Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
13.15, Thursday 8 September 2022
Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			13.15
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 14 July 2022**	Approval	Enc 1	13.20
5	**Matters arising from Board meeting held on 14 July 2022**	Assurance		
6	**Patient Story** *Katie Parker-Roberts, Head of Quality*	Information	Presentation	13.25
7	**Chief Executive's Briefing** *Mark Pietroni, Interim Chief Executive Officer*	Information	Enc 2	13.45
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	14.00
9	**Trust Risk Register** *Alex D'Agapeyeff, Interim Medical Director*	Assurance	Enc 4 *To follow*	14.10
10	**Quality and Performance Committee Report** *Alison Moon, Non-Executive Director, Matt Holdaway, Chief Nurse and Director of Quality, and Qadar Zada, Chief Operating Officer*	Assurance	Enc 5	14.20
11	**Organ Donation Annual Report** *Mark Haslam, Clinical Lead for Organ Donation*	Assurance	Enc 6	14.45
	Break (15.00-15.10)			
12	**Fit for the Future Programme: Engagement Report** *Micky Griffith, Programme Director*	Assurance	Enc 7	15.10
13	**Finance and Digital Committee Report** *Robert Graves, Non-Executive Director, Karen Johnson, Director of Finance and Mark Hutchinson, Executive Chief Digital and Information Officer*	Assurance	Enc 8	15.25
14	**Audit and Assurance Committee Report** *Claire Feehily, Non-Executive Director*	Assurance	Enc 9	15.40
15	**Emergency Preparedness, Resilience and Response Report** *Qadar Zada, Chief Operating Officer*	Assurance	Enc 10	15.50
16	**Estates and Facilities Committee Report** *Mike Napier, Non-Executive Director*	Assurance	Enc 11	15.55
17	**Guardian of Safe Working Hours Quarterly Report** *Jessica Gunn, Guardian of Safe Working Hours*	Assurance	Enc 12	16.05
18	**Any other business**		None	16.10
19	**Governor Observations**			
	Close by 16.15			

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 14 July 2022, 10.30, Room 3 Sandford Education Centre			
Chair	Robert Graves	RG	Non-Executive Director and Vice-Chair
Present	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	Matt Holdaway	MHo	Chief Nurse and Director of Quality
	Sarah Hammond	SH	Head of Business Intelligence (deputising for MH)
	Mark Hutchinson	MH	Executive Chief Digital and Information Officer (until 13.00)
	Karen Johnson	KJ	Director of Finance
	Simon Lanceley	SL	Director of Strategy and Transformation
	Alison Moon	AM	Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Interim Chief Executive Officer
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director for People and Organisational Development
	Elaine Warwicker	EW	Non-Executive Director
	Qadar Zada	QZ	Chief Operating Officer
Attending	Elinor Beattie	EB	Emergency Medicine Consultant (item 11 only)
	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Andrew Seaton	AS	Quality Improvement and Safety Director
	Prof Peter Scanlon	PS	Consultant Ophthalmologist (item 6 only)
	Alan Thomas	AT	Lead Governor
	Lee Troake	LT	Head of Corporate Risk, Health and Safety
	Scott Vallance	SV	Ophthalmic Imaging and Digital Quality Manager (item 6 only)
Observers	Six governors, staff members and members of the public observed the meeting virtually. Two governors, including the Lead Governor, observed the meeting in person.		

Ref	Item
1	**Chair's welcome and introduction** RG welcomed everyone to the meeting.
2	**Apologies for absence** Deborah Evans, Chair, Alex D'Agapeyeff, Interim Medical Director, Mark Hutchinson (from 13.00), Executive Chief Digital and Information Officer, and Sally Moyle, Associate Non-Executive Director.
3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 9 June 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 9 June 2022** All matters arising were updated.
6	**Staff Story**

	The Board heard how the Ophthalmology Department had successfully adapted to virtual imaging clinics throughout the pandemic, and how the team was now looking to implement these clinics as business as usual, linking to the Trust's overall IT and Digital strategy. MAG asked how the department managed with a stretched team. PS advised that the team worked very flexibly, was very positive about work/life balance and managing around staff and their lives outside of work. The Board was advised that the team also managed its own research budget. The Board was impressed with the team's innovation, pragmatism, and positive and inclusive treatment of its staff.
7	**Chief Executive's Briefing** MP briefed the Board as follows: • There had been national changes to Covid-19 sickness pay, which would be absorbed into usual sickness pay arrangements. • The Trust had seen an increase in Covid-19 cases, with projections suggesting that this particular wave would peak towards the end of the month and may result in the same number of people in hospital as in March/April. However, the majority of people in hospital with Covid-19 were not in hospital because they had the illness, but because they tested positive as part of routine screening. Although there was no national guidance in relation to face masks within hospitals, the Trust had decided to reintroduce the requirement to wear a face mask during the peak period. • The CQC had visited the Trust on 14-16 June to carry out a well-led inspection. High-level feedback was received on the final day of the inspection, and was formally set out in the letter which was presented to the Board as part of the CEO Report. Areas of concern related to organisational culture, disconnection between the Board and the organisation, and corporate governance processes. The CQC had made positive comments around the Trust's committed and passionate staff who are keen to be involved in solutions, and acknowledged that the Trust had plans in place to address key areas relating to culture and corporate governance. EW asked how communication with staff had been handled around the CQC inspection and feedback; MP advised that regular communication had been sent to all staff via the Staff Blog and continued references to the feedback and improvement plans would be shared. Feedback from staff so far had been positive, particularly around the honesty from the Executive team. Access to information for staff without email would be ensured. • There had been continued engagement and feedback with Surgery and Midwifery teams, following the respective inspections. The Board was assured that the Trust had been transparent, open and honest with staff about the feedback received and had recognised the opportunity to improve. CR reflected on the tone of communications to staff, noting that humility and vulnerability was appropriate; there was a group acting as critical friends on communications as previous may not have reflected the reality of the situation. • Operational issues continued in relation to waiting lists and ambulance handover delays, however some improvements had been seen. • Deborah Lee continued to make a good recovery and was expected back at work in August. • The Board was advised that the Trust was working closely with the system to develop plans and arrangements in relation to the forecast heatwave. • QZ informed the Board that the Trust was in discussion with NHSEI in relation to offering mutual aid; a group of Chief Operating Officers met regularly to discuss and share challenges, and coordinate mutual aid opportunities.

Unconfirmed

8	**Board Assurance Framework** The Quality and Performance Committee had discussed SR1 *Breach of CQC regulations or other quality related regulatory standards* and recommended increasing the risk score to 20. A full review and rationalisation of risk would take place over the summer, with a quarterly analysis of the BAF due in the autumn.
9	**Trust Risk Register** The report was received for information. Three new risks had been added to the register, related to workforce and retention, and patient flow. The risk related to nosocomial covid risk had been downgraded. RP queried the risk related to the national shortage of therapeutic radiographers and the pay grade which had contributed to the situation. MHo responded that this was a historical pay structure, however the banding was under review as the Trust was an outlier in this area.
10	**Quality and Performance Committee Report** AM advised the Board that the Committee continued to see a very challenged environment within the Trust. The Committee continued to seek assurance around patient experience and safety, particularly in relation to twelve-hour breaches. Workforce challenges continued to impact care. The Committee had noted the improvement in PALS performance, with the increased team capacity. Falls and pressure ulcers was key area of concern, and was reported separately to Board as requested by the Committee. A temporary derogation from national cleaning standards had been supported, with additional assurance on compliance required. The Committee had been pleased to report a substantial assurance rated internal audit review into waiting list management at the Trust. MN commented that the metrics on Quality and Performance scorecard did not currently reflect the CQC KLOEs. The Board was advised that quality reporting was under development to ensure alignment to the CQC KLOE areas, along with an integrated performance report for Board which aimed to reduce duplication and streamline reporting. **Falls and Pressure Ulcers Harm Review** A review of harm associated with falls and pressure ulcers had been undertaken; there was a clear link between the availability of registered nurse hours and a reduction in incidences, and no correlation between harm incidents and the use of temporary workforce. The report detailed a comprehensive improvement plan which aimed to further reduce the incidence of harm from falls and pressure ulcers. The Board was advised that work was ongoing to improve compliance with the digital falls assessment. NHSEI had been invited to walkabout and review the falls team, which would take place next week. RP asked how the Trust was caring for patients on corridor care to ensure no exacerbations of pressure ulcers. The Board was assured that pressure relieving equipment was in place for all patients in ambulances, which Emergency Department colleagues had access to in order to support patients waiting on trolleys. The Board noted the improvement in the rate of falls and pressure ulcers, and supported the recommendations within the report. **Learning from Deaths Report** The report detailed the governance systems in place for reviewing deaths and compliance with the national guidance. The Board was advised that structured reviews formed key learning opportunities for clinicians, although operational pressures presented a challenge in relation to feedback not always reaching teams in a timely manner.

	CF commented that the report described a well-established mechanism and queried whether a methodology was in place to review mortality patterns that occurred as a result of system pressures. Whilst there was currently no system wide process in place, the Board was assured that every death in hospital was reviewed by a Medical Examiner, a process which was being rolled out in the community. All child deaths were subject to independent scrutiny. **Journey to Outstanding Visits Report** The Board was advised that Executives were reflecting on the nature and purpose of the visits, and were looking to introduce less formality and more shadowing opportunities. Data would be utilised to inform where the team would visit, including corporate areas. Further discussion would be taken through the People and Organisational Development Committee.
11	**Medical Appraisal and Revalidation Report** Appraisal and revalidation processes had returned to normal, with no appraisals missed due to Covid-19. There had been 540 out of 560 appraisals completed within an appropriate timeframe. Seventeen missed appraisals were approved, resulting in very positive completion rates. The appraisal team had expanded, with eight new appraisers recruited, taking the team to forty-one. A new IT system was due to be implemented from September to support the process. The Board was assured by the success of the team and formally **approved** the report for submission.
12	**Finance and Digital Committee Report** The Trust was reporting a deficit of £6.5m, which was £3.7m adverse to plan. The key drivers for this were pay overspends due to the use of temporary staffing in Medicine and Surgery divisions for Nursing and Medical staff. The Board was advised that a supportive mechanism had been put in place to improve the divisions run rate, with Surgery reporting a surplus for month three. The Board noted that the divisions were fully engaged with the process and owned their budgets, plans and decisions with support from the finance team. The Trust was not yet meeting the Elective Recovery Fund target, and there was a risk that this additional income would not be achieved. The Board was advised that the best-case scenario would be to end quarter one with a deficit of £1.3m, however the forecast position was significant worse than that. Some benefits were being reported in procurement, with overachievement on some targets. The fundamental key was to reduce the run rate, and the Board was assured that a significant amount of work was underway to achieve this. **Digital Programme Report** The Board was fully assured by the report, noting in particular the progression of action plans in relation to the Cyber Security internal audit review, and the digital work plan for 2022-23.
13	**People and Organisational Development Committee Report** The Committee had focused on a revised dashboard and refocus of priorities and key issues. The Committee was encouraged by the new workforce transformation programmes, and supported the development of the new performance dashboard.
14	**Provider Licence Self-Certification** The Board **approved** the self-certification for publication.

Unconfirmed

15	**Any other business** The Board thanked EW for her contributions as Non-Executive Director, and wished her all the best for the future.
16	**Governor Observations** AT provided the following feedback: • Governors wished to record thanks to EW and wished her luck for the future. • The new Board Assurance Framework was commended, with recognition that there was still more work to do to ensure risks were rationalised and accurate. • Board members were asked to pass on any ideas or feedback on skill mix for the Board, in relation to the upcoming Non-Executive Director recruitment. • More information was required on the governor training section of the provider licence. • The Board was encouraged to consider the communications plan for sharing the CQC feedback and reports.
Close	

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Provider Licence Self-Certification	The Board approved the self-certification for publication.		
Medical Appraisal and Revalidation Report	The Board approved the report for submission.		

Gloucestershire Hospitals
NHS Foundation Trust

Public Board of Directors, September 2022

CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

At the time of writing, our new Prime Minister has not yet been announced and so we do not yet know whether Steve Barclay remains the Secretary of State for Health and Social Care. I recently had the pleasure of a (virtual) meeting with him along with several other Chief Executives to discuss the issues around ambulance handover delays; of which more below. Since the last Public Board meeting, we have returned to no mask wearing except in clinically high-risk areas (e.g. oncology, covid wards) and from 1 September all routine testing of staff and patients has been stood down. Testing for patients now follows pre-pandemic rules for influenzas i.e., symptomatic individuals only or where there is clinical suspicion. Staff can still access tests online but twice weekly routine testing is no longer required. Plans for winter 'flu vaccination are being developed and will include covid vaccination for all NHS staff. Staff are encouraged to get vaccinated as soon as they can once bookings become available as we are anticipating an earlier 'flu season this year.

The CQC Surgery and Well Led draft report has been received. We are in the process of the factual accuracy checking and can release no details of the report at this stage. Publication is expected mid-September. In the meantime, we are working to deliver the action plans generated in response to the S29a Warning Notices and the Maternity Services report. This work sits locally within the Divisions and the governance route is via the local quality committee / Maternity Delivery Group into Quality and Performance Committee. We have invited both the new Integrated Care Board and CQC to take part in this process. Formal re-inspection of both surgery and maternity is likely soon, perhaps even before the end of the year but will depend on progress having been made.

Executives have started a 'back to the floor' programme spending two half-days a month in frontline areas 'volunteering' as receptionists, health care assistants, with corporate teams and in other roles. A seminar with the 100 Leaders group was held last week as part of our desire to improve the way in which staff can be heard including, but not limited to the annual staff survey, in order to improve staff experience. All of this feeds into our long-term approach to improving the culture in the organisation and embedding, for example, a Just and Restorative approach across the whole organisation.

Operational Context

Operationally, the Trust continues to perform well in the delivery of our elective programme, and Diagnostics and Cancer performance. In each of these areas it remains in the top quartile within the South West. We have provided some mutual aid to other regions where we have capacity and can do this without disadvantaging patients in Gloucestershire. Despite our relatively low waiting lists our elective activity, especially day case, is not as high as it can be and we are working to improve productivity in a number of areas. Some of this relates to staffing issues but we have made progress in recruitment, especially to operating theatre staff, recently.

Recent improvements in ambulance handover delays have been sustained and are starting to result in significant improvements in ambulance response times in Gloucestershire. There has been significant scrutiny of the Trust's (poor) performance including my meeting with the SoS and we are now required to report weekly via the ICB to NHSE nationally. There has been significant financial support, revenue and capital, to help us deliver agreed actions including a new / expanded discharge waiting area, flow coordinators and extra staff in ED and on the wards at the weekends. Step-wise improvement will only come with system change which results in an improvement in flow within the Trust and a reduction in

the number of patients who are Medically Optimised for Discharge, which briefly dropped under 200 but is back at about 230 now. The ICB has increasingly grasped both the need to hold individual organisations to account for performance against issues within their control and for simplification and improvement in cross-organisational working.

Despite the pressures we have just started the long-planned provision of 24/7 emergency angioplasty and stenting in Cheltenham General Hospital meaning that patients no longer need to travel to Bristol for this service overnight.

Cost of Living Crisis

The Cost of Living Crisis is something that we cannot ignore. It will have significant impacts on our patients and our staff this winter. The Trust doesn't set pay scales as these are negotiated nationally. The pay award for Agenda for Change staff will be implemented this month with staff receiving their new salary, plus arrears backdated to April 22, in their September pay – this will include staff in GMS on retained Agenda for Change employment terms. Weekly paid staff will receive pay on the new rates this week and arrears next week. At the end of September the GMS Board will be considering the cost of living increase for staff on their local terms and conditions. We do know that several hundred of our GHT and GMS staff are paid less than the Real Living Wage. While we are not yet in a position to make any commitment we are investigating the possibility and implications of making sure that all our GMS and GHT staff receive at least the Real Living Wage.

Our current offer to staff includes:

- The 2020 Hub Financial health and wellbeing intranet page has recently been significantly updated and restructured. We now include signposting to financial support and debt advice, managing your money, telephone numbers for local agencies such Citizens Advice, as well as a discounts/offers page. The 2020 Hub team will continue to regularly maintain and update this with the latest information.
- The 2020 hub is proactively contacting local shops and businesses (such as retail, hairdressers, vets/pet care, hardware and repairs) to see what offers/discounts are available to NHS staff and posting these on the Discounts and Offers intranet page.
- In partnership with the Communications team, we are planning to run a 3-month long comms campaign (October-December) to highlight and promote the sources of support that are available. In addition to the financial wellbeing page above we will highlight existing offers available including promotion of:
    - Salary Sacrifice and discount schemes (Vivup)
    - Salary Finance (loans, savings, advance)
    - The Vivup EAP which, in addition to providing counselling, can offer certain kinds of financial advice
    - 2020 Hub offering a listening and signposting service to colleagues who are anxious and worried about money
- We have begun working with the catering team to identify where savings/discounts can be offered to colleagues. A range of options are being developed and costed, for further discussion with Finance colleagues and the Executive team. This may include reward schemes e.g., buy 4 meals and get one free; lunchtime Meal Deals; budget meal of the day; discounts on freshly prepared meals.
- We have started working with GMS and Finance colleagues to explore opportunities and mechanisms for offering staff interest-free loans on annual travel passes (rail, coach, bus).
- We are just commencing work with system colleagues in One Gloucestershire to identify where we can agree a consistent financial wellbeing offer to colleagues. A Task-and-Finish

group is due to meet in early September and will report into the ICS OD Steering Group. Areas we are likely to explore collectively include, in addition to what's already been listed:

- Provision of Hardship funds/grants
- Parking charges
- Provision of food bank vouchers to staff

Other Highlights

The estates work continues at pace and we opened the new Frailty Ward in the Gallery Wing in August. This is part of a planned reorganisation of frailty services aiming to provide direct pathways that avoid the Emergency Departments and faster turnaround for patients who do need hospital care.

September 20th is Maternity Safety Champions Day. We are holding an event to share good practice and safety improvement projects in maternity and to share the future work of the safety champions to inspire more direct care staff to be involved.

Fundraising for the Gloucestershire Cancer Institute is about to launch with an inaugural event at Berkeley Castle on the evening of September 29th. The event aims to create momentum with the private phase of our appeal. Significant donations will be crucial for the success of this £16.5M Capital Appeal, and the charity team will work with our Appeal Board following the event to convert interest into engagement and pledges of support.

Finally, Deb Lee has completed her phased return to work and is now on annual leave. She will take back the Chief Executive responsibilities on September 12th (when I head off for my summer holiday). We shared a VLOG about our very different experiences of the last 4 months which can be found here: https://intranet.gloshospitals.nhs.uk/news/marks-vlog-010922/. I would like to take this opportunity to thank everyone who supported me so well over this period. The Exec team in particular has been amazing and a large number of people have been keeping an eye out for my personal wellbeing. I am very grateful. However, I would like to pick out Dr Alex d'Agapeyeff as the unsung hero of the last 4 months. He has covered 100% of my Medical Director role, acted as Chief of Service for D&S, and continued his clinical practice as an ITU consultant. Throughout this time he has remained jovial and upbeat and denied that we are working him too hard despite all appearances to the contrary. I certainly couldn't have done what I have done without his immense contribution.

Mark Pietroni
Interim Chief Executive Officer

1 September 2022

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges							
SR1	Breach of CQC regulations or other quality related regulatory standards.	July 2019	July 2022	CNO/DOQ	3x4=12	4x4=16	5x4=20
2. We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people							
SR2	Failure to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve.	April 2019	June 2022	DOP	3x4=12	n/a	5x4=20
3. Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other							
SR3	Failure to deliver the Trust's enabling Quality Strategy and implement the Quality Framework	July 2019	July 2022	MD	2x3=6	n/a	3x3=9
4. We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners							
SR4	Risk that individual organisational priorities and decisions are not aligned.	July 2019	July 2022	COO	2x3=6	n/a	4x3=12
5. Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services							
SR5	Poor engagement and involvement with/from patients, colleagues, stakeholders and the public.	July 2019	July 2022	DoST	1x3	n/a	3x3=9
7. We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources							
SR7	Failure to deliver financial balance.	July 2019	June 2022	DOF	4x3=12	n/a	4x4=16
8. We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact							
SR8	Failure to develop our estate which will affect access to services and our environmental impact.	July 2019	July 2022	DST	4x3=12	n/a	4x4=16
SR9	Inability to access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings.	July 2019	July 2022	DST	4x3=12	n/a	4x4=16
9. We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care							
SR10	Our IT infrastructure and digital capability are not able to deliver our ambitions for safe, reliable, responsible care.	July 2019	April 2022	CDIO	2x1=2	n/a	2x2=4

Board Assurance Framework Summary

10. We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK							
SR11	Failure to meet University Hospitals Association (UHA), membership criteria, a pre-requisite for UHA accreditation.	July 2019	April 2022	DST	4x2=8	n/a	4x3=12
SR12	Inability to secure funding to support individuals and teams to dedicate time to research due to competing priorities limiting our ability to extend our research portfolio.	July 2019	April 2022	MD	3x3=9	n/a	4x3=12

Archived Risks (score of 4 and below)

We have established centres of excellence that provide urgent, planned and specialist care to the highest standards, and ensure as many Gloucestershire residents as possible receive care within county	
SR6	Risk that the phased approach to implementation of our Centre of Excellence model is extended beyond reasonable timescales due to a range of dependencies e.g., estate, capital, workforce, technology delaying the realisation of patient benefits.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR1: Breach of regulatory activity July 2022

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**CQC regulations or other quality related regulatory standards are breached**	We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	A range of quality issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance	**Chief Nurse (CN)**	S3316 C2819N C2669N C1945NTVN D&S2976 Rad WC3536O bs M2353Diab D&S3103 Path C2667NIC C1850NSafe C3034N C3295COOCOVID WC3257Gyn WC3536Obs WC3685Obs M3682Emer C2628COO C1798COO S2715Th C2715 C3084 C1437POD C3767COO D&S2938RT

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Dec 2023	Dec 2024	-		2019/2020	
4X5=20	Risk, control and assurance identification and monitoring processes have highlighted a number of risks to quality and therefore to the strategic objective.	**3x4=12**	**3x4=12**		A number of quality and workforce plans focused on improved culture would have positive impact on quality.	2020/2021	
						2021/2022	
						2022 Q4	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee oversees progress of improvement plans in areas of significant concern highlighted by external reviews, incidents, complaints etc. • Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board	• Quality Strategy in need of refresh due to key milestones needing to be reprioritised due to challenges caused by changes in personnel. • Inability to match recruitment needs due to national and local shortages and the impact on quality of care (links with People and OD Strategy) • Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR1: Breach of regulatory activity July 2022

• Monitoring of performance, access and quality metrics via Quality & Performance Report • Operational Plan 2022/23 • Quality Strategy and delivery plan • Risk Management processes • Quality priorities for 2022/23 (as identified in Quality Account 2021/22) • QIA processes • Improvement programmes • Executive Review process • Internal audit plan adapted to respond to significant quality issues. • J20 Director walkabouts • Trust investment plans prioritised according to risk. • Inspection and review by external bodies (including CQC inspections). • GIRFT review programme. • External reviews of services • Patient Experience Reporting • Learning from deaths reporting • Key issues and Assurance Report (KIAR)	• Quality and Performance Report in need of refresh to enable monitor of key metrics

ACTIONS PLANNED

Action	Lead	Due date	Update
Workforce - Monitoring of impact of workforce challenges on quality and performance	DoQ &CN	Q2 2022/23	- Safer staffing reviews due Sept so that there can be close monitoring of workforce challenges impact on quality of care via Safer Staffing Report.
Operational Plan - Development of plan in response to NHSE/I planning guidance	COO	Q4 21/22 Q1/2 22/23 Q4 22/23	- Received by Q&P Committee - Operational Plan agreed with external regulators - Delivery of defined planned operational improvements
Quality Strategy and QPR - Review and refresh strategy and delivery plan - Review of metrics within QPR - Define quality priorities for 2022/23 - Development of separate Whole Person Care Strategy	DoQ &CN	End of Q2 2022/23 21/22 Q4 Q2 22/23	- This work has been delayed and will commence in July 2022 - Work underway – delayed because of CQC regulatory activity - Complete and Q1 progress reported to QDG. - Draft received by QDG and Board development strategy session completed.
External reviews of services - Develop action plans in response to recent inspections	DoQ &CN	End of Q2 2022/23	- Complete - CQC Medical Care and UEC Care report received action plan developed. - CQC Maternity focused inspection final report received and embargoed until 22 July 2022. - CQC unannounced core service inspection of surgery awaiting report – with Well Led report due end July/August - CQC Well led feedback to CEO and Board raising concerns/issues with the organisation.

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

			- NHSE/I review of Maternity Service and LMNS 18/19 July delayed due to extreme weather national alert and Business Continuity plans in place.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
- Learning from Deaths Report - Internal Audit: Waiting List Management	**CQC** - Section 29a warning notices for maternity and surgery and maternity focused inspection report due to be published 22 July 2022. **Staff Survey** - Below average NHS Staff Survey results (metrics for Quality Strategy Delivery). **Urgent and Emergency Care** – Ambulance handovers remained a key challenge, although overall hours lost had reduced. – 12-hour breaches remained stable with no further deterioration. – Improvements from the Urgent and Emergency Care Board were anticipated to make a positive impact. – The system remained very challenged overall, with the Trust an outlier on ambulance handover performance. **Quality and Performance Report** – There had been an increase in cases of C.Diff which continued to be monitored and investigated. – The Friends and Family Test score was at 87% in May, with improvements seen in both urgent care and maternity. – The gynaecology bed base continued to be challenged. – There were currently 1248 patients waiting over 52 weeks, with a total Patient Tracking List of 58k. The total PTL had grown by 700 due to an increase in overall referrals. – Waiting times for urgent Echocardiography was an area of concern and was currently being reviewed. – Covid cases were increasing and being monitored. – There had been one case of monkeypox reported within the Trust, which had resulted in approximately twenty members of staff isolating for 21 days. – The 62-day standard for cancer performance was experiencing some challenge, particularly within skin and lower GI.	• Inspection and review by an external body - CQC Well Led Inspection June 2022 (report due end of July/August 2022) • Internal audit reviews 2022-25: ○ Outpatient Clinic Management ○ MCA and Consent ○ Discharge Processes ○ Divisional Governance ○ Cross health economy reviews ○ Risk Maturity ○ Patient Safety (Learning from Complaints/Incidents) ○ Clinical Programme Group ○ Environmental Sustainability ○ Data Quality ○ Patient Deterioration ○ Pressure Ulcer Management ○ Clinical Audit ○ Medical Records ○ Infection Prevention and Control

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Workforce June 2022

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR2	**Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve.**	We have a compassionate, skilful and sustainable workforce, organised around the patient which describes us as an outstanding employer who attracts, develops and retains the very best people.	Staffing issues across multiple professions on national scale. Lack of resilience in staff teams. Increased pressure leads to high sickness and turnover levels.	Reduced capacity to deliver key strategies, operational plan and high-quality services. Increased staff pressure. Increased reliance on temporary staffing. Reduced ability to recruit the best people due to deterioration in reputation.	People and Organisational Development Committee	DoP	C3648POD C1437POD C3321POD C2803POD C2908POD

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
5x4=20	The ongoing impact of the pandemic is affecting staff in all areas of the organisation. Staff shortages and deteriorating staff experience will impact further.	**Jan 2023** **3x4=12**	A number of workforce plans focused on recruitment, retention and improved culture would have positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce	

CONTROLS/MITIGATIONS

- Diversity Network with three sub-groups (ethnic minority; LGBTQ+, and disability).
- Compassionate Behaviours Framework
- Compassionate Leadership mandatory training for all leaders and managers
- International recruitment pipeline
- Increased apprenticeships, TNA Cohorts and student placement capacity
- Induction pilot of cohorts for HCA/HCSW
- Advanced Care and other alternative speciality roles
- Accreditation of Preceptorship module
- Technology Enhanced Learning and Simulation Based Education
- Divisional colleague engagement plans
- Proactive Health and Wellbeing interventions
- Formalised workforce Operational Plan submission 2022/2023 to NHSE, integrated with the ICS

GAPS IN CONTROL

- Delays in time to hire
- No formalised marketing and attraction strategy / plan
- Inability to match recruitment needs (due to national and local shortages)
- Staff flight risk post pandemic
- Increased staff sickness absence including the impact of Long Covid related illness
- Pace of operational performance recovery leading to staff burnout
- Absence of full roll out of e-rostering across all staff groups for improved productivity
- Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience
- Lack of time for staff to complete e-learning training
- Absence of co-joined educational planning throughout the Trust

ACTIONS PLANNED

Action	Lead	Due date	Update
Initial scope of e2e transactional recruitment leading to formal transformation change programme	DDfPOD	Commence 7th June 2022	Full recruitment review formally commences on 7th June 2002 reporting into the Workforce Sustainability Programme Board.

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

Development of a marketing and strategy / plan	AD of Resourcing	Commence May 2022	This will now form part of the Workforce Sustainability Programme structure and will include the procurement of an external marketing company to work in close partnership with the Trust to support the design and implementation of innovative and creative attraction solutions. Work has specifically commenced in May with plans to address the increasing challenges with admin & clerical vacancy levels.
Delivery of 2022/23 workforce plan including new roles, increased overseas recruitment and robust pipeline plans	DDfPOD	2022-23	Positive feedback was received from NHSE on the Trust's submission into the ICS workforce plan for 2022/23. Interventions and activities to deliver the workforce plan across the Trust has commenced. This will be formalised through the Workforce Sustainability Programme.
Immediate focussed planning in response to the 2021 Staff Survey outcomes	Head of L&OD/DoP	Commence April 2022	Commencement of a staff engagement and culture programme has been seen in May, with clear workstreams focussing on organisational values, staff engagement, staff survey responses, and Restorative and Just Learning.
Commencement of Workforce Sustainability Programme	DfPOD	2022-23	Presented to the Workforce Sustainability Programme Board in May 2022. Focus in the last month has seen the governance, structures and formal programme management frameworks being established to support the traction and pace critical for positive delivery outcomes.
Focussed planning of a Preceptorship Academy and commencement of a master accredited module	ADED	June 2023	Development of an accredited master module as part of the Preceptorship Programme for AHPs and RNs.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Ability to offer flexible working arrangements • Flexibility with the targeted use of Bank incentives and Trust-wide reward • Focussed health and wellbeing plan	• Below average staff survey results • Diversity gaps in senior positions • Gender pay gap • Significant workforce gaps • Reduced appraisal compliance • Reduction in Essential Training compliance • Exit interview trends • Cost of living increases with AfC pay-scales not as competitive as some private sector roles • WRES and WDES indicator 2 (likelihood of appointment from shortlisting)	• Workforce Sustainability Programme Board • Internal audit reviews 2022-25: - Workforce Planning - Cultural Maturity - Cross health economy reviews - Equalities, Diversity and Inclusion - Health and Wellbeing - Recruitment and Retention - Staff Engagement

Key: **Blue: completed**
Green: on track to be delivered in timeframes
Amber: on track with some delays to the achievement timescale
Red: unlikely to be achieve in the time frame

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR3: Failure to deliver the Quality Strategy July 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR3	**Failure to deliver the Trust's enabling Quality Strategy and implement the Quality Framework**	Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other	A range of quality issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance	MD	SR2 - Quality Improvement – 268 risks linked to this BAF / 15 of these risks are Trust risks (red)

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Mar 2023	Mar 2024	-			
3x3=9	The QS high level indicators are reflected in the staff survey results which have deteriorated	**3x3=9**	**2x2=4**		Implementation and embedding of the QS and Just, Learning and Restorative approach will take time to alter behaviours, staff perceptions and survey results		

CONTROLS/MITIGATIONS

- Quality and Performance Committee oversees progress of improvement plans in areas of significant concern highlighted by external reviews, incidents, complaints etc.
- Internal audit plan adapted to respond to significant quality issues.
- Trust investment plans prioritised according to risk.

GAPS IN CONTROL

- Development of larger scale change projects
- Regular update of QS and monitoring of goals

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of Programme team to incorporate improvement methodology	SL	March 23	Restructure of programme team completed
Review QS with new Chief Nurse on appointment	MH	Q3/Q4 22/23	Scoping begun for new milestones
Development of the Just, Learning and Restorative (JL&R) approach	CB	March 23	Planning team established

POSITIVE ASSURANCES

- Progress reported on QS to QPC in October 2021 and forms part of QDG update
- Quality priorities agreed
- Quality Account published which describes the work of the Quality Strategy priorities
- Learning from deaths report

NEGATIVE ASSURANCES

- Staff survey results

PLANNED ASSURANCE

- Update to QPC on QS
- Improvement Programme for JL&R approach
- Improvement Programme for Staff survey
- Internal audit reviews: Workforce Planning; Discharge Processes; Cultural Maturity; Divisional Governance; Cross health economy reviews; Risk Maturity

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR4: Individual and organisational priorities not aligned July 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR4	**Risk that individual organisational priorities and decisions are not aligned, which would result in restriction of the movement of resources (including financial and workforce) leading to an impact upon the scope of integration**	We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners	• New divisional Management teams • New COO and Deputy COO • C-19 extraordinary response and interim arrangements	Loss of some 'historical' context. Availability of resources and investment at a time of flux/pandemic. Usual planning cycles suspended/adjusted.	Quality and Performance	COO	M3682Emer D&S3507RT WC3536Obs C1850NSafe

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023	-			
4x3=12	Division of Medicine management support still not fully recruited to with some Directorate gaps. Substantive Triumvirate in place by Q2	**3x3=9**	**2x3=6**			Q2 2021/22	
						Q4 2021/22	

CONTROLS/MITIGATIONS

- Weekly and monthly business cycles in place to monitor/deliver progress against all key KPIs
- Agreed Operational Plan (2022/23) to be in place by Q1/M1
- Substantive Triumvirates in place (or appointed to) for the Operational/Clinical Divisions
- Close working relationships between Operational Divisions and Finance/HR proven in delivery of H2 and other priorities
- Assurance meeting established twice per month to monitor and mitigate/escalate gaps in control identified (led by Finance/Operations/BI)

GAPS IN CONTROL

- Quality KPIs may not be met fully within the Operational plan
- Operational Plan 2022/23 not fully compliant in all domains (Activity agreed to delivery 104%; however not all quality measures planned to be met; Financial gap identified and not fully mitigated).

ACTIONS PLANNED

Action	Lead	Due date	Update
Continuation of Operational Plan delivery monitoring (led by BI, Finance and dCOO)	NHL	June 2022	Meeting confirmed and in diaries twice per month. Reporting being finalised
'Flow' Focussed strategy group planned. Sits with Strategy PMO.	IQ	June 2022	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Elective Recovery Board in place • Regular 'systemwide' planning meetings in place	• Operational Plan 2022/23 not fully compliant and not yet formally agreed	• Operational Plan 2022/23 to be established to monitor delivery on formal basis from June 2022.

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

• KPI (Cancer performance, diagnostics etc) monitoring meetings are fully established		• 'Flow' focussed strategy and delivery group planned June '22
		• Internal audit reviews 2022-25:
		  ○ Outpatient Clinic Management
		  ○ Discharge Processes
		  ○ Cultural Maturity
		  ○ Clinical Programme Group
		  ○ Patient Safety: Learning from Complaints/Incidents
		  ○ Patient Deterioration
		  ○ Equalities, Diversity and Inclusion
		  ○ Infection Prevention and Control

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR5: Poor engagement — July 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR5	**Poor engagement and involvement with/from patients, colleagues, stakeholders and the public.**	Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services	Insufficient engagement and involvement approach, methodologies or timing.	Colleagues feel 'done to', external stakeholders feel uninformed	Quality and Performance / People and OD	DoST	C3738S&T

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023	Sept 2023			
3x3=9	External engagement has improved but internal engagement and involvement needs more work	**2x3=6**	**2x3=6**	**1x3**		Aug 2021	**3x2=6**
						Nov 2021	**3x2=6**
						March 2022	**3x3=9**

CONTROLS/MITIGATIONS

- Board approved Engagement and Involvement Strategy
- Quarterly Strategy and Engagement Governors Group
- Monthly Team Brief to cascade key messages
- Annual Members' Meeting (Sept 27 2022)
- Friends and Family Test
- NHS Staff Survey and NHS Quarterly Pulse Survey
- Quarterly patient experience report to Quality and Performance Committee
- One Gloucestershire approach to public involvement – additional dedicated resources
- New Colleague Experience and Internal Communications Manager recruited.

GAPS IN CONTROL

- Objective measurement of how well key messages are being cascaded to colleagues.
- Resource gap for engaging, involving and growing Trust Membership.

