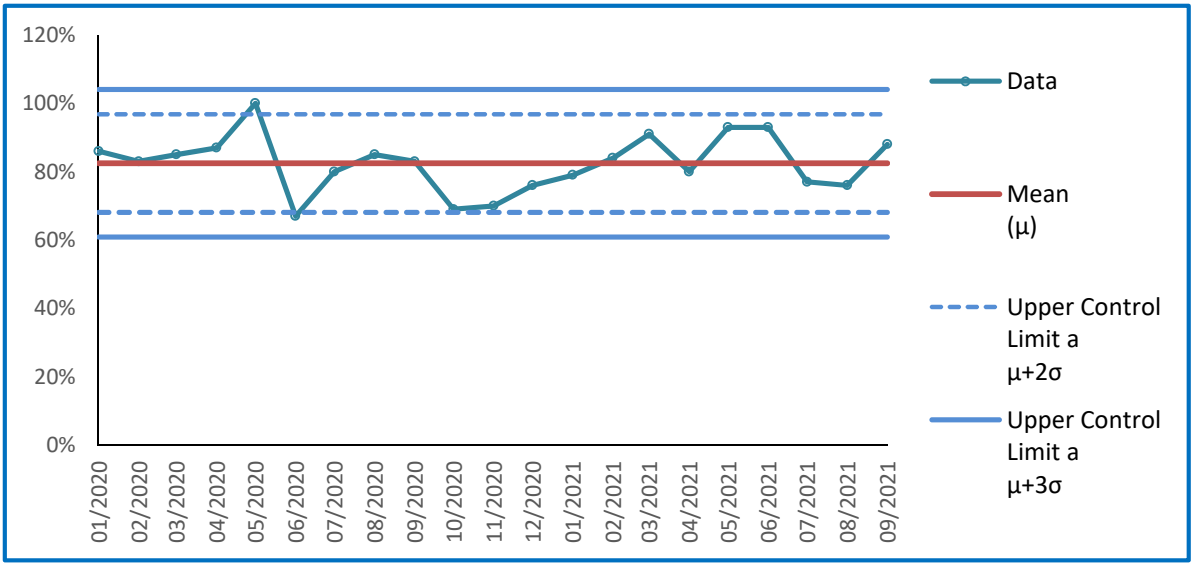
of meeting Life (as the expert group) as part of their meetings and inform discussion on assurance and improvement work with updates featuring in this report.

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

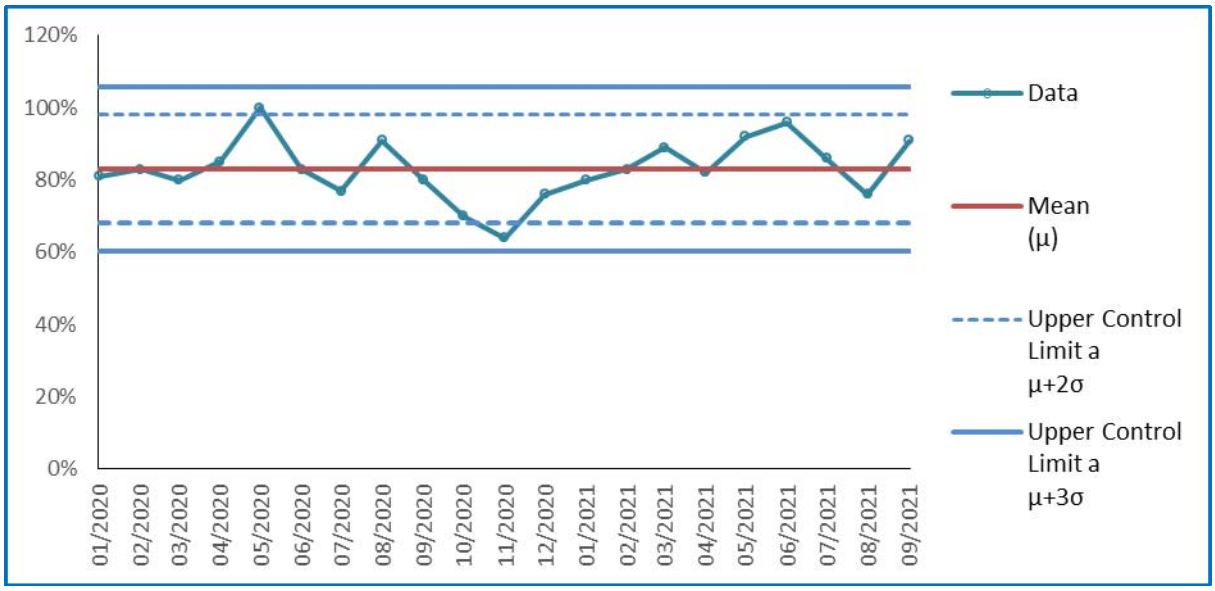
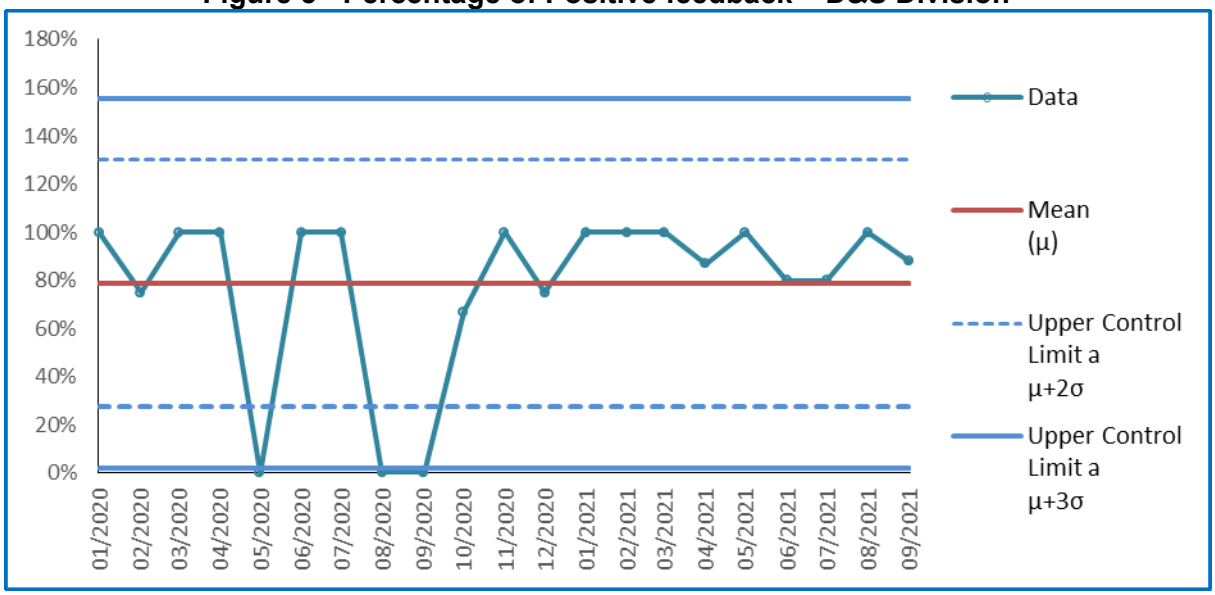


Figure 4 - Percentage of Positive feedback – Surgery Division

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 Themes of Feedback (July-Sept 2021)

These themes are taken from the National Audit of Care at the End of Life and will be linked to the audit at the End of Life Committee.

<u>Communication with the dying person</u>

There were 2 positive comments regarding the manner of communication with the dying person:

> "treated him as a person and not as an alcoholic"

> "treated like a person despite his lack of speech."

Communication with families and others

Where communication was mentioned it was mainly negative. Four comments regarding an inability to get through on the phones and two further comments regarding booking of visiting times. The latter was exacerbated by the failure to answer phones. There were three comments re a failure to notify family of transfers between wards or between hospitals, one failure to communicate a fall and one failure to notify of death.

There were comments regarding the difficulty in getting honest communication over the phone and insensitivity of phone calls. Two comments reported not understanding that the patient was as poorly as they were and not having the do not resuscitate explained.

> "Telephone system is a shambles. No-one answers most of the time."

> "frustrating trying to get through on phone - it would ring then cut off after a while"

> "needed more honest communication over the phone especially as this was the way communication was mostly done due to visiting restrictions."

> "at one point the sister said 'she was too busy to talk and that there was someone more poorly"

Needs of families and others

There were mainly positive comments regarding the compassion shown by staff, being looked after and provided with cups of tea and sleeping facilities.
The negative comments related to the environment e.g. temperature and light and being nursed in a bay.

> "Son was made to feel very welcome; was even found a proper bed which he was very grateful for".

Individualised plan of care

The majority of comments are not specific to plans of care. There were two individual negative comments re missed doses and feeding.

> "Staff overwhelmed, family noticed stroke before staff, missed medications including 6 doses of antibiotics."

> "Difficulties with feeding on ward - given sandwich when should have been pureed."

Families and others experience of care

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

> "the care was perfect on the ward, everything was done with compassion"

> "Staff would be given 101%! Looked after family too."

> "The family said the care was incredible, the staff were inspirational and showed great compassion to both patient and family . Faultless!!"

> "The family cannot stress enough how caring the staff were, pulled out all the stops to make her end very dignified. All staff extremely kind and caring"

> "The nurses were absolutely fabulous - superb.!! They were hardworking, professional , and full of empathy and we couldn't praise them enough, they were exemplary"

There were two negative comments regarding waits in the emergency department, two comments about the inability of patients to die at home due to lack of carers and funding and one regarding lack of bedding.

> "Only sadness is that "relative" couldn't die at home which was his wish but there were no carers available."

"Staff were frustrated and in tears one day as there was no bedding to change the sheets. This was awful for them and for the patients and appalling that they didn't have the basic necessities to look after their patients."

5.4 Conclusion

Feedback responses have been maintained from the last quarter at pre-covid levels.

There has been continued improvement in positive feedback from November 2020 to March 2021 and now is showing normal variation with a mean of 82%.

Thematic review will feature in the End of Life committee with future recommendations or actions highlighted in this report.

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) and resuscitation decisions on admission (Being reviewed by the End of Life Committee).

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

6.4 LeDeR

During Q1 and Q2 to date in 2021 we had a slightly higher than usual numbers of LD

deaths, but this has not been the case in Q3.

LeDeR reviewers are regularly attending GHFT to review notes and QA meetings occur every month. There is a backlog of reviews on deaths occurring since April, but the presentation order of reviews at LeDeR is not under the control of GHFT

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 (For Q&PC only)

Appendix 3
a) Mortality indicators – Dr Foster report

Appendix 4
a) Medical Division example (For Q&PC only)

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 through specialty & divisional learning

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

8.4 Family feedback shows good satisfaction, analysis is reported under the national end of life clinical audit themes and will be interpreted by the End of Life group to identify areas for improvement.

8.5 Mortality indicators across most parameters are showing a general increase and are above expected ranges which is likely to be affected by COVID, with the exception of SHIMI which has COVID patients removed prior to calculation.

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

February 2022

Gloucestershire Hospitals NHS Foundation Trust

Appendix 1

Mortality Quarterly Dashboard: Quarter 2 (July-Sept 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
75	67	**2**	0	**3**	1	**9**	9	**10**	10 (15%)	**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
142	340	**2**	6	**4**	24	**18**	91	**20**	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**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Critical care	29	**0**	2 (7%)	0	0	0
T&O	14	**1**	4 (29%)	0	0	0
Upper GI	11	**0**	2 (18%)	0	0	0
Lower GI	10	**0**	2 (20%)	0	0	1
Vascular	7	0	0 (0%)	N/A	N/A	N/A
Urology	1	**0**	0 (0%)	N/A	N/A	N/A
Breast	0	0	N/A	N/A	N/A	N/A
ENT	3	**0**	0 (0%)	N/A	N/A	N/A
OMF	0	0	N/A	N/A	N/A	N/A

Ophthalmology	0	**0**	N/A	N/A	N/A	N/A

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death (measurement ceased)		**Deaths reviewed within 3 months of request (% 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 19/01/2022 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
Not measured	0 (0%)	**4 (44%)**	Measurement amended	**N/A**	N/A	**4 (40%)**	3 (30%)	**2 (20%)**	1(10%)
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
Not measured	9 (38%)	**Measurement amended**	Measurement amended	**N/A**	2 (0%)	**7 (35%)**	83 (73%)	**3 (15%)**	0 (0%)

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

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
446	376	**0**	2	**11**	12	**135**	130	**144 (32%)**	134 (36%)	**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
822	1633	**2**	8	**23**	61	**265**	275	**278 (34%)**	330 (20%)	**1**	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	**150**	0	74 (49%)	**0**	**1**	**2**
Cardiology	**28**	0	8 (29%)	**0**	**0**	**0**
Emergency Department	**43**	0	41 (95%)	**1**	**3**	**11**
Gastroenterology	**8**	0	1 (12%)	**0**	**0**	**1**
Neurology	**3**	0	2 (66%)	**0**	**0**	**0**
Renal	**31**	0	2 (6%)	**0**	**0**	**0**
Respiratory	**66**	0	4 (6%)	**0**	**0**	**0**
Rheumatology	**0**	0	N/A	**N/A**	**N/A**	**N/A**
Stroke	**26**	0	1 (4%)	**0**	**0**	**0**

COTE	**81**	0	10 (12%)	**0**	**1**	**2**
Diabetology	**10**	0	1 (10%)	**0**	**0**	**1**
Endoscopy	**0**	0	N/A	**N/A**	**N/A**	**N/A**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death (measurement ceased)		**Deaths reviewed within 3 months of request (% 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 19/01/2022 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
Measurement ceased	0 (0%)	**80 (54%)**	Measurement amended	**4 (80%)**	2 (66%)	**48 (33%)**	14 (10%)	**68 (47%)**	23 (17%)
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
Measurement ceased	19 (31%)	**Measurement amended**	Measurement amended	**6 (75%)**	4 (44%)	**62 (22%)**	311 (94%)	**91 (33%)**	8 (2%)

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

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
28	29	**0**	0	**0**	0	**2**	2	**3 (11%)**	2 (7%)	**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
57	72	**1**	0	**0**	4	**4**	14	**5 (9%)**	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	**24**	**0**	**1 (4%)**	**0**	**0**	**0**
Clinical haematology	**4**	**0**	**1 (25%)**	**0**	**0**	**0**

Performance against standards for review									
Deaths with concerns reviewed within 1 month of death (Measurement ceased)		**Deaths reviewed within 3 months of request (% 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 19/01/2022 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter

Measurement ceased	0 (0%)	**1 (33%)**	Measurement amended	**N/A**	N/A	**1 (33%)**	0 (0%)	**2 (67%)**	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
Measurement ceased	1 (50%)	**Measurement amended**	Measurement amended	**N/A**	**2 (100%)**	**1 (20%)**	14 (78%)	**2 (40%)**	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
3	0	**0**	0	**0**	0	**1**	0	1	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
3	2	**0**	1	**0**	0	**1**	0	1	0 (0%)	**0**	0

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

Deaths with concerns reviewed within 1 month of death (measurement ceased)		**Deaths reviewed within 3 months of request (% 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 19/01/2022 (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
Measurement ceased	N/A	**1 (100%)**	Measurement amended	**N/A**	N/A	**1 (100%)**	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
Measurement ceased	N/A	**Measurement amended**	Measurement amended	**N/A**	**N/A**	**1 (100%)**	N/A	**0**	0