ACTIONS PLANNED

Action	Lead	Due date	Update
FFTF phase 2 engagement and involvement programme underway, with regular cascades to staff and communities	DoST	Aug 2022	FFTF Phase 2 extended to end of July 2022. Regular staff engagement and communication. 10+ public information bus events and attendance at community events.
Review of Team Brief and internal communications channels	DEI&C	Oct 2022	Feedback on Team Brief cascade, review of communication channels aimed at colleagues who do not use email or digital systems regularly.
Development of Staff Survey engagement programme, including a review of engaging services and back to the floor programme.	DEI&C	Oct-Nov 2022	Working Group established and plan developed. Key interventions and resources developing to support all divisions.

POSITIVE ASSURANCES

- Approach and feedback from the Consultation Institute on Fit for the Future engagement and consultation programme
- Progress demonstrated in publication of Engagement & Involvement Annual Review 2021/22
- Level of engagement and involvement from Governors

NEGATIVE ASSURANCES

- Engagement score from 2021 NHS staff survey saw 0.3 point reduction on 2020 score (6.6 from 6.9) and is now below national average of 6.8.
- Drop in net promoter scores within Staff Survey (I would recommend the Trust as a place to work or receive care).

PLANNED ASSURANCE

Internal audit reviews 2022-25:

- Cultural Maturity
- Outpatient Clinic Management
- Patient Safety: Learning from Complaints/Incidents
- Equalities, Diversity and Inclusion
- Staff Engagement

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

• Inclusion of patient and staff stories at Trust Board including bi-annual learning report • One Gloucestershire involvement group established – ensuring joined up priorities and work.		• Recruitment and Retention

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Financial balance — June 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR7	Failure to deliver financial balance	We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources.	• The ability to spend with minimal restrictions on the overall financial pot during the pandemic resulting in an increase to the underlying position; • Recovery financial regime conflicts with elective recovery; • History of delivering efficiencies by non-recurrent means; • Staff engagement in the agenda whilst balancing operational pressures.	The Trust and ICS continues to have an underlying financial baseline deficit which may grow in size. Higher efficiency targets for the following year, creating an increased risk of an impact on patient services; impact on future regulatory ratings and reputation; regulatory scrutiny/intervention leading to increased risk of impact on staff; inability to achieve strategic objectives, particularly investment plans.	Finance and Digital	DOF	F2895, F3633, F3679, F3393, F3680, F3387, F3681, F3339, F3336, F3434,

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY
4x4=16	Draft plan for 22/23 indicates a significant system deficit, of which the Trust is contributing. Increase cost of temporary staffing due to workforce challenges. The lack of flow in the hospital causing restrictions on elective recovery impacting on the ability to earn ERF. Pressure on operational capacity, limiting the focus on how to drive out efficiencies whilst improving patient outcomes. The system has now submit a balanced plan but one that has a significant volume of non-recurrent benefits.	**Apr 2023**	**Jun 2023**	-	The Trust needs to develop a medium-term financial plan to understand how the financial health of the organisation moves over time (by August 2022). Full review of all revenue investments made during the pandemic to determine whether they are still to be supported or if financial commitment should be removed (by July 2022). Continued monthly monitoring to understand the drivers of the deficit. Drive the financial sustainability programme to start to see the recurrent benefits of financial improvement. Targeted weekly financial oversight meetings in place for the two divisions who are experiencing adverse movement from budget. These meetings are chaired by the Chief of	
		3x4=12	**3x4=12**			

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

	Months 1 and 2 actuals are suggesting the financial position is under pressure. Financial sustainability remains a significant risk in terms of deliverability.				Service and Director of Finance is there to seek assurance. Early indications show an improved position but one that isn't at breakeven yet.		

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Service Development Group peer review business cases • Programme Delivery Group for financial sustainability • ICS one savings programme to share ideas, resources and drive consistency • Monthly monitoring of the financial position • Controls around temporary staffing • Driving productivity through transformation programmes i.e., theatres and OP • Weekly financial recovery meetings in place with those adversely deviating from plan	• Finance strategy in draft and needs completing • Clear line of accountability • Robust benefits identification, delivery and tracking across major projects • Controls on the approval of WLIs needs strengthening • No accountability framework

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of the financial sustainability team reporting within the strategy and transformation portfolio	DOF/ DOS	Feb 22	This team has now moved across, training and development ongoing. Vacancies being filled by a combination of permanent and interim staff to get the governance and reporting in place by Mar 22. Detailed plans around deliverability of the financial sustainability programme will be in first draft by end of April.
Robust benefits identification, delivery and tracking across major projects	DOF/ DOS	Jun 22	Capacity now in place to develop the process, format and framework around how we capture the benefits. This will be tested during the financial year and where necessary adapted to ensure the process is robust and effective.
Set up weekly meetings for those division that are showing financial pressure	CoS	Jun 22	This has been set up and progress is good.
Trust wide communication is being developed and sent out to inform the organisation of the financial position to get the message understood	Comms	Jul 22	Initial comms going out in term briefs in July, Financial sustainability on the agenda for 100 leaders in July. Development of Trust wide workshops to gain more traction on ideas for medium term plan during the financial year.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Achieved key annual financial targets in 2020-21. • Achieved key annual financial targets in 2021-22. • Achieved key annual financial targets in 2022-23 • Continued the monitoring of financial sustainability during the pandemic.	• Moderate/Limited assurance rating from internal auditor on key financial controls and payroll 2020-21. • Temporary staff spend consistently above target. • Planned Trust and System underlying deficit moving into 22/23 a significant concern. • Continuing under-delivery of recurring efficiency programme.	Internal Audits planned 2022-25: • Cross health economy reviews • Shared Services reviews • Risk Maturity • Data Quality • Budgetary Control • Charitable Funds

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Financial balance June 2022

• Move of financial sustainability to Strategy and Transformation to give focus on quality of service which should drive financial improvement • ERF monies being generated by Trust. • Improved and co-ordinated system working. • External Audit VFM report, Sept 21.	• ERF tightening of trajectories has impacted upon the system and H2 outlook doesn't look positive • Lack of benefit realisation on schemes that should be delivering financial improvement; no real consequences of financial deviation, no review on whether to continue to stop a project if overspending	• Payroll Overpayments NHSE/I scrutiny of Trust/system finances. ICS accountability and assurance on system wide transformational changes.

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR8: Failure to continually improve our estate — July 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR8	**Failure to continually improve our estate which will impact on: patient experience and access to services; patient & colleague experience; our ability to reduce our environmental impact.**	**Estate Strategic Objective:** We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact.	• National Capital Department Expenditure Limits (CDEL) • Age, condition and inefficiency of GHFT buildings & infrastructure • Clinical services provided from estate that does not align to our centres of excellence vision.	Access, experience, environmental & financial impact on patients, colleagues and the Trust of providing services from older building stock and infrastructure.	Estates and Facilities	DoST	SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Jan 2023	Jan 2024				
4x4=16	GHFT is not included in National Hospital Programme which is committed to 2025/2030. NHSE/I capital programmes require schemes that provide a 4:1 return on investment which cannot be achieved for building replacement programmes	**4x4=16**	**4x4=16**		National Hospital Programme is already committed to 2025 but is currently unaffordable so unlikely to take on additional schemes. One Gloucestershire CDEL results in an annual £24M capital budget for GHFT, which is currently split equally across estates, digital and equipment. £8M is insufficient to support both strategic and estate backlog priorities	April 2022 April 2021 Oct 2020 June 2020	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Strategic Site Development Programme (SSD) Full Business Case secured £39.5M of national funding in 2021 • SSD scheme rated as BREAM 'good' • £13M of Public Sector Decarbonisation Scheme (PSDS) funding secured in 2021/22 • Further PSDS application to be submitted in September 2022 • Gloucestershire Cancer Institute scheme at OBC stage, but reliant on charitable fundraising anticipated to take 5-6 years (construction start date est. 2027) • Board approved Green Plan and supporting governance structure: Executive Lead, Green Champions, Green Council, Climate Emergency Leadership Group reporting into E&F Committee • £50K Green fund secured on non-recurring basis to support local initiatives in 2022/23	• Maturity of ICS Estates Group impacting on pace of shared use of ICS estate • Lack of ICS Estates Strategy • Lack of alternative routes to large-scale capital other than NHSE/I.

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

• Continue to develop library of capital business cases to respond to future NHSE/I capital schemes • Continue to explore off-site solutions with ICS partners e.g. Dermatology to GP surgery.	

ACTIONS PLANNED

Action	Lead	Due date	Update
ICS Estates Strategy	ICS DoF	Q4 22/23	
Oversight of Green Plan	DST	2022/23	DoST nominated Executive Lead from April 2022
Further PSDS applications	GMS	Q4 2023	Application to PSDS Phase 3b in September 2022
Targeted Investment Fund (TIF) bid for 5th Ortho theatre	DST	June 2022	Short form business case submitted 30th June 2022. 10-12 week NHSE/I approval process.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• SSD Programme progressing to plan • PSDS (Salix) funding schemes delivered in 2021/22 • Trust ability to respond to and secure ad-hoc capital funding in-year from NHSE&I and grants • Declaration of Climate Emergency in 2020 resulting in Green Plan • 22/23 TIF bid – 5th Orthopaedic theatre at CGH • Vital energy contract performance – reducing emissions and returning power to national grid	• Scale of estates backlog at £72m of which £41m is rated as Critical Infrastructure Risk • £8M per year allocated to estates limits progress that can be made on reducing backlog, particularly given strategic pre-commitments (SSD & IGIS) • Electrical infrastructure capacity constraints • ICS CDEL limits	Internal audit reviews 2023-2025: • Environmental Sustainability • Estates Management

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR9: Inability to access sufficient capital — July 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR9	**Inability to access capital required to i) make any significant reduction in our estate backlog maintenance and critical infrastructure risk ii) replace equipment within lifecycle**	**Estate Strategic Objective:** We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact.	• National Capital Department Expenditure Limits (CDEL) • Age, condition and inefficiency of GHFT buildings & infrastructure • Lumpy equipment purchase profile • Scale of backlog maintenance: £72M (2021 6-facet survey)	Unable to address backlog and critical infrastructure risks and/or replace equipment within lifecycle impacting on service delivery, patient access and experience and staff experience	Estates and Facilities	DST	SR8

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Jan 2023	Jan 2024	-			
4x4=16	One Gloucestershire CDEL results in an annual capital budget of c£24M per year for GHFT. This is split equally across estates, digital and equipment. £8M is insufficient to address the scale of backlog maintenance (£72M) and critical infrastructure risk (£41M) the Trust is carrying.	**4x4=16**	**4x4=16**		• CDEL limits constrain the level of capital investment One Gloucestershire can commit to • Estate backlog maintenance is competing with other strategic and operational priorities, including: strategic estate schemes (GSSD and IGIS); digital and equipment replacement • Equipment Managed Equipment Service (MES) procurement on hold as business case did not demonstrate value for money and impact of IFRS16 was unknown in 21/22.	April 2022 April 2021 Oct 2020 June 2020	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Trust is sighted on the scale of backlog and Critical Infrastructure Risk as a 6-facet survey was completed in 2021 • Now ensuring all NHSE/I capital bids include costs of address backlog maintenance risks in immediate and/or linked development areas • Improved risk reporting of estates risks through GMS, RMG, Committee & Board • Transition to longer term planning approach to develop a 3-5 year estates capital programme to provide assurance of when highest risks will be addressed • Exploring options to dispose of estate with capital receipt used to address backlog risks	• Lack of alternative routes to capital other than NHSE/I. • Lack of a CDEL prioritisation process across the ICS that recognises the level of risk being carried by each organisation • Lack of clarity on scale of national funding and application route for New Hospital Programme post 2025.

ACTIONS PLANNED

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR9: Inability to access sufficient capital July 2022

Action	Lead	Due date	Update
Review equipment MES business case	DoF/ DST	Q2 22/23	Work needs to be recommissioned and resourced
Targeted Investment Fund (TIF) bid for 5th Ortho theatre	DST	June 2022	Short form business case submitted 30th June 2022. 10-12 week NHSE/I approval process. Includes capital to reduce electrical infrastructure risk at CGH
Review scope, function, priorities and resourcing of ICS Estates Strategy Group	DST	Q3 22/23	Raise via ICS Strategic Executive post transition period
Agree plan to address electrical infrastructure risks over next 5-years	DST	Q2 22/23	Plan defined. Funding mechanism tbc.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Trust ability to respond to and secure ad-hoc capital funding in-year from NHSE&I. Schemes include backlog maintenance element • PFI is being maintained to 'Condition B' in line with contract • GSSD comes on line in 2022/23 providing good quality estate with reduced maintenance requirement. GSSD has addressed areas carrying backlog e.g. Gallery Wing, DSU at CGH.	• Strategic pre-commitments have reduced budget available for backlog maintenance to £3M in 2022/23 and £1.5M in 2023/24. • Level of risk is increasing reflected through risk scores.	Internal audit reviews 2023-25: • Environmental Sustainability • Estates Management

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR10: IT and Digital — April 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR10	Our IT infrastructure and digital capability are not able to deliver our ambitions for safe, reliable, responsible care.	Our electronic patient record system and other technology drives safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care.		• Reduced ability to innovate, keep pace with health care developments and undertake research. • Negative reputation in comparison with peers, impacting on recruitment and retention. • Inability to work effectively across the system, providing poor joined-up care. • Inefficient operational practice. • Inefficient systems/poor data can be a contributing factor in clinical errors. • Unable to meet expectations of patients, commissioners and regulators.	Finance and Digital	CDIO	

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
2x2=4		2022			
		2x1=2			

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Electronic Patient Record established across the organisation • Increased electronic attendance, discharge and outpatient information sent to GPs • EPR Procurement of open APIs and FHIR compliant system meaning the EPR will use JUYI to link • Joining Up Your Information (JUYI) implemented in partnership with external partners • EPR delivery group • Digital Care Delivery Group representation includes representatives from Gloucestershire Health Partners. • Roll out of access to Sunrise EPR to primary care and some community colleagues • Delivery workstreams including clinical/business and IT leads with sufficient seniority and oversight/awareness of wider Gloucestershire strategy and requirements. • Internal audit of cyber completed and action plan implemented to resolve issues and gaps in security • Digital Strategy	• As cyber security risk increases globally, focus needs to continue on identifying and mitigating new and increasing risks • Use of different systems across the organisation and ICS

ACTIONS PLANNED

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

Action	Lead	Due date	Update
Review GHC technical and digital representation on key groups	CDIO	Oct 22	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Regular reviews to Finance and Digital Committee	• Digital maturity assessment • Independent reviews	Internal audit reviews 2022-25: • Data Security and Protection Toolkit • Cyber Security • Risk Maturity

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR11: Failure to meet UHA membership criteria — April 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR11	**Failure to meet University Hospitals Association (UHA), membership criteria, a pre-requisite for UHA accreditation**	We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK	The UHA has updated its membership criteria in three areas: 1. NED should be from a University with a Medical or Dental School. 2. A minimum of 20 consultants with substantive contracts of employment with the university with a medical or dental school. 3. 2-year average Research Capability Funding (RCF) of at least £200k p.a.	Unable to secure UHA membership	People and Organisational Development Committee	DoST	

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023	-			
4x3=12	Unlikely to meet new UHA criteria by 2024.	**4x2=8**	**4x2=8**		Impact is low as the Board is committed to improving research, education and university strategic relationships delivering benefits for colleagues, patients and partners		

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• University Programme is developing 'plan b' to deliver benefits without necessarily achieving UHA accreditation • Continued Board commitment to this programme • Programme progress monitored through S&T Delivery Group and TLT • Ongoing work to further develop strategic relationships with University partners	• Lack of clear plan and timeline to increase NIHR grant funded research and RCF income • Need to set realistic target for number of honorary contracts • Need to improve relationship with UHA to increase awareness of GHFT and level of research and education programmes in place

ACTIONS PLANNED

Action	Lead	Due date	Update

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

Continue to work with University partners, WoE Clinical Research Network (CRN) and other partners to increase our research activity and NIHR grant income	DST	2022/23	
Memorandum of Understanding (MoUs) in development with 3 University partners	DST	Q2 22/23	
Appoint new Academic Non-Executive Director appointed	DST	Q1 22/23	Interviews held in March 22 and appointment made. New ANED to start in June 22

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Strong collaborative working and relationship with University of Gloucestershire e.g. Nursing and Radiographer programmes • Strong collaborative and working relationship with Bristol University e.g. Bristol Medical School • Developing relationship with University of Worcestershire e.g. Three Counties Medical School • Allocation of 51 additional F1 and F2 trainee doctors to GHFT in recognition of education programme and size of Trust • Availability of library, IT and teaching facilities for postgraduate and undergraduate education • Lead placement role in place responsible for undergraduate education	• UHA is currently closed to new applications • Establishing x20 honorary contracts is a challenge • Achieving NIHR research grant income of £725,000 per annum and the resulting RCF income of £200,000 by 2024 is a challenge given our baseline of £91k NIHR research grant income and £26k RCF	Internal audit reviews 2022-25: • Cultural Maturity • Cross health economy reviews • Risk Maturity • Environmental Sustainability

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR12: Inability to secure funding for research time April 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR12	**Inability to secure funding to support individuals and teams to dedicate time to research due to competing priorities limiting our ability to extend our research portfolio.**	We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK	Investment of funding and time into both clinical teams and R&D teams. High vacancy rates within clinical teams and inability to backfill. Non-recurrent nature of external funding. Difficulty in supporting growth of portfolio due to limited capacity of R&D teams due to non-recurrent nature of external funding (CRN). Limited capacity within support services (pharmacy, labs, radiology etc) due to lack of infrastructure and ability to guarantee long term research funding. Restrictions on use of external main funding source (CRN) impede ability to grow support to develop grant applications in house.	If we are unable to at least maintain current activity levels they will decline as will the funding, creating a vicious downward spiral. Increasingly more stringent requirements of university hospital status mean that it is less likely the Trust will achieve the status without significant funding and commitment.	People and Organisational Development	MD	PR 10.1 PR 10.2

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023	-			
4x3=12	Increase in requirements for University Hospital Status with additional focus on research specific income and joint academic posts. Growth in research delivery areas has highlighted need for growth and investment in other areas which have now	**On track to 3x3=9**	**3x3=9**		If additional posts currently funded through non-recurrent funding can be continued (i.e. in pharmacy) along with new posts required to continue current state and standard growth of activity this will prevent a decrease in activity. If additional resource can be identified to support investment in clinical teams and grant development infrastructure (including activities such as developing CRF facilities to truly enable rapid growth of commercial research activity) this will enable growth at the rate which would enable significant change in a reasonable timescale		

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

	become the growth limiting areas						

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Annual business plan to key funder NIHR CRN – details plans to increase the number of commercial studies, which are a source of income. • Progress against all High Level Objectives – defined by the National Institute Health Research (NIHR) – reviewed and reported quarterly internally to Research and Innovation Forum and externally to WE Clinical Research Network. Also reviewed regularly at Trust Research Senior Management Team meetings. • Support for non-NIHR funded studies is provided by the Gloucestershire Research Support Service (GRSS) via an SLA with the NHS research active organisations in the county and including Public Health in Gloucestershire County Council. Statement of intent to work more closely with the University of Gloucestershire signed. • Annual business plan submitted to West of England Clinical Research Network (CRN), who provide the main source of income to research through non-recurring, activity-based funding. • Board Approved Research Strategy (October 2019) • Capability and capacity assessments for new studies to maximise workforce utilisation • Oversight of the research portfolio by C&C, Delivery Teams and SMT • Oversight of the research portfolio by CRN West of England • Review and closure of poor performing studies to release staff with regular review of staffing at relevant meetings via monthly 1:1s and SMT • Research interests & experience incorporated into consultant interview questions. Briefing paper developed in discussion with medical staffing presented at Dec PODDG. • University Hospital Programme Group reports into relevant groups inc Strategy and Transformation, People and OD, Research governance routes.	• Annual Business Plan that covers all research income streams rather than just NIHR funding. • Ability to produce a business case for investment that is financially neutral over the longer term • Review and refresh of strategy for final two years of strategic period (currently under development) • Progress has paused due to change in University criteria. • Model for non-medic staffing to be developed in tandem to complement the medic version to ensure a whole team approach. • Need to regroup University Hospital Implementation Group and ensure that all relevant stakeholder groups are covered.

ACTIONS PLANNED

Action	Lead	Due date	Update
Develop a business case to secure investment for the trailblazer team model to commit a number of PAs per team to support growth and development of research activity within that department. Each team taking part in this would commit to an income generation target and level of activity. In return the R&D department would also need to provide a level of activity to support that growth. The R&D department would also require investment to do this	SE/CS/ CJ	May 2022	Business case in development with relevant teams and University Hospital programme group.

Risk Score: Likelihood x Consequence: 1-6 = low, 8-12 = moderate, 15-25 = high.

Review and refresh of the research strategy for final two years of the strategic period	CS / CJ	May 2022	In progress
Develop an annual Business Plan that covers all research income streams rather than just NIHR funding.	CS	June 2022	To be started

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Growth of activity has been rapid over the last 3 years. The plan to focus on commercial and income generating research activity in September 2020 is now showing results with a significant increase in both the commercial oncology and haematology portfolio (and activity generally) and the successful implementation and delivery of the covid vaccine portfolio together our regional colleagues. This growth can be seen both in size of portfolio and increase in income	• Growth has been almost entirely within the research delivery teams and is based on non-recurrent funding. The posts based on the non-recurrent funding need to continue to help prevent a sudden decline in activity. Growth within the R&D infrastructure is now needed to support continued levels of activity and ensure growth	Development of business case Review and refresh of strategy Continuation within academic programme development activity across all areas Internal audit reviews 2022-25: • Cultural Maturity • Cross health economy reviews • Risk Maturity • Environmental Sustainability

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 27 July 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**
CQC Maternity Services Report	The report had been published and rated the Trust's Maternity Services as 'Inadequate'. Prior to this, a Section 29A notice had been received. Key drivers contributing to this assessment were staffing, training in key skills, timely response to investigations and safety incidents, lack of clear vision and values, staff not feeling respected and supported, capacity to concentrate on governance and risk management, and an insufficient competency framework. A number of 'must dos' related to the completion of appraisals, mandatory training, infection prevention and control procedures and cleaning of birth pools, and the introduction of safety huddles. The Committee was advised that the service was already on an improvement journey to rectify many of the issues raised in the report, and further consideration would be given to how the voice of staff and service users could help inform and develop improvements. The Committee was assured that staff would be supported by the Executive team.	Core themes from CQC reports to be shared across divisions. An executive review of quality governance across the organisation was underway to ensure effective systems and processes were in place to address issues. The Committee would receive the full action plan at the next meeting for assurance. The Maternity Delivery Group would continue to closely monitor the maternity action plan, which would report through to the Committee and to Board.
Quality and Performance Report	***Heatwave Response*** NHSEI had issued a letter setting out expectations that there would be no ambulances waiting over 30 minutes during the heatwave period. The Committee was advised that all operational teams within the Trust had met to discuss the best course of action to move waits from ambulance bays to hospital. Corridor care had been reintroduced where appropriate, and patients were pre-empted every two hours to ensure best care. The Trust would continue to remove ambulance queues and care for patients in corridors if staffing was available. Reflections on success and sustainability would be shared with the Committee.	Teams had worked very successfully together to manage the heatwave, and had moved from the worst-performing to the best-performing Trust in relation to ambulance handovers. Corridor care could not be a business-as-usual response, and should only be used in extreme situations when appropriately staffed.
Serious Incidents Report	Six serious incidents had been reported. There had been one Healthcare Safety Investigation Branch (HSIB) report raised, which had since been rejected by HSIB and therefore downgraded. Complaints per month was stable, with one partly upheld Parliamentary and Health Service Ombudsman (PHSO) report and eight under consideration. Overall incident reporting activity had increased by 20% in the past two years, with increases in complaints and Duty of Candour work seen. The Patient Safety team and investigation team had adapted and standardised processes and procedures, however demand was outweighing capacity and there was lack of resilience in the teams.	The new Patient Safety Incident Response Framework would require a complete review of the incident investigation process. A short-term plan to introduce temporary staff to support the team was in place, with medium-term plans to establish a revised structure and be part of the clinical governance review work. An integration of qualitative data would be considered to ensure a holistic review of patients and their experiences in the Trust.
Eating Disorders Report	The Trust saw an average of seven patients per month, with an average length of stay of 13 days. The Trust had no inpatient facility, no child and young adult home service in Gloucestershire and was not adequately set up to provide an effective service.	The Whole Person Care Strategy would support key improvements in eating disorder services. A systemwide approach would be discussed. A training needs analysis would be carried out, along with a

		service review. The Committee supported the recommendations and would receive further updates.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Risk Register	Two new risks had been added to the register, and one risk had been downgraded. Progress continued on improvement work related to Never Events, specifically around wrong site and wrong implants. An event had been planned in the next few months to feedback on improvement work. The Committee was assured that any issues were raised through Quality Delivery Group. No Never Events had been reported in Theatres for six months.	A National Patient Safety Standards development session for the Board was scheduled to take place in October. Divisional risk governance would be incorporated to provide additional assurance on non-compliance at divisional level.
End PJ Paralysis	The report set out the plan to support and advocate for patients to mobilise out of bed each day and perform daily activities to maintain a sense of person, identity and general dignity. This was linked to ongoing delay-related harm work and Medically Optimised for Discharge (MOFD) patients with no criteria to reside; as the number of these patients was particularly high, it was critical to ensure they continued to remain optimised with the best possible chance of going home with maximum functionality.	Evidence of sustainable improvements would be reported through to the Committee. Work continued to fully embed the audit tool. The team would aim to widen this out into the community as a system approach.
Quality and Performance Report	Key points were highlighted as follows: • A number of MRSA and C. diff infections had been reported and were under investigation. • A reduction in pressure ulcers had been seen, and the Trust was performing well nationally. Issues related to staffing and documentation remained, but plans were in place to address this. • There had been a reduction in falls with harm and without harm over the last three months. • Maternity Services was reviewing the percentage of women booked by 12-weeks gestation as the reported rate had just dipped below 90%. It was likely that staffing issues were the key driver for this, however it was being closely monitored and would be brought back to the Committee if issues continued. • There had been an increase in mixed-sex accommodation breaches, which were related to patient moves required for Covid-19 infections. • Friends and Family Test feedback was at 88%, with key themes related to waiting times, access to services, and delays. There were clear links to challenges related to patient flow and delayed transfers of care. • PALS continued to improve, with 77% of concerns closed within five days. • Violence and Aggression work was underway, with a key aim to review and reduce porter involvement in patient feeding. • The action plan from Surgery's CQC Report was being reviewed, and risks to all patients were being assessed. The CQC had been invited on a walkabout of the division. • The Committee was advised that ambulance handover total hours was reducing, with the overall situation slightly improved.	Findings from the clinical governance review would support some of the issues around resourcing. The Infection Prevention and Control Annual Report would be received at the next meeting.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Getting it Right First Time Report	The Committee was assured by the progress made, and was advised of a Urology deep dive visit that had taken place in April. A deep dive into Neonatal Medicine was planned for May. Two key areas for review following the Urology visit were: additional training for Advanced Nurse Practitioners, and scope to provide procedures both in Outpatients and	Clinical lead recruitment was underway to support the programme. High-volume, low-complexity opportunities continued to be

	the Urology Assessment Unit. Seven national recommendation documents had been submitted for the following services: Neonatal, Paediatric Trauma and Orthopaedics, Stroke, Acute and General Medicine, and Lung Cancer.	explored. Governance work was underway to review structures and resources following a pause during the pandemic.
Patient Experience Annual Report	The Committee was assured by the report, and commended the team.	None.
Items not Rated		
System feedback	Quality Strategy Progress Update	
Impact on Board Assurance Framework (BAF)		
Risk rationalisation would take place during August with Executives and Committee Chairs. A potential development session to ensure the enablers remain relevant would be discussed and agreed. The Committee was advised that the document should be a succinct capture of strategic risks, however risks can be added and removed according to the events and issues taking place within the Trust.		

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	10	Enclosure Number:	5
Date	8 September 2022		
Title	Quality and Performance Report – July 2022		
Author /Sponsoring Director/Presenter	Roger Blake, Associate Director of elective care, Katie Parker-Roberts, Head of Quality, and Suzie Cro, Deputy Director of Quality and Programme Director for Nursing and Midwifery Excellence Qadar Zada, Chief Operating Officer, Matt Holdaway, Director of Quality and Chief Nurse, Alex D'agapayeff, Interim Medical Director		

Purpose of Report			Tick all that apply ✓
To provide assurance	X	**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 July 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.

This report also highlights the issues to note from Quality Delivery Group in August 2022.

QDG key issues to note

CQC update

An update was provided on the CQC inspection activity, including maternity and well-led, and action plans were discussed for surgery and unscheduled care.

S29a Action Plan Surgery

The group reviewed the action plan update against the S29a notice; some have moved forward, some actions had been completed and some are being monitored for sustained improvement before turning to blue. Flow and capacity are issues impacting ability to deliver some of the actions. Updates on the action plan will be brought to QDG on a monthly basis. The timeline below shows more detail about the surgery inspection, receiving the warning notice and monitoring improvement plans:

Date	Event

12 & 13 April 2022	Unannounced core service inspection
7 July 2022	Improvement report sent to CQC
10 July	Advised by CQC that Section 29a warning notice to be published
12 July 2022	QDG received improvement action plan
27 July 2022	Q&P Surgery CQC action plan appendix to QDG Exception report
1 September 2022	Meeting with CQC and ICB to review progress
Core service report	Draft report to be sent with well led inspection at the end of August

U&EC CQC Action Plan

There were four outstanding action plans which have now been merged into one document to help increase visibility and oversight of the existing actions and any historic which had not been fully closed.

The new combined 2022 action plan would now have 143 actions, in one place, held centrally and on one drive. The action plan is progressing; the U&EC Action Plan update would provide an update quarterly to QDG.

Maternity Delivery Group

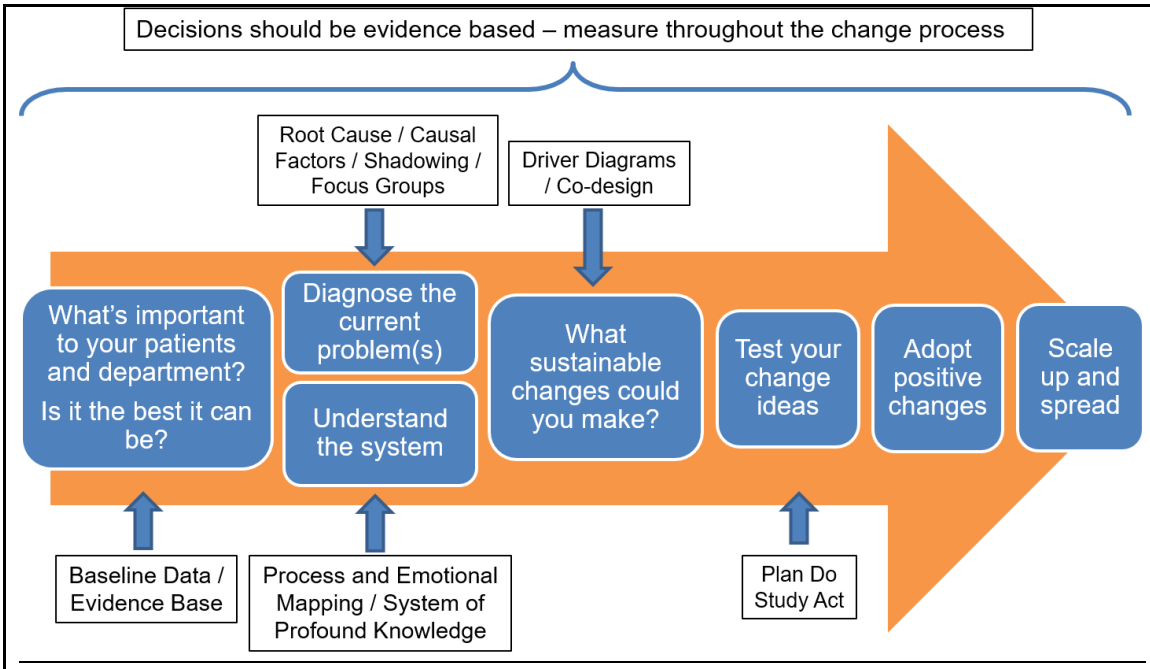
The Maternity CQC Section 29A action plan was reviewed and this was due to be submitted to CQC on 29 August.

Improvement Programmes:

Our ratified Quality Strategy outlines a clear approach to ensuring we have robust systems and processes in place to gather and analyse patient experience data, and involve patients, colleagues and communities in a cycle of continuous improvement. The Quality Strategy was approved by the Quality and Performance Committee in October 2019.

The strategy outlines our approach to delivering Outstanding across the Trust and this is through the Insight, Involvement and Improvement model:

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



Never Events

There have been no Never Events in theatre for a period of 6 months. Progress continued with the improvement work for wrong site and wrong implant risks; improvement work would be presented back at a Graduation event on the 23rd September 2022, and the learning from this work and approach will be written up and shared widely.

Violence & Aggression

Violence & Aggression has been an emerging risk that is being reviewed and managed through the Violence and Aggression Steering Group. From the diagnostic review, there are a number of contributory issues being reviewed as part of this improvement work:

- How to look at the issues as a system rather than the individual areas/components;
- Security approach key issue for V&A in how act as an Acute Trust depended on what GMS would do in terms of security. (GMS are currently recruiting 15 more porters to support site with V&A calls)
- Security presence in ED and AMUs was significant. AMU had higher levels of verbal abuse. AMU had higher levels of physical abuse. Therefore, approach would need to be different from the rest of the hospital.
- V&A response also had some significant issues to think about. Dementia was still the highest contributing factor to incidents reported for V&A.
- Cohort of patients require feeding, in both Adult and Paediatric areas
- Impact of increased mental health patients in our hospital who have long stays, and the trauma this has cause for a number of ward staff in managing these patients
- Site Team and supporting V&A calls; needed a plan how to remove site from V&A calls as receiving multiple calls per night and taking staff away from site.
- Standards around V&A calls. Needed a leader for V&A calls and some senior input and this was the purpose of Site.
- Currently we have 136 clinical staff trained in V&A and 56 porters

Divisional colleagues are meeting with Quality Improvement and Safety Director, Deputy Chief Nurse and Chief Operating Officer to review current plans, and ensure plan in place before site step down from supporting the V&A calls.

QPR key issues to note

Quality

MRSA infection rate per 100,000 bed days

In July the trust had one MRSA bacteraemia case; this case represents a hospital onset and healthcare associated case. The source of the bacteraemia has yet to be identified; however the patient's history of MRSA colonisation is likely to be the contributing cause. A post infection review meeting was held on 10/8/2022 with the ward team and IPCT to review the finding of the investigation and actions have been agreed to address the issues identified related to PVC documentation and care, MRSA screening and decolonisation and the findings of the investigation will be shared with the wider ward team. It is noted that the patient had been moved/ transferred several times between different wards so the findings of this investigation will be shared with the other areas who were involved in providing care to this patient. The findings will also be shared with Risk who are currently undertaking a review of the harms associated with increased patient transfers as evidence of the impact of frequent ward moves. Risk will be undertaking duty of candour actions. The patient remains an inpatient but had extended length of stay as a result of the MRSA bacteraemia.

MSSA infection rate per 100,000 bed days

During July we had 5 health care associated MSSA blood stream infections; 3 hospital onset health care associated (HO-HA) and 2 community onset health care associated cases. All HO-HA cases will be reviewed via rapid post infection review and findings discussed with teams for action; those with moderate or significant harm will be datixed and escalated to risk for review.

Reducing MSSA bacteraemias continue to be a focus of the IPC strategy 2022/23 specifically related to improving the management and care of invasive devices. There are actions within the programme that will be implemented to ensure we do not breach our internally set annual limit of no more than 30 healthcare associated cases for 2022/23.

Number of bed days lost due to infection control outbreaks

During July we had 52 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. 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.

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. The Tissue Viability Team have worked with SWAST to provide pressure relieving equipment and training on its use to paramedics. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available thereisa 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 taking place monthly to increase throughput.

Falls Update

The number of falls per 1,000 bed days was 7.5 in July, and the 12 month rolling average is 7.3 per month, which is comparable to the previous rolling 12 month average. The number of falls resulting in moderate or severe harm was 5 in July, and the 12 month rolling average is 5.6 per month. All of these cases are reviewed in the weekly Preventing Harm Hub and rapid feedback on safety improvements is given. The Trust Falls Prevention plan is focussed on evidence-based approach to falls risk assessment and interventions. Recently, NHS England carried out an onsite peer review at our request; we are awaiting feedback on their recommendations.