Gloucestershire Hospitals NHS Foundation Trust

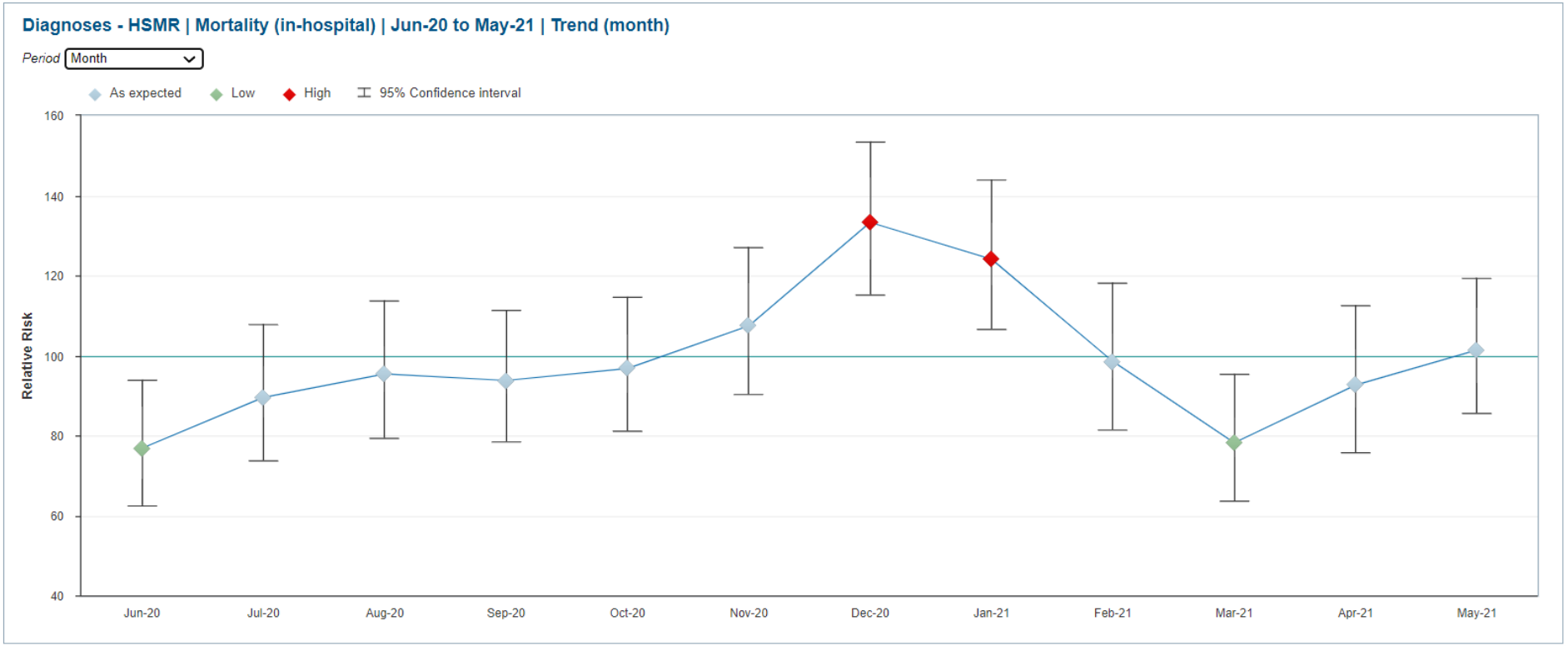
Appendix 3

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

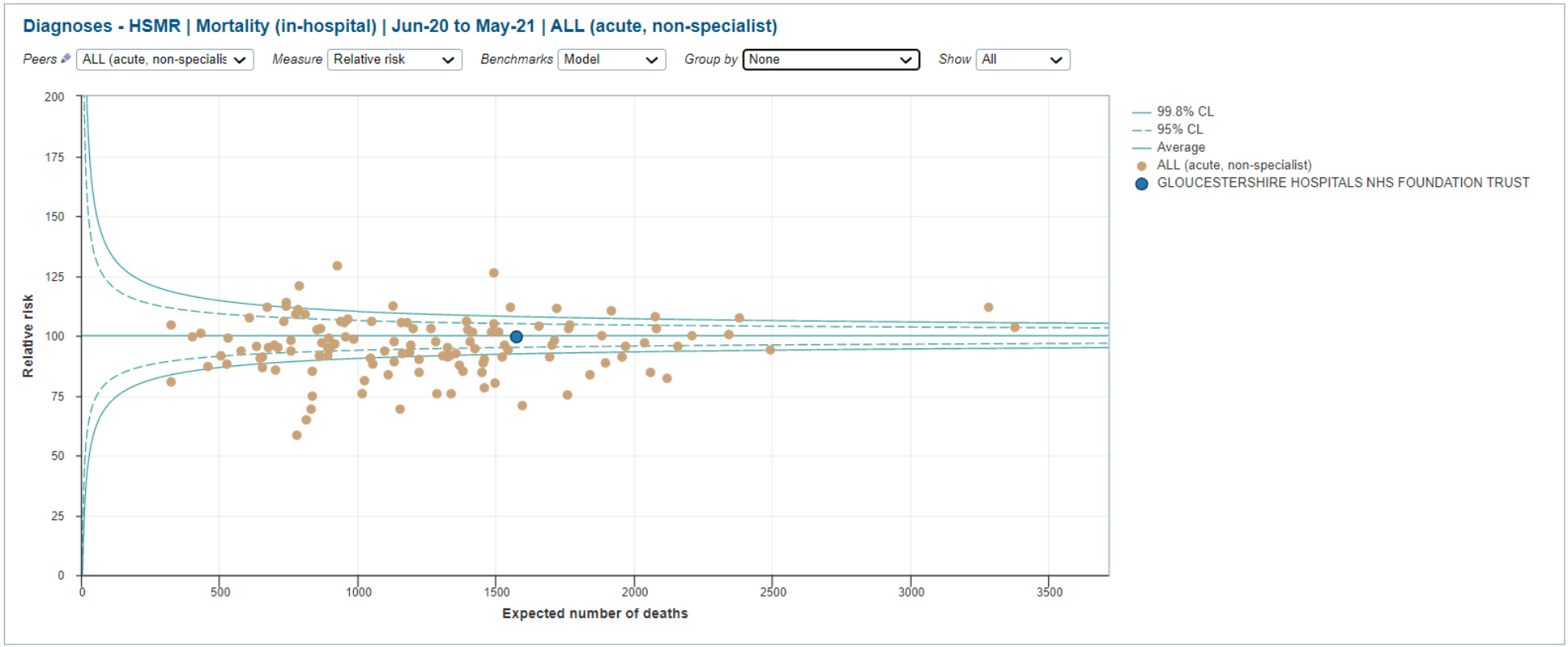
Metric	Result (arrows indicate change vs. previous 12 month period)
HSMR	99.7, within the expected range (↑) If COVID-19 is excluded, HSMR reduces to 93.0, statistically significantly lower than expected
SMR	97.7, statistically significantly higher than expected (↑) If COVID-19 is excluded, SMR reduces 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 (↑)**

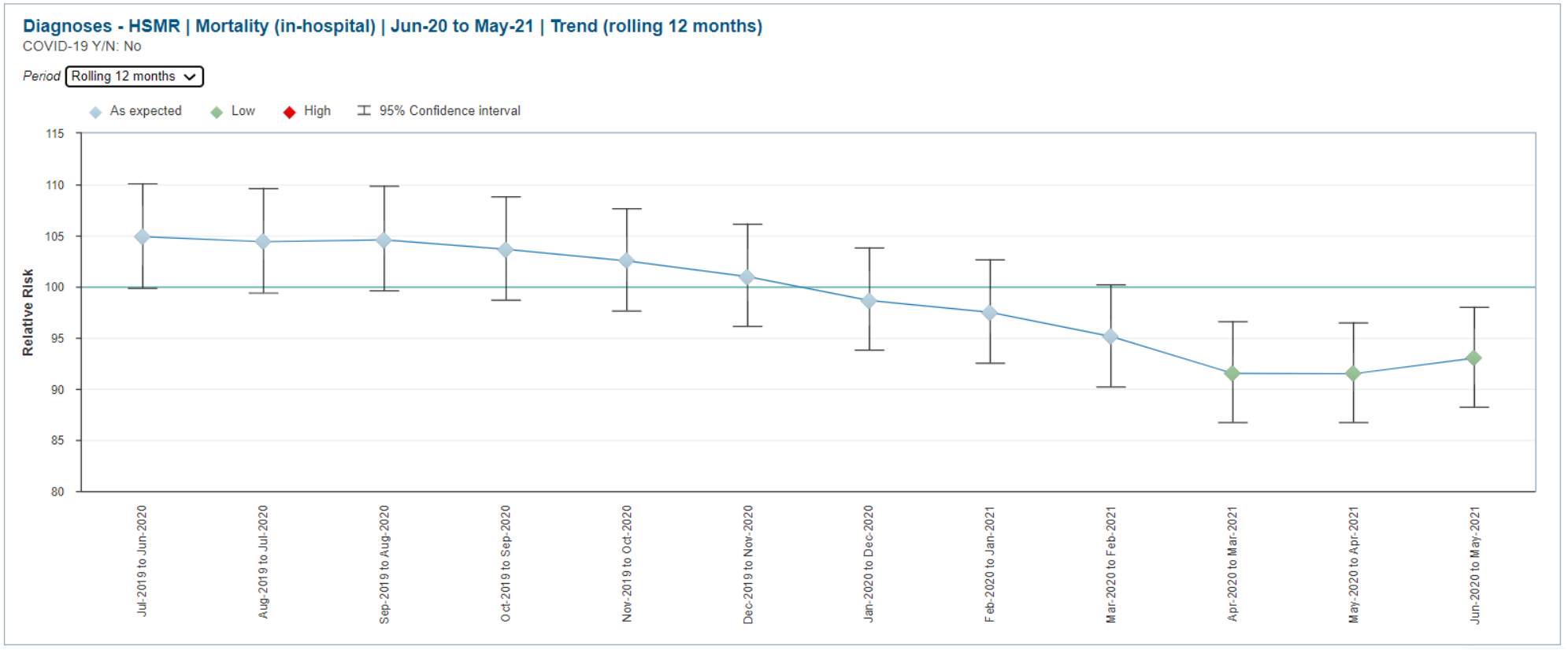
The HSMR for the 12 month period is 99.7 (94.9 – 104.8), this is within the expected range



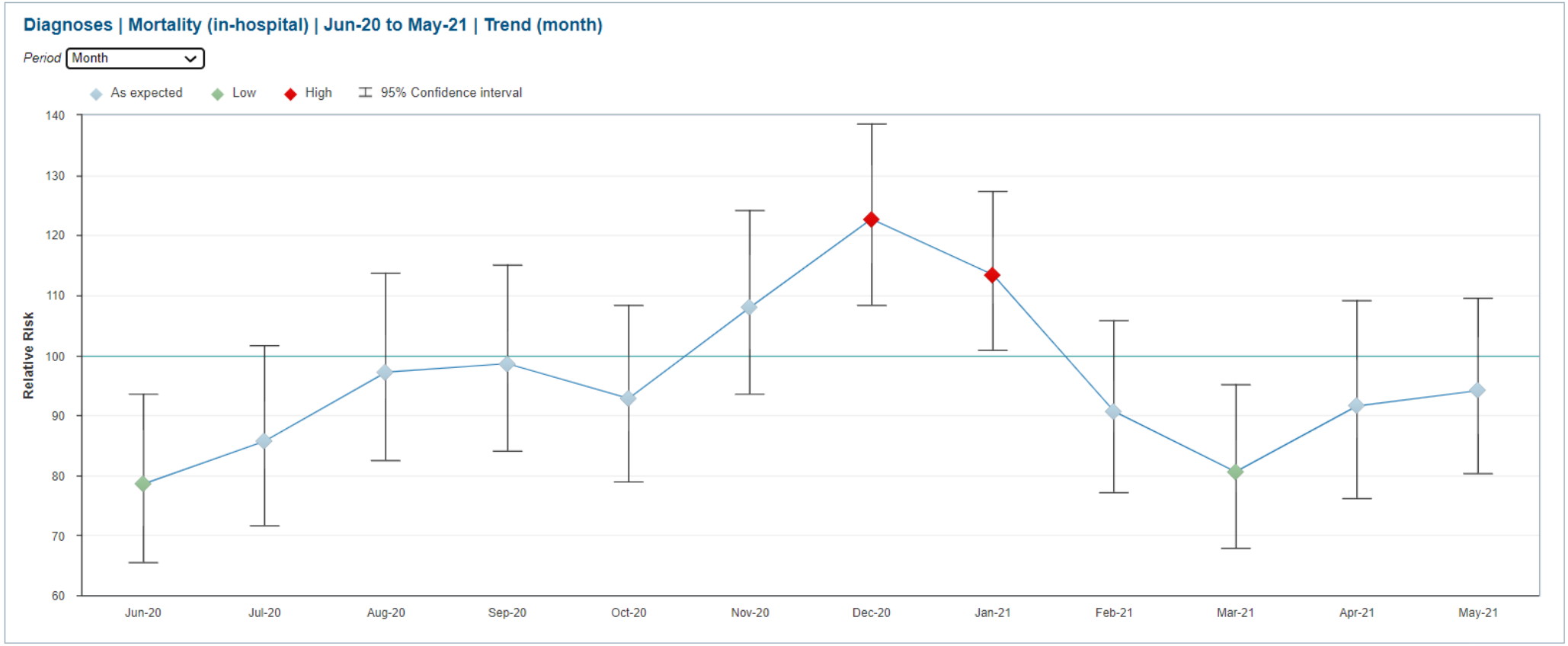
National Comparison - The HSMR remains within the expected range using 99.8% control limits



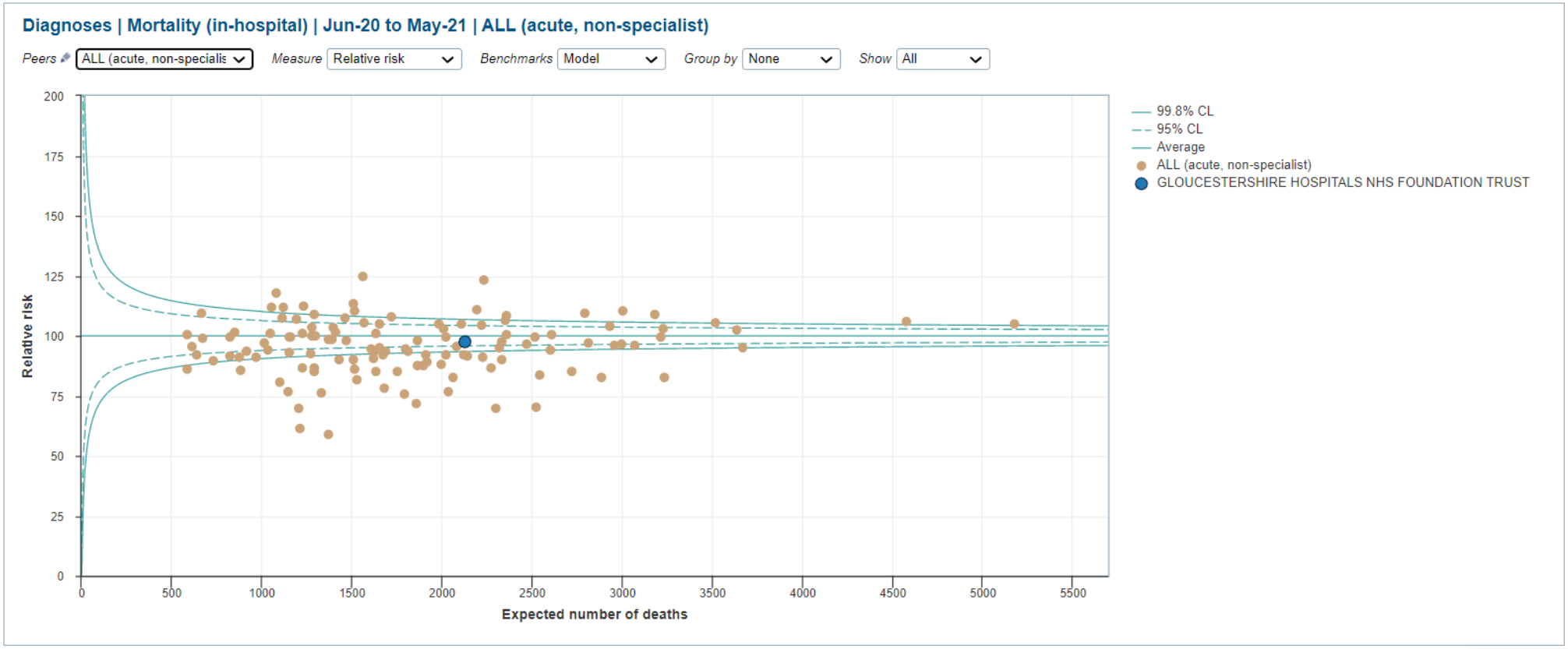
If COVID-19 activity is excluded from the HSMR (where it is in a secondary diagnosis position) the HSMR for the latest 12 month period reduces to 93.0 (88.2 – 98.0), this is statistically significantly lower than expected. The rolling 12 month trend shows a linear decrease.



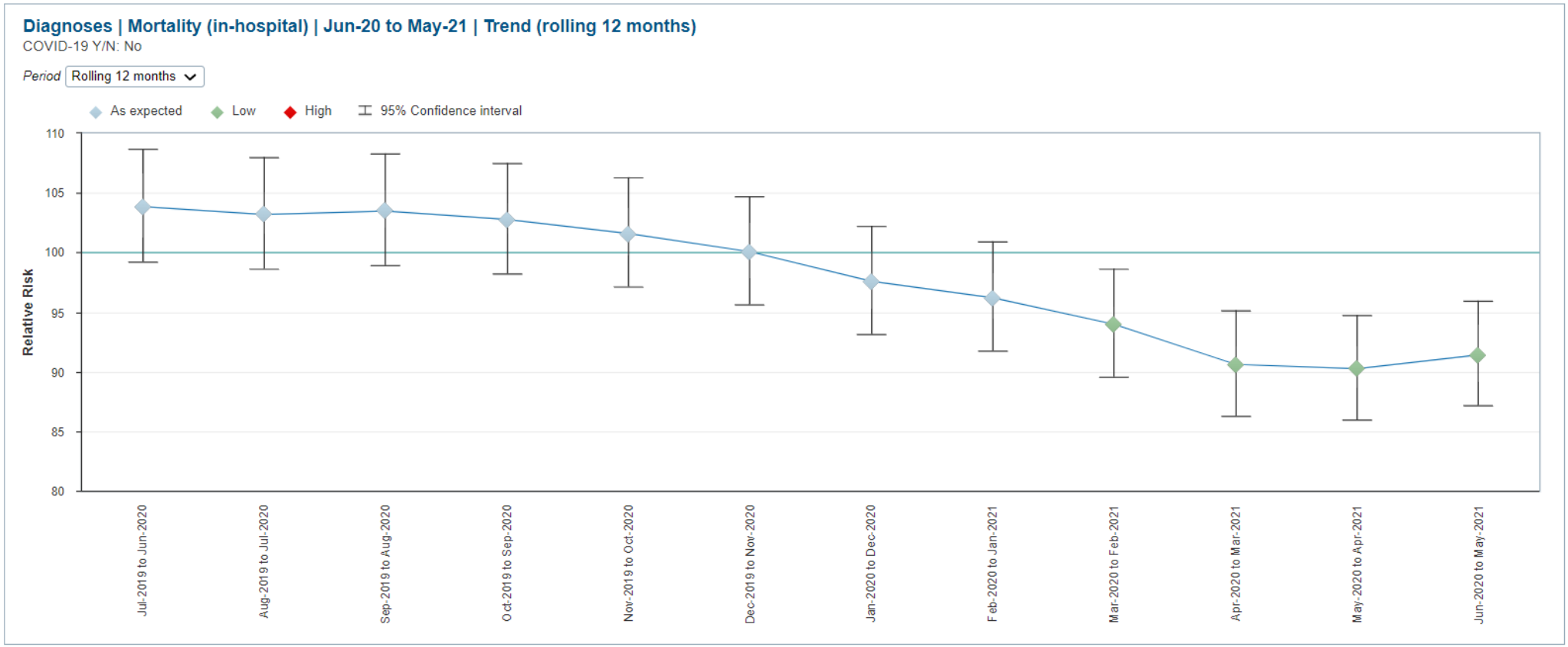
The SMR for the 12 month period is 97.7 (93.5 – 102.0), this is within the expected range



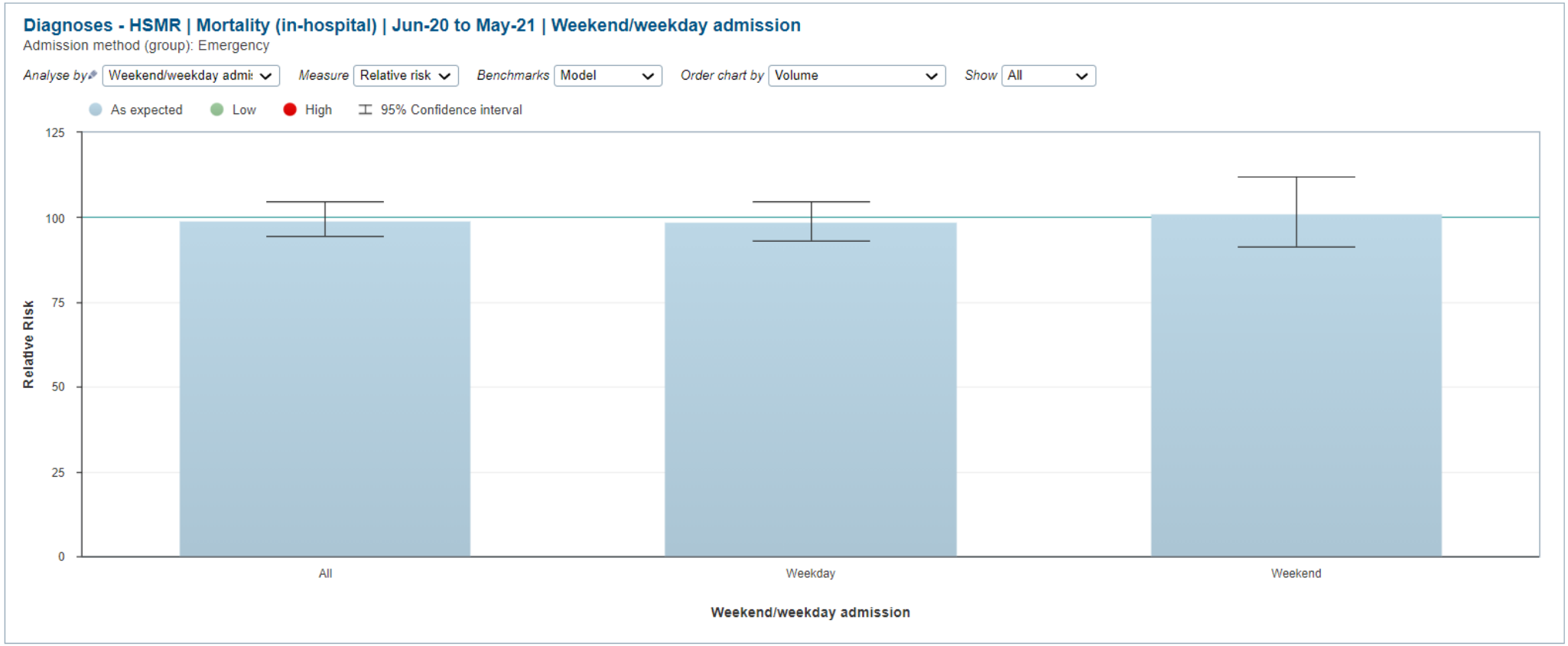
National Comparison - The SMR remains within the expected range using 99.8% control limits



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



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



NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	11	Enclosure Number:	6
Date	14 April 2022		
Title	Finance Report		
Author /Sponsoring Director/Presenter	Johanna Bogle, Associate Director of Financial Management Craig Marshall, Projects Accountant Karen Johnson, Director of Finance		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

Purpose

This purpose of this report is to present the Financial position of the Trust at Month 11 to the Trust Board.

Revenue

Key issues to note

The Trust is reporting a £138k surplus, which is on plan for the year to date.

Month 11 overview

Month 11 reports a £133k deficit in month, which is on plan for the month. We have planned to report a small deficit each month for the rest of the year to bring us back to our planned £6k surplus. The profiling of these deficits is due to the one-off release of a legal provision in Month 7. For the YTD we report £138k surplus, which is on plan.