% women booked by 12 weeks gestation

Staff shortages are potentially having an impact on this metric, and it is also possible that there is an element of late data entry impacting on this metric. The service are looking into specific areas to identify if any one area has a worse rate than another, enabling them to target support where it is needed. The Trust is moving across to a new data warehouse which requires re-writing of all reports and may result in slight delays in updating of reports as have to be subject to validation and reconciliation. Some figures may also change as the new data warehouse takes data directly from Trak with no processing in the background eg it may be that data will be based on more appropriate fields, differences in rounding up or down, so this too could be having an impact.

Number of Breaches of Mixed Sex Accommodation

The Trust is now reporting mixed-sex accommodation breaches in line with national policy following a period of local agreement with the CCG that resulted in recording the MSA breaches but not reporting them due to operational pressure. All breaches, categorised in accordance with national guidelines, must be authorised by the Chief Nurse or Deputy Chief Nurse. Each month the reasons are reviewed overall, delay in transfers from critical care and recovery areas beyond 4-hours result in an MSA breach. Accurate numbers are now reported to the ICB.

Friends and Family Test

The current positive FFT score for the Trust overall is at 89%, which is up slightly from 88.3% in June. The main themes emerging this month were focussed on wait times, communication issues, and delays to appointments. Divisions provide updates through QDG each quarter on improvement plans happening within divisions, and the patient experience team are reviewing current reporting offer to improve the way that FFT and PALS data is triangulated to support improvement plans.

% PALS concerns closed in 5 days

The % of PALS Concerns closed within 5 days is 69.5%, a decrease from 77% in June. This is due to a large increase in the number of concerns received (285 in July which is the highest number this year, which is approx. 12% higher than the average for the year to date). The actual number of concerns closed within 5 days was 198 which is consistent with previous months for the team, so the fall in % closed is largely down to the increased volume of concerns raised as well.

Performance

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.

Unscheduled care and ambulance handover delays

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. During July, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4-hour ED standard, but continue to achieve the zero 104 weeks breaches target.

July continued to be a challenging month for the Emergency Department (ED) but saw a decrease in performance from 73.02% to 70.62% compared to the previous month. Ambulance handover delays increased for 30-60 minutes handovers delays however reduced slightly for those 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.

Diagnostics

Overall diagnostic performance has deteriorated in month, with the breach performance moving from 19.38% last month to 20.76% in July. This change has been influenced by a slight reduction in the total waiting list (moving from 10,903 to 10,518) which is encouraging, together with an increase in the number of patients that have breached (2,113 last month to 2,184). Cardiology has reduced both the patients breaching and patients waiting for Echo's which is the first time this year.

Cancer Services

For cancer, performance data showed the Trust met 3 out of 9 standards with all 7 out of 9 standards above national average clearly showing a challenging month. The Trust achieved the 2ww breast symptomatic standard in June with 94.1% performance. The Trust continued strong 28 day Faster Diagnosis Standard performance with 79% of patients receiving their diagnosis in June. 62 day standard performance for June was 51.9% which will rise following final submission but still a very poor month. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity.

Elective care

For elective care, the RTT performance did not meet the national standard with a reduction in performance and an anticipated month end submission of 71.4%. The total incompletes continues to rise and the unconfirmed July position is expected to be around 63,750. The number of patients waiting over 52 weeks has increased slightly to 1,439 (compared to a validated June position of 1,367). Although focus continues to be placed on patients over 70 weeks, this cohort remains high, largely influenced by approximately 40 Haematology patients. Their recovery plan is in the process of being implemented and therefore these patients should be booked shortly. The over 78 week cohort however has reduced by approximately 10 in month, and 104 breaches remains at zero.

The Elective Care Hub are continuing to contact patients via varying methods and will shortly be contacting patients in the 18-21 week non-admitted cohort. At the same time "nudge" letters are being issued to patients who have not responded to date, and further non-response will be escalated to the service and GP accordingly. Engagement will then take place with specialties to consider how this approach is applied to the outpatient follow up backlog.

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

Recommendation

The Board is asked to note the report for assurance.

Enclosures

QPR July 2022 – Dashboard

QPR July 2022 – SPC Document

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period *July* 2022

Presented at August 2022 Q&P and September 2022 Trust Board

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Gloucestershire Hospitals
NHS Foundation Trust

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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. During July, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4-hour ED standard, but continue to achieve the zero 104 weeks breaches target.

July continued to be a challenging month for the Emergency Department (ED) but saw an decrease in performance from 73.02% to 70.62% compared to the previous month. Ambulance handover delays increased for 30-60 minutes handovers delays however reduced slightly for those 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.

Overall diagnostic performance has deteriorated in month, with the breach performance moving from 19.38% last month to 20.76% in July. This change has been influenced by a slight reduction in the total waiting list (moving from 10,903 to 10,518) which is encouraging, together with an increase in the number of patients that have breached (2,113 last month to 2,184).
Cardiology has reduced both the patients breaching and patients waiting for Echo's which is the first time this year.

For cancer, performance data showed the Trust met 3 out of 9 standards with all 7 out of 9 standards above national average clearly showing a challenging month. The Trust achieved the 2ww breast symptomatic standard in June with 94.1% performance. The Trust continued strong 28 day Faster Diagnosis Standard performance with 79% of patients receiving their diagnosis in June. 62 day standard performance for June was 51.9% which will rise following final submission but still a very poor month. 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 national standard with a reduction in performance and an anticipated month end submission of 71.4%. The total incompletes continues to rise and the unconfirmed July position is expected to be around 63,750. The number of patients waiting over 52 weeks has increased slightly to 1,439 (compared to a validated June position of 1,367). Although focus continues to be placed on patients over 70 weeks, this cohort remains high, largely influenced by approximately 40 Haematology patients. Their recovery plan is in the process of being implemented and therefore these patients should be booked shortly. The over 78 week cohort however has reduced by approximately 10 in month, and 104 breaches remains at zero.

The Elective Care Hub are continuing to contact patients via varying methods and will shortly be contacting patients in the 18-21 week non-admitted cohort. At the same time "nudge" letters are being issued to patients who have not responded to date, and further non-response will be escalated to the service and GP accordingly. Engagement will then take place with specialties to consider how this approach is applied to the outpatient follow up backlog.

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		Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	440	354	500	523	467	446	504	330	328	315	449	496	552
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	475	294	692	752	1074	952	1057	1093	1263	1357	1434	1203	1081
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	72.68%	75.81%	72.24%	73.80%	74.54%	73.36%	73.67%	70.92%	69.98%	68.67%	69.73%	73.02%	70.62%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.79%	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	58.99%	63.89%	59.43%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%	55.41%	59.43%	56.00%
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	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.81%	73.01%	72.52%	71.20%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	1724	1554	1598	1590	1492	1430	1273	1112	1125	1231	1248	1367	1446
% 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	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.77%	18.99%	19.38%	20.76%
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	91.90%	93.50%	92.00%	93.40%	92.10%	92.20%	87.00%	94.60%	94.00%	89.90%	93.40%	86.50%	87.40%
2 week wait breast symptomatic referrals	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	96.60%	93.20%	90.80%	89.80%	88.60%	84.80%	87.40%	93.90%	91.30%	89.70%	95.50%	94.10%	91.80%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	98.30%	97.10%	95.90%	97.80%	96.10%	94.70%	95.50%	97.70%	98.00%	95.10%	96.80%	94.20%	96.00%
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%	100.00%	99.50%	99.50%	99.60%	100.00%	100.00%	100.00%	100.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	97.50%	98.50%	99.40%	100.00%	98.80%	100.00%	99.50%	99.50%	100.00%	94.50%	91.10%	74.40%	66.70%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	94.00%	92.60%	88.10%	91.50%	95.20%	94.30%	88.40%	90.80%	91.00%	88.70%	95.90%	89.70%	82.00%
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	92.00%	82.90%	90.80%	76.50%	85.30%	91.50%	85.90%	80.00%	90.90%	85.20%	79.20%	88.00%	89.70%
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	82.10%	63.60%	72.10%	84.10%	70.60%	73.10%	75.00%	69.70%	80.60%	70.40%	76.90%	62.90%	58.10%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	77.60%	72.10%	71.00%	71.80%	72.20%	64.70%	68.40%	71.30%	78.30%	64.30%	63.60%	53.30%	51.00%

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

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

Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	% growth from previous year Monthly (Jul)	YTD
GP Referrals	8,667	7,916	8,306	8,145	8,511	7,159	7,919	8,165	9,326	8,256	9,228	8,986	8,758	1.0%	1.7%
OP Attendances	52,155	47,546	52,912	49,516	56,469	47,728	51,666	49,131	57,151	47,386	55,620	50,945	49,835	-4.4%	-2.3%
New OP Attendances	16,158	14,662	16,658	15,956	18,297	15,355	16,423	16,107	18,593	14,819	17,660	16,393	16,263	0.6%	-0.9%
FUP OP Attendances	35,997	32,884	36,254	33,560	38,172	32,373	35,243	33,024	38,558	32,567	37,960	34,552	33,572	-6.7%	-3.0%
Day cases	4,801	4,525	4,309	4,187	4,536	3,941	4,121	4,201	4,959	4,099	4,712	4,612	4,628	-3.6%	-1.4%
All electives	5,831	5,469	5,236	5,218	5,492	4,941	4,798	5,050	5,988	4,978	5,783	5,604	5,585	-4.2%	-0.2%
ED Attendances	12,295	12,006	13,186	13,044	11,988	10,943	11,433	10,545	12,306	11,616	12,551	12,092	12,596	2.4%	3.4%
Non Electives	4,531	4,333	4,244	3,998	3,867	3,445	3,461	2,948	3,311	3,032	3,369	3,352	3,327	-26.6%	-25.6%

Trust Scorecard - Safe (1)

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

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Infection Control																		
COVID-19 community-onset - First positive specimen <=2 days after admission	1,332	120	134	110	186	122	124	174	148	214	142	63	89	120	294	414	No target	
COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	404	15	12	14	16	28	52	62	87	118	125	58	32	91	215	306	No target	
COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	138	5	2	0	1	1	21	22	35	51	37	30	26	55	93	148	No target	
COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	237	3	9	1	9	4	24	30	76	81	68	41	29	91	138	229	No target	
Number of trust apportioned MRSA bacteraemia	2	0	0	0	0	0	0	1	0	0	0	0	0	1	0	1	Zero	
MRSA bacteraemia - infection rate per 100,000 bed days	0.6	0	0	0	0	0	0	3.4	0	0	0	0	0	3.5	0	.9	Zero	
Number of trust apportioned Clostridium difficile cases per month	113	10	15	7	4	12	8	3	7	8	15	8	12	4	35	39	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	69	5	9	4	1	8	5	2	5	6	10	6	7	2	23	25	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	44	5	6	3	3	4	3	1	2	2	5	2	5	2	12	14	<=5	
Clostridium difficile - infection rate per 100,000 bed days	30.5	34.9	51.1	23.5	13	40.6	27.3	10.2	25.9	27	53.9	27.6	42.9	13.9	41.3	34.4	<30.2	
Number of MSSA bacteraemia cases	33	2	5	5	0	2	5	3	3	2	2	1	5	5	8	13	<=8	
MSSA - infection rate per 100,000 bed days	9.9	7	17	16.8		6.8	17	10.2	11.1	6.8	7.2	3.5	17.9	17.4	9.4	11.5	<=12.7	
Number of ecoli cases	56	2	0	3	5	7	5	5	5	2	9	4	4	7	17	25	No target	
Number of pseudomona cases	6	0	1	1	0	1	0	0	0	0	0	1	0	1	1	2	No target	
Number of klebsiella cases	23	3	3	4	2	2	2	0	0	1	1	3	0	1	4	5	No target	
Number of bed days lost due to infection control outbreaks	2,381	15	60	1	93	176	453	444	637	335	74	2	12	52	88	128	<10	>30

Trust Scorecard - Safe (2)

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding		1	0	0	0	1	1										Zero	
Number of falls per 1,000 bed days	7	7.1	7.5	7	6.7	7	6.7	7.3	7.6	8.2	7.5	6.9	7.6	7.5	7.3	7.4	<=6	
Number of falls resulting in harm (moderate/severe)	67	9	5	5	5	3	9	5	10	9	4	4	4	5	12	17	<=3	
Number of patient safety incidents - severe harm (major/death)	97	9	3	6	7	10	7	7	10	28	6	8	10	14	24	38	No target	
Number of category 2 pressure ulcers acquired as in-patient	358	24	27	19	22	41	43	37	40	50	46	39	34	24	119	143	<=30	
Number of category 3 pressure ulcers acquired as in-patient	17	0	3	0	1	2	4	2	1	2	2	3	1	1	6	7	<=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	78	3	5	1	4	9	9	12	14	10	12	18	14	10	44	54	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	80	9	4	6	1	7	12	13	7	8	12	21	10	2	43	45	<=5	
RIDDOR																		
Number of RIDDOR		3	2			3	5	10	10	8	5	10		10			SPC	
Safeguarding																		
Number of DoLs applied for		55	59	69	53	48	68	64	53	69	47	67	69	55	183	183	TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	35	3	7	4	6	1	5	2	3	4	3	7	6	3	16	19	TBC	
Total attendances for infants aged < 6 months, other serious injury		0	0	0	0	0	0	0	1	0	0	0	0	1	0	0	TBC	
Total admissions aged 0-17 with DSH	239	13	11	18	35	39	18	46	24	35	32	29	34	29	95	124	TBC	
Total ED attendances aged 0-17 with DSH	768	65	52	73	102	115	54	125	69	113	90	75	93	86	258	344	TBC	
Total number of maternity social concerns forms completed		63	46	72	58	65	52	67	70	71	72	72	80	78	222	222	TBC	
Total admissions aged 0-17 with an eating disorder		9	6	9	11	5	8	5	7	10	7	10	11	12	28	28	TBC	

Trust Scorecard - Safe (3)

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Serious Incidents																		
Number of never events reported	11	0	1	0	1	1	2	1	2	0	0	0	1	0	1	1	Zero	
Number of serious incidents reported	44	4	4	6	4	4	4	4	3	4	6	5	4	6	15	21	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	89.5%	87.0%	87.1%	92.0%	92.3%	90.7%	90.9%	87.5%	87.1%	90.7%	90.8%	88.5%	80.8%	79.9%	86.8%	86.8%	>95%	

Trust Scorecard - Effective (1)

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Maternity																		
% of women on a Continuity of Carer pathway	10.90%	9.70%	10.80%	10.90%	11.80%	10.30%	9.60%	10.20%	14.70%	12.60%	10.10%	9.10%	9.30%	8.70%	9.10%	9.40%	No target	
% C-section rate (planned and emergency)	31.53%	29.04%	32.02%	30.42%	31.59%	31.63%	32.44%	33.19%	31.45%	33.48%	34.48%	35.65%	37.93%	35.34%	36.06%	35.87%	No target	
% emergency C-section rate	16.94%	15.58%	17.98%	16.76%	17.76%	17.05%	15.61%	17.77%	15.72%	18.03%	19.08%	19.57%	21.55%	19.40%	20.09%	19.91%	No target	
% of women booked by 12 weeks gestation	91.4%	91.9%	91.4%	88.8%	91.0%	91.7%	92.6%	91.1%	90.5%	92.1%	90.4%	92.2%	89.9%	88.9%	90.9%	90.4%	>90%	
% of women that have an induced labour	27.47%	25.90%	28.49%	25.41%	25.00%	25.66%	24.95%	29.42%	33.09%	31.21%	30.52%	35.14%	29.49%	31.21%	31.73%	31.59%	<=33%	>30%
% stillbirths as percentage of all pregnancies	0.17%	0.19%	0.00%	0.00%	0.19%	0.00%	0.00%	0.43%	0.00%	0.64%	0.00%	0.00%	0.00%	0.22%	100.00%	0.05%	<0.52%	
% of women smoking at delivery	10.10%	10.48%	8.19%	10.16%	10.07%	8.80%	11.86%	12.58%	10.78%	11.46%	8.88%	9.11%	8.76%	9.13%	8.92%	8.97%	<=14.5%	
% breastfeeding (discharge to CMW)	49.4%	51.1%	48.4%	53.9%	48.0%	50.3%	48.1%	47.1%	46.0%	46.3%	45.5%	48.8%	59.8%	59.9%	60.4%	60.2%		
Percentage of babies <3rd centile born > 37+6 weeks	2.0%	1.9%	0.9%	1.4%	1.1%	1.9%	2.4%	3.2%	1.7%	4.2%	1.4%	2.4%	0.6%	2.1%	1.4%	1.6%		
% breastfeeding (initiation)	78.9%	78.5%	79.8%	80.8%	81.1%	79.5%	76.3%	78.8%	76.8%	78.2%	78.7%	77.6%	81.5%	78.6%	79.3%	79.2%	>=81%	
% PPH >1.5 litres	4.5%	5.2%	6.7%	4.9%	4.5%	3.4%	4.9%	3.6%	2.2%	3.9%	3.5%	2.4%	4.0%	4.5%	3.2%	3.6%	<=4%	
Number of births less than 27 weeks	11	0	0	1	2	2	0	1	0	1	3	0	4	0	7	7		
Number of births less than 34 weeks	123	8	11	18	13	9	10	7	4	9	13	8	15	4	36	39		
Number of births less than 37 weeks	446	41	33	47	49	32	44	33	19	43	49	35	50	38	134	171		
Number of maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total births	5,982	526	544	558	546	537	497	471	413	473	442	465	475	471	1,384	1,853		
Mortality																		
Summary hospital mortality indicator (SHMI) - national data	1	1	1	1	1	1	1.1	1.1	1.1	1.1							NHS Digital	
Hospital standardised mortality ratio (HSMR)	106.7	108.4	108.6	108.3	108.8	106.9	102.6	100.9	104	106.7	107.9					107.9	Dr Foster	
Hospital standardised mortality ratio (HSMR) - weekend	114.6	113.4	113.8	113.8	115.6	113.8	109.4	108	111.7	114.6	115.9					115.9	Dr Foster	
Number of inpatient deaths	1,644	182	156	163	183	191	189	218	183	179	185	174	172	170	531	701	No target	
Number of deaths of patients with a learning disability	23	4	2	2	2	4	1	3	1	1	3	2	2	1	7	7	No target	

Trust Scorecard - Effective (2)

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	8.36%	9.42%	9.54%	9.04%	8.18%	8.10%	8.10%	8.05%	7.32%	7.06%	7.52%	7.49%	7.78%		7.60%	7.60%	<8.25%	>8.75%
Research																		
Research accruals	3,333	183	192	456	426	236	172	185	173	142	191	193	184	124	568		No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	72.7%			47.5%	51.9%	50.0%	45.8%	72.7%	70.0%	73.4%	69.2%	67.6%	73.2%	71.4%	69.3%	70.3%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	87.3%	82.7%	91.8%	84.9%	66.7%	72.7%	75.4%	46.3%	91.0%	96.3%	97.7%	97.3%	96.30%		97.10%	97.10%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	9.10%			12.70%	15.10%	16.70%	8.70%	9.10%	75.00%	56.40%	69.20%	71.00%	61.00%	63.50%	57.00%	58.40%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	54.50%			44.60%	48.80%	40.50%	39.60%	54.50%	75.00%	59.50%	72.40%	70.40%	67.60%	61.90%	72.00%	64.40%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	53.6%	68.2%	60.7%	56.1%	43.5%	50.8%	47.9%	59.4%	43.4%	50.7%	24.3%	26.7%	27.3%	37.7%	25.9%	28.5%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	53.15%	68.18%	59.02%	56.10%	43.55%	50.77%	47.95%	57.97%	41.51%	50.68%	24.32%	26.67%	27.27%	37.74%	25.93%	28.51%	>=65%	<55%

Trust Scorecard - Caring (1)

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	86.5%	87.0%	85.4%	86.4%	85.0%	88.0%	87.8%	89.1%	87.1%	88.3%	88.0%	87.2%	87.2%	90.0%	87.5%	87.9%	>=90%	<86%
ED % positive	67.5%	62.7%	70.5%	60.9%	66.7%	68.0%	78.8%	78.6%	67.6%	63.5%	62.7%	66.9%	69.8%	68.1%	66.5%	67.0%	>=84%	<81%
Maternity % positive	86.3%	92.9%	84.8%	87.7%	82.4%	89.7%	84.3%	94.1%	91.9%	85.7%	78.2%	85.2%	88.9%	91.8%	83.6%	85.7%	>=97%	<94%
Outpatients % positive	93.8%	93.1%	93.7%	93.2%	93.3%	93.9%	94.7%	94.3%	93.4%	93.2%	93.1%	92.8%	93.2%	93.0%	93.0%	93.0%	>=94.5%	<93%
Total % positive	88.1%	90.7%	88.5%	86.2%	85.4%	89.4%	91.2%	91.0%	88.6%	88.0%	87.2%	87.4%	88.3%	88.5%	87.6%	87.9%	>=93%	<91%
Number of PALS concerns logged	3,006	241	238	264	274	248	230	266	248	254	229	253	231	285	713	998	No Target	
% of PALS concerns closed in 5 days	79%	85%	82%	76%	65%	78%	71%	65%	73%	78%	67%	75%	77%	70%	73%	72%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	1	0	1	0	0	0	0	0	0	0	21	7	23	17	51	68	<=10	>=20

Trust Scorecard - Responsive (1)

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Cancer																		
Cancer - 28 day FDS (all routes)	79.3%	79.9%	78.9%	78.3%	81.0%	78.4%	78.8%	73.7%	82.9%	81.7%	78.4%	79.8%	73.5%	79.6%	77.1%	77.8%	>=75%	
Cancer - urgent referrals seen in under 2 weeks from GP	92.4%	91.9%	93.5%	92.0%	93.4%	92.1%	92.2%	87.0%	94.6%	94.0%	89.9%	93.4%	86.5%	87.4%	90.1%	89.3%	>=93%	<90%
Cancer - 2 week wait breast symptomatic referrals	90.4%	96.6%	93.2%	90.8%	89.8%	88.6%	84.8%	87.4%	93.9%	91.3%	89.7%	95.5%	94.1%	91.8%	93.2%	93.0%	>=93%	<90%
Cancer - 31 day diagnosis to treatment (first treatments)	96.8%	98.3%	97.1%	95.9%	97.8%	96.1%	94.7%	95.5%	97.7%	98.0%	95.1%	96.8%	94.2%	96.0%	95.4%	95.5%	>=96%	<94%
Cancer - 31 day diagnosis to treatment (subsequent – drug)	99.8%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	99.5%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>=98%	<96%
Cancer - 31 day diagnosis to treatment (subsequent – surgery)	91.6%	94.0%	92.6%	88.1%	91.5%	95.2%	94.3%	88.4%	90.8%	91.0%	88.7%	95.9%	89.7%	82.0%	91.1%	88.8%	>=94%	<92%
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	99.3%	97.5%	98.5%	99.4%	100.0%	98.8%	100.0%	99.5%	99.5%	100.0%	94.5%	91.1%	74.4%	66.7%	88.5%	84.3%	>=94%	<92%
Cancer - 62 day referral to treatment (urgent GP referral)	72.0%	77.6%	72.1%	71.0%	71.8%	72.2%	64.7%	68.4%	71.3%	78.3%	64.3%	63.6%	53.3%	51.0%	61.2%	59.1%	>=85%	<80%
Cancer - 62 day referral to treatment (screenings)	87.3%	92.0%	82.9%	90.8%	76.5%	85.3%	91.5%	85.9%	80.0%	90.9%	85.2%	79.2%	88.0%	89.7%	82.1%	84.1%	>=90%	<85%
Cancer - 62 day referral to treatment (upgrades)	84.1%	82.1%	63.6%	72.1%	84.1%	70.6%	73.1%	75.0%	69.7%	80.6%	70.4%	76.9%	62.9%	58.1%	70.4%	63.8%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	47	3	4	9	10	4	3	2	2	5	2	2	15	12	19	31	Zero	
Number of patients waiting over 104 days without a TCI date	229	9	12	18	21	23	25	14	22	50	73	58	47	46	178	224	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	18.03%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.77%	18.99%	19.38%	20.76%	19.38%	20.76%	<=1%	>2%
The number of planned/surveillance endoscopy patients waiting at month end	1,455	1,482	1,439	1,435	1,397	1,410	1,422	1,334	1,269	1,286	1,365	1,367	1,371	1,367	1,368	1,368	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	60.7%	62.3%	61.1%	61.7%	60.5%	61.4%	58.4%	58.7%	62.0%	59.7%	60.1%	60.7%	59.5%		60.1%	60.1%	>=88%	<75%

Trust Scorecard - Responsive (2)

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Emergency Department																		
ED: % total time in department - under 4 hours (type 1)	60.96%	58.99%	63.89%	59.43%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%	55.41%	59.43%	56.00%	56.46%	56.34%	>=95%	<90%
ED: % total time in department - under 4 hours (types 1 & 3)	73.02%	72.68%	75.81%	72.24%	73.80%	74.54%	73.36%	73.67%	70.92%	69.98%	68.67%	69.73%	73.02%	70.62%	70.52%	70.54%	>=95%	<90%
ED: % total time in department - under 4 hours CGH	79.01%	84.95%	88.74%	77.05%	83.00%	79.80%	79.03%	79.17%	73.72%	65.48%	65.44%	65.10%	69.81%	66.22%	66.78%	66.63%	>=95%	<90%
ED: % total time in department - under 4 hours GRH	52.27%	46.30%	51.93%	50.80%	52.48%	54.91%	53.96%	55.55%	52.12%	52.88%	49.00%	50.54%	54.23%	50.84%	51.28%	51.17%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	2,812	10	1	15	53	448	631	653	394	606	690	616	634	629	1,940	2,569	Zero	
ED: % of time to initial assessment - under 15 minutes	12.9%	39.6%	43.5%	28.0%	30.3%	30.2%	37.4%	35.4%	30.0%	22.9%	20.7%	36.9%	38.1%	41.1%	37.5%	38.7%	>=95%	<92%
ED: % of time to start of treatment - under 60 minutes	8.9%	21.8%	30.7%	22.8%	27.8%	27.1%	32.6%	31.8%	26.1%	23.1%	22.2%	22.3%	25.3%	23.0%	23.8%	23.5%	>=90%	<87%
Number of ambulance handovers over 60 minutes	8,091	475	294	692	752	1,074	952	1,057	1,093	1,263	1,357	1,434	1,203	1,081	3,994	3,994	Zero	
% of ambulance handovers < 15 minutes	21.55%					23.11%	23.53%	24.72%	18.20%	15.73%	9.81%	11.80%	14.97%	13.85%	12.28%	12.28%	>=65%	
% of ambulance handovers < 30 minutes	40.14%					42.28%	45.54%	44.45%	34.48%	29.58%	21.14%	24.68%	30.96%	32.57%	25.76%	25.76%	>=95%	
% of ambulance handovers 30-60 minutes	11.60%	11.91%	9.48%	13.85%	14.55%	14.21%	13.90%	15.56%	13.25%	13.17%	13.32%	16.72%	18.66%	19.80%	16.34%	16.34%	<=2.96%	
% of ambulance handovers over 60 minutes	19.87%	12.86%	7.88%	19.16%	20.92%	32.67%	29.68%	32.62%	43.90%	50.70%	57.38%	53.39%	45.26%	38.77%	51.81%	51.81%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	81.58%	80.95%	89.06%	80.60%	73.75%	74.03%	80.23%	71.60%	93.48%	95.59%	76.90%	81.48%	78.05%	87.18%	78.50%		>=95%	
Urgent cancelled operations	107	12	10	1	44	24	1	1	0	0	0	0	0	0	0		No target	
Number of patients stable for discharge	200	160	158	179	178	213	162	239	252	257	232	232	211	229	225	226	<=70	
Number of stranded patients with a length of stay of greater than 7 days	477	367	421	472	468	503	499	491	537	538	513	492	498	491	501	499	<=380	
Average length of stay (spell)	5.73	4.98	4.84	5.32	5.47	6.03	6.02	6.13	6.67	6.68	6.62	6.68	6.32	6.17	6.54	6.45	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	6.55	5.57	5.39	5.99	6.22	6.97	7	6.78	7.93	8.06	7.91	8.03	7.46	7.18	7.8	7.64	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.31	2.43	2.31	2.25	2.48	2.28	2.46	2.42	2.07	2.13	2.13	2.26	2.32	2.53	2.24	2.31	<=3.4	>4.5
% day cases of all electives	82.41%	82.32%	82.72%	82.28%	80.22%	82.57%	79.74%	85.87%	83.17%	82.80%	82.32%	81.46%	82.28%	82.85%	82.00%	82.23%	>80%	<70%
Intra-session theatre utilisation rate	86.64%	89.47%	89.11%	85.36%	87.86%	85.46%	83.34%	85.83%	84.99%	87.39%	87.87%	88.22%	85.00%	85.49%	87.01%	86.64%	>85%	<70%

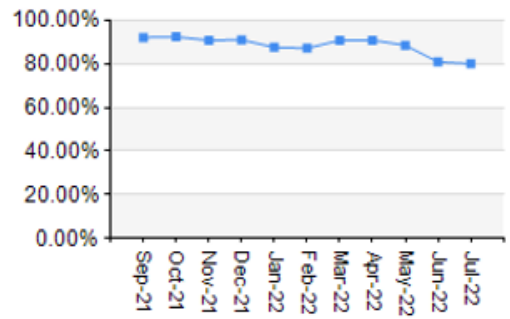
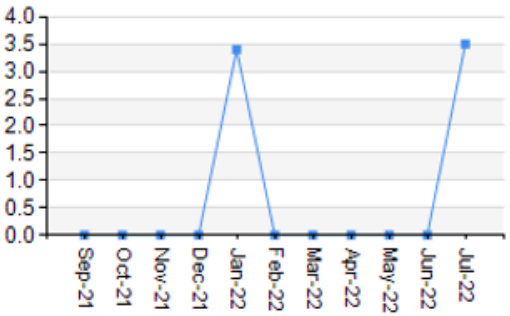
Trust Scorecard - Responsive (3)

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	1.98	2.1	2.13	2	1.94	1.93	1.96	1.95	1.87	1.96	2.04	2.02	1.97	1.96	2.01	2	<=1.9	
Did not attend (DNA) rates	7.20%	7.05%	7.24%	7.15%	7.17%	7.03%	7.23%	7.62%	7.01%	7.31%	7.44%	6.85%	6.63%	6.74%	6.96%	6.91%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	72.30%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.81%	73.01%	72.52%	71.20%	72.45%	72.14%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	5,720	5,713	5,582	5,642	5,593	5,642	5,847	5,272	5,087	5,135	5,419	5,386	5,806	6,350	5,537	5,740	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,840	2,854	2,906	2,946	2,935	2,641	2,605	2,292	2,165	2,182	2,421	2,490	2,579	2,692	2,497	2,546	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,653	1,724	1,554	1,598	1,590	1,492	1,430	1,273	1,112	1,125	1,231	1,248	1,367	1,446	1,282	1,323	Zero	
Referral to treatment ongoing pathway over 70 Weeks (number)	426	806	611	403	295	228	205	207	185	148	128	145	125	170	133	142	0	

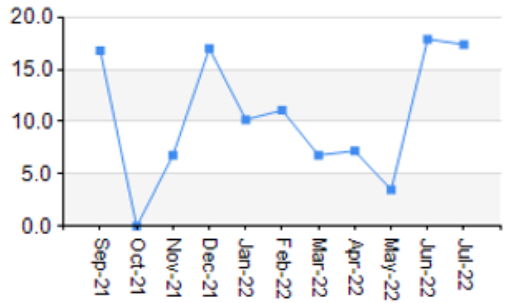
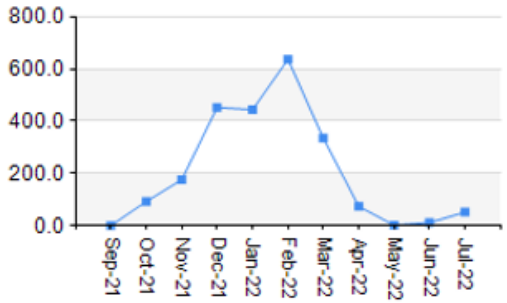
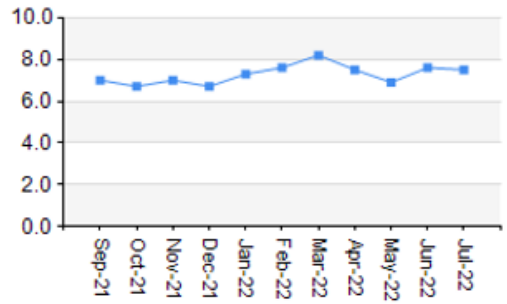
Trust Scorecard - Well Led (1)

	21/22	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	22/23 Q1	22/23	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	77.0%	80.0%	79.0%	78.0%	78.0%	79.0%	80.0%	80.0%	78.0%	77.0%	78.0%	80.0%	80.0%	79.0%	80.0%		>=90%	<70%
Trust total % mandatory training compliance	86%	90%	90%	88%	87%	87%	87%	87%	87%	86%	86%	86%	86%	86%	86%		>=90%	<70%
Overall % of nursing shifts filled with substantive staff	93.00%	96.56%	97.22%	99.61%	97.11%	95.93%	89.16%	85.93%	87.53%	85.28%	92.70%	90.90%			91.79%	91.79%	>=75%	<70%
% registered nurse day	91.30%	94.84%	95.11%	98.11%	95.49%	94.07%	87.59%	84.20%	85.30%	82.60%	89.11%	89.31%			89.21%	89.21%	>=90%	<80%
% unregistered care staff day	92.80%	100.44%	98.32%	96.58%	95.82%	95.07%	84.77%	83.85%	83.66%	74.95%	89.59%	88.03%			88.79%	88.79%	>=90%	<80%
% registered nurse night	96.06%	99.57%	101.09%	102.46%	100.10%	99.31%	91.99%	89.02%	91.54%	90.13%	99.35%	93.78%			96.52%	96.52%	>=90%	<80%
% unregistered care staff night	103.64%	109.58%	111.39%	111.67%	105.90%	103.45%	94.98%	95.26%	97.78%	91.50%	103.36%	101.17%			102.25%	102.25%	>=90%	<80%
Care hours per patient day RN	4.9	5.3	4.7	4.6	5	5.1	5	4.9	4.8	4.8	5.2	5.2			5.2	5.2	>=5	
Care hours per patient day HCA	3.1	3.5	3.3	3.5	3.2	3.1	3.1	3	2.9	2.8	3.2	3.2			3.2	3.2	>=3	
Care hours per patient day total	8.1	8.8	8	8.1	8.1	8.3	8.1	7.9	7.8	7.6	8.4	8.3			8.4	8.4	>=8	
Vacancy and WTE																		
% total vacancy rate		7.00%	7.50%	6.82%	6.39%	7.37%	8.09%	11.16%	10.68%	10.45%	10.79%	10.61%	10.97%	10.66%			<=11.5%	>13%
% vacancy rate for doctors		9.40%	7.80%	7.41%	6.74%	7.45%	7.05%	8.88%	8.35%	7.99%	7.91%	7.79%	7.75%	7.98%			<=5%	>5.5%
% vacancy rate for registered nurses		8.50%	9.40%	7.89%	7.87%	8.17%	8.64%	14.46%	14.29%	14.09%	14.34%	14.60%	15.05%	14.54%			<=5%	>5.5%
Staff in post FTE		6680.26	6685.55	6730.66	6718.8	6686.83	6627.94	6648.33	6678.52	6707.09	6683.74	6683.28	6659.49	6688.51			No target	
Vacancy FTE		505.63	537.29	491.56	457.02	530.17	582.02	834.81	799.75	782.28	807.64	794.16	821.21	906.67			No target	
Starters FTE	1123.04	36.05	36.53	79.76	42.43	59.94	70.65	77.03	69.31	51.46	91.38	85.03	60.58	94.35			No target	
Leavers FTE	1128.86	52.16	78.84	68.51	89.94	66.53	81.1	88.76	47.74	84.88	67.55	83.93	67.04	75.62			No target	
Workforce Expenditure and Efficiency																		
% turnover		10.2%	10.7%	11.1%	11.7%	11.7%	12.3%	12.9%	11.8%	13.8%	14.2%	14.4%	14.5%	14.5%			<=12.6%	>15%
% turnover rate for nursing		9.80%	9.77%	9.72%	9.70%	10.52%	10.83%	10.99%	10.69%	12.15%	12.80%	13.03%	13.05%	13.80%			<=12.6%	>15%
% sickness rate		3.6%	3.8%	3.9%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%	4.1%	4.2%	4.2%	4.2%			<=4.05%	>4.5%