Activity delivered 100% of the YTD 19/20 activity levels, and 95% of the February 2020 levels.

Forecast Outturn

We are reporting to NHSEI a forecast outturn of £500k surplus for the full year.

There have been a number of mitigations which have allowed the Trust to fund items of expenditure to support increased patient care, replace aging equipment and support staff wellbeing

2022/23 Planning update

The Trust is currently working through the system position for 2022/23 with system partners.

Conclusions

The Trust is reporting a year-to-date surplus of £138k, on plan for the year to date.

Capital

Funding

The Trust's forecast capital envelope is currently at £66.2m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£29m), IFRIC 12 (£0.9m) and Government Grant/Donations (£11.8m).

M11 Position

As at M11, the Trust had goods delivered, works done or services received to the value of £46.4m.

The Trust has reported within the M11 NHSIE financial monitoring return a forecast that equals the funding available of £66.2m.

Forecast for March

There remains a significant challenge to deliver £19.7m within the next month.

There remain significant concerns around the volume of projects due to be completed and the level of expenditure to be accounted.

The programme continues to be monitored and mitigations explored for any potential slippage that may materialise.

There is a significant amount of effort being put into to maximise the deliverability of the schemes with project leads and coupled with the most recent project forecasts there remains a degree of confidence around getting close to the reported forecast outturn. However, given the amount still left to spend, delivering the full programme remains a significant risk.

Recommendation

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.

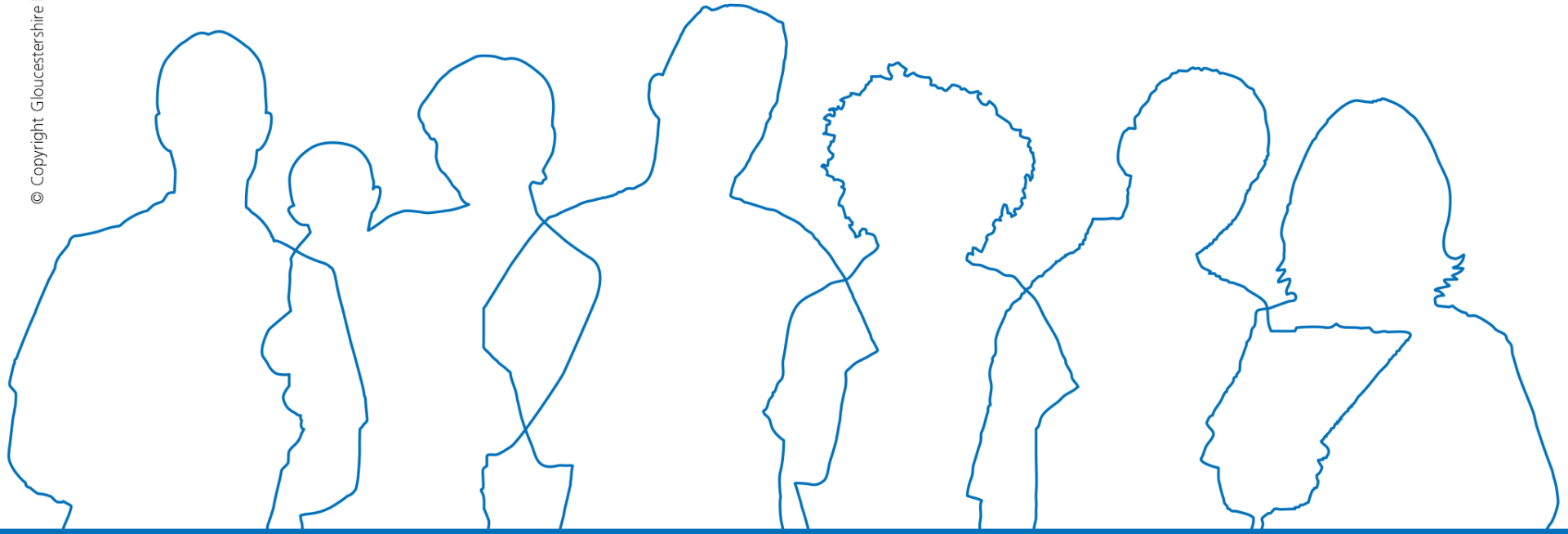
Enclosures

- M11 Finance Report

Gloucestershire Hospitals
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 28th February 2022



Revenue

Director of Finance Summary

System Position for Full Year

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

For H2 (October 2021 – March 2022), the ICS partners are working together to review and mitigated the overall system's financial position - currently it has been communicated to NHS England that there is the potential for an unmitigated surplus of c£7m. Of this c£4-5m is linked to additional ERF income generated from performance within the independent sector.

Month 11 overview

Month 11 reports a £133k deficit in month, which is on plan for the month. We have planned to report a small deficit each month for the rest of the year to bring us back to our planned £6k surplus. The profiling of these deficits are due to the one-off release of a legal provision in Month 7. For the YTD we report £138k surplus, which is on plan.

Activity delivered 100% of the YTD 19/20 activity levels, and 95% of the February 2020 levels.

Forecast Outturn

As previously reported, the Trust was heading towards a surplus position. Although there have been a number of mitigations which have allowed the Trust to fund items of expenditure to support increased patient care, replace aging equipment and support staff wellbeing, the Trust is now forecasting a year end surplus of £500k. This position has been reported to through the system to NHSEI.

2022/23 Planning update

The Trust is currently finalising the system position for 2022/23 with partners.

Month 11 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £138k surplus		Overall YTD financial performance is £138k surplus. This is on plan. £133k deficit in month, reflecting the plan phasing of income and cost relating to the Month 7 release of a legal provision from 2018/19 that we will not need to pay out.
Income is better than plan at £617.9m YTD.		YTD £29.3m better than plan, predominantly due to £7.9m Salix grant funding (removed in the final reported position), £8.8m high cost drugs and devices above plan, £3.1m Elective Recovery Fund (ERF) above plan, £3.2m Winter ERF Funding above plan, £3.8m pay award funding, £2.9m Covid (outside envelope) funding, less £0.4m net of 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 £370.8m YTD.		YTD £9.9m adverse to plan. Broadly, the pay award cost amounts to £4.0m, Covid outside envelope not included in the plan at £1.4m YTD, Covid inside envelope overspends £1.3m, plus Waiting List Initiatives of £1.0m, Registered Mental Health Nurses £1.1m, plus £1.0m other overspends, mainly around temporary staffing.
Non-Pay expenditure is more than plan at £231.5m.		YTD this is £11.6m adverse to plan. The main drivers of this are the £8.8m high cost drugs and devices above plan, £1.6m Covid outside envelope costs excluded from the plan, Gen Med VAT costs £1.0m, Cath labs hire £0.2m.
Financial Sustainability schemes are ahead of plan at YTD.		The Trust has delivered £7.5m of efficiency ytd. This is £1.4m ahead of plan. These additional savings have mitigated some of the overspends seen in our Medicine division to date.
The cash balance is £91.8m.		Increase in cash is reflected in the increase of accruals and provisions.

Month by Month Trend

Gloucestershire Hospitals
NHS Foundation Trust

Month 10 to Month 11 overall has a difference of zero and a £133k deficit in month. This is on plan in month for the YTD.

While individual categories of income and spend have changed month-on-month, the net difference is minimal. This is due to the Trust managing the additional non-recurrent funding we have been allocated with additional costs that reflect our one-off opportunity to replace aging equipment and support staff wellbeing. This is being tightly controlled so that there will be no detrimental impact to our costs on an ongoing basis as we move into 2022/23, when funding is expected to be more restricted.

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.

6 months' Run Rate Actuals	M06	M07	M08	M09	M10	M11	Month 10 to Month 11 change
Pay	(36,577)	(33,498)	(32,746)	(32,824)	(33,535)	(34,345)	(810)
Non Pay	(19,001)	(19,939)	(20,939)	(21,230)	(22,190)	(20,742)	1,447
Pay - Covid (in envelope)	(239)	(309)	(327)	(389)	(348)	(400)	(52)
Non Pay - Covid (in envelope)	(260)	(279)	(212)	(412)	(207)	(218)	(11)
Covid Costs (in envelope)	(499)	(588)	(539)	(801)	(555)	(618)	(63)
Pay - Covid (outside envelope)	(51)	(128)	(98)	(171)	(162)	0	162
Non Pay - Covid (outside envelope)	(139)	(229)	(121)	(52)	(254)	(103)	151
Covid Costs (outside envelope)	(190)	(357)	(219)	(223)	(416)	(103)	313
Non-operating Costs	(704)	(765)	(769)	(795)	(730)	(653)	78
Remove impact of Salix Grant	(484)	(1,249)	(693)	(722)	(350)	(608)	(258)
Remove impact of Donated Asset Depreciation / impairments	48	48	49	48	49	124	75
Total Cost	(59,223)	(56,348)	(55,857)	(56,547)	(57,728)	(56,945)	783
Run Rate Funding / Billable Income	57,797	57,127	55,034	56,190	57,179	56,709	(470)
Est Elective Recovery Fund Income	1,101		0				0
Covid Income (outside envelope)	190	357	219	223	416	103	(313)
Total Reported Surplus / (Deficit)	**(135)**	**1,136**	**(604)**	**(135)**	**(133)**	**(133)**	**(0)**

M11 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of February 2022 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 February the Group's consolidated position shows a £138k surplus. This is on plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 11 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	533,855	548,037	14,181			0	533,855	548,037	14,181
PP, Overseas and RTA Income	3,350	3,592	242			0	3,350	3,592	242
Other Income from Patient Activities	4,290	8,074	3,784			0	4,290	8,074	3,784
Elective Recovery Fund	3,000	6,071	3,071			0	3,000	6,071	3,071
Operating Income	40,174	48,102	7,927	55,572	64,942	9,370	44,093	52,076	7,983
Total Income	**584,670**	**613,875**	**29,205**	**55,572**	**64,942**	**9,370**	**588,589**	**617,850**	**29,261**
Pay	(340,932)	(351,018)	(10,085)	(19,960)	(19,742)	217	(360,892)	(370,760)	(9,868)
Non-Pay	(238,104)	(250,261)	(12,157)	(33,441)	(42,197)	(8,757)	(219,892)	(231,491)	(11,599)
Total Expenditure	**(579,036)**	**(601,279)**	**(22,243)**	**(53,400)**	**(61,940)**	**(8,539)**	**(580,784)**	**(602,251)**	**(21,467)**
EBITDA	**5,634**	**12,596**	**6,962**	**2,172**	**3,003**	**831**	**7,805**	**15,599**	**7,794**
EBITDA %age	**1.0%**	**2.1%**	**1.1%**	**3.9%**	**4.6%**	**0.7%**	**1.3%**	**2.5%**	**1.2%**
Non-Operating Costs	(6,013)	(5,173)	840	(2,172)	(3,003)	(831)	(8,184)	(8,176)	8
Surplus / (Deficit)	**(379)**	**7,423**	**7,803**	**0**	**(0)**	**(0)**	**(379)**	**7,423**	**7,803**
Fixed Asset Impairments	0								
Surplus / (Deficit) after Impairments	**(379)**	**7,423**	**7,803**	**0**	**(0)**	**(0)**	**(379)**	**7,423**	**7,803**
Excluding Donated Assets & Salix grant	518	(7,285)	(7,803)				518	(7,285)	(7,803)
Control Total Surplus / (Deficit)	**138**	**138**	**0**	**0**	**(0)**	**(0)**	**138**	**138**	**0**

* Trust position excludes £34.5m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £61.0m of inter-company transactions, including dividends

*** YTD Plan excludes a late adjustment in H1 ICS-agreed cost and income for ERF-related transactions.

Balance Sheet

	Opening Balance 31st March 2021 £000	GROUP Balance as at M11 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	7,172	(1,108)
Property, Plant and Equipment	276,161	304,169	28,008
Trade and Other Receivables	6,149	3,697	(2,452)
Total Non-Current Assets	**290,590**	**315,038**	**24,448**
Current Assets			
Inventories	8,934	9,791	857
Trade and Other Receivables	18,054	18,110	56
Cash and Cash Equivalents	77,216	98,836	21,620
Total Current Assets	**104,204**	**126,737**	**22,533**
Current Liabilities			
Trade and Other Payables	(87,606)	(106,267)	(18,661)
Other Liabilities	(11,585)	(11,819)	(234)
Borrowings	(3,404)	(3,774)	(370)
Provisions	(10,824)	(16,662)	(5,838)
Total Current Liabilities	**(113,419)**	**(138,522)**	**(25,103)**
Net Current Assets	**(9,215)**	**(11,785)**	**(2,570)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,017)	500
Borrowings	(37,438)	(35,359)	2,079
Provisions	(2,892)	(1,489)	1,403
Total Non-Current Liabilities	**(46,847)**	**(42,865)**	**3,982**
Total Assets Employed	**234,528**	**260,388**	**25,860**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	350,469	18,436
Reserves	27,975	27,975	0
Retained Earnings	(125,480)	(118,056)	7,424
Total Taxpayers' Equity	**234,528**	**260,388**	**25,860**

Gloucestershire Hospitals NHS Foundation Trust

The table shows the M11 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.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals
NHS Foundation Trust

Funding
The Trust's forecast capital envelope is currently at £66.2m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£29.0m), IFRIC 12 (£0.9m) and Government Grant/Donations (£11.8m)

M11 Position
As at M11, the Trust had goods delivered, works done or services received to the value of £46.4m.

The Trust has reported within the M11 NHSIE financial monitoring return a forecast that equals the funding available of £66.2m

Forecast for March
There remains a significant challenge to deliver £19.7m within the next month.

There remain significant concerns around the volume of projects due to be completed and the level of expenditure to be accounted.

The programme continues to be monitored and mitigations explored for any potential slippage that may materialise.

There is a significant amount of effort being put into to maximise the deliverability of the schemes with project leads and coupled with the most recent project forecasts there remains a degree of confidence around getting close to the reported forecast outturn. However, given the amount still left to spend, delivering the full programme remains a significant risk.

21/22 Programme Funding Overview

Gloucestershire Hospitals
NHS Foundation Trust

The Trust's forecast capital envelope is currently at £66.2m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£29.0m), IFRIC 12 (£0.9m) and Government Grant/Donations (£11.8m)

This decreased by £1.8m due to the £2.2m adjustment to the Salix project following removal of the BMS component of the scheme netted off by £0.4m further TIF funding being allocated.

	M10	M11	Change
Programme Allocation	**£000's**	**£000's**	**£000's**
System Capital	24,404	24,404	0
National Programme	28,639	29,022	383
Donations and Government Grants	14,050	11,847	(2,203)
IFRIC 12	874	874	0
Total Programme (Reported)	**67,967**	**66,147**	**(1,820)**

21/22 Programme Spend Overview

Gloucestershire Hospitals
NHS Foundation Trust

As at M11, the Trust had goods delivered, works done or services received to the value of £46.4m. The breakdown of the YTD expenditure by programme allocation and the reported forecast returned within the M11 NHSIE financial monitoring return is shown below.

	In Month	Year to Date	Forecast		
Programme Allocation	**Actual £000's**	**Actual £000's**	**Forecast Funds £000's**	**Actual £000's**	**Variance £000's**
System Capital	2,467	16,643	24,404	24,404	0
National Programme	3,860	18,662	29,022	29,022	0
Donation and Government Grants	864	10,302	11,847	11,847	0
IFRIC 12	73	802	874	874	0
Total Programme	**7,264**	**46,409**	**66,147**	**66,147**	**0**
Forecast to spend last month	**7,233**				
Difference to Forecast	**(31)**				

The forecasts received last month indicated that the Trust would deliver £7.2m this month. The Trust delivered £7.3m. - A significant challenge remains to deliver £19.7m to deliver in March

Whilst the latest forecasts and assurances from project leads suggest that significant spend and delivery of the programme is still possible, the volume and limited time that remains leaves this as a significant risk.

Daily tracking of the position is underway to maximise deliverability and to understand and manage any issues as early as possible.

Risks

Gloucestershire Hospitals
NHS Foundation Trust

Key risks to the 21/22 capital programme include:

- 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.
- The large volume of items being procured will place a bottleneck to transact and account for the items (including; procurement, Finance, GMS and Divisions)
- The physical delivery of schemes remains essential and the Project Accountant needs to be informed where delivery is not to take place. Transfer of Ownership documents may be considered where there is strong evidence from the supplier that a supply chain risk exists and that by paying for the items now eliminates this risk and represents a commercial, value for money reason for doing so. The Trust will not enter Transfer of Ownerships without strong evidence as this would pose a risk to the true and fair view of the accounts and external audit. There is a risk that Audit do not support all of the Transfer of Ownership arrangements.
- Risks of not accurately reflecting expenditure within the 21/22 position would impact against the true and fair view that needs reported in the Trust's annual accounts.
- Risks of not accurately reflecting expenditure within the 21/22 position could impact on spend being missed and therefore impacting on the already stretched 22/23 capital programme.

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date surplus of £138k, which is on plan.
- Note the Trust is forecasting a £500k surplus for the year end.

Capital

- Note the reported M11 year to date capital position and reported year end forecast outturn.
- Note the current risks to delivery.

Authors:	**Johanna Bogle, Associate Director of Financial Management** **Caroline Parker, Head of Financial Services** **Craig Marshall, Project Accountant**
Presenting Director:	**Karen Johnson, Director of Finance**
Date:	**March 2022**

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	12	Enclosure Number:	7
Date	14 April 2022		
Title	Digital and Electronic Patient Record Programme		
Author /Sponsoring Director/Presenter	Nicola Davies, Digital Engagement and Change Manager Mark Hutchinson, Executive Chief Digital and Information Officer		

Purpose of Report	Tick all that apply ✓		
To provide assurance	✓	**To obtain approval**	
Regulatory requirement		**To highlight an emerging risk or issue**	
To canvas opinion		**For information**	✓
To provide advice		**To highlight patient or staff experience**	

Summary of Report

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

- New clinical documentation went live on 23rd February 2022.
- The new implementation included the first major drop of doctor's documentation, including clerking, ward round notes and take lists.
- AHPs are now also adding clinical notes on EPR.
- Additional nursing flowsheets and the tissue donation form went live at the same time.
- Office 2016 roll-out continues at pace across the organisation.

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.

Recommendation

The Board is asked to note the contents of the report.

Enclosures

- Digital and EPR Report

FINANCE AND DIGITAL COMMITTEE – MARCH 2022

DIGITAL AND EPR PROGRAMME REPORT

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)	Jan 2022	
Documentation for Doctors	February 2022	23 Feb 2022
EPR New Nursing Documentation	February 2022	23 Feb 2022
Order Communications (theatres & outpatients expansion)	TBC	
Electronic Prescribing & Medicines Administration (known as ePMA)	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. These updates are correct as reported to Programme Delivery Group on February 22nd.

Key issues to note:

- New clinical documentation has gone live, see the update at 3.1.
- Work is progressing in preparation for the delivery of the new maternity EPR system.
- Work has commenced on the scoping and development of a model of care using virtual wards across Gloucestershire ICS.
- The revised ePMA plan has been accepted and work has commenced to progress the schedule.
- Necessary network and power works for ePMA early adopter wards have commenced.
- The load of the Drug Catalogue and Allergies workbook into the ePMA Development Environment has commenced.
- The implementation of Pre-Assessment Digital Workflows has been delayed, but work is continuing to complete configuration and enable UAT and sign-off to allow progress to completion.

3.1. Clinical Documentation and Flowsheets - Go Live Update

On 23rd February the first major implementation of doctor's documentation was delivered to adult inpatient areas, bringing ward rounds and clinical notes onto EPR for the first time. This is a step change for clinicians; and for many senior consultants it has been their first experience of using Sunrise EPR in their daily routines.

As you know, clinicians in our emergency departments have been using EPR for almost all clinical documentation since last year; but this is the first-time doctors and therapists (AHPs) will use it on inpatient wards for clinical notes.