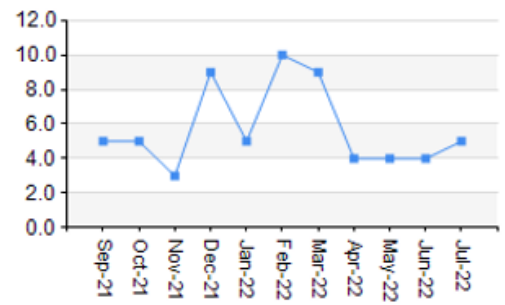
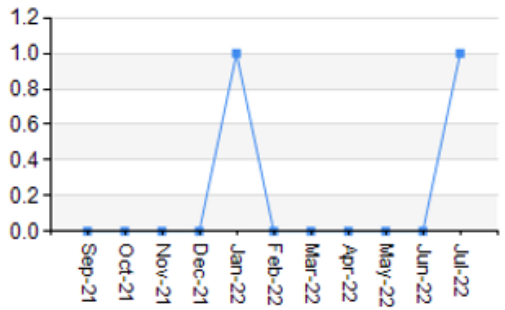
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		The plan remains the introduction of the electronic prescribing which will include an assessment for each patient	**Quality Improvement & Safety Director**
MRSA bacteraemia - infection rate per 100,000 bed days **Standard: Zero**		In July the trust had one MRSA bacteraemia case; this case represents a hospital onset and healthcare associated case. The source of the bacteraemia has yet to be identified; however the patient's history of MRSA colonisation is likely to be the contributing cause. A post infection review meeting was held on 10/8/2022 with the ward team and IPCT to review the finding of the investigation and actions have been agreed to address the issues identified related to PVC documentation and care, MRSA screening and decolonisation and the findings of the investigation will be shared with the wider ward team. It is noted that the patient had been moved/ transferred several times between different wards so the findings of this investigation will be shared with the other areas who were involved in providing care to this patient. The findings will also be shared with Risk who are currently undertaking a review of the harms associated with increased patient transfers as evidence of the impact of frequent ward moves. Risk will be undertaking duty of candour actions. The patient remains an inpatient but had extended length of stay as a result of the MRSA bacteraemia.	**Associate Chief Nurse, Director of Infection Prevention & Control**

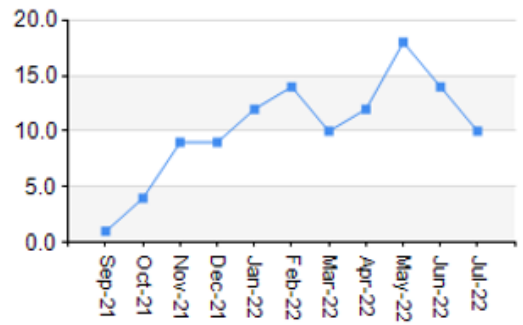
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
MSSA - infection rate per 100,000 bed days **Standard: <=12.7**		During we July we had 5 health care associated MSSA blood stream infections; 3 hospital onset health care associated (HO-HA) and 2 community onset health care associated cases. All HO-HA cases will be reviewed via rapid post infection review and findings discussed with teams for action; those with moderate or significant harm will be datixed and escalated to risk for review. Reducing MSSA bacteraemias continue to be a focus of the IPC strategy 2022/23 specifically related to improving the management and care of invasive devices. There are actions within the programme that will be implemented to ensure we do not breach our internally set annual limit of no more than 30 healthcare associated cases for 2022/23.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of bed days lost due to infection control outbreaks **Standard: <10**		During July we had 52 closed empty beds due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways and being cohorted together in bays. 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. Patients who are red recovered (completed isolation after testing positive for COVID) are moved to closed empty beds to minimise empty closed bed numbers. Bay are also no longer closed due to COVID exposure; admissions can	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls per 1,000 bed days **Standard: <=6**		The rate of falls per 1,000 bed days is running at 7.5 in July and the 12-month rolling average is 7.3 which is comparable to the previous rolling 12-month average. The Trust Falls Prevention plan is focussed on evidence-based approach to falls risk assessment and interventions. Recently, NHS England carried out an on site peer review at our request, we are awaiting feedback on thier recommendations.	**Associate Chief Nurse, Director of Infection Prevention & Control**

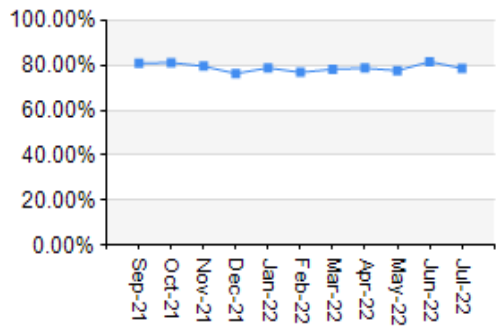
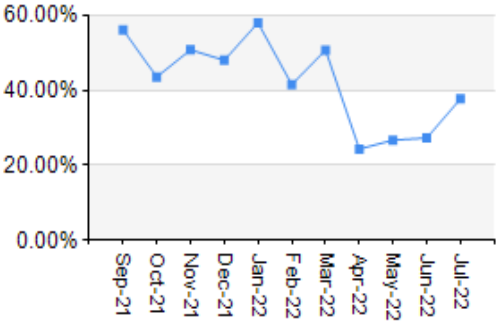
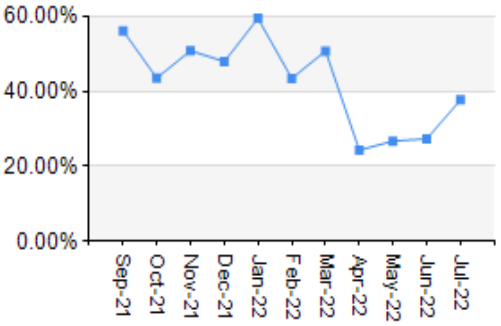
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		The number of falls resulting in moderate or severe harm is 5 in July and the 12-month rolling average is 5.6 per month. All of these cases are reviewed in the weekly Preventing Harm Hub and rapid feedback on safety improvements is given. The Trust Falls Prevention plan is focussed on evidence-based approach to falls risk assessment and interventions. Recently, NHS England carried out an onsite peer review at our request, we are awaiting feedback on their recommendations.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of trust apportioned MRSA bacteraemia **Standard: Zero**		In July the trust had one MRSA bacteraemia case; this case represents a hospital onset and healthcare associated case. The source of the bacteraemia has yet to be identified; however the patient's history of MRSA colonisation is likely to be the contributing cause. A post infection review meeting was held on 10/8/2022 with the ward team and IPCT to review the finding of the investigation and actions have been agreed to address the issues identified related to PVC documentation and care, MRSA screening and decolonisation and the findings of the investigation will be shared with the wider ward team. It is noted that the patient had been moved/ transferred several times between different wards so the findings of this investigation will be shared with the other areas who were involved in providing care to this patient. The findings will also be shared with Risk who are currently undertaking a review of the harms associated with increased patient transfers as evidence of the impact of frequent ward moves. Risk will be undertaking duty of candour actions. The patient remains an inpatient but had extended length of stay as a result of the MRSA bacteraemia.	**Associate Chief Nurse, Director of Infection Prevention & Control**

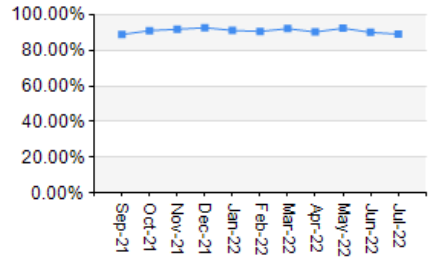
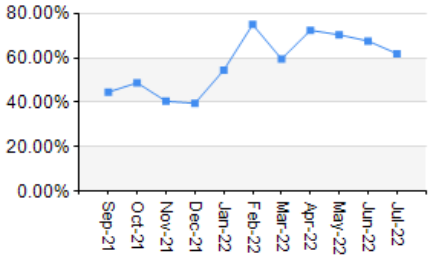
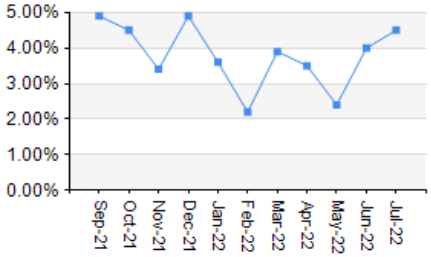
Exception Reports - Safe (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. The Tissue Viability Team have worked with SWAST to provide pressure relieving equipment and training on its use to paramedics. 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 taking place monthly to increase throughput.	**Associate Chief Nurse, Director of Infection Prevention & Control**

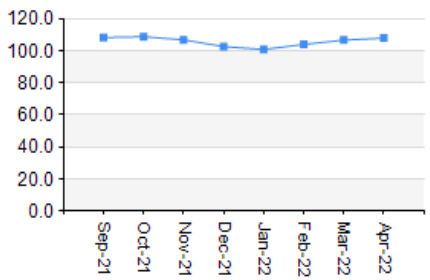
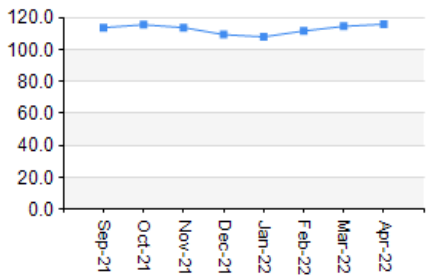
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		Most antenatal classes are now back face to face and numbers of couples being able to attend have increased due to reduction in covid restrictions. Therefore information is being shared with more families and this should help to improve mothers wanting to initiate breast feeding. Staff are still being encouraged to do their mandatory training in addition to their contracted hours to ensure most up to date information given. Due to staffing levels, this is still not possible for all staff.	**Divisional Director of Quality and Nursing and Chief Midwife**
% fractured neck of femur patients meeting best practice criteria **Standard: >=65%**		The #NOF pathway is a key performance indicator within T&O and Orthogeriatric services, with performance monitored through specialty governance meetings and the Service Line Review report, and data and specific commentary on improvement/deteriorating in month is provided at Exec Review. #NOFs are now cohorted onto the 3rd floor as standard practice, and work is ongoing on a number of actions to support improving performance, including prioritising NOF on triage in ED, NOF admission proforma on EPR and looking to increase therapist funding and radiographer support.	**General Manager – Trauma & Orthopaedics**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		The #NOF pathway is a key performance indicator within T&O and Orthogeriatric services, with performance monitored through specialty governance meetings and the Service Line Review report, and data and specific commentary on improvement/deteriorating in month is provided at Exec Review. #NOFs are now cohorted onto the 3rd floor as standard practice, and work is ongoing on a number of actions to support improving performance, including prioritising NOF on triage in ED, NOF admission proforma on EPR and looking to increase therapist funding and radiographer support.	**General Manager – Trauma & Orthopaedics**

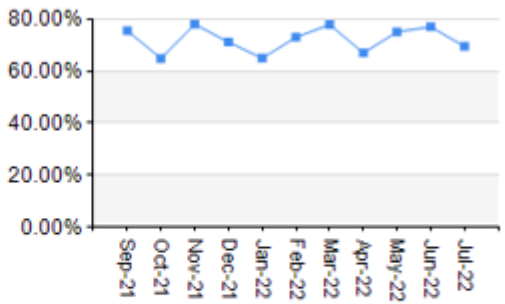
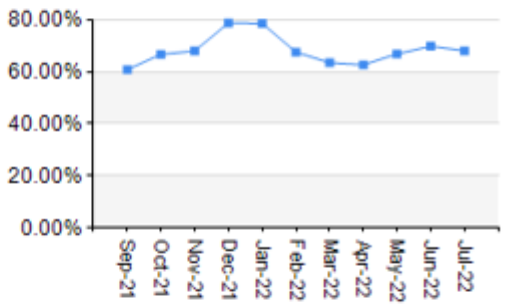
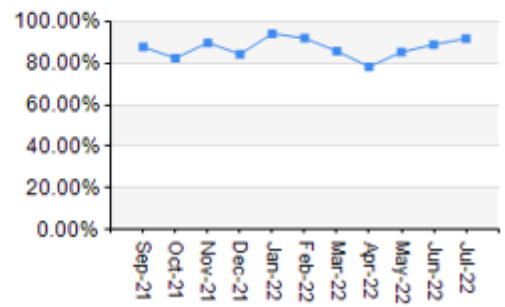
Exception Reports - Effective (2)

KLOE	MetricID	Metric Name & Standard	Trend Chart	Exception Notes	Owner
Effective	138	% of women booked by 12 weeks gestation Standard: >90%		Staff shortages are potentially having an impact. It is also possible that there is an element of late data entry impacting on this metric. The service are going to look into specific areas to identify if any one area has a worse rate than another, enabling them to target support where it is needed. The Trust is moving across to a new data warehouse which requires re-writing of all reports and may result in slight delays in updating of reports as have to be subject to validation and reconciliation. Some figures may also change as the new data warehouse takes data directly from Trak with no processing in the background eg it may be that data will be based on more appropriate fields, differences in rounding up or down, so this too could be	Divisional Director of Quality and Nursing and Chief Midwife
Effective	474	% patients receiving a swallow screen within 4 hours of arrival Standard: >=75%		There has been a general improved performance since co-locating on one site. The main contributing factors for these are strokes that are not admitted through the direct admit stroke pathway, for example patients with atypical stroke presentations that attend ED causing a delay in request for the swallow screen to be performed and patients who are too unwell for swallow screen to be performed.	General Manager - COTE, Neuro and Stroke
Effective	574	% PPH >1.5 litres Standard: <=4%		Our PPH rate until July 22 has been on a downward trajectory following initiation of the PPH prevention project in November 2021. This has primarily aimed to renew focus on PPH risk assessment and 'back to basic' intrapartum principles surrounding avoidance of a prolonged second stage and third stage management. An audit of July case notes is required. However a recent audit, yet to be shared with staff, focussing on one aspect of the project -syntometrine rather than oxytocin for trials of instrumental birth has shown almost 25% were given oxytocin, so in the interim (before July audit data available) this will be an area for improvement to highlight to staff. Recent recruitment to the PDM team will enable greater communication and reminders of the principle messages to staff.	Divisional Director of Quality and Nursing and Chief Midwife

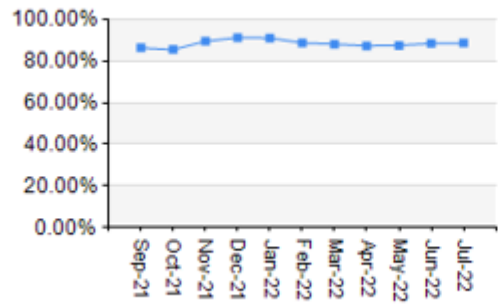
Exception Reports - Effective (3)

KLOE	MetricID	Metric Name & Standard	Trend Chart	Exception Notes	Owner
Effective	**128**	**Hospital standardised mortality ratio (HSMR)** **Standard: Dr Foster**		The HSMR and the weekend HSMR have deteriorated progressively over the last 3 months. There is an affect due to reduced comorbidity scoring and this being actively addressed. However this is not ablet o explain what we are seeing the exact cause is not clear but may well be related to ongoing issues with congestion being felt throughout the trust. This is being monitored in HMG	**Deputy Medical Director**
Effective	**264**	**Hospital standardised mortality ratio (HSMR) - weekend** **Standard: Dr Foster**		The HSMR and the weekend HSMR have deteriorated progressively over the last 3 months. There is an affect due to reduced comorbidity scoring and this being actively addressed. However this is not ablet o explain what we are seeing the exact cause is not clear but may well be related to ongoing issues with congestion being felt throughout the trust. This is being monitored in HMG	**Deputy Medical Director**

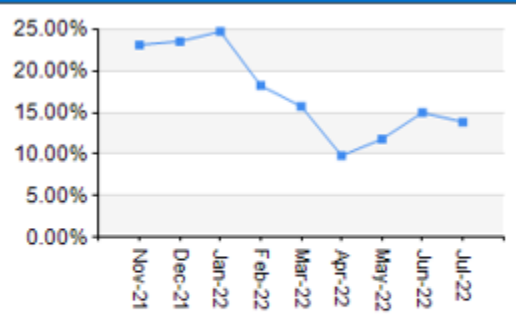
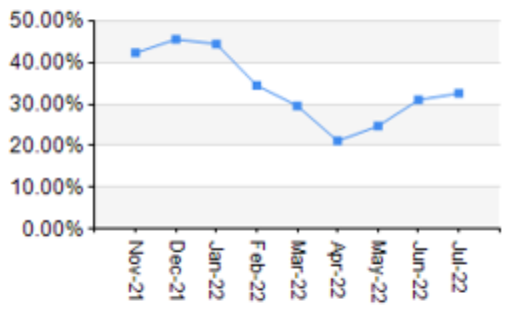
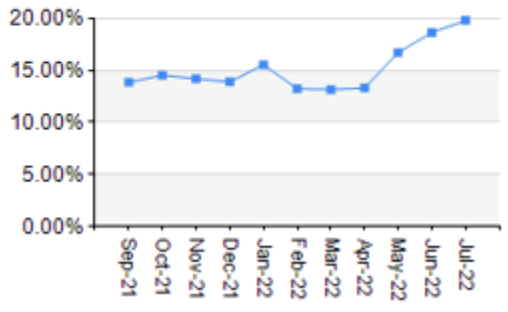
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		The % of PALS Concerns closed within 5 days is 69.5%, a decrease from 77% in June. This is due to a large increase in the number of concerns received (285 in July which is approx. 12% higher than the average for the year to date). The actual number of concerns closed within 5 days was 198 which is consistent with previous months for the team, so the fall in % closed is largely down to the increased volume of concerns raised.	**Head of Quality**
ED % positive **Standard: >=84%**		The current positive FFT score for ED is at 68% across both sites, slightly decreased from 69.8% in June, with the main theme emerging focussed on wait times, which is reflective of the operational pressures in the department. This month showed a greater difference between CGH score (76%) and GRH score (61.9%). The team are receiving reports on the feedback weekly, to support local real time improvement in response to emerging themes, and provide updates through to QDG.	**Head of Quality**
Maternity % positive **Standard: >=97%**		The current positive FFT score for Maternity services is 92%, up from 88.9% in June. The division are working with the Maternity Voices Partnership to review feedback themes emerging from FFT and other sources, to put an improvement plan in place which is monitored in the division, and updates provided through to QDG and MDG. This work is being supported by the Patient Experience team.	**Head of Quality**

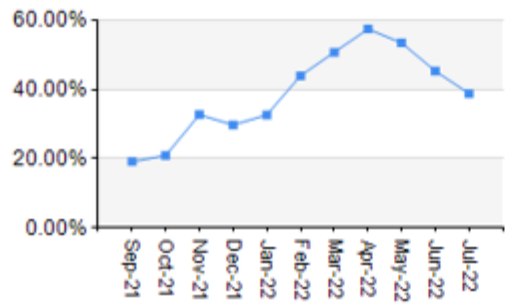
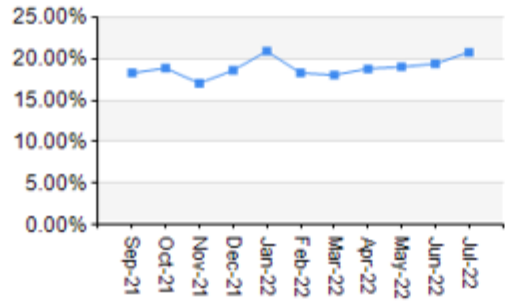
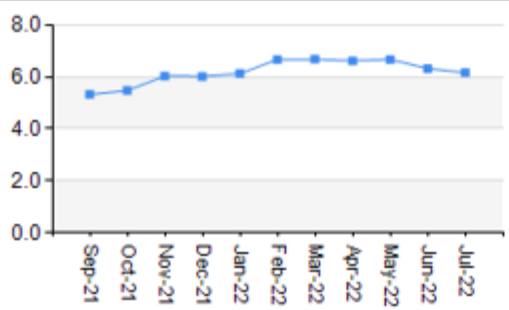
Exception Reports - Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Total % positive Standard: >=93%		The current positive FFT score for the Trust overall is at 89%, which is up slightly from 88.3% in June. The main themes emerging this month were focussed on wait times, communication issues, and delays to appointments. Divisions provide updates through QDG each quarter on improvement plans happening within divisions, and the patient experience team are reviewing current reporting offer to improve the way that FFT and PALS data is triangulated to support improvement plans.	**Head of Quality**

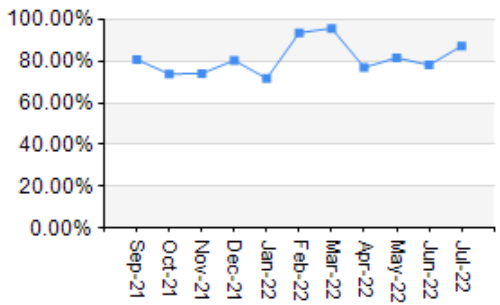
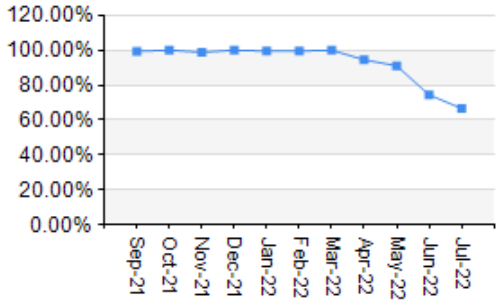
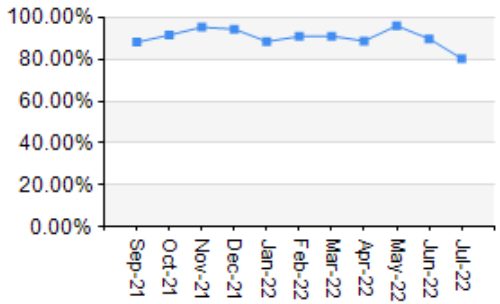
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers < 15 minutes Standard: >=65%		Ambulance Triage within 15 mins has improved by 4.31% across both our sites over last month's data	General Manager of Unscheduled Care
% of ambulance handovers < 30 minutes Standard: >=95%		The >30 minute handover delays increased by 17.6% from June	General Manager of Unscheduled Care
% of ambulance handovers 30-60 minutes Standard: <=2.96%		Handover percentage between 30-60 minutes increased by 1.14% for an overall Trust wide performance of 19.80%	General Manager of Unscheduled Care

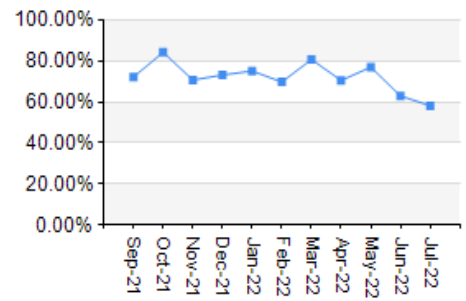
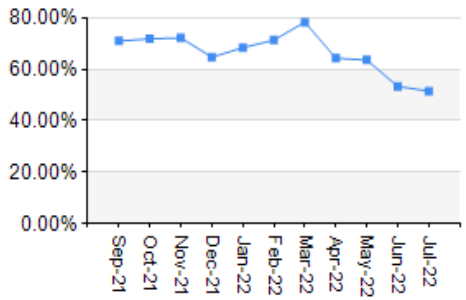
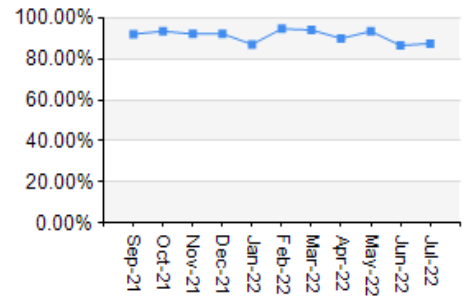
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers over 60 minutes Standard: <=1%		>60 minute handover delays saw further decrease by 10.1% on top of June reduction of 14%	General Manager of Unscheduled Care
% waiting for diagnostics 6 week wait and over (15 key tests) Standard: <=1%		Overall diagnostic performance has deteriorated in month, with the breach performance moving from 19.38% last month to 20.76% in July. This change has been influenced by a slight reduction in the total waiting list (moving from 10,903 to 10,518) which is encouraging, together with an increase in the number of patients that have breached (2,113 last month to 2,184). Cardiology has reduced both the patients breaching and patients waiting for Echo's which is the first time this year. Overall diagnostic performance has deteriorated in month, with the breach performance moving from 19.38% last month to 20.76% in July. This change has been influenced by a slight reduction in the total waiting list (moving from 10,903 to 10,518) which is encouraging, together with an increase in the number of patients that have breached (2,113 last month to 2,184). Cardiology has reduced both the patients breaching and patients waiting for Echo's which is the first time this year.	Associate Director of Elective Care
Average length of stay (spell) Standard: <=5.06		ALOS continues to reduce with an improvement of 0.15days in month. Efforts continue to be focussed on creating capacity in light of ongoing operational challenges.	Deputy Chief Operating Officer

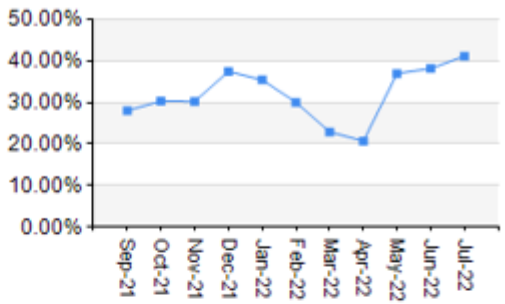
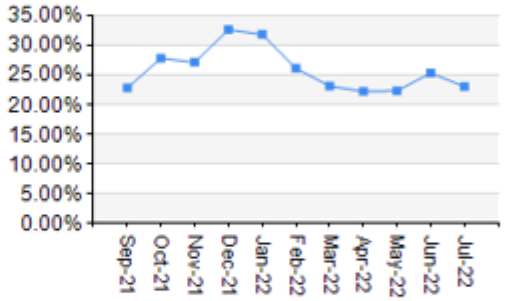
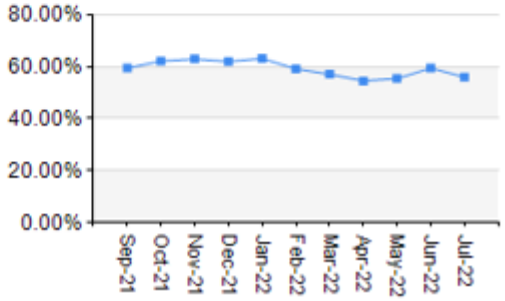
Exception Reports - Responsive (3)

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 June there were 5 patients cancelled on the day that could not be rescheduled within 28 days, a reduction on the previous month. This included 1 Gynae, 1 Ophthalmology, 1 Urology and 2 T&O patients.	**Associate Director of Elective Care**
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy) **Standard: >=94%**		GHFT = 66.7% Standard = 94% National = 91% 99 treatments 33 breaches Performance impacted by capacity issues in summer. Backlog is rapidly reducing and performance will improve in next few months.	**General Manager - Cancer**
Cancer - 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		GHFT = 80.6% Standard = 94% National = 80% 62 treatments 12 breaches Breast 5, Gynae 3, Urology 3, UGI 1 All breaches relating to elective capacity	**General Manager - Cancer**

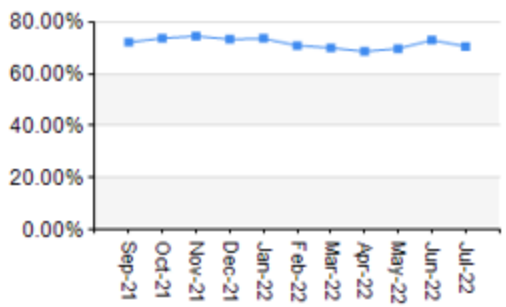
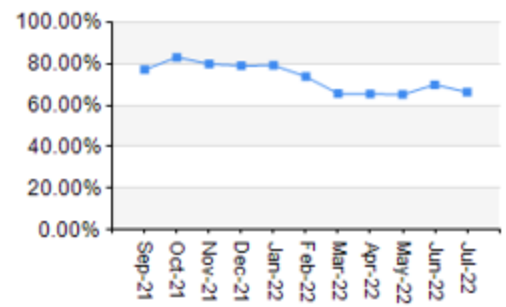
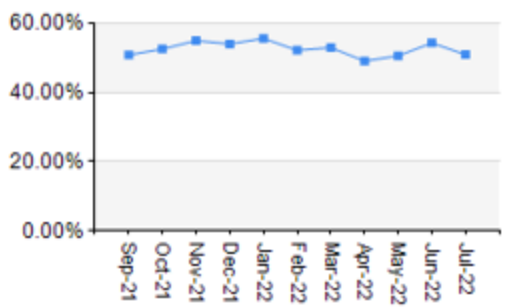
Exception Reports - Responsive (4)

MetricID	Metric Name & Standard	Trend Chart	Exception Notes	Owner
177	Cancer - 62 day referral to treatment (upgrades) Standard: >=90%		Performance = 76.6% Standard = n/a National = 74% Treatments = 16.5 Breaches = 6.5 Uro = 3 H&N = 2 Lung = 1.5	General Manager - Cancer
175	Cancer - 62 day referral to treatment (urgent GP referral) Standard: >=85%		Performance = 55.1% Standard 85% National = 59% Treatments = 183.5 Breaches = 89 Uro = 49 LGI = 11 Haem = 6 Skin = 5.5	General Manager - Cancer
169	Cancer - urgent referrals seen in under 2 weeks from GP Standard: >=93%		GHFT = 87.4% Standard = 93% National = 77.7% DFS = 2535 Breaches 319, Skin=162, Lower GI=88, Gynae=26 High demand and capacity issues impacting Dermatology and Lower GI (Surgical and Endoscopy). Recovery plans initiated with signs of improvements in August.	General Manager - Cancer

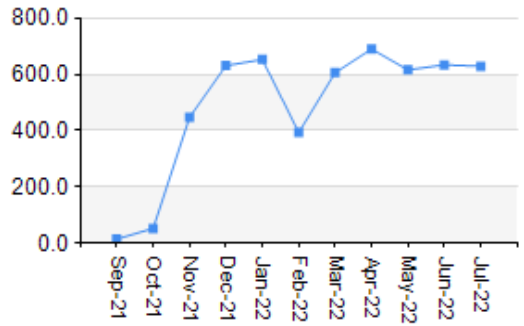
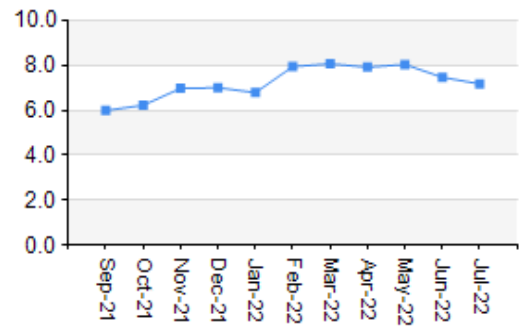
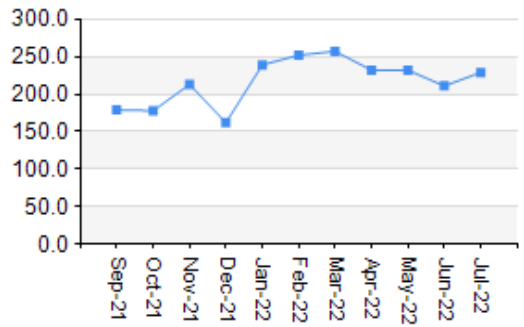
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment - under 15 minutes Standard: >=95%		Total Trust reduction of 8.8% since June	General Manager of Unscheduled Care
ED: % of time to start of treatment - under 60 minutes Standard: >=90%		A downward change of 2.3% was seen in the month of July for a Trust wide performance of 23.0%	General Manager of Unscheduled Care
ED: % total time in department - under 4 hours (type 1) Standard: >=95%		There was a decrease in the ED 4-hour performance metric by 3.40% resulting in a Trust wide achievement of 56.11%.	General Manager of Unscheduled Care

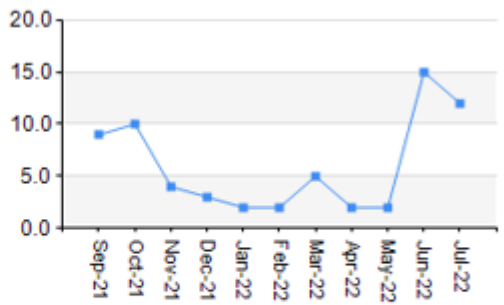
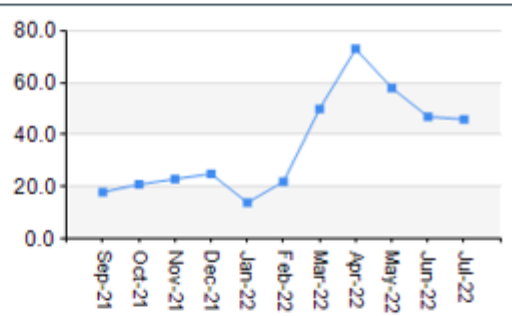
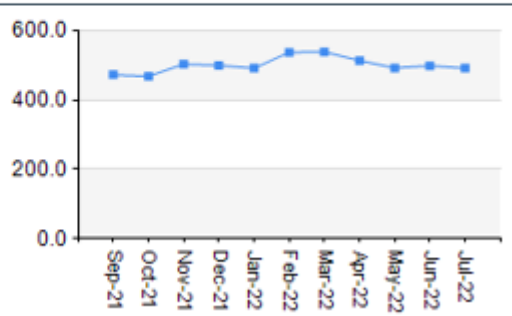
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department - under 4 hours (types 1 & 3) Standard: >=95%		There was a decrease in the ED 4-hour metric for types 1 and 3 by 2.4% resulting in a Trust wide achievement of 70.62%	General Manager of Unscheduled Care
ED: % total time in department - under 4 hours CGH Standard: >=95%		Total time in CGH ED percentage decreased by 3.59% for an overall performance of 66.22% in July	General Manager of Unscheduled Care
ED: % total time in department - under 4 hours GRH Standard: >=95%		Total time in GRH ED percentage decreased by 3.39% for an overall performance of 50.84% in July	General Manager of Unscheduled Care

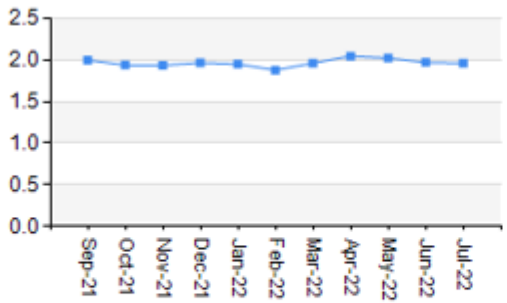
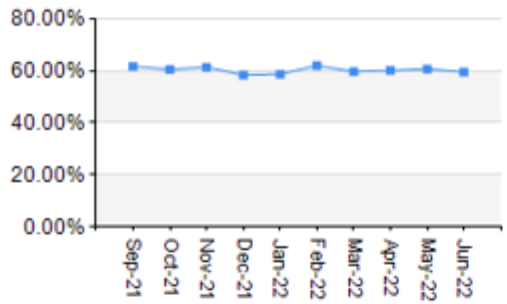
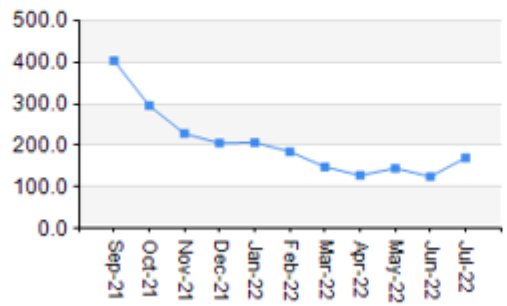
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		The number of 12 hour trolley waits decreased by 5 patient from last month	**General Manager of Unscheduled Care**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		Consecutive monthly improvements continue to be made, with an reduction of 0.3 bed days in month. There continue to be no remarkable factors affecting this indicator at this time.	**Deputy Chief Operating Officer**
Number of patients stable for discharge **Standard: <=70**		The number of patients stable for discharges remains below the baseline taken in April, but has seen a rise back up to 230 in recent weeks. There is ongoing discussions with system partners alongside the Sloman work being undertaken as an ICS, along with ongoing work to resolve internal action delays and process issues.	**Head of Therapy & OCT**

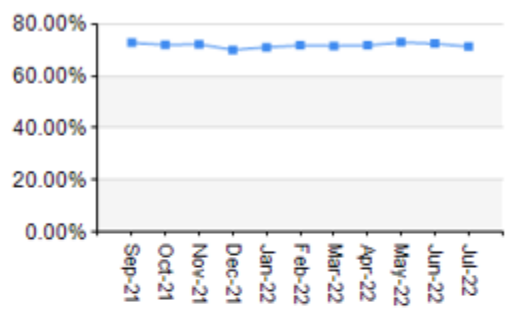
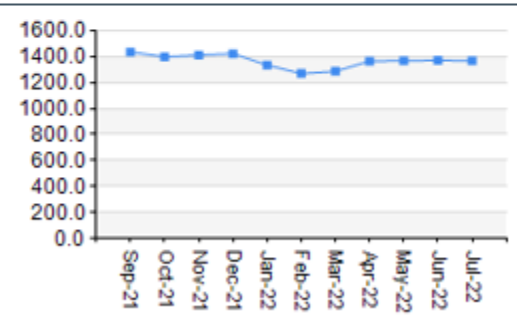
Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Urological 11 Lower GI 3 Gynaecological 2 Haematological 1 Head & neck 1 Sarcomas 1 Upper GI 1 Total 20	**General Manager - Cancer**
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		Total = 34 (Uro 14, LGI 11, H&N 3, UGI 3, Lung 2, Skin 1) Tertiary referred patients = 8 Awaiting TCI = 2 Continued investigations = 13 Awaiting pathology = 11	**General Manager - Cancer**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		Minimal gains have been made in month, with a reduction of just 7 patients, potentially in line with reducing covid-19 cases.	**Deputy Chief Operating Officer**

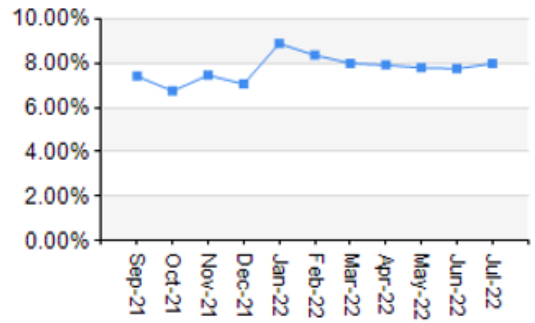
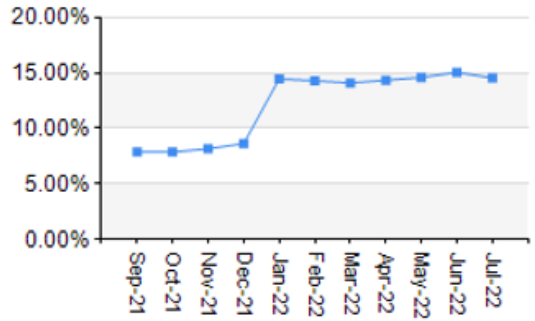
Exception Reports - Responsive (9)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Outpatient new to follow up ratio's **Standard: <=1.9**		Improved slightly, down to 1.96 and remains marginally above target.	**Associate Director of Elective Care**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		This metric remains static as stated before we are awaiting EPMA implementation to review this whole process	**Medical Director**
Referral to treatment ongoing pathway over 70 Weeks (number) **Standard: 0**		This cohort has jumped in month, with a further 45 patients. That services impacted the most remains Clinical Haematology and Oral Surgery both of which have recovery plans in place which should result in reductions over the coming months.	**Associate Director of Elective Care**

Exception Reports - Responsive (10)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. RTT performance is currently reported as 71.3% and is not anticipated to change significantly prior to submission. Performance has therefore dipped by approximately 1%. GHT remains significantly above the national average of 61.9%.	**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. Planned surveillance endoscopy breaches continue to remain static due to reduced admin validation support. The position is suspected to decrease in the coming month with additional bank admin to support the process of dedicated clinical validation sessions to confirm if patients still require the procedure and continuing to carve out capacity in month.	**Deputy General Manager of Endoscopy**

Exception Reports - Well Led (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors **Standard: <=5%**		The intake of Junior Doctors during August has been the highest yet; supported further by the arrival of a cohort of internationally recruited Doctors from Mumbai being deployed within Medicine and Surgery. This will positively affect the current vacancy position, however, ongoing recruitment remains a focus.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses **Standard: <=5%**		The International Nurse recruitment plan remains on track with approval awaited from the recent NHSEi bid for an additional 64 overseas nurses to be recruited by 31st December 2022. The current projection for c50 newly qualified nurses to join the Trust in September remains on track.	**Director of Human Resources and Operational Development**

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period July 2022

Presented at August 2022 Q&P and September 2022 Trust Board

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Gloucestershire Hospitals
NHS Foundation Trust

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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. During July, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4-hour ED standard, but continue to achieve the zero 104 weeks breaches target.

July continued to be a challenging month for the Emergency Department (ED) but saw an decrease in performance from 73.02% to 70.62% compared to the previous month. Ambulance handover delays increased for 30-60 minutes handovers delays however reduced slightly for those 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.

Overall diagnostic performance has deteriorated in month, with the breach performance moving from 19.38% last month to 20.76% in July. This change has been influenced by a slight reduction in the total waiting list (moving from 10,903 to 10,518) which is encouraging, together with an increase in the number of patients that have breached (2,113 last month to 2,184).
Cardiology has reduced both the patients breaching and patients waiting for Echo's which is the first time this year.

For cancer, performance data showed the Trust met 3 out of 9 standards with all 7 out of 9 standards above national average clearly showing a challenging month. The Trust achieved the 2ww breast symptomatic standard in June with 94.1% performance. The Trust continued strong 28 day Faster Diagnosis Standard performance with 79% of patients receiving their diagnosis in June. 62 day standard performance for June was 51.9% which will rise following final submission but still a very poor month. 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 national standard with a reduction in performance and an anticipated month end submission of 71.4%. The total incompletes continues to rise and the unconfirmed July position is expected to be around 63,750. The number of patients waiting over 52 weeks has increased slightly to 1,439 (compared to a validated June position of 1,367). Although focus continues to be placed on patients over 70 weeks, this cohort remains high, largely influenced by approximately 40 Haematology patients. Their recovery plan is in the process of being implemented and therefore these patients should be booked shortly. The over 78 week cohort however has reduced by approximately 10 in month, and 104 breaches remains at zero.

The Elective Care Hub are continuing to contact patients via varying methods and will shortly be contacting patients in the 18-21 week non-admitted cohort. At the same time "nudge" letters are being issued to patients who have not responded to date, and further non-response will be escalated to the service and GP accordingly. Engagement will then take place with specialties to consider how this approach is applied to the outpatient follow up backlog.

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

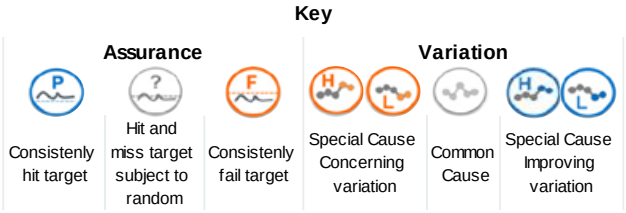
MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Cancer	Cancer - 28 day FDS (all routes)	>=75%		Jul-22	79.6%	
Cancer	Cancer - urgent referrals seen in under 2 weeks from GP	>=93%		Jul-22	87.4%	
Cancer	Cancer - 2 week wait breast symptomatic referrals	>=93%		Jul-22	91.8%	
Cancer	Cancer - 31 day diagnosis to treatment (first treatments)	>=96%		Jul-22	96.0%	
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – drug)	>=98%		Jul-22	100.0%	
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	>=94%		Jul-22	82.0%	
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%		Jul-22	66.7%	
Cancer	Cancer - 62 day referral to treatment (urgent GP referral)	>=85%		Jul-22	51.0%	
Cancer	Cancer - 62 day referral to treatment (screenings)	>=90%		Jul-22	89.7%	
Cancer	Cancer - 62 day referral to treatment (upgrades)	>=90%		Jul-22	58.1%	
Cancer	Number of patients waiting over 104 days with a TCI date	Zero		Jul-22	12	
Cancer	Number of patients waiting over 104 days without a TCI date	<=24		Jul-22	46	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%		Jul-22	20.76%	
Diagnostics	The number of planned/surveillance endoscopy patients waiting at month end	<=600		Jul-22	1,367	
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%		Jun-22	59.50%	
Emergency Department	ED: % total time in department - under 4 hours (type 1)	>=95%		Jul-22	56.00%	
Emergency Department	ED: % total time in department - under 4 hours (types 1 & 3)	>=95%		Jul-22	70.62%	
Emergency Department	ED: % total time in department - under 4 hours CGH	>=95%		Jul-22	66.22%	
Emergency Department	ED: % total time in department - under 4 hours GRH	>=95%		Jul-22	50.84%	

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero		Jul-22	629	
Emergency Department	ED: % of time to initial assessment - under 15 minutes	>=95%		Jul-22	41.1%	
Emergency Department	ED: % of time to start of treatment - under 60 minutes	>=90%		Jul-22	23.0%	
Emergency Department	Number of ambulance handovers over 60 minutes	Zero		Jul-22	1,081	
Emergency Department	% of ambulance handovers < 15 minutes	>=65%		Jul-22	13.9%	
Emergency Department	% of ambulance handovers < 30 minutes	>=95%		Jul-22	32.6%	
Emergency Department	% of ambulance handovers 30-60 minutes	<=2.96%		Jul-22	19.8%	
Emergency Department	% of ambulance handovers over 60 minutes	<=1%		Jul-22	38.8%	
Maternity	% of women booked by 12 weeks gestation	>90%		Jul-22	88.9%	
Operational Efficiency	Number of patients stable for discharge	<=70		Jul-22	229	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380		Jul-22	491	
Operational Efficiency	Average length of stay (spell)	<=5.06		Jul-22	6.2	
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65		Jul-22	7.2	
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4		Jul-22	2.5	
Operational Efficiency	% day cases of all electives	>80%		Jul-22	82.9%	
Operational Efficiency	Intra-session theatre utilisation rate	>85%		Jul-22	85.5%	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%		Jul-22	87.2%	
Operational Efficiency	Urgent cancelled operations	No target		Jul-22	0	

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

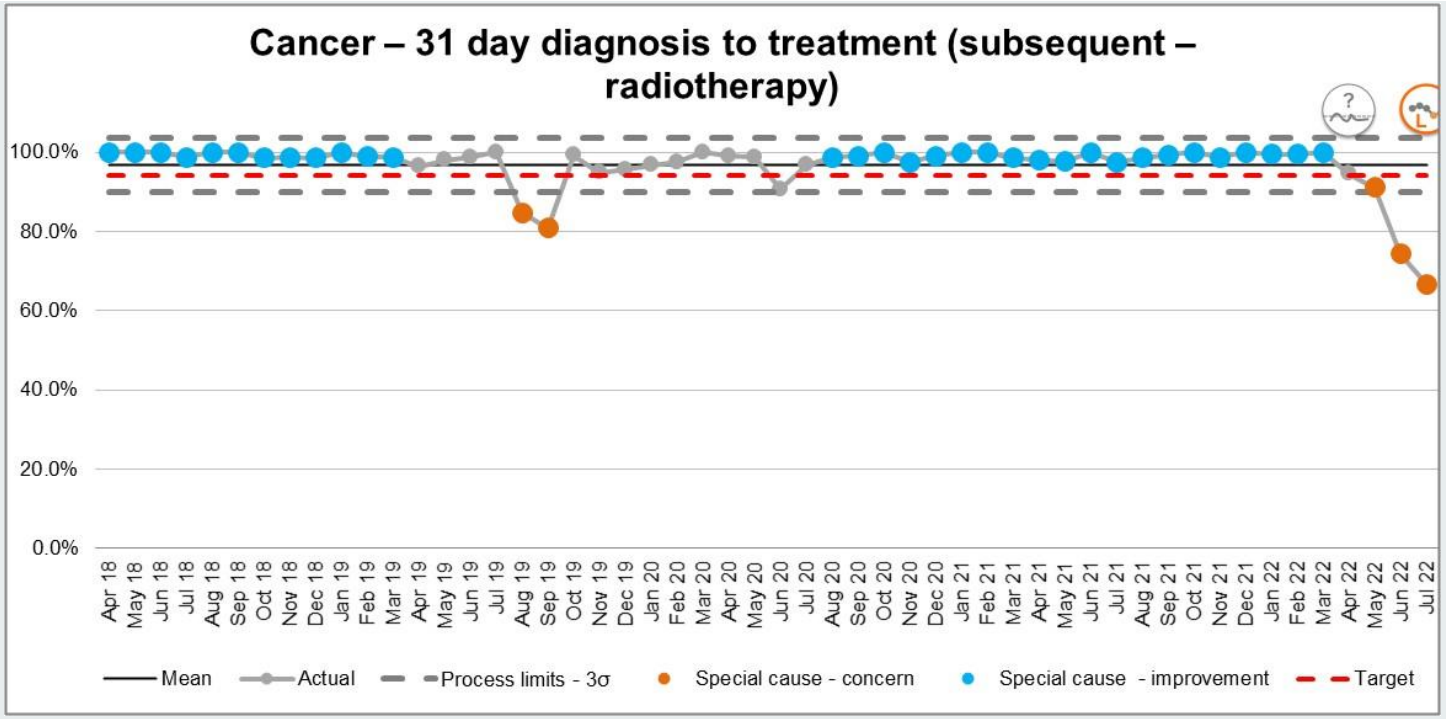
This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Outpatient	Outpatient new to follow up ratio's	<=1.9	?	Jul-22	1.96	
Outpatient	Did not attend (DNA) rates	<=7.6%	P	Jul-22	6.7%	H
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	?	Jun-22	7.8%	
Research	Research accruals	No target		Jul-22	124	
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%	F	Jul-22	71.20%	L
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Jul-22	6,350	H
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Jul-22	2,692	H
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero	F	Jul-22	1,446	H
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	0		Jul-22	170	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%	?	Jul-22	71.4%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%	?	May-22	97.3%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%	?	Jul-22	63.5%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%	?	Jul-22	61.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%	?	Jul-22	37.70%	L
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%	?	Jul-22	37.7%	L

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

GHFT = 66.7%
Standard = 94%
National = 91%

99 treatments 33 breaches
Performance impacted by capacity issues in summer. Backlog is rapidly reducing and performance will improve in next few months.

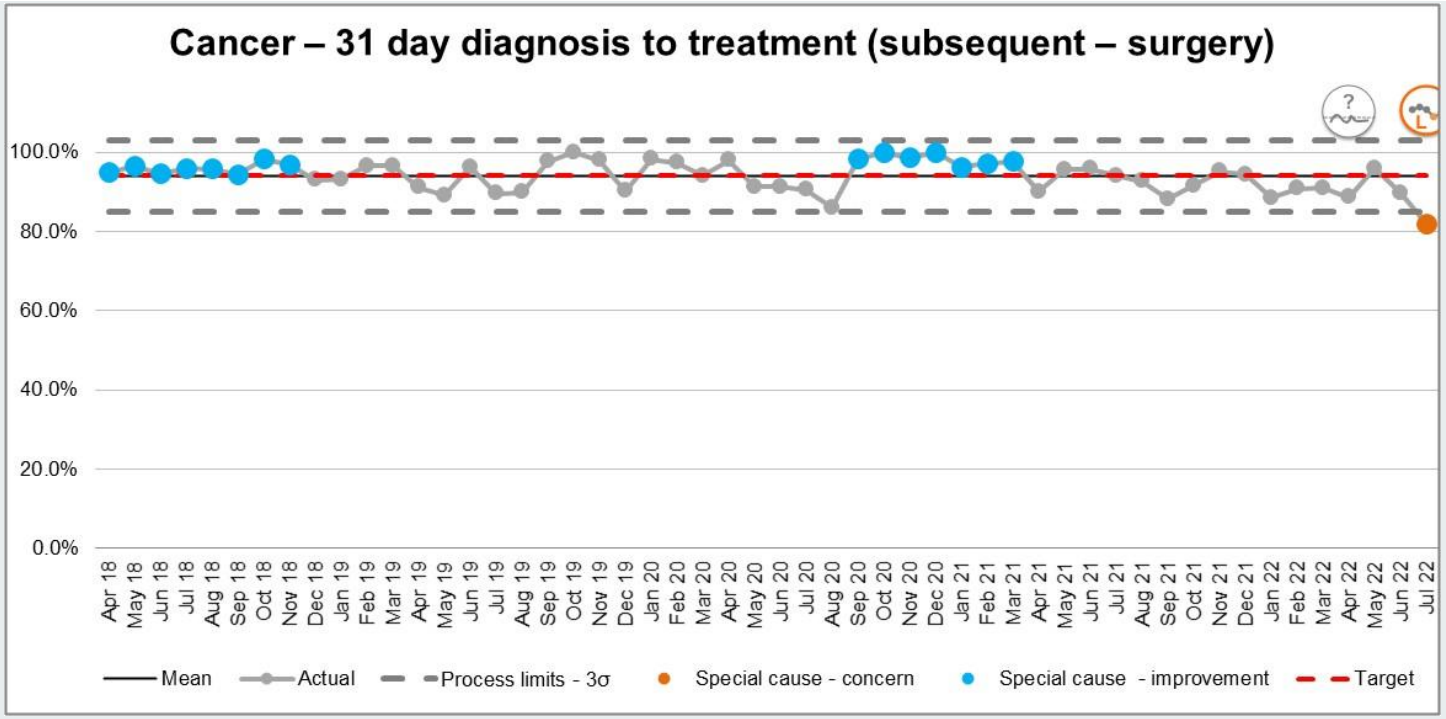
- General Manager - Cancer

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

GHFT = 80.6%
Standard = 94%
National = 80%
62 treatments 12 breaches
Breast 5, Gynae 3, Urology 3, UGI 1
All breaches relating to elective capacity

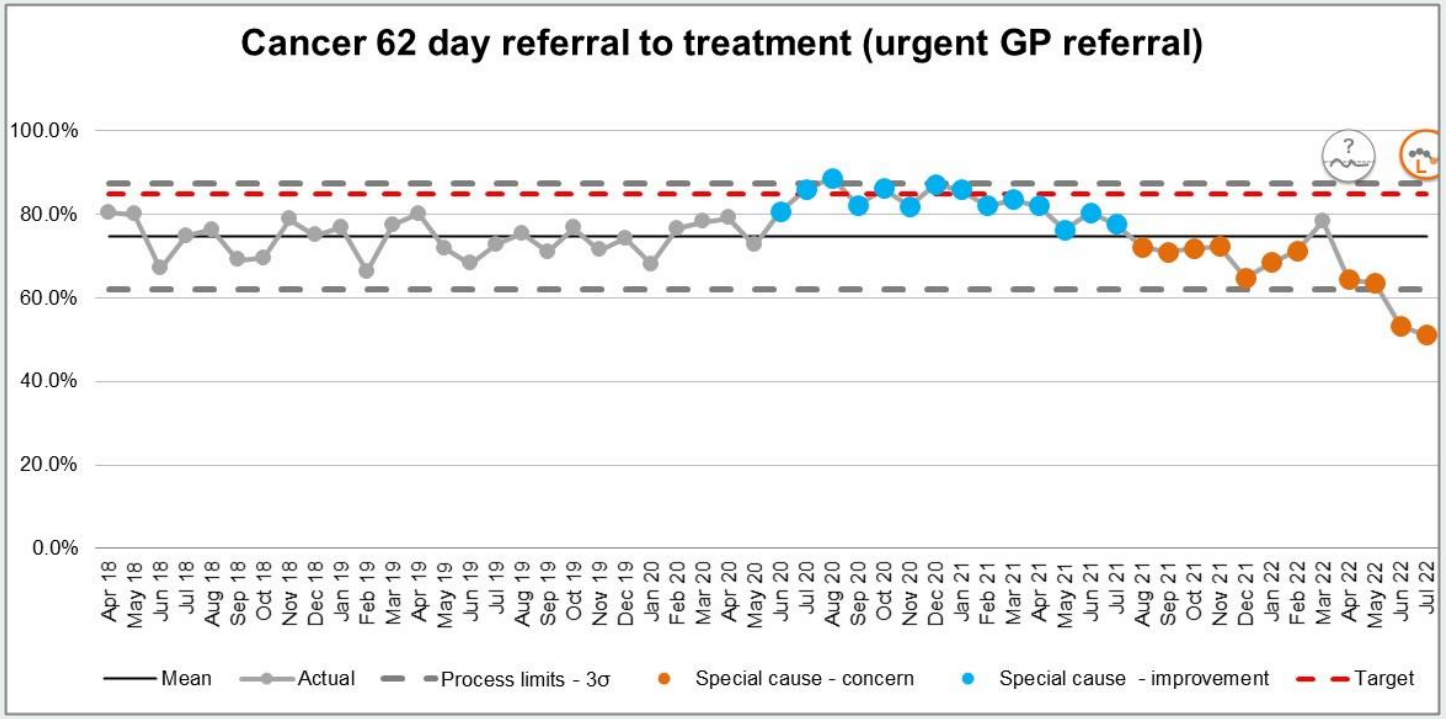
- General Manager - Cancer

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(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

Performance = 55.1%
Standard 85%
National = 59%
Treatments = 183.5/Breaches = 89
Uro = 49, LGI = 11, Haem = 6, Skin = 5.5, Breast = 3.5, Other = 3.5

Performance significantly impacted by 49 breaches predominantly on the prostate pathway

- 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 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 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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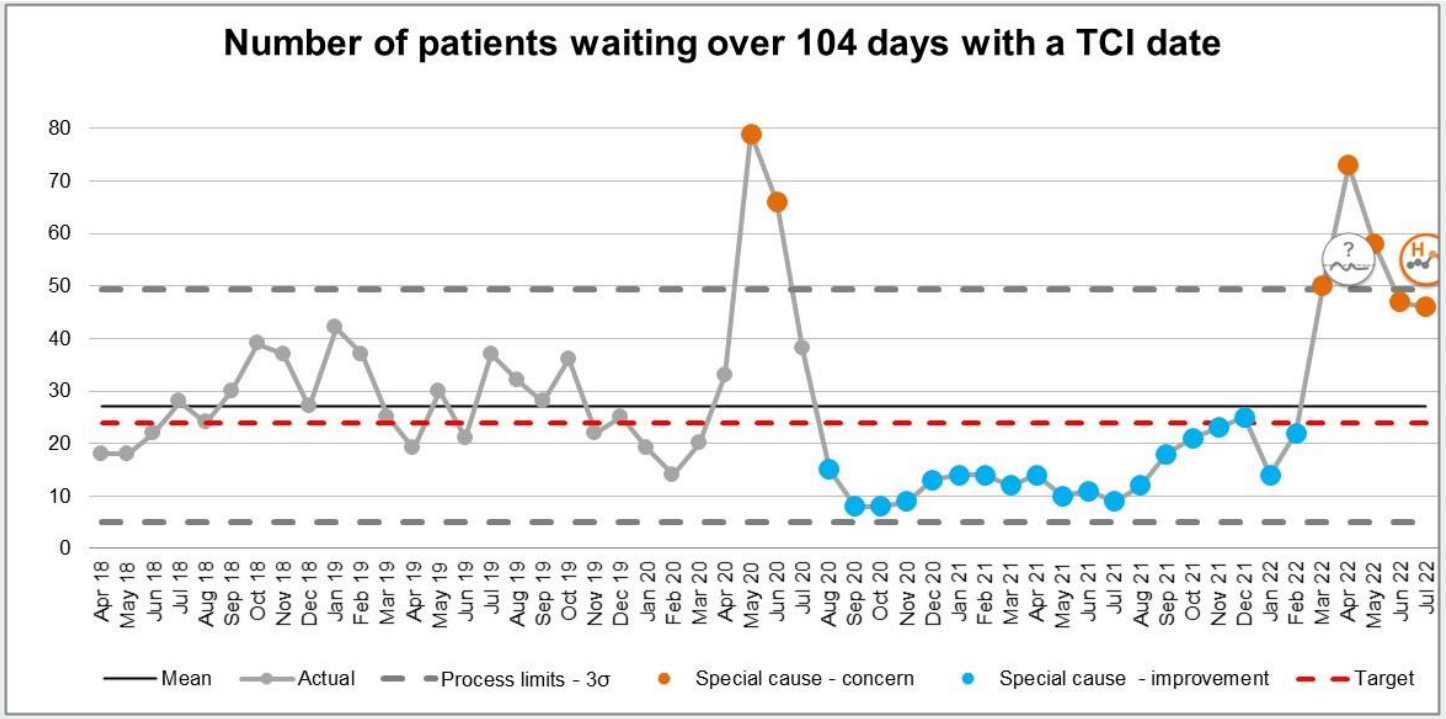

Commentary

Urological 11
Lower GI 3
Gynaecological 2
Haematological 1
Head & neck 1
Sarcomas 1
Upper GI 1

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

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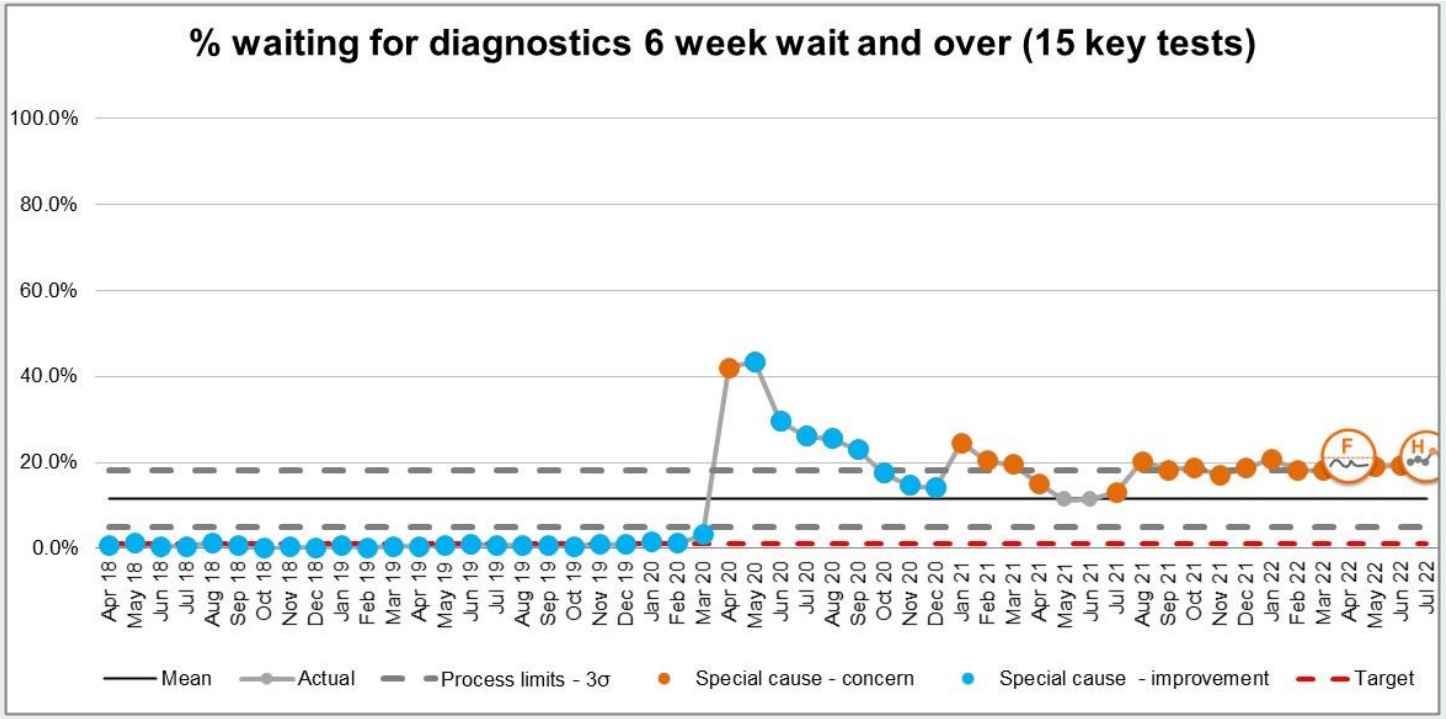

Commentary

Overall diagnostic performance has deteriorated in month, with the breach performance moving from 19.38% last month to 20.76% in July. This change has been influenced by a slight reduction in the total waiting list (moving from 10,903 to 10,518) which is encouraging, together with an increase in the number of patients that have breached (2,113 last month to 2,184).
Cardiology has reduced both the patients breaching and patients waiting for Echo's which is the first time this year.
Overall diagnostic performance has deteriorated in month, with the breach performance moving from 19.38% last month to 20.76% in July. This change has been influenced by a slight reduction in the total waiting list (moving from 10,903 to 10,518) which is encouraging, together with an increase in the number of patients that have breached (2,113 last month to 2,184).
Cardiology has reduced both the patients breaching and patients waiting for Echo's which is the first time this 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 19 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

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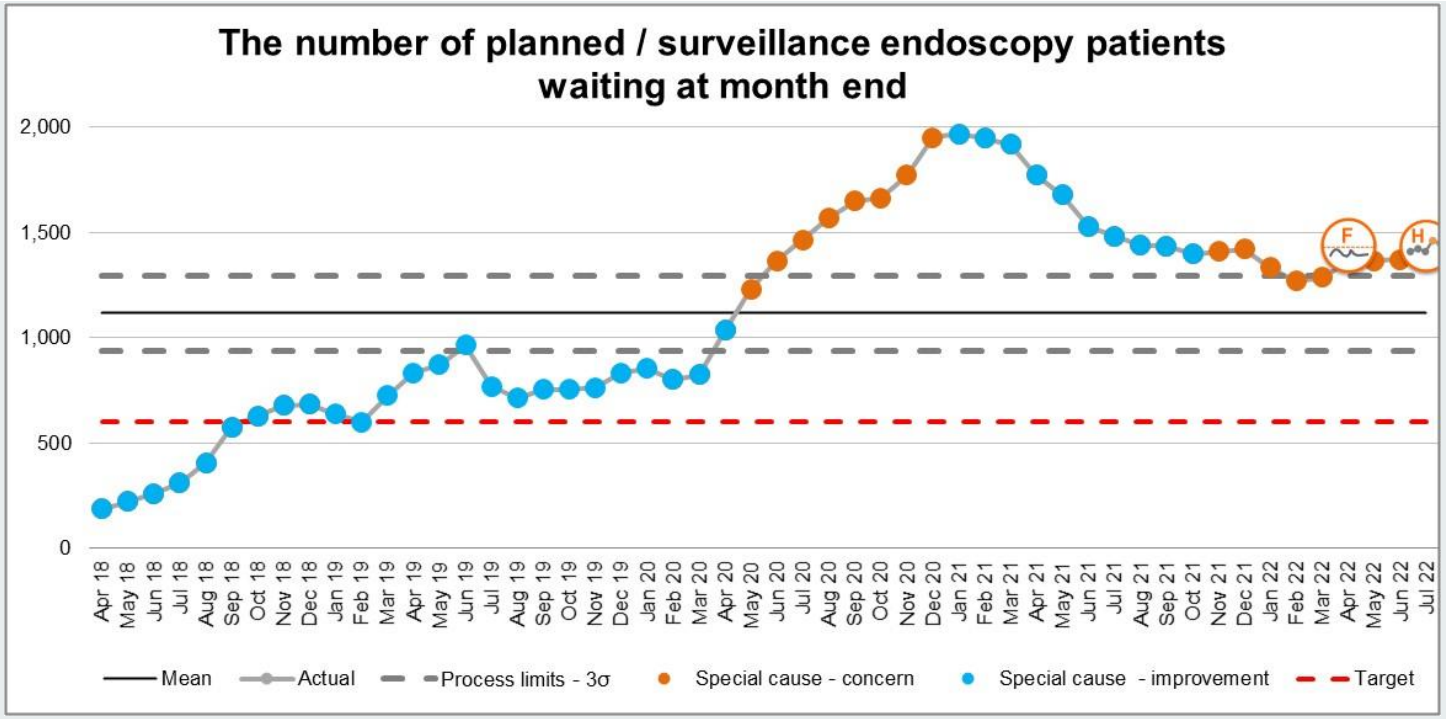

Commentary

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. Planned surveillance endoscopy breaches continue to remain static due to reduced admin validation support. The position is suspected to decrease in the coming month with additional bank admin to support the process of dedicated clinical validation sessions to confirm if patients still require the procedure and continuing to carve out capacity in month.

- 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 24 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:
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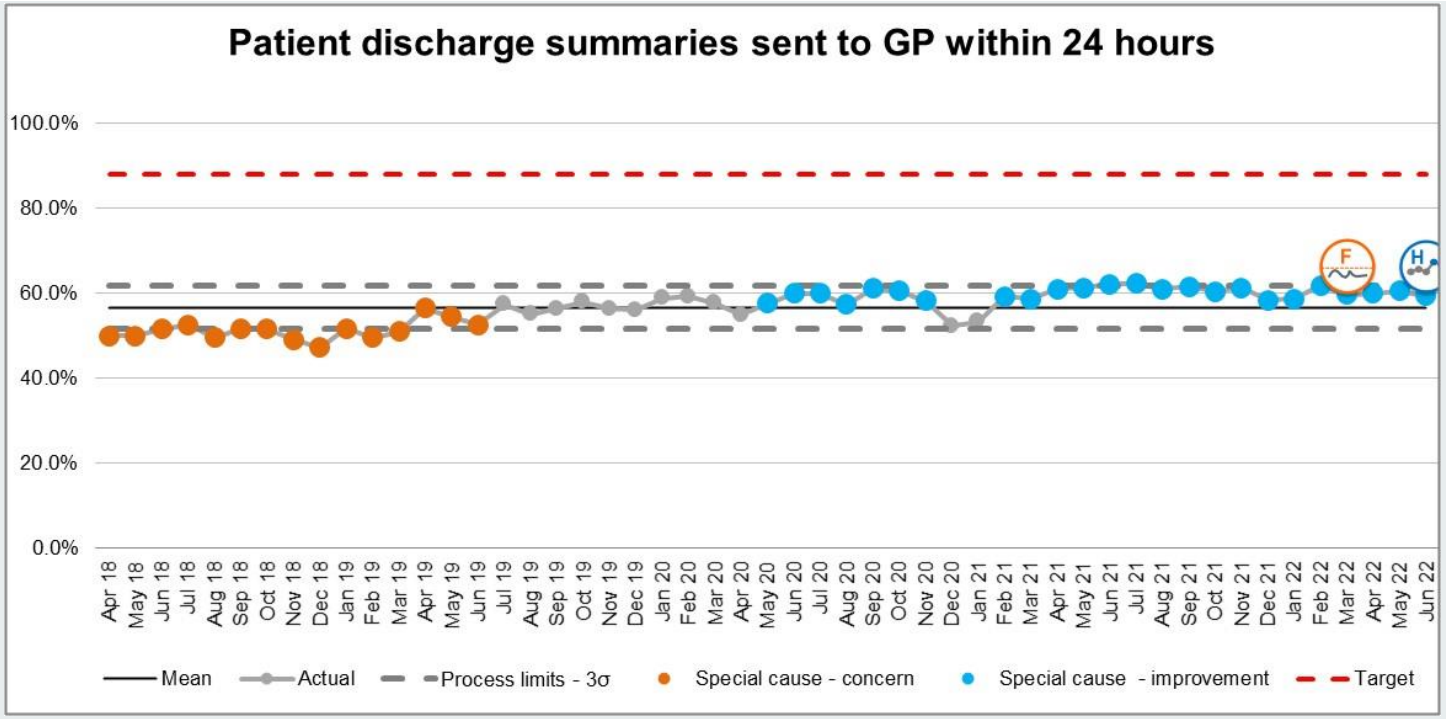

Commentary

This metric remains static as stated before we are awaiting EPMA implementation to review this whole process

- Medical Director

Data Observations

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

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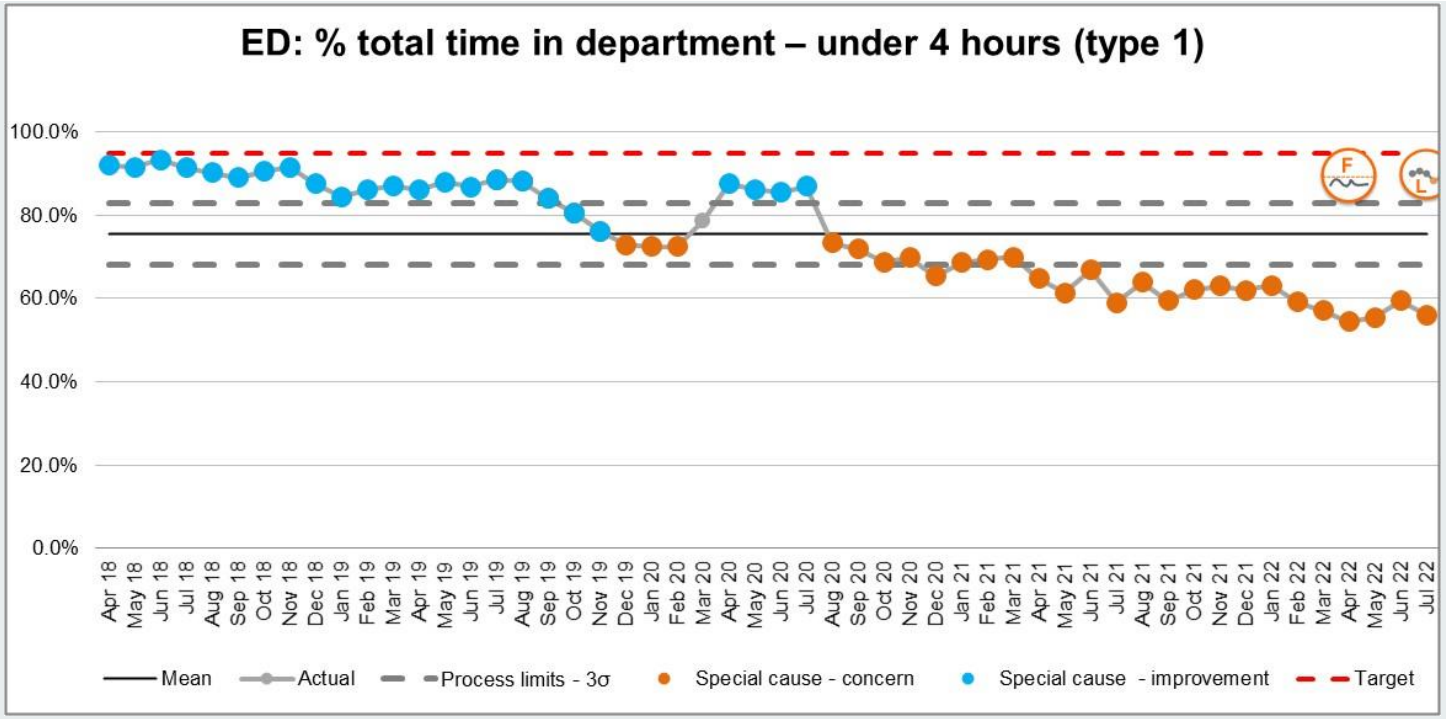

Commentary

There was a decrease in the ED 4-hour performance metric by 3.40% resulting in a Trust wide achievement of 56.11%.