An army of floorwalkers covered both hospital sites and for two weeks, 24 hours a day – at the time of writing the floorwalking is into its third week covering 7am until 11pm. Senior digital staff and EPR staff have supported daily ward rounds in key areas and this will continue. This has been a great way to not only support clinicians in using the system, but also get immediate feedback and make improvements to the way the system works. A go live is the start of the improvement journey and optimisations will continue for the coming weeks, as clinicians learn to work in a new way. A number of improvements have already been delivered.

Alongside this, additional nursing documentation went live focussing on food and fluid balance charts. This is a huge step towards our target of having 90% of nursing documentation on EPR by 2023. The response from nursing teams as always has been brilliant, with lots of engagement, questions and enthusiasm, despite us throwing more change at them. Nursing staff have been using EPR since November 2019 and take each addition to the system in their stride – whilst continuing to challenge us and suggest improvements as we go. Digital Super User nursing staff have supported the EPR team and their colleagues throughout.

Therapists have also started using the system for the first time. They now also complete reviews within the EPR clinical notes and have been overwhelmingly positive; suggesting improvements almost immediately. Requests from AHPs on the morning of go live to allow much more text in the note boxes, were responded to quickly by the EPR team and delivered within the hour.

The challenge now is ensuring that we have the right kit available, in the right areas, at the right time. There are IT support staff dedicated to this task and monitoring is ongoing.

No go-live comes without its challenges and despite extensive testing and two issues came to light in the first few days. Clinical and EPR teams worked together to find solutions and put in place temporary work arounds until they were fixed. The first optimisation drop took place on Thursday 3rd March.

Overall, the support from clinical colleagues has been phenomenal and the EPR team will continue to listen, respond and make changes as required over the coming weeks.

3.2. Clinical Data Storage Platform (Onbase)

The implementation of a new clinical data storage platform (Onbase) is a major step towards ensuring that Sunrise EPR is the single source of clinical information in our hospitals. The platform will enable clinicians to access information from a range of other systems, without leaving Sunrise.

The implementation is happening in a phased approach and has been pushed back from the original planned go live of 23rd February. A new date will be communicated soon.

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 no projects have been completed and closed and one project has gone into closure.

There are currently thirty new project requests in various stages of processing from receipt and triage. Key issues to note:

- The Data Centre Refurbishment project has moved into closure.
- Further activities relating to both CGH and GRH Data Centres, regarding air conditioning and fire suppression upgrades have been descoped from the Data Centre Refurbishment and will form part of a separate project for delivery in the 2022-2023 financial year.
- A project to install Infrastructure for a New Portering System (MyPorter) has commenced and is progressing at pace.

4.1 Areas of concern and mitigating actions

CVIS
Work is continuing to ensure that solutions are in place as soon as possible to enable the project closure and transition to business as usual.

SQL Migration & Windows 2003 Upgrade
A re-planning exercise is underway to ensure that there is a schedule for the migration/upgrade of the remaining servers and that this timetable aligns with the current cyber mitigation in place, together with a prioritisation focusing on those elements with the highest risk.

Windows 7 Dependant Applications Eradication
An additional 12 months of Extended Security Updates has been put in place to ensure that the continuing cyber risk is mitigated whilst removal of Win7 is completed. A re-planning exercise is underway to ensure that there is a schedule for the removal/upgrade of the remaining devices, together with a prioritisation focusing on those elements with the highest risk.

Mindray Bedside Monitoring – Cardiology
Mindray Telemetry testing on Trust wi-fi has identified a number of gaps in coverage within the unit. Discussion has commenced to agree specific metrics for acceptable coverage of wi-fi.

4.2 Conclusion

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) Annual Report

A performance report from Countywide IT Services (CITS) is submitted to Digital Care Delivery Group every month (in arrears). This section provides a summary of January 2022 report. Key highlights:

- Increased number of calls for January. Mainly user accounts and NHSmail password resets. 98% of incidents resolved within SLA times - up 1%.
- Service Desk first-time fix continuing to improve.
- One P1 breach with 200 incidents raised with the major incident - hibernation issue on Toshiba laptops.
- Desktop incidents logged by users are the lowest figures for over 12 months.
- CITS satisfaction survey: 4.8 (5.0) continues to improve.

6. Cyber Security - Increasing global cyber security threat

GCHQ and NHS England are warning against an increased cyber threat following the Russian invasion of Ukraine. The importance of ensuring that critical NHS systems remain available has never been greater.

Global cyber security organisations are also reporting an increase in sophisticated, high-impact ransomware incidents against critical infrastructure organisations.

The National Cyber Security Centre (NCSC) is clear that there are groups and individuals who want to target the NHS. These groups have already impacted many organisations, including hospitals and companies who are within the NHS supply chain. A significant ransomware attack in the current climate would have major implications for the system.

In response, the Trust is currently monitoring all systems and ensuring that:

- Systems are patched.
- Improved access controls and multi-factor authentication.
- Incident response plans are up to date and business continuity plans in place.
- Backups and restore mechanisms are working.
- Online defences are working as expected.
- Keeping up to date with the latest threat and mitigation information.

7. Information Governance

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

This includes:

- Data Security and Protection (DSP) Toolkit 2021/2022 requirement update.
- Monthly local incident and ICO reporting position (January 2022).
- Polices for approval.
- ICO audit preparation.
- Change to records management.

-Ends-

KEY ISSUES AND ASSURANCE REPORT
Quality and Performance Committee, 23 March 2022

The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.

Items rated Red

Item	Rationale for rating	Actions/Outcome
Risk Summit	An intelligence sharing conference would be arranged as the first step towards holding a risk summit into urgent and emergency care with system partners. An Urgent and Emergency Care Improvement Board would be established within the Trust, chaired by the CEO, to focus on mitigation and control of risks. Internal reviews would focus on oversight and compliance of key measures and check and challenge around improvement initiatives. A review of the environment, staffing models and care would take place to ensure improvements were made to mitigate harm, and to ensure the Trust was providing the best possible care it could to vulnerable patients.	Delay related harm would be a standing item on the agenda.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Quality and Performance Report	The following key points were noted: • Ambulance delays remained a challenge for the Trust's performance; a static cabin had been situated to support patient care. • Diagnostic performance was stable. • The Trust had not achieved the two-week wait performance target in January; however, performance had recovered in February. • Referral to treatment times were now at 71%, with no delays on the 104 week-wait. The Elective Recovery Board continued to monitor waiting lists, which reduced on a weekly basis. • An elective hub had been established, with eight people recruited so far. Translation provision for patients had been included. • The Committee was informed that two falls had resulted in the deaths of Medically Optimised for Discharge (MOFD) patients. • A piece of work was underway to review bed moves across the organisation and how they can be reduced to improve patient outcomes. • The Committee was informed that a correlation between delays and incidents of pressure ulcers and falls was now being seen and would be reflected in next month's report. • Staffing levels continued to be challenging, with some covid outbreaks having a further impact. • PALS contacts continued to increase; recruitment to the team was ongoing, with advisor positions now fully recruited to. Significant improvements were expected to be seen in the following months. • Some reductions in Friends and Family Test feedback had been seen, including in the Emergency Department which had previously shown significant increases. • The Committee was advised that another Trust had been invited to carry out a review into Falls arrangements. The Committee agreed that staffing challenges could not be understated and although the Committee acknowledged the development of good recruitment and retention plans, it would not be a quick fix.	Breakdown of 12- hour breaches would be incorporated into future reports. Targeted recruitment to the elective hub would be considered to support work around health inequalities. The Committee would receive the output of a review into harm to patients contracting nosocomial covid. The Committee would receive the output of the peer review into falls.
Gynaecology Bed	The Committee was concerned about the number of complaints	The staffing model for the

Assurance Key	
Rating	**Level of Assurance**
Green	Assured – there are no gaps.
Amber	Partially assured – there are gaps in assurance but we are assured appropriate plans are in place to address these.
Red	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of action plans.

Base Report	received, but acknowledged the long-term plan and the positive impact that short-term actions were having on improving patient experience, including the provision of a telephone help line.	telephone advice line would be reviewed.
Operational Plan 2022-23	The plan reflected the ambition of the system to recover performance against national standards, continue to build on progress to date, and address significant backlogs. The Committee acknowledged that this would take some considerable time, but was supportive of the planned headline achievements. The Committee reflected on concern about performance that was below baseline levels and how efficiency could be recovered to pre-pandemic levels.	The Committee was supportive of the plan and the amount of work undertaken.
Serious Incidents Report	One further never event had been declared, which resulted in the Trust reporting the highest number of never events in the country. Five serious incidents were reported, two related to falls resulting in deaths. A review was underway following a series of harm events related to the Majors 3 area function. The Committee took some assurance that systematic reviews of incidents continued, with key words flagged on Datix reports to support early interventions.	The Committee was concerned about the number of Never Events, and agreed that a report would be received at the next meeting for additional review.
Maternity Report: Journey to Outstanding Action Plan	Lack of progress during the quarter was related to staffing shortages and the need to focus on providing clinical services. The next iteration of the report would reflect the various sources of the actions, identify all projects that would be completed by September, and incorporate all action plans within the division for greater clarity.	None.
Patient Property Policy	The Committee noted the progress against the findings and recommendations from the patient property report. The Policy was currently in development, and the action plan was reviewed on a monthly basis at Quality Delivery Group.	The Policy would be brought to the meeting in June.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Quality Performance System	The Committee was assured by the plan to improve quality reporting.	None.
Learning from Deaths Report	The Committee was assured by the process of review for all deaths in the Trust, noting that other triggered deaths were further reviewed through the structured judgement process, serious incident investigation, and national programmes that drove local learning, feedback and system improvement.	The Committee was assured by the governance systems around reviewing deaths and compliance with the National Guidance on Learning from Deaths.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
The Board Assurance Framework was under review, and risks linked to Quality would be discussed at future Committee meetings.		