- 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 22 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.
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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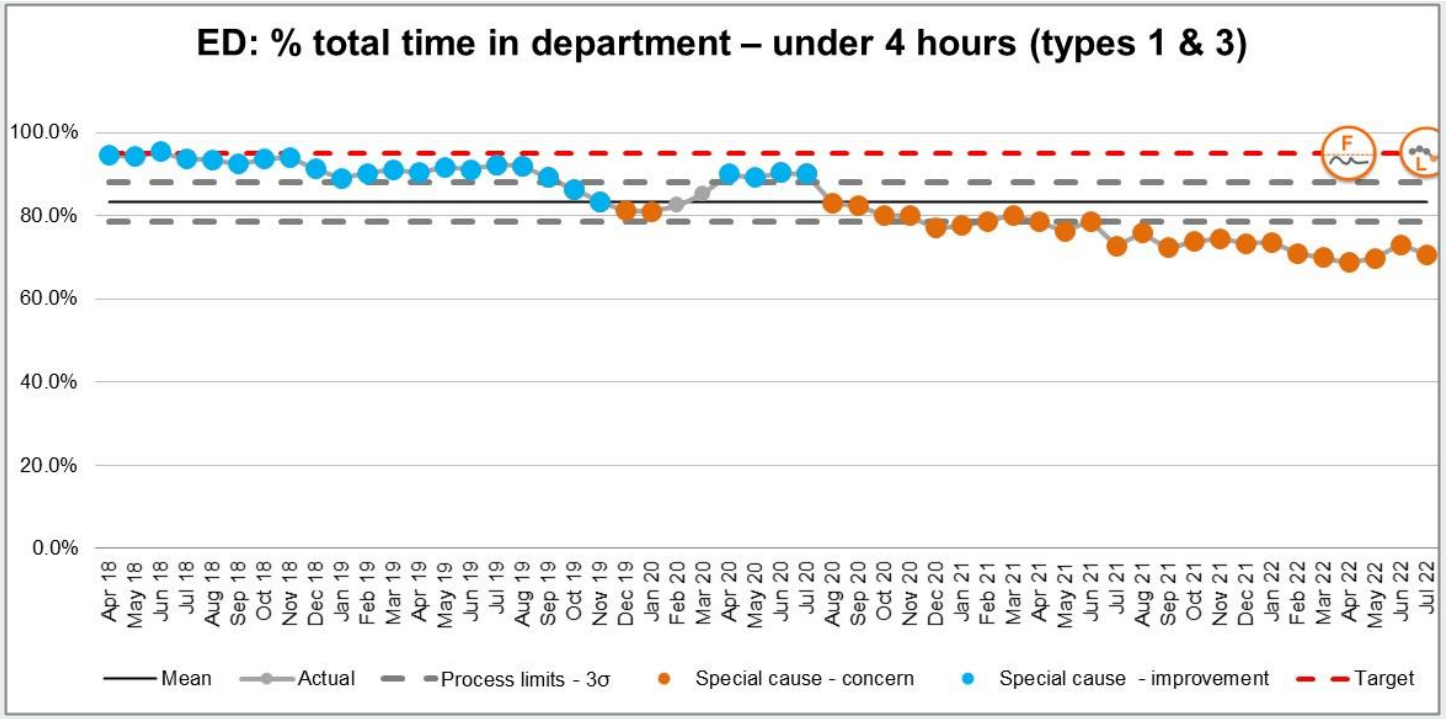

Commentary

There was a decrease in the ED 4-hour metric for types 1 and 3 by 2.4% resulting in a Trust wide achievement of 70.62%

- 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 22 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 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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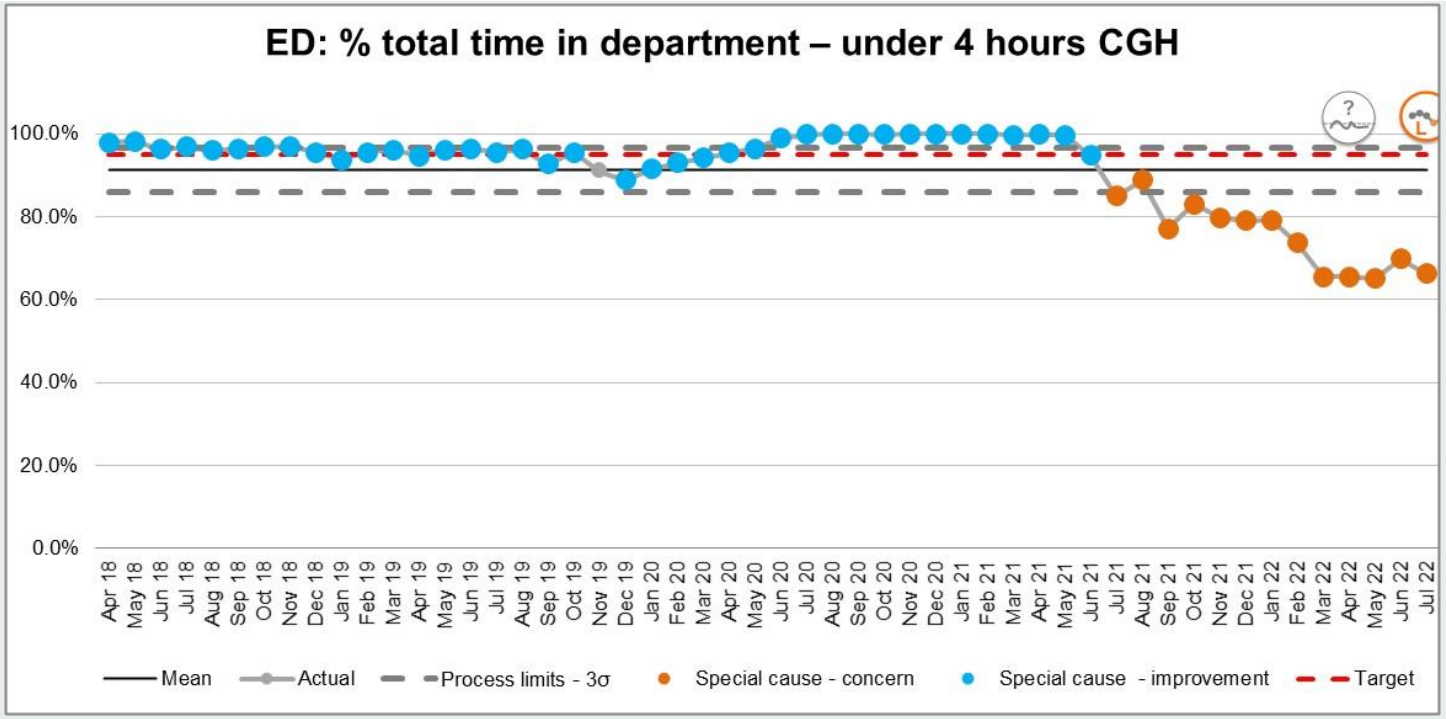

Commentary

Total time in CGH ED percentage decreased by 3.59% for an overall performance of 66.22% in July

- 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 17 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 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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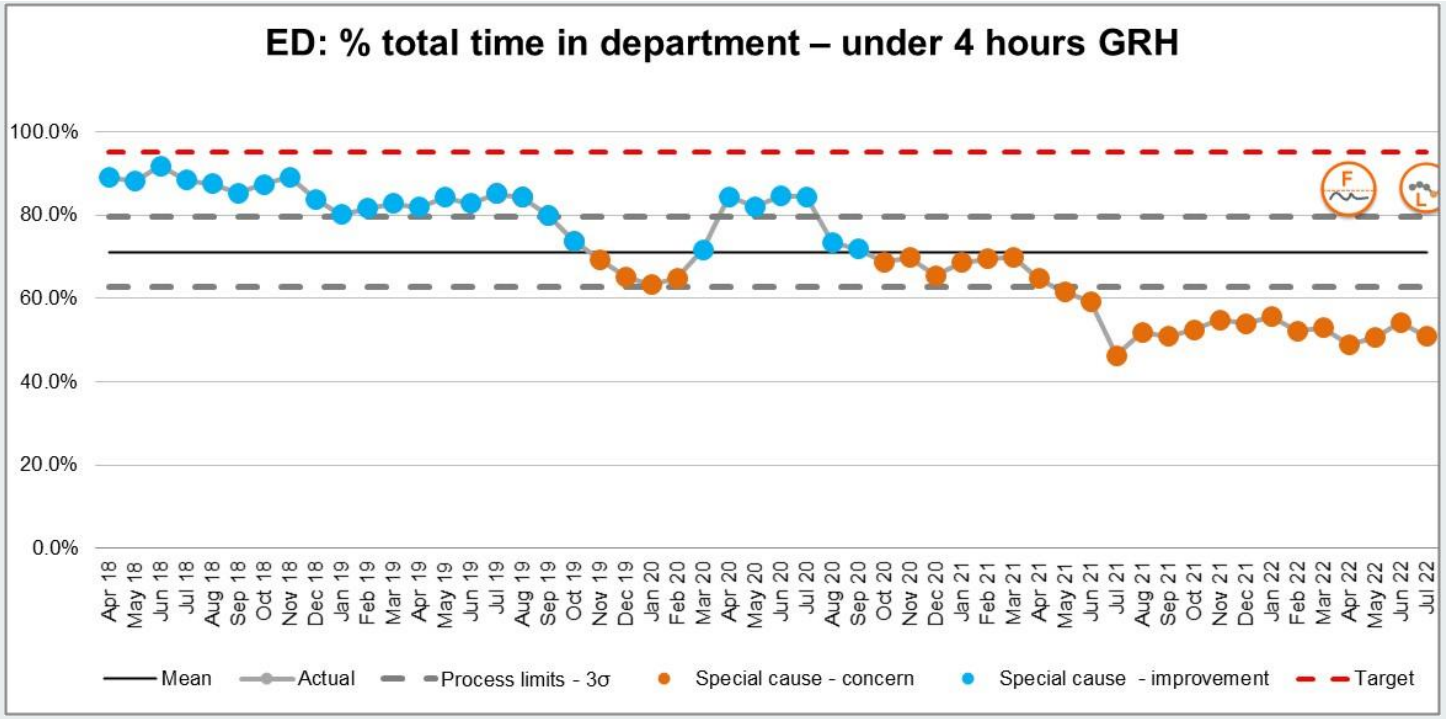

Commentary

Total time in GRH ED percentage decreased by 3.39% for an overall performance of 50.84% in July

- 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 22 data points which are above the line. There are 15data 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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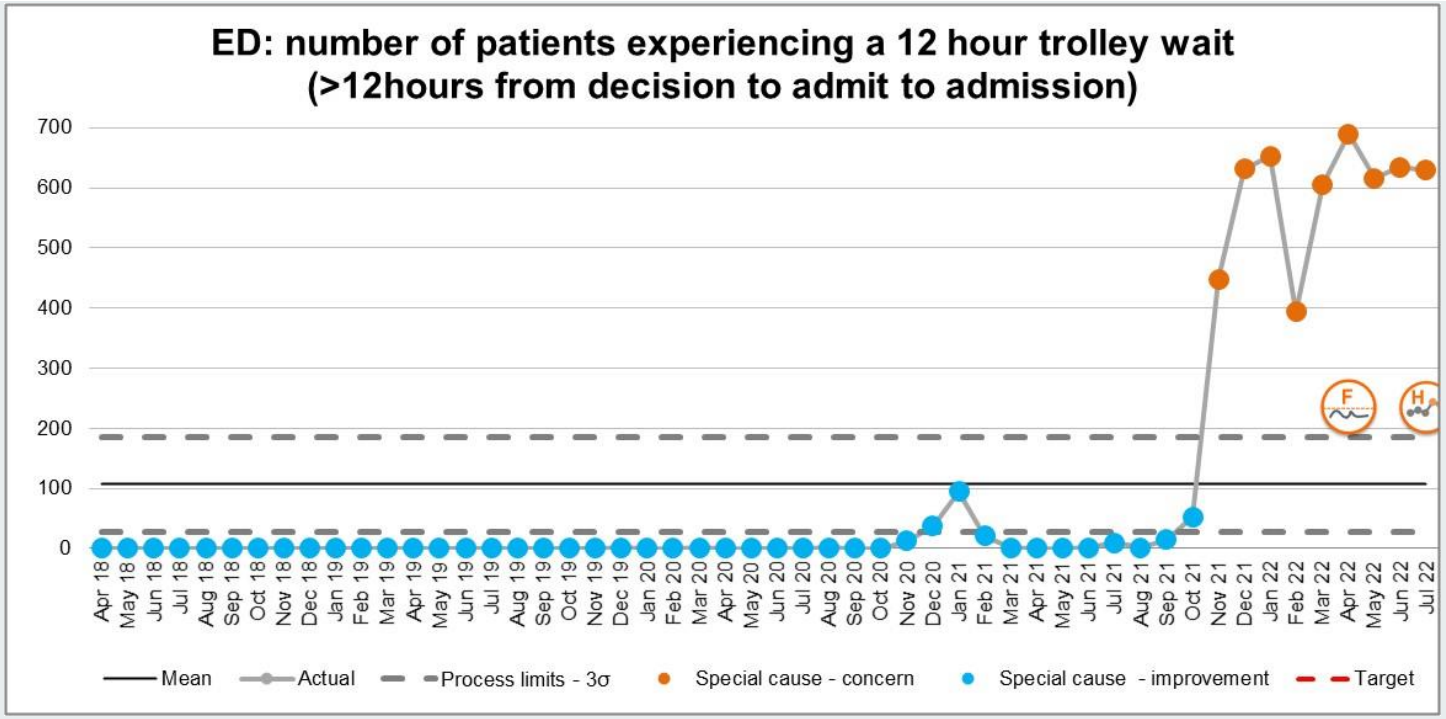

Commentary

The number of 12 hour trolley waits decreased by 5 patient from last month

- 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 9 data points which are above the line. There are 40 data points 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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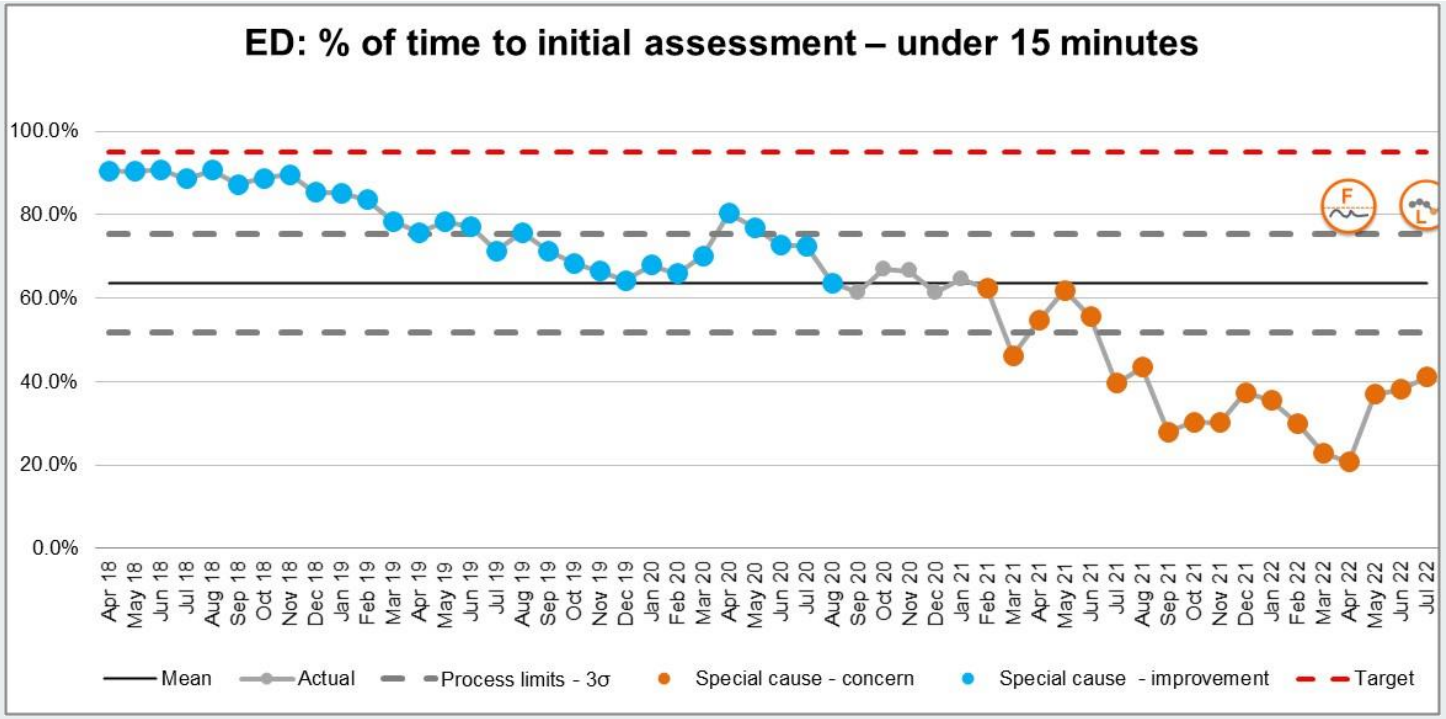

Commentary

Total Trust reduction of 8.8% since June

- 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 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.
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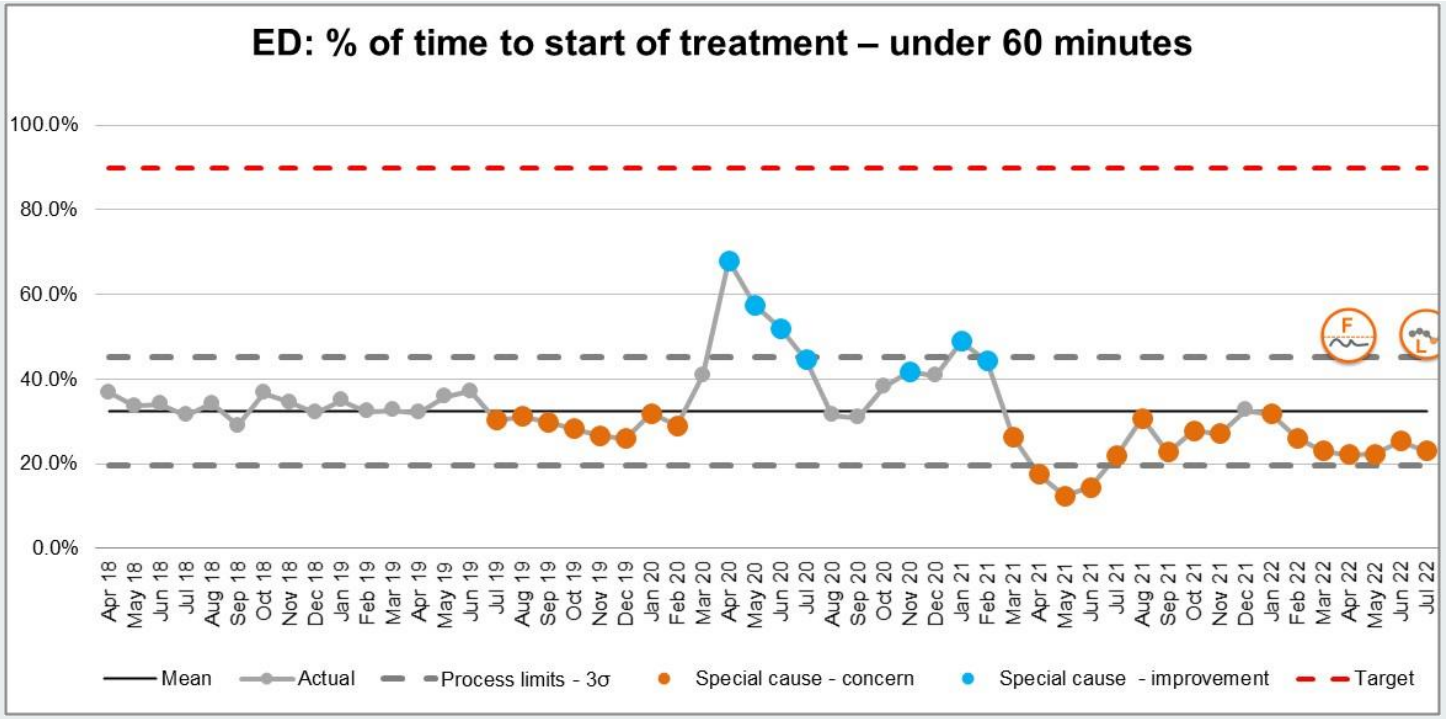

Commentary

A downward change of 2.3% was seen in the month of July for a Trust wide performance of 23.0%

- 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. 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 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

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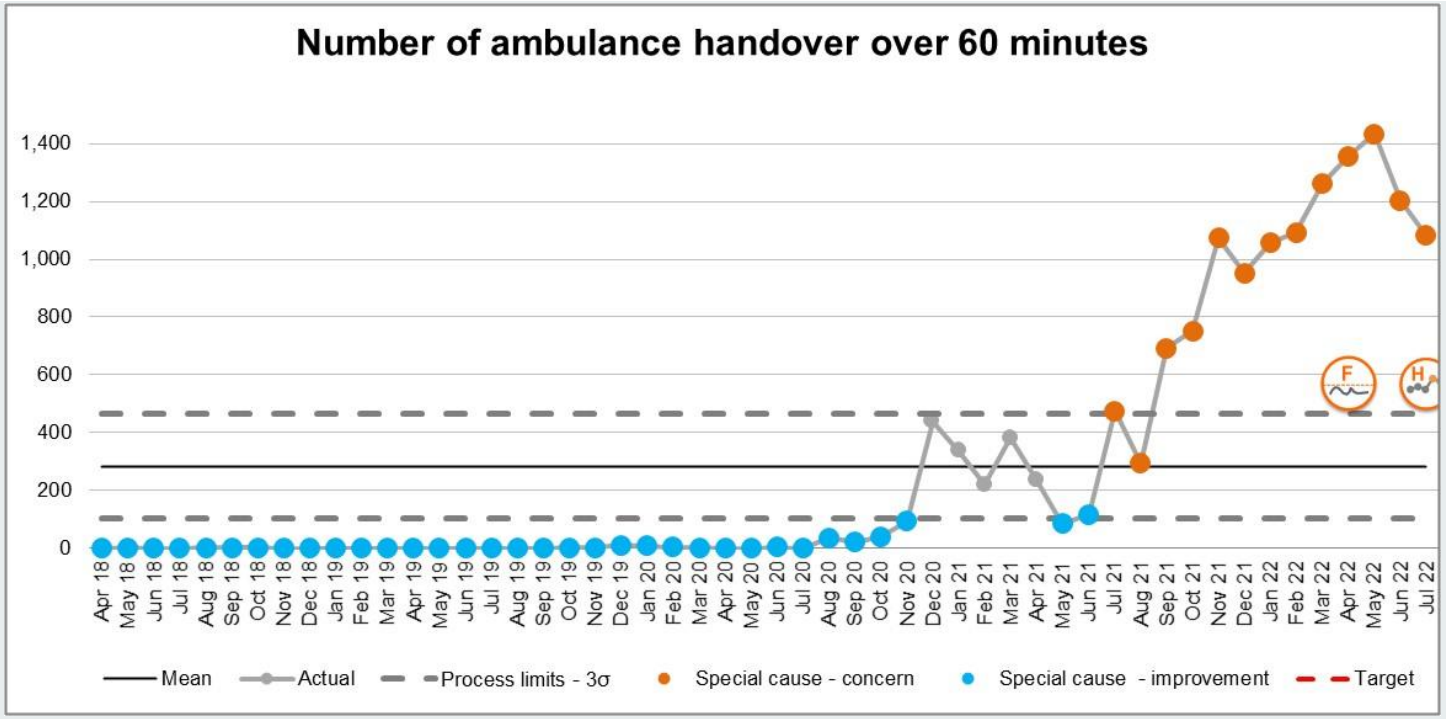

Commentary

The number of ambulance handovers remained the same from June – July at 3,994

- 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 33 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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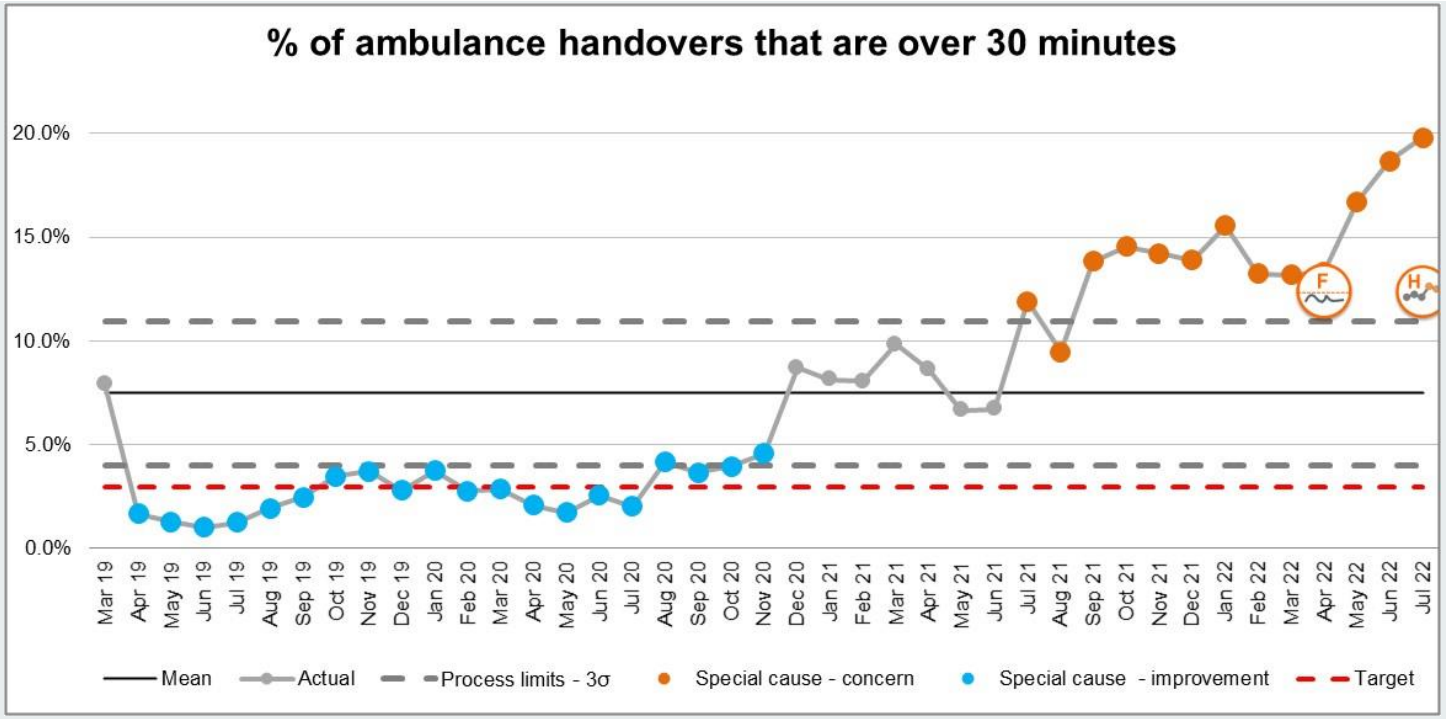

Commentary

Handover percentage between 30-60 minutes increased by 1.14% for an overall Trust wide performance of 19.80%

- 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 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.
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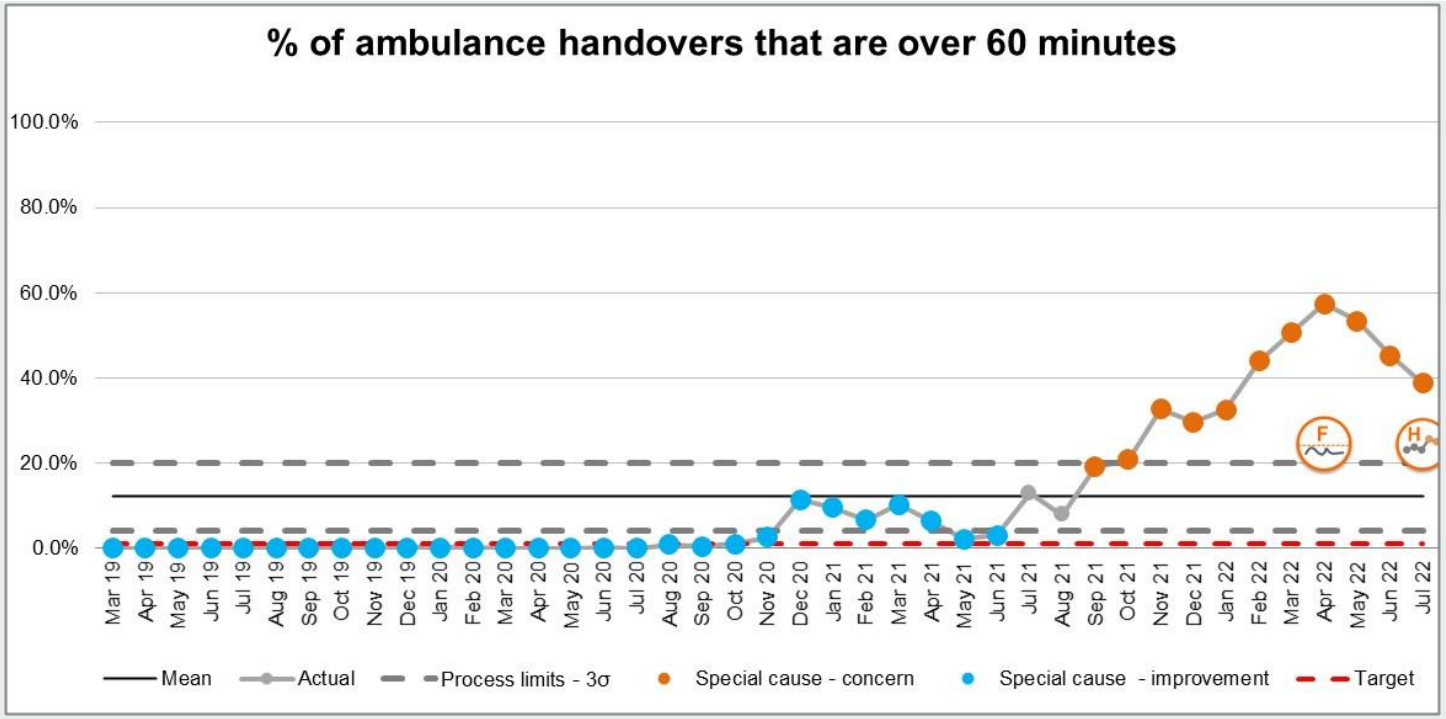

Commentary

>60 minute handover delays saw further decrease by 10.1% on top of June reduction of 14%

- 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 10 data points which are above the line. There are 23 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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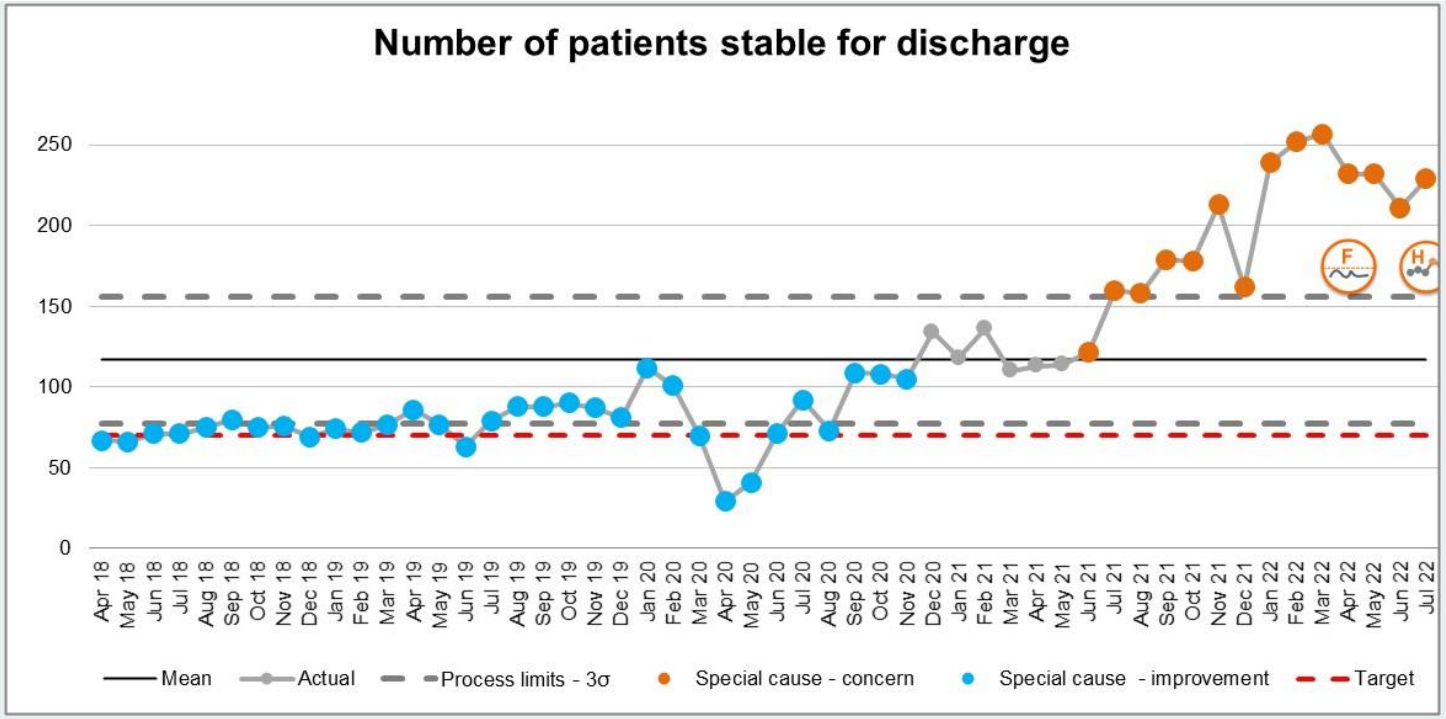

Commentary

The number of patients stable for discharges remains below the baseline taken in April, but has seen a rise back up to 230 in recent weeks. There is ongoing discussions with system partners alongside the Sloman work being undertaken as an ICS, along with ongoing work to resolve internal action delays and process issues.

- 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 13 data points which are above the line. There are 18 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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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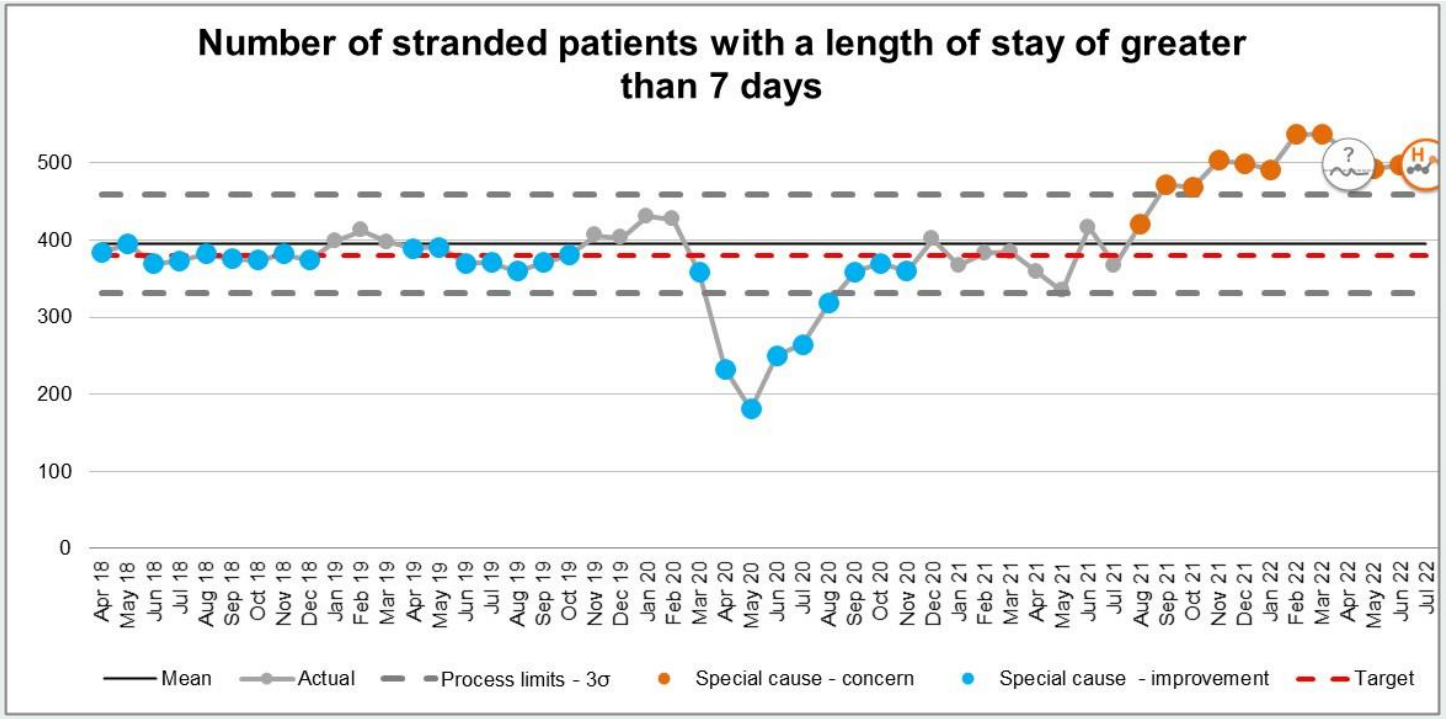

Commentary

Minimal gains have been made in month, with a reduction of just 7 patients, potentially in line with reducing covid-19 cases.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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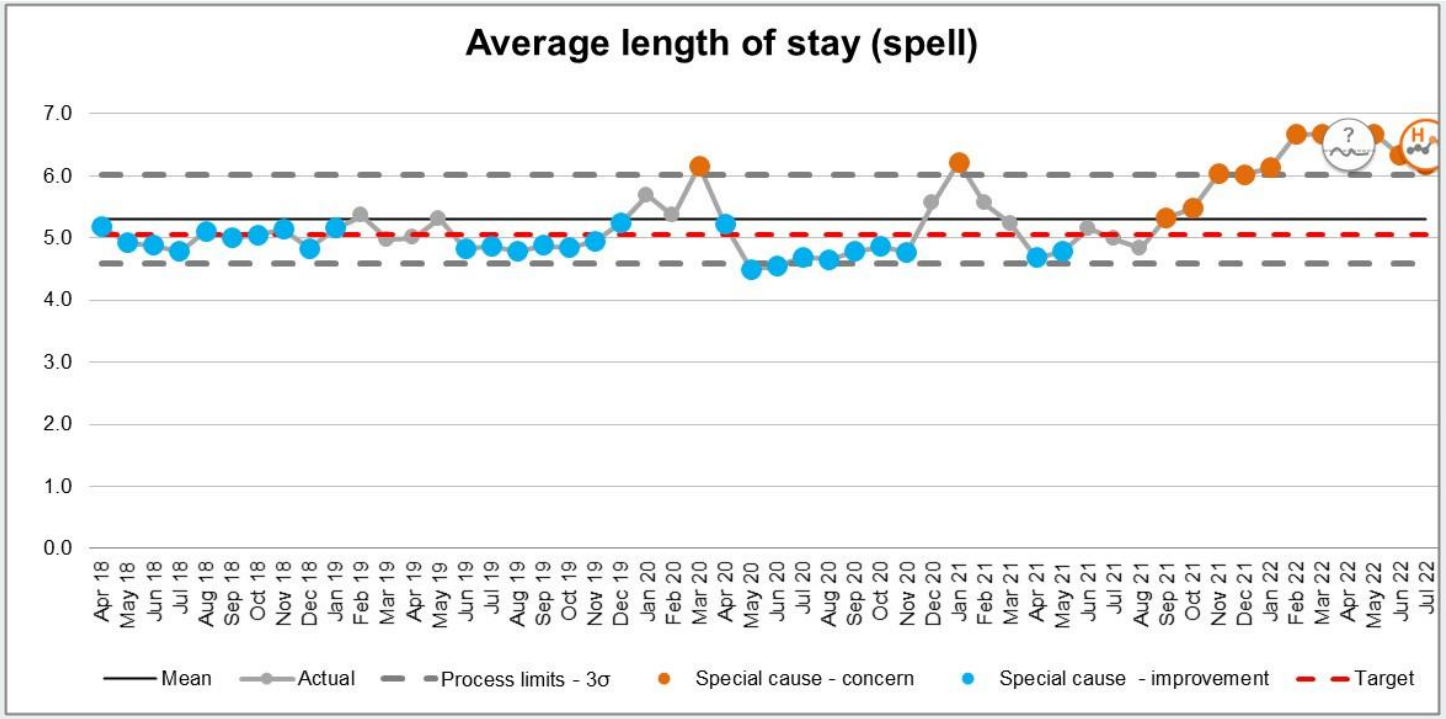

Commentary

ALOS continues to reduce with an improvement of 0.15days in month. Efforts continue to be focussed on creating capacity in light of ongoing operational challenges.

- Deputy Chief Operating Officer

Data Observations

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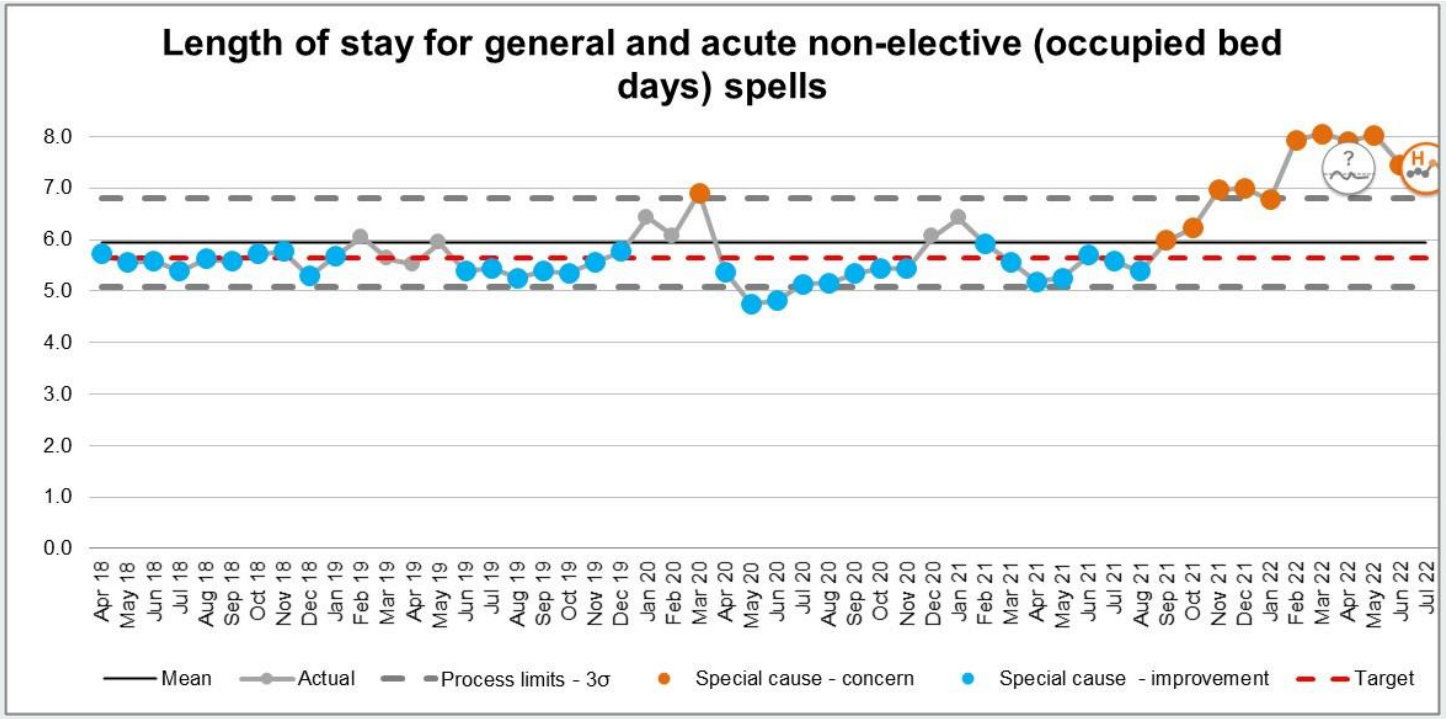

Commentary

Consecutive monthly improvements continue to be made, with an reduction of 0.3 bed days in month. There continue to be no remarkable factors affecting this indicator at this time.

- 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 9 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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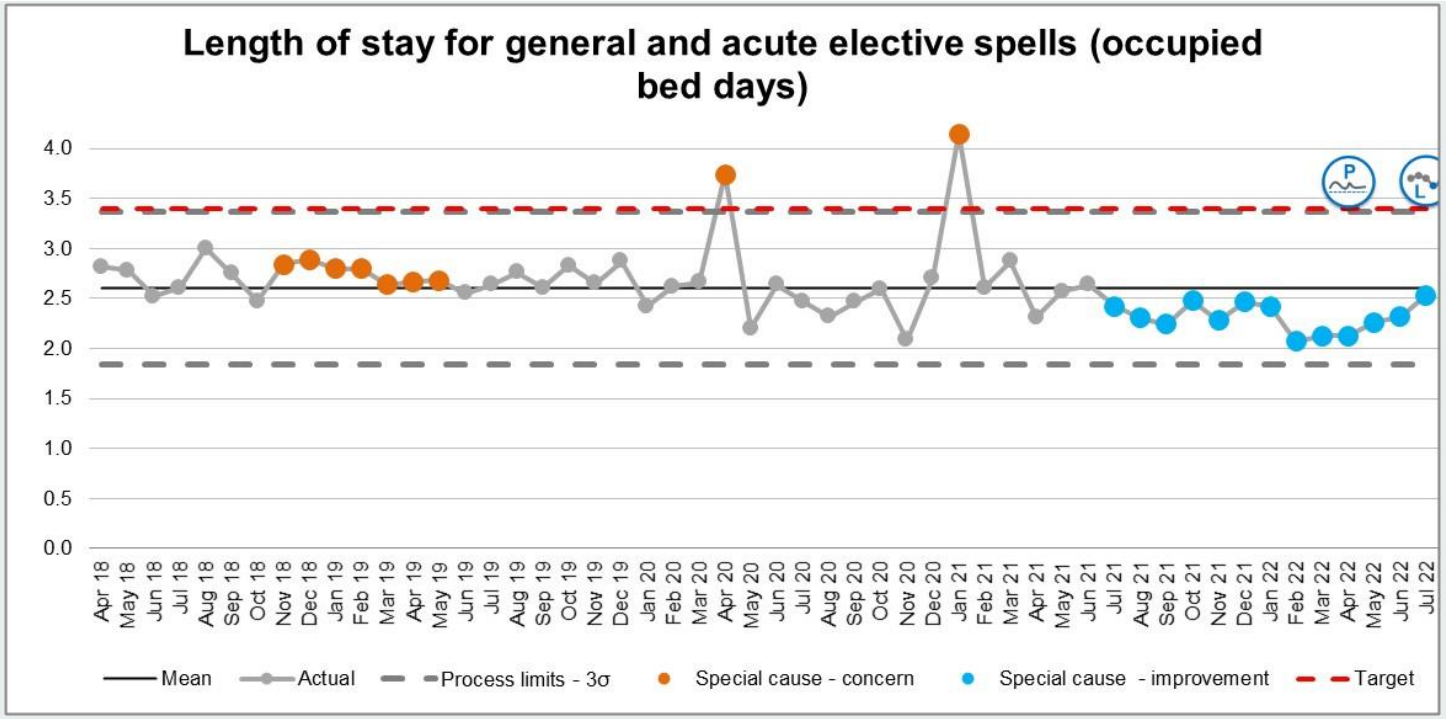

Commentary

Although the beds days has increased again this metric continues to remain stable and within target.

- 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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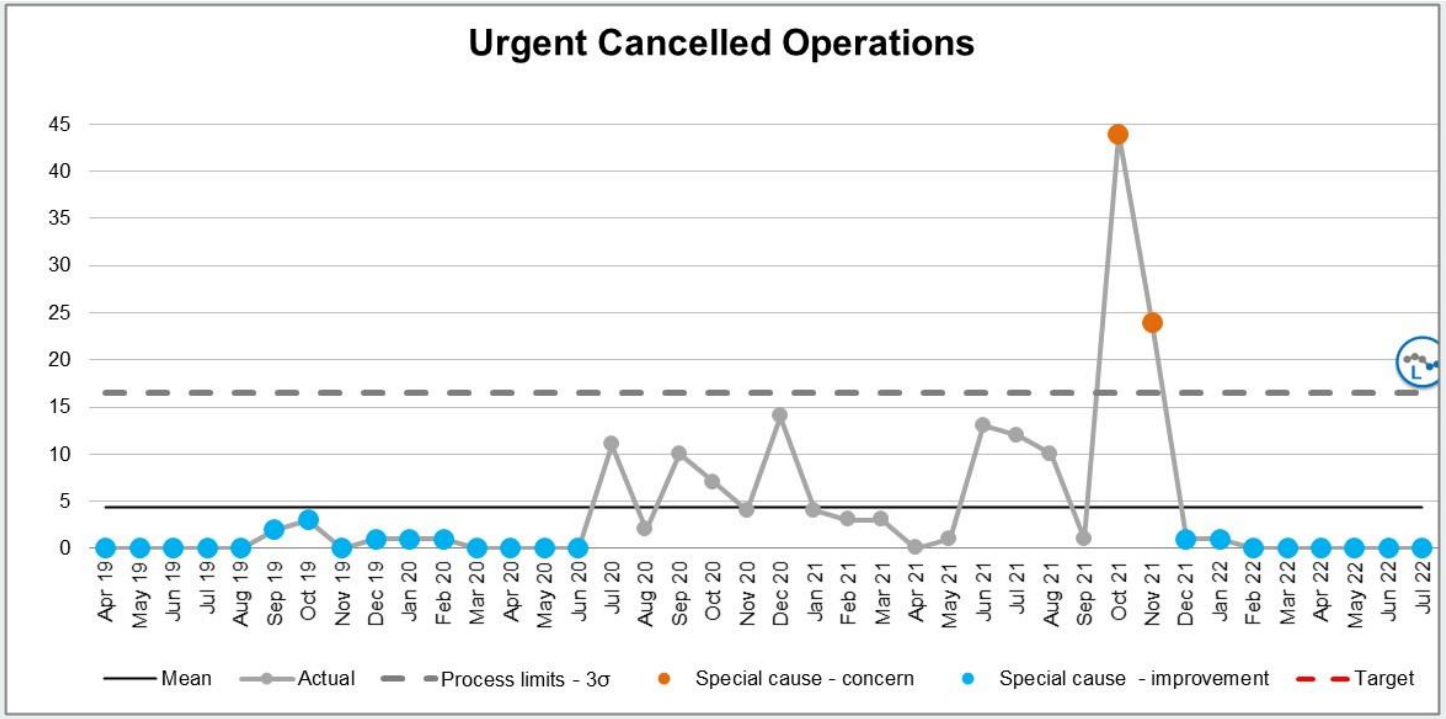

Commentary

Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In June there were 5 patients cancelled on the day that could not be rescheduled within 28 days, a reduction on the previous month. This included 1 Gynae, 1 Ophthalmology, 1 Urology and 2 T&O patients.

- Deputy Chief Operating Officer

Data Observations

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

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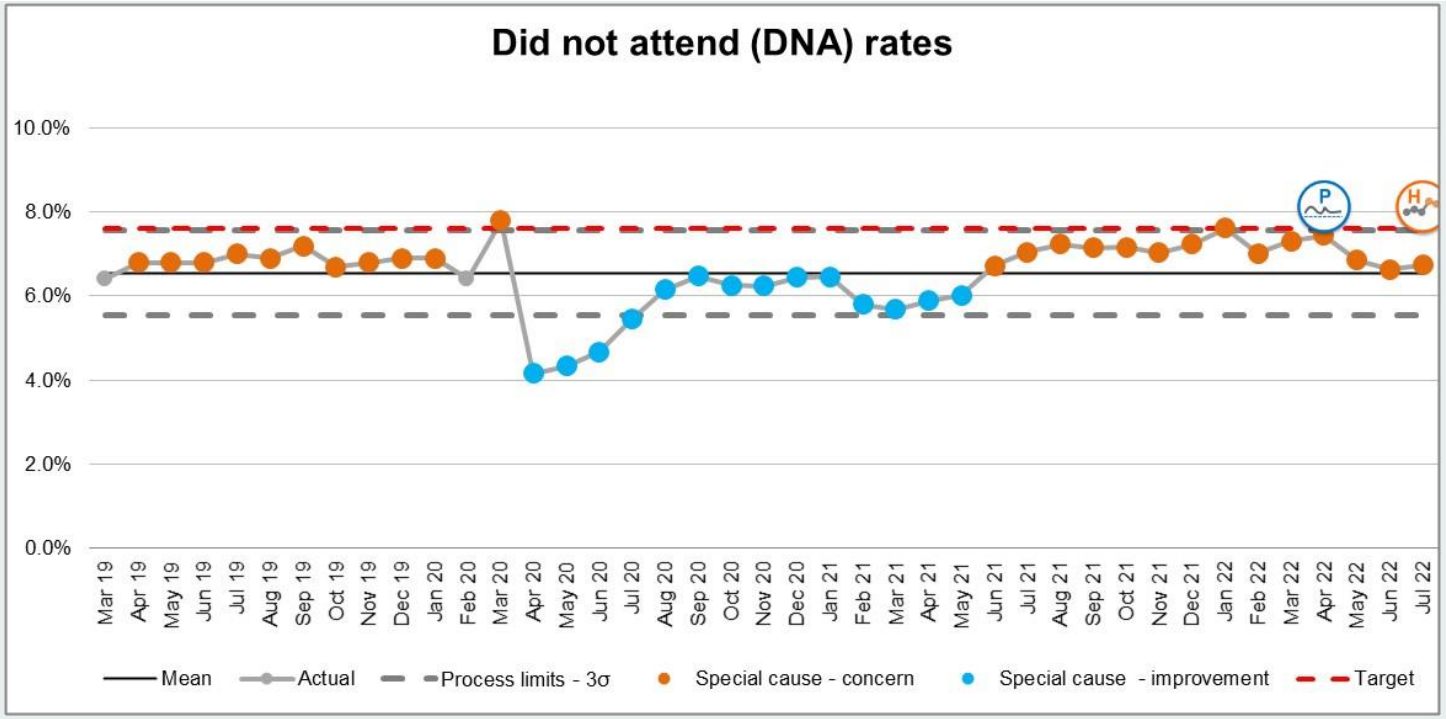


Commentary

The DNA rate continues to remain well within target although having increased very slightly (0.1%). Further work is continuing to increase the use of text reminders which is considered to positively impact on attendance (or cancellations).

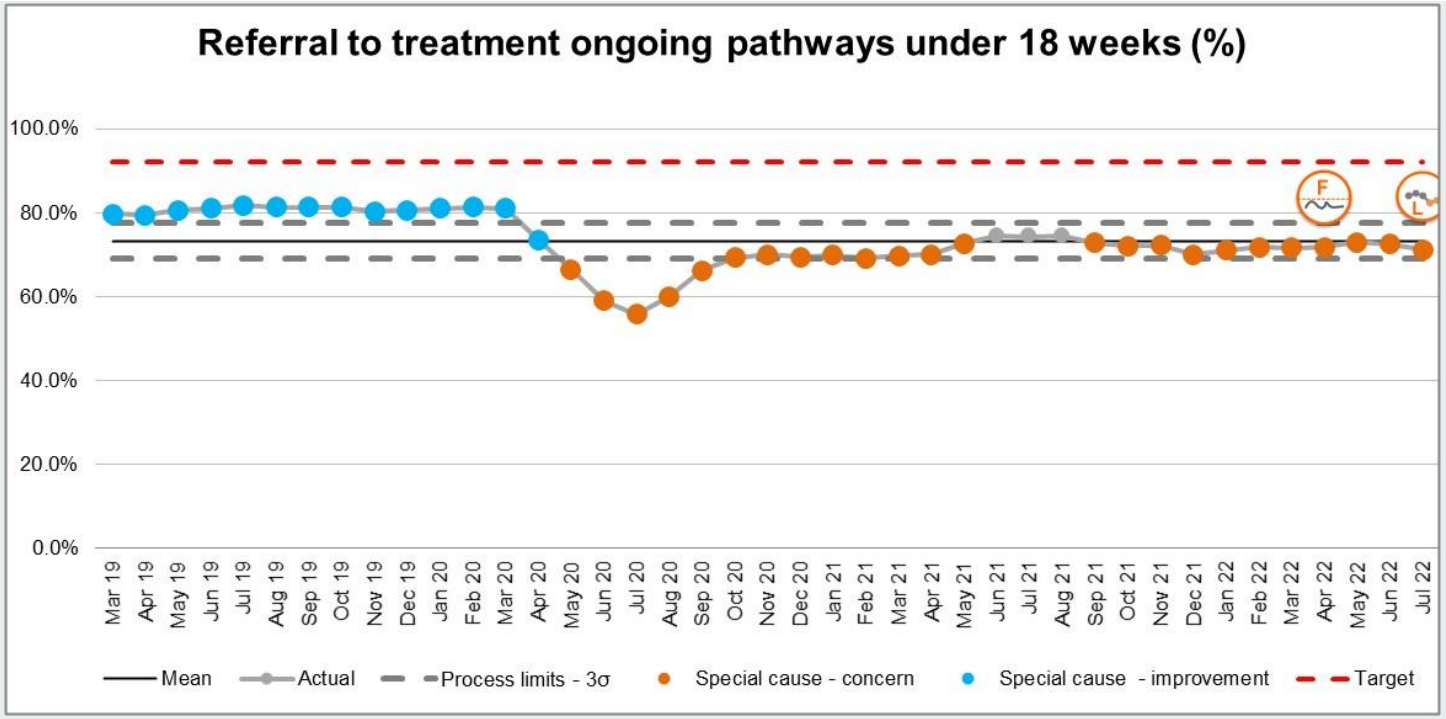
- Associate Director of Elective Care

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

See Planned Care Exception report for full details. RTT performance is currently reported as 71.3% and is not anticipated to change significantly prior to submission. Performance has therefore dipped by approximately 1%. GHT remains significantly above the national average of 61.9%.

- 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 13 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
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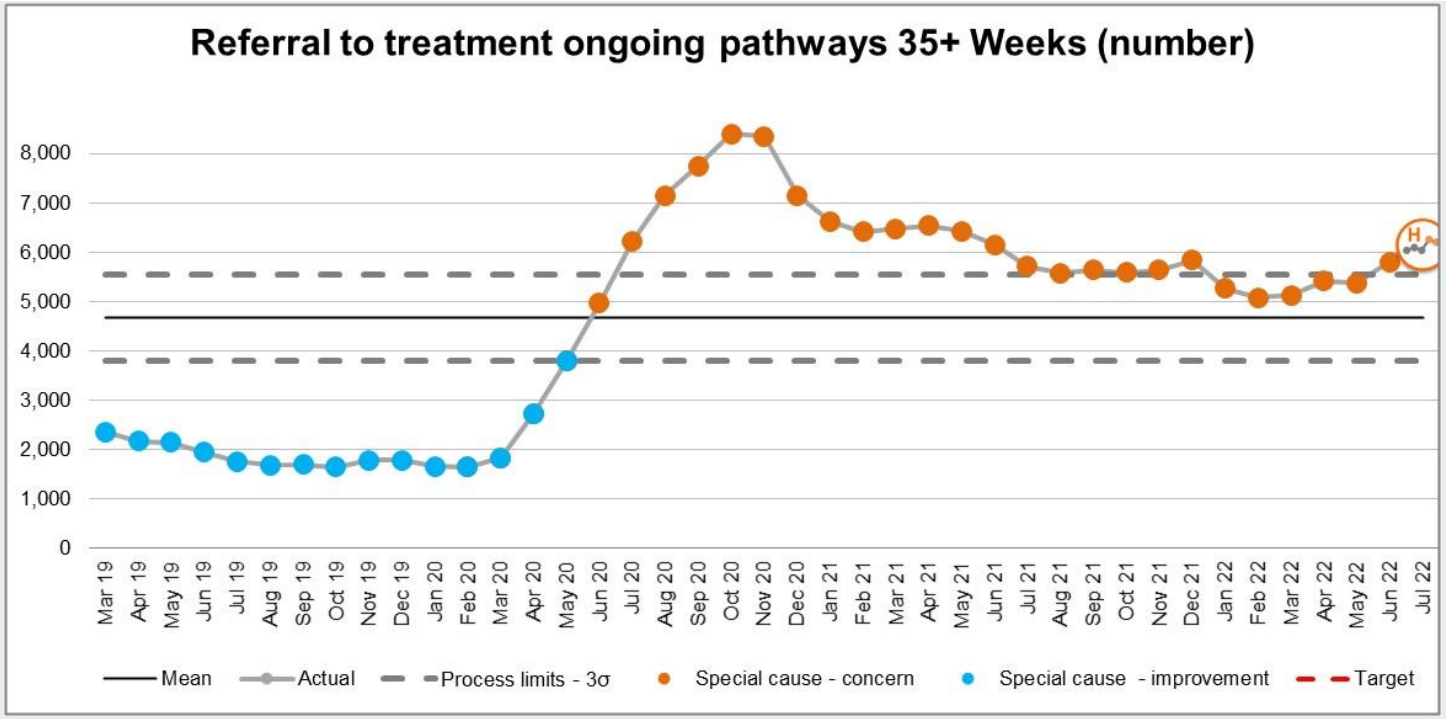
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The number of patients over 35 weeks has increased in month, by approximately 500 patients. This is now the highest level this financial 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 20 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 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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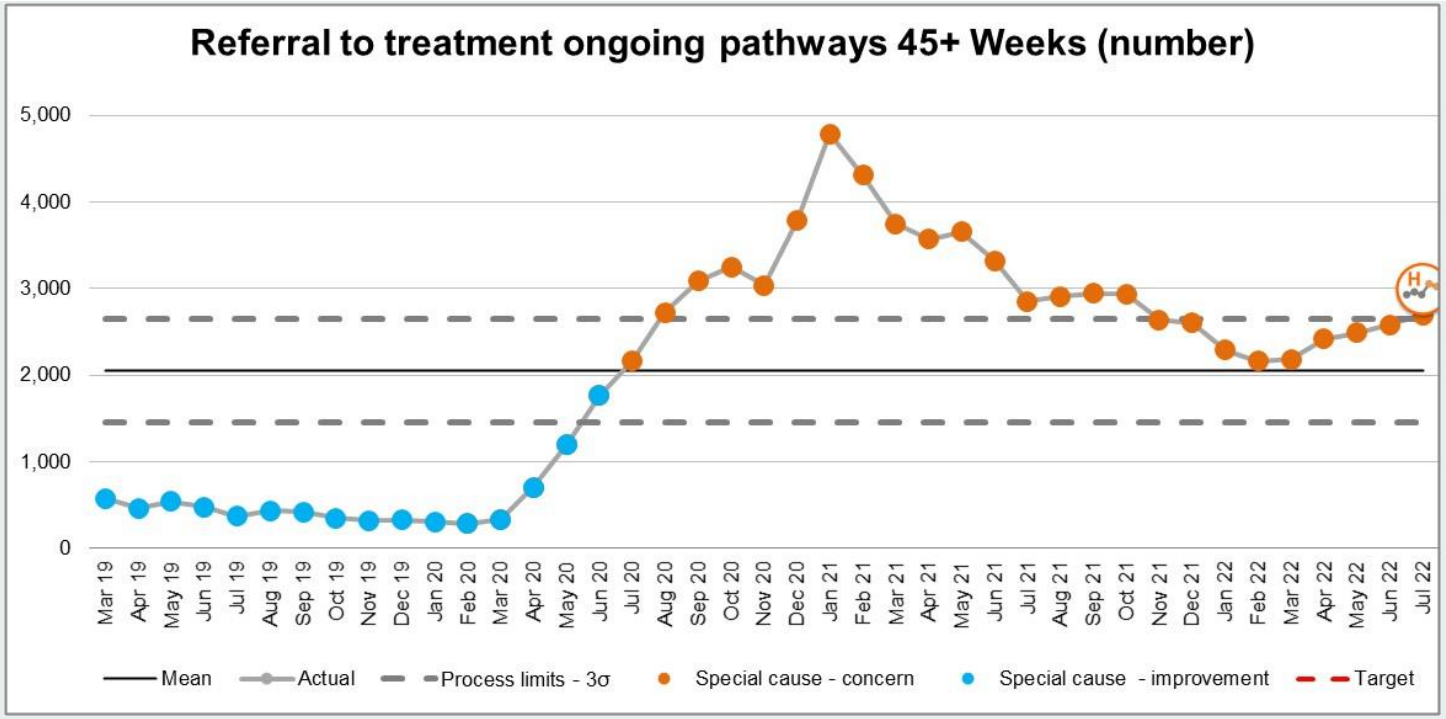

Commentary

This cohort has increased 113 over the past month. This is a gradual trend that has been observed since February 2022.

- 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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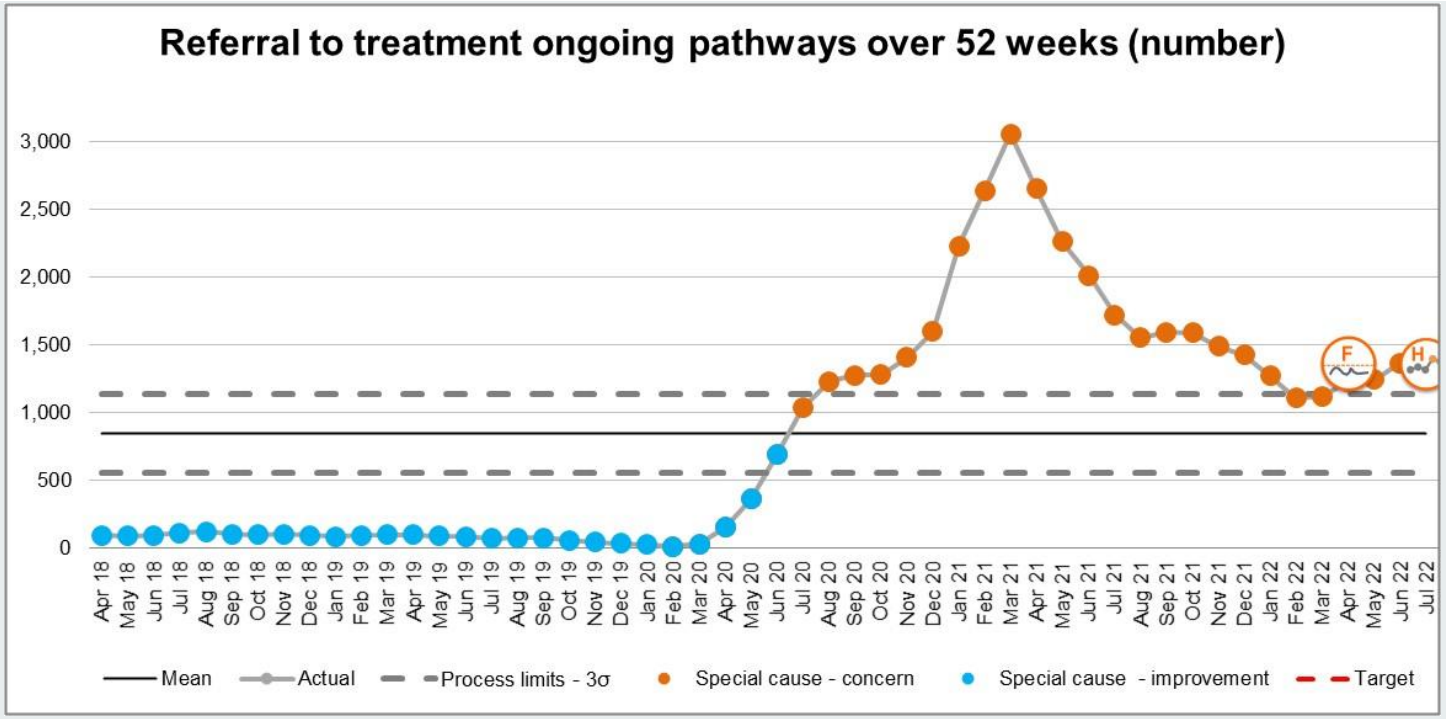
Gloucestershire Hospitals NHS Foundation Trust



Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 22 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

Commentary

See Planned Care Exception report for a full breakdown. Performance in July was forecast to be slightly higher than that of June. The increases predominantly being within Oral Surgery (which was anticipated, with a recovery plan in place), with smaller increases in ENT, Gastro, Cardiology, and GI services.

- Associate Director of Elective Care

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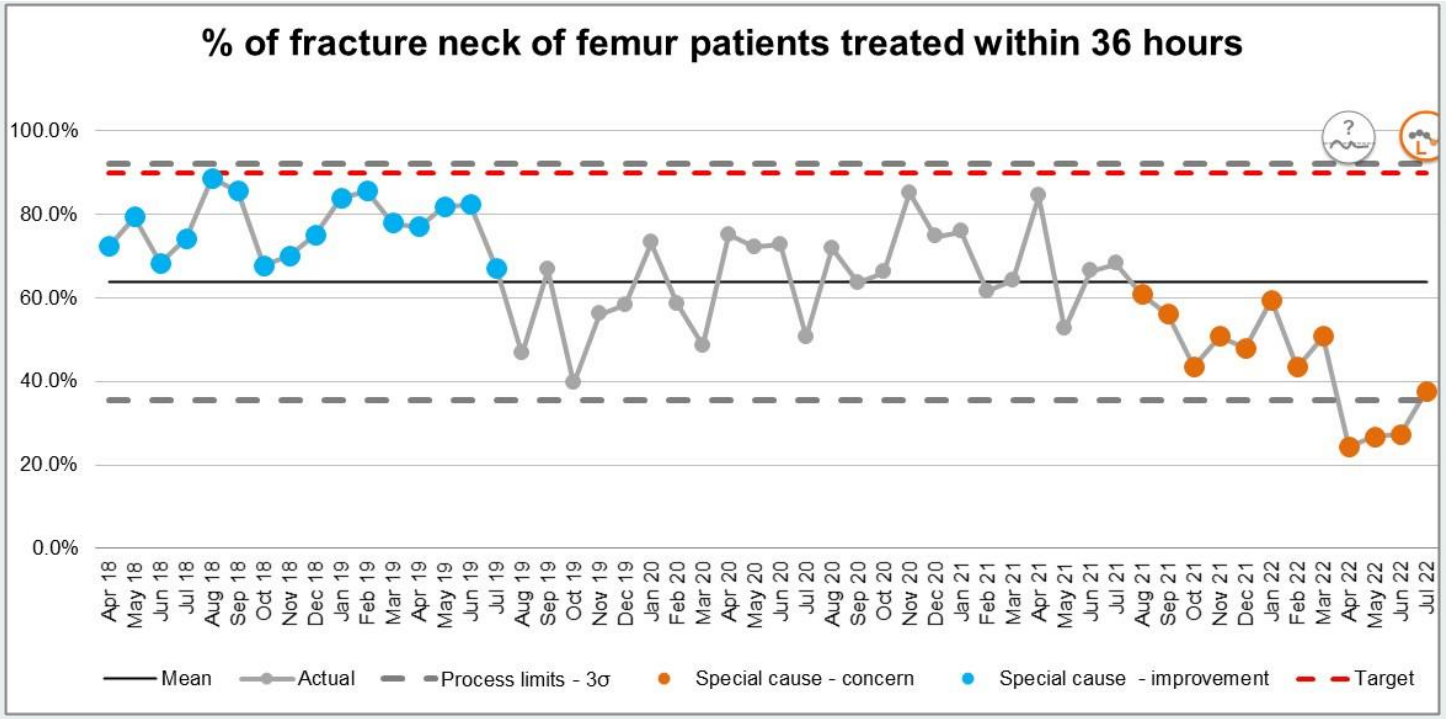

Data Observations

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

Commentary

The #NOF pathway is a key performance indicator within T&O and Orthogeriatric services, with performance monitored through specialty governance meetings and the Service Line Review report, and data and specific commentary on improvement/deteriorating in month is provided at Exec Review. #NOFs are now cohorted onto the 3rd floor as standard practice, and work is ongoing on a number of actions to support improving performance, including prioritising NOF on triage in ED, NOF admission proforma on EPR and looking to increase therapist funding and radiographer support.