KEY ISSUES AND ASSURANCE REPORT Finance and Digital Committee, 31 March 2022		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Capital Programme Update	The Trust had delivered £7.3m in February, leaving £19.7m to deliver in March. The Committee remained concerned around the volume of projects due to be completed by year-end and the associated level of expenditure to be booked, however the Committee acknowledged the significant effort being taken to maximise the delivery of schemes. Although some assurance was received that the Trust would be very close to reaching the forecast outturn by year-end, a significant risk remained around delivering the full programme at this point in the year.	The programme continued to be monitored and mitigations explored for any potential slippage. The Committee noted the fully committed capital programme for 2022-23.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Digital Risk Register	The Committee was assured by the report, noting the only red risk related to the rollout of Office 365, which would be concluded by the end of May.	None.
Financial Performance Report	The following key points were noted: • The Trust reported a year-to-date £138k surplus, which was in line with the plan. • The forecast outturn showed a mitigated surplus of £0.5m which continued to be closely monitored. • The Trust reported a £133k deficit in month, which was in line with the plan to deliver deficits each month for the rest of the financial year. • The Committee was advised that, despite a number of mitigations allowing the Trust to fund items of expenditure to support increased patient care, replace ageing equipment, and support staff wellbeing, the Trust was now forecasting a year-end surplus of £500k. • The Trust was finalising the system position for 2022-23, in conjunction with partners. The Committee was advised that the interim audit had not been finalised; the Committee noted its disappointment, particularly as assurance was provided at Audit and Assurance Committee that it was on plan.	The Committee supported the inclusion of the GMS VAT provision for 2021-22, totalling £6.2m.
Planning and Budget Setting	The Trust's expenditure budget for 2022-23 was set at £686m. The Committee was advised of the system's significant financial sustainability challenge; the Trust had been set an efficiency target of £14.9m, although would also be required to contribute towards the £29m gap across the system. The Trust currently had schemes of £2.6m in development or implementation; a significant increase in sustainability schemes was required.	The Committee approved the budget position for 2022-23, and supported the continued identification, implementation and delivery of sustainability schemes.
Financial Sustainability Programme	The Committee was assured by the key actions and progress against the development of new arrangements. The proposed team structure and programme approach was currently being put in place to support transformational, recurrent financial sustainability in 2022-23 and beyond. Assurance was provided around the robust management of the Trust's efficiency target for 2022-23, which had been set at £14.9m, £12.9m of	None.

	which would be delivered through the Financial Sustainability Programme.	
Operational Plan 2022-23	A draft submission had been made on 17 March, with final submission required by 28 April. The plan reflected the ambition of the system to recover performance against national standards, continue to build on progress to date, and address significant backlogs. Financial stability and further improvement of the financial position represented a key risk, and focus on ensuring the deliverability of efficiencies and whether the deficit plan could be reduced would be important.	The Committee was supportive of the plan.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Digital and EPR Programme Report	The Committee was assured by the delivery of Digital workstreams and projects, noting that clinical documentation went live on 23 February and continued to be well used by doctors, AHPs and nurses. Other projects for implementation included the use of Badgernet for maternity services, and NHS at Home virtual ward sessions.	The Committee was fully assured by the report, and encouraged the continuation of the programme at pace.
GMS Dividend Proposal	The GMS Board recommended that, based on projected performance, the Trust was paid a dividend of £2.7m for the 2021-22 financial year.	The Committee approved the proposal.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
The Board Assurance Framework was under review, and risks linked to Finance and Digital would be discussed at future Committee meetings.		

KEY ISSUES AND ASSURANCE REPORT
Audit and Assurance Committee 22 March 2022

The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.

Items rated Red

Item	Rationale for rating	Actions/Outcome
Internal Audit Review: Divisional Governance (Medicine)	The review presented was an advisory report. Six medium recommendations had been made relating to scrutiny of service line reports, risk management controls and training, and complaints and incident investigation review processes. The Committee recognised the significant pressure on the division, however there was concern around a number of elements in the report. The Committee received assurance that a new leadership team was in place and that they were fully committed to implementing the recommendations.	The Divisional Governance follow-up review for Medicine would be scheduled sooner than September 2022, with a greater focus on executive assessment of progress. Quality and Performance Committee would have oversight of progress through executive reporting.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit Progress Report	Auditors had experienced ongoing delays during 2021-22 due to operational pressures within the Trust, however remaining reviews into Research and Development, Recruitment Practices, and the Data Security and Protection Toolkit would be completed in time for the Head of Internal Audit opinion.	None.
Internal Audit Recommendation Follow Up Report	The Committee was assured by the number of recommendations that had now been completed, noting that the three medium recommendations related to consultant job planning were still on hold due to the impact of the pandemic.	Consultant job planning would be brought to a future Committee meeting for additional assurance.
Internal Audit Annual Plan 2022-23	The Committee was assured by the draft plan, noting that health inequalities and sustainability would be reflected throughout. Auditors were looking to ensure clear NED and Executive accountability and contacts for all audits.	A systemwide patient deterioration review would be considered.
Internal Audit Review: Asset Management	The review was given a moderate assurance rating for the design of asset management arrangements, and limited assurance for operational effectiveness. There was one high priority recommendation related to controls and procedures of the asset register, and one medium recommendation related to the development of an asset management policy, which the Committee was assured was in progress.	None.
Single Tender Actions Report	Four waivers had been received between January-March at a total of £717,982.85. Two retrospective waivers had been received at a total of £25k.	The Committee noted the need for some additional training into the waiver process, but was assured by the report. There will be an update to the next Committee meeting on the VFM aspect of the report.
Risk Assurance Report	Data accuracy was being analysed, particularly around risks that were shared between various Committees. The Committee was advised of some technical issues in relation to the implementation of the Datix system.	The risk management process would be RAG-rated for additional assurance. Operational risks related to time delays in Datix implementation would be discussed at Finance and Digital Committee.
GMS Update	The interim external audit was currently taking place, with no issues raised so far. A number of internal audit reviews were in progress, including Shared Corporate Services, Organisational Effectiveness, and Workforce Planning. The Committee was advised that a number of	None.

Assurance Key	
Rating	**Level of Assurance**
Green	Assured – there are no gaps.
Amber	Partially assured – there are gaps in assurance but we are assured appropriate plans are in place to address these.
Red	Not assured – there are significant gaps in assurance and we are not assured as to the adequacy of action plans.

	outstanding internal audit actions were due to an Estates organisational review which was currently taking place.	
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
External Audit	The Committee was assured that the interim audit was progressing according to plan, with nothing material to report. The Committee was advised that auditors were satisfied with the Trust's well-resourced plan. A partner from Deloitte attended the meeting and provided useful national context and confirmed the Trust's satisfactory local position. The Committee was advised that there were no issues with the GMS interim audit.	None.
Losses and Compensations Report	The Committee was assured by the management of the process of losses and compensations, and approved the write off of 66 invoices totalling £15,332.26, and the write off of the balance sheet credit balance.	The Patient Property Policy would be discussed at Quality and Performance Committee in March.
Annual Report Update	The Committee was assured by the plan.	None.
Committee Effectiveness and TOR review	The Committee was assured by the effectiveness review and noted full compliance against the majority of the terms of reference areas. The Committee discussed the revised terms of reference and approved them, subject to a few minor changes.	None.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
The Board Assurance Framework was under review, and the Committee would receive the full BAF at each meeting for discussion from June.		

KEY ISSUES AND ASSURANCE REPORT
Estates and Facilities Committee, 24 March 2022

The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.

Items rated Red

Item	Rationale for rating	Actions/Outcome
National Cleaning Standards	New national cleaning standards were published in April 2021 and were due to be introduced from May 2022. The Trust had yet to confirm the specific standards against which the Trust's cleaning operations would be measured, and would need decision by the Infection Prevention and Control team. Due to ongoing recruitment challenges, current services were operating on business continuity measures and were unable to achieve the required standard before the implementation date.	The Infection Prevention and Control team would propose the cleaning standards to be adopted, which would be ratified by Quality and Performance Committee. A six-month extension to the implementation of standards would be sought from NHSEI.
Workforce Plan	GMS reported c.120 vacancies, with domestics and chefs a particularly challenging staff group to recruit to. A review had been undertaken into staff recruitment and retention, including how jobs were advertised to reach a wider audience, and how opportunities, including secondments, were offered. The Committee took some assurance that there was a good understanding of the challenges faced, however additional work was required to develop a remediation plan to address the issues.	Further analysis was required, including a viable action plan to address the issues. A further update would be received in May.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
GMS Review Report	The Committee had seen the report into the review carried out by PWC and noted that the findings and recommendations would be discussed at the Board development session on 12 May.	None.
GMS Contract Management Group Report	The Committee was assured on the following key points: • Data Protection and Information Governance: Discussions had taken place to ensure GMS was fully compliant with requirements. • Community Diagnostic Centres: GMS was now involved in the plans at Quayside House, due to the specialist nature of the required facilities. • Capital: Allocated works for 2021-22 had been progressed with the majority of schemes completed. The Committee was advised that allocated capital for 2022-23 was insufficient to address the findings of the six-facet survey. A prioritisation exercise had taken place to ensure appropriate spend. Electrical infrastructure works would not be included; however, the Trust was bidding for TIF monies which would support this work. • A KPI related to completion of food hygiene inspections in ward pantries/kitchens and GMS kitchens was red, with an achievement of 11% against a target of 90%. • A new system was being implemented for the portering team, which was impacting on the data related to input and request times; this may be the driver for the KPI related to emergency requests showing an achievement of 46% against a target of 95%.	None.
GMS Annual Strategic Plan 2022-27	The Plan had been approved by the GMS Board. The Plan set out new enabling activities to facilitate its journey, a Corporate Plan to improve alignment to the Trust, and deliverability against a range of initiatives within the financial envelope, both capital and revenue. The Committee was advised that the financial forecast would be reviewed on an annual basis. The Committee was assured by the Annual Delivery Plans.	The Committee supported the strategic plan. The Financial Plan would be approved by the Trust Leadership Team and Finance and Digital Committee.

Estates Strategy Update	The Committee was supportive of the revised Trust Estates Strategy, which focused on Phase 2 of the Strategic Site Development Programme across two time periods (years 0-10, and year 10+). The Strategy would be shared with system partners to support the ICS Estates programme.	Agile working arrangements would be clearly reflected. An outline scope of the programme would be produced for May.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None.		
Items not Rated		
GMS Chair Update	Risk Log	
Impact on Board Assurance Framework (BAF)		
The Board Assurance Framework was under review, and risks linked to Estates and Facilities would be discussed at future Committee meetings.		