- General Manager - Trauma & Orthopaedics

Access:
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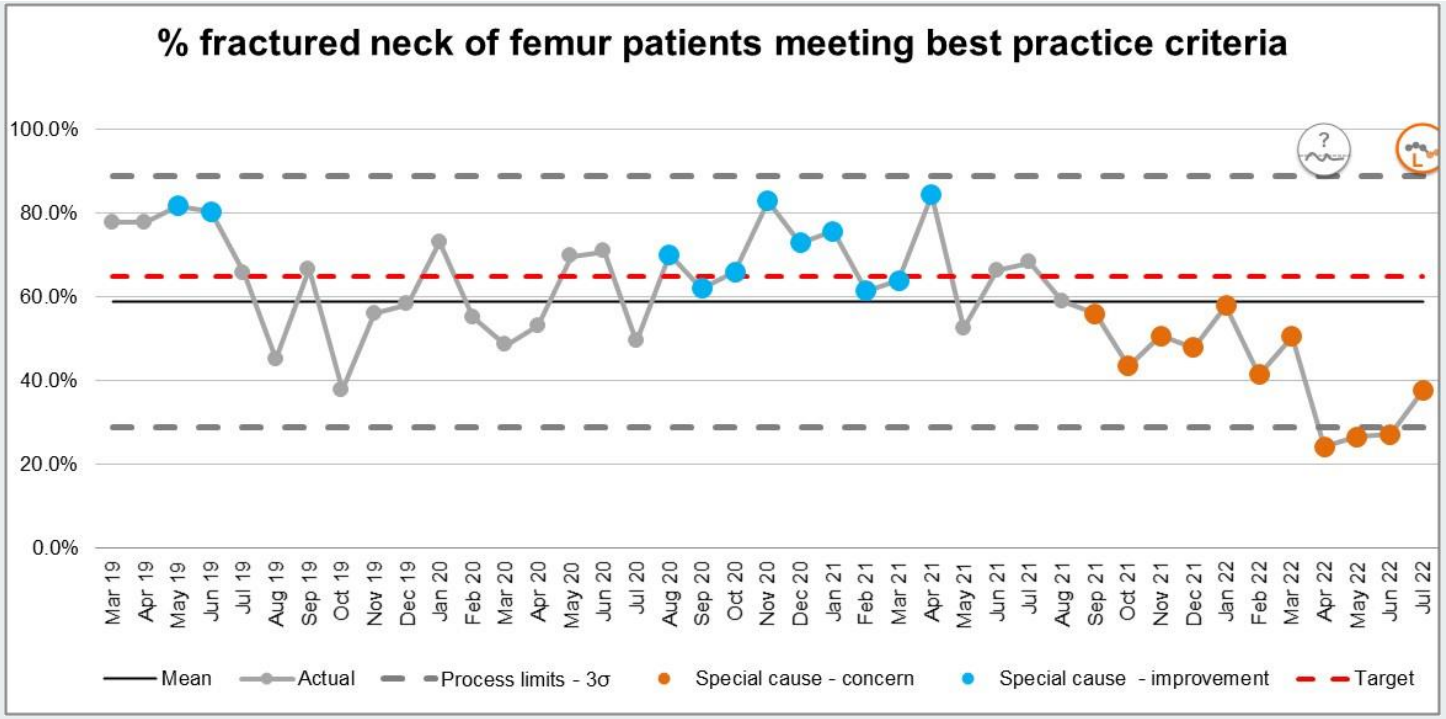

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- **General Manager - Trauma & Orthopaedics**

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 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

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	
Friends & Family Test	Inpatients % positive	>=90%	Jul-22	90.0%
Friends & Family Test	ED % positive	>=84%	Jul-22	68.1%
Friends & Family Test	Maternity % positive	>=97%	Jul-22	91.8%
Friends & Family Test	Outpatients % positive	>=94.5%	Jul-22	93.0%
Friends & Family Test	Total % positive	>=93%	Jul-22	88.5%
Friends & Family Test	Number of PALS concerns logged	No Target	Jul-22	285
Friends & Family Test	% of PALS concerns closed in 5 days	>=95%	Jul-22	70%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Jul-22	1
Infection Control	MRSA bacteraemia - infection rate per 100,000 bed days	Zero	Jul-22	3.5
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Jul-22	4
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jul-22	2
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jul-22	2
Infection Control	Clostridium difficile - infection rate per 100,000 bed days	<30.2	Jul-22	13.9
Infection Control	Number of MSSA bacteraemia cases	<=8	Jul-22	5
Infection Control	MSSA - infection rate per 100,000 bed days	<=12.7	Jul-22	17.4
Infection Control	Number of ecoli cases	No target	Jul-22	7
Infection Control	Number of pseudomona cases	No target	Jul-22	1
Infection Control	Number of klebsiella cases	No target	Jul-22	1
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Jul-22	52
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No target	Jul-22	120

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	Jul-22	91
Infection Control	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	No target	Jul-22	55
Infection Control	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	No target	Jul-22	91
Maternity	% C-section rate (planned and emergency)	No target	Jul-22	0
Maternity	% emergency C-section rate	No target	Jul-22	19.4%
Maternity	% of women smoking at delivery	<=14.5%	Jul-22	0
Maternity	% of women that have an induced labour	<=33%	Jul-22	31.2%
Maternity	% stillbirths as percentage of all pregnancies	<0.52%	Jul-22	0.22%
Maternity	% of women on a Continuity of Carer pathway	No target	Jul-22	8.70%
Maternity	% breastfeeding (initiation)	>=81%	Jul-22	78.6%
Maternity	% PPH >1.5 litres	<=4%	Jul-22	4.5%
Maternity	Number of births less than 27 weeks	NULL	Jul-22	0
Maternity	Number of births less than 34 weeks	NULL	Jul-22	4
Maternity	Number of births less than 37 weeks	NULL	Jul-22	38
Maternity	Number of maternal deaths	NULL	Jul-22	0
Maternity	Total births	NULL	Jul-22	471
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Jul-22	2.10%
Maternity	% breastfeeding (discharge to CMW)	NULL	Jul-22	59.9%
Mortality	Summary hospital mortality indicator (SHMI) - national data	NHS Digital	Mar-22	1.1
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Apr-22	107.9
Mortality	Hospital standardised mortality ratio (HSMR) - weekend	Dr Foster	Apr-22	115.9

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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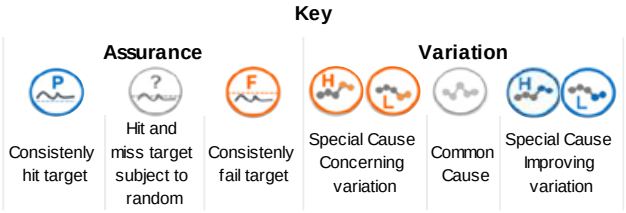
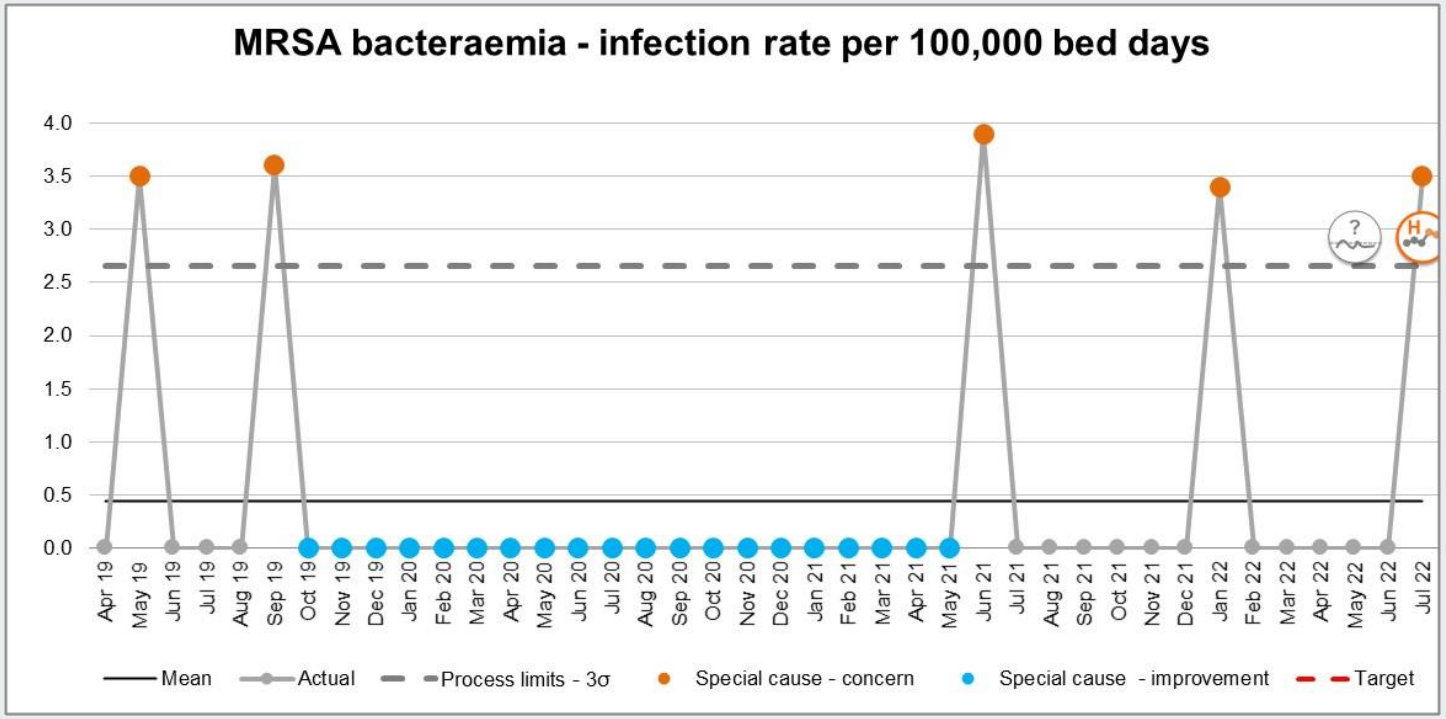


MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Mortality	Number of inpatient deaths	No target	Jul-22	170
Mortality	Number of deaths of patients with a learning disability	No target	Jul-22	1
MSA	Number of breaches of mixed sex accommodation	<=10	Jul-22	17
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Dec-21	1
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Jul-22	7.5
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Jul-22	5
Patient Safety Incidents	Number of patient safety incidents - severe harm (major/death)	No target	Jul-22	14
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Jul-22	24
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Jul-22	1
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Jul-22	0
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Jul-22	10
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Jul-22	2
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	Jul-22	10
Safety Thermometer	Safety thermometer - % of new harms	>96%	Mar-20	97.8%
Serious Incidents	Number of never events reported	Zero	Jul-22	0
Serious Incidents	Number of serious incidents reported	No target	Jul-22	6

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Serious Incidents	Serious incidents - 72 hour report completed within contract timescale	>90%	Jul-22	100.0%
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Jul-22	100%
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Jul-22	79.9%
Safeguarding	Level 2 safeguarding adult training - e-learning package	TBC	Nov-19	95%
Safeguarding	Number of DoLs applied for	TBC	Jul-22	55
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	TBC	Jul-22	3
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	TBC	Jul-22	1
Safeguarding	Total admissions aged 0-17 with DSH	TBC	Jul-22	29
Safeguarding	Total ED attendances aged 0-17 with DSH	TBC	Jul-22	86
Safeguarding	Total admissions aged 0-17 with an eating disorder	TBC	Jul-22	12
Safeguarding	Total number of maternity social concerns forms completed	TBC	Jul-22	78

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

In July the trust had one MRSA bacteraemia case; this case represents a hospital onset and healthcare associated case. The source of the bacteraemia has yet to be identified; however the patient's history of MRSA colonisation is likely to be the contributing cause. A post infection review meeting was held on 10/8/2022 with the ward team and IPCT to review the finding of the investigation and actions have been agreed to address the issues identified related to PVC documentation and care, MRSA screening and decolonisation and the findings of the investigation will be shared with the wider ward team. It is noted that the patient had been moved/ transferred several times between different wards so the findings of this investigation will be shared with the other areas who were involved in providing care to this patient. The findings will also be shared with Risk who are currently undertaking a review of the harms associated with increased patient transfers as evidence of the impact of frequent ward moves. Risk will be undertaking duty of candour actions. The patient remains an inpatient but had extended length of stay as a result of the MRSA bacteraemia.

- 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 5 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points below the mean.
Rule 4	When more than 15 consecutive points lie within the mean +/- 1σ this process is considered to be out of control.

Quality:
SPC – Special Cause Variation

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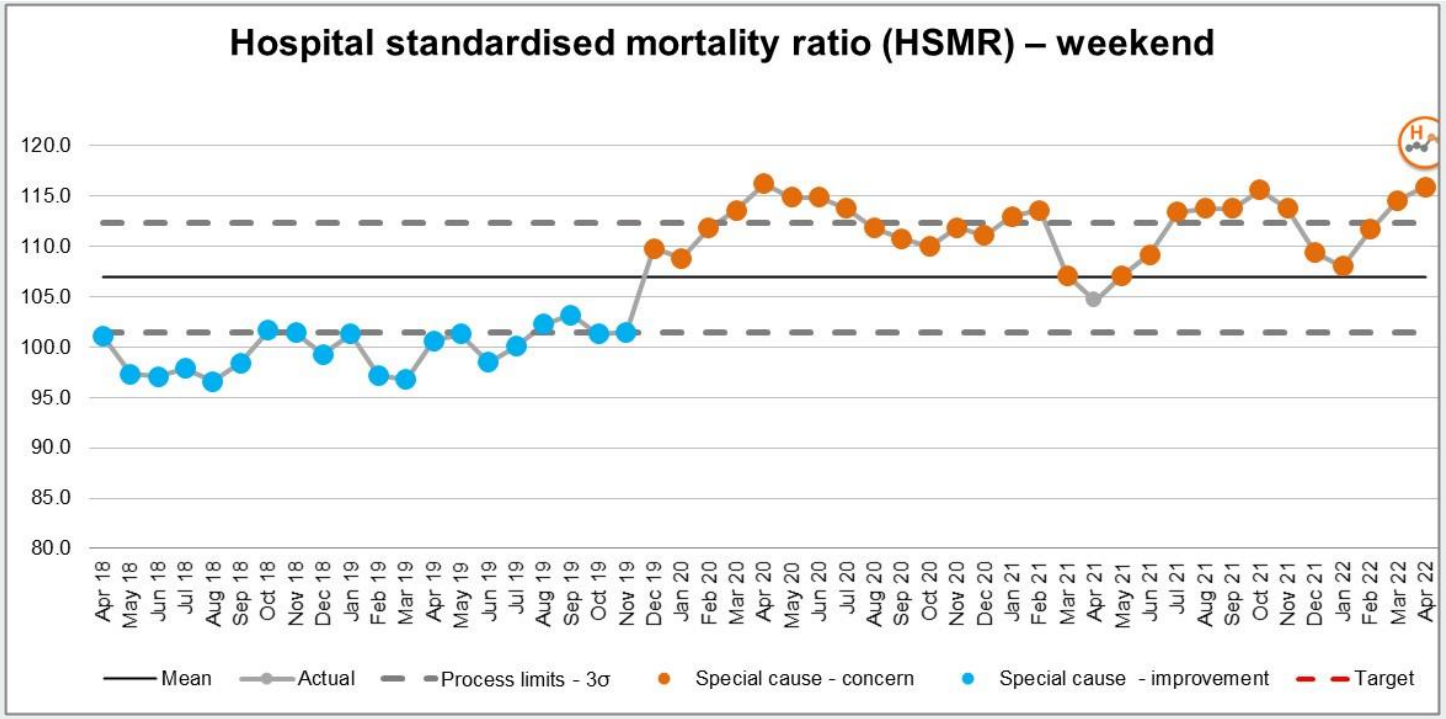
NHS Foundation Trust



Commentary

The HSMR and the weekend HSMR have deteriorated progressively over the last 3 months. There is an affect due to reduced comorbidity scoring and this being actively addressed. However this is not ablet o explain what we are seeing the exact cause is not clear but may well be related to ongoing issues with congestion being felt throughout the trust. This is being monitored in 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 14 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.
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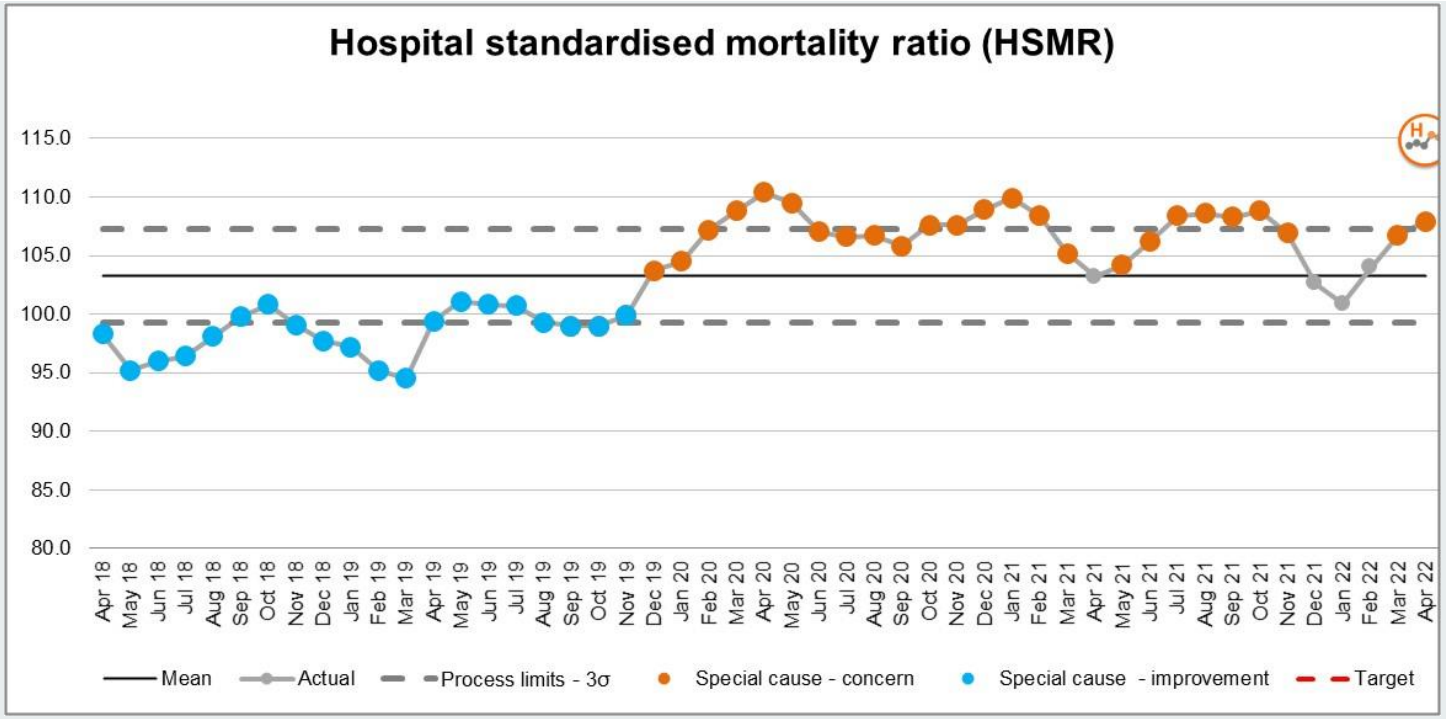

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- Deputy Medical Director

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 13 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.
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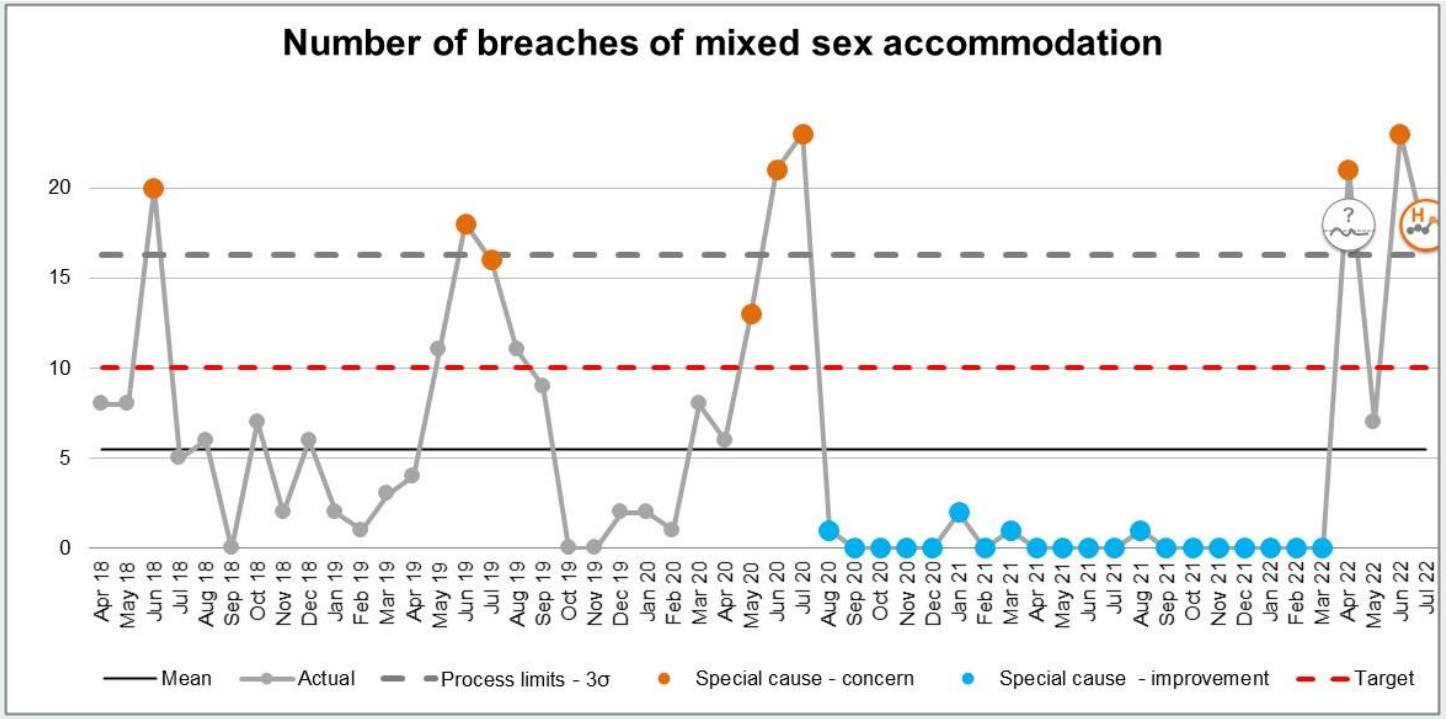

Commentary

The Trust is now reporting mixed-sex accommodation breaches in line with national policy following a period of local agreement with the CCG that resulted in recording the MSA breaches but not reporting them due to operational pressure. All breaches, categorised in accordance with national guidelines, must be authorised by the Chief Nurse or Deputy Chief Nurse. Each month the reasons are reviewed overall, delay in transfers from critical care and recovery areas beyond 4-hours result in an MSA breach. Accurate numbers are now reported to the ICB.

- 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 7 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 sigificant change in process. This process is not in control. There is a run of points below the mean.
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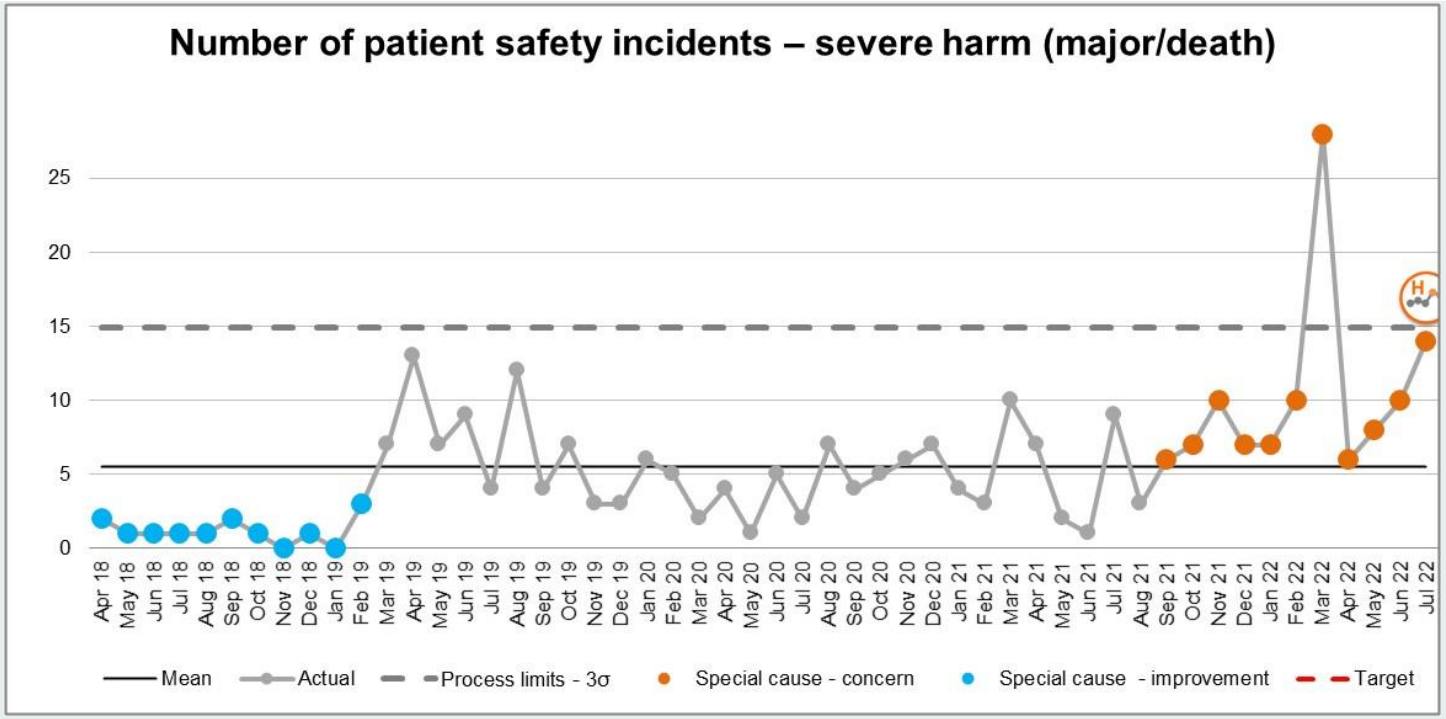
NHS Foundation Trust



Commentary

Under Review

- 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.

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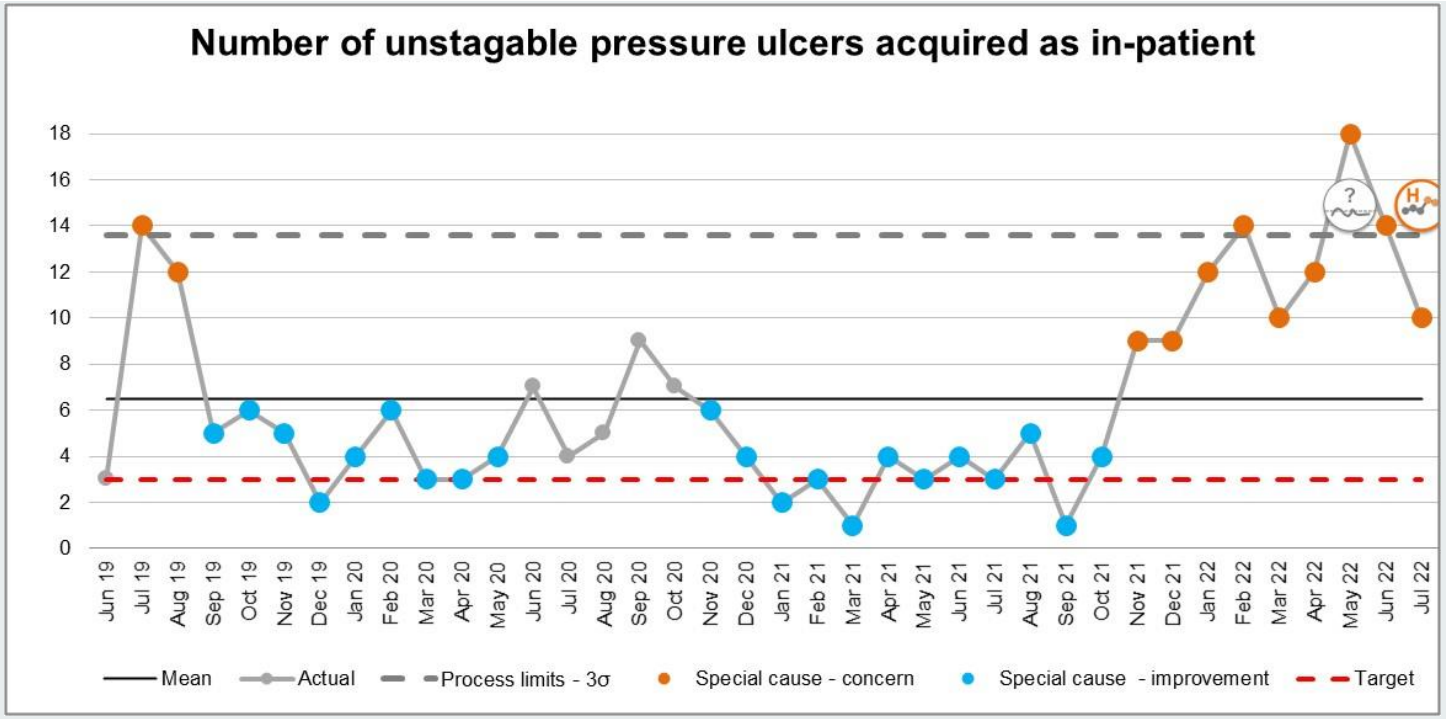

Commentary

Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. The Tissue Viability Team have worked with SWAST to provide pressure relieving equipment and training on its use to paramedics. 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 taking place monthly to increase throughput.

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

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

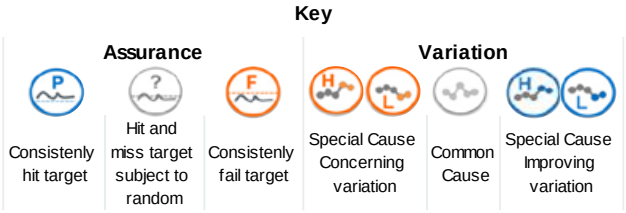
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	
Finance	NHSI Financial Risk Rating		Sep-20	
Finance	Capital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

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

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

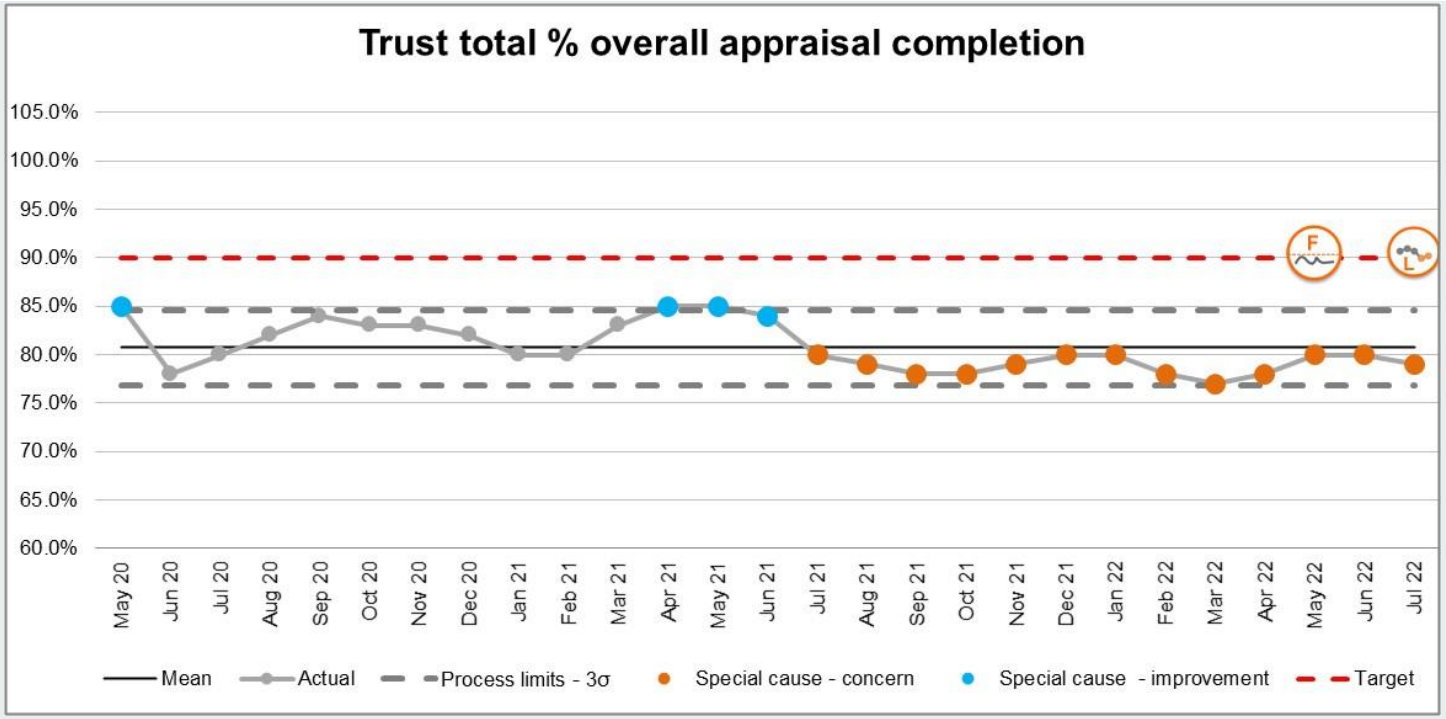
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	Jul-22	79%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	?	Jul-22	86%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	P	May-22	90.9%	
Safe Nurse Staffing	% registered nurse day	>=90%	?	May-22	89.3%	
Safe Nurse Staffing	% unregistered care staff day	>=90%	?	May-22	88.0%	
Safe Nurse Staffing	% registered nurse night	>=90%	?	May-22	93.8%	
Safe Nurse Staffing	% unregistered care staff night	>=90%	P	May-22	101.2%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		May-22	5.2	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	P	May-22	3.2	
Safe Nurse Staffing	Care hours per patient day total	>=8		May-22	8.3	
Vacancy and WTE	Staff in post FTE	No target		Jul-22	6688.5	
Vacancy and WTE	Vacancy FTE	No target		Jul-22	906.67	
Vacancy and WTE	Starters FTE	No target		Jul-22	94.35	
Vacancy and WTE	Leavers FTE	No target		Jul-22	75.62	
Vacancy and WTE	% total vacancy rate	<=11.5%		Jul-22	10.66%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Jul-22	7.98%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Jul-22	14.54%	
Workforce Expenditure	% turnover	<=12.6%	P	Jul-22	14.5%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%	P	Jul-22	13.8%	
Workforce Expenditure	% sickness rate	<=4.05%	P	Jul-22	4.2%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The Trust appraisal rate continues to fall below the trust target of 90% and has fallen from 80% to 79%. Medicine (86%), Surgery (80%) and D&S (79%) Divisions have the highest compliance rates. The lowest Divisional Appraisal rates are Corporate (73%) and Women & Children (69%). Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process. Communication is happening with L&OD as to how best support staff to receive a yearly appraisal and for managers to have the ability to undertake them.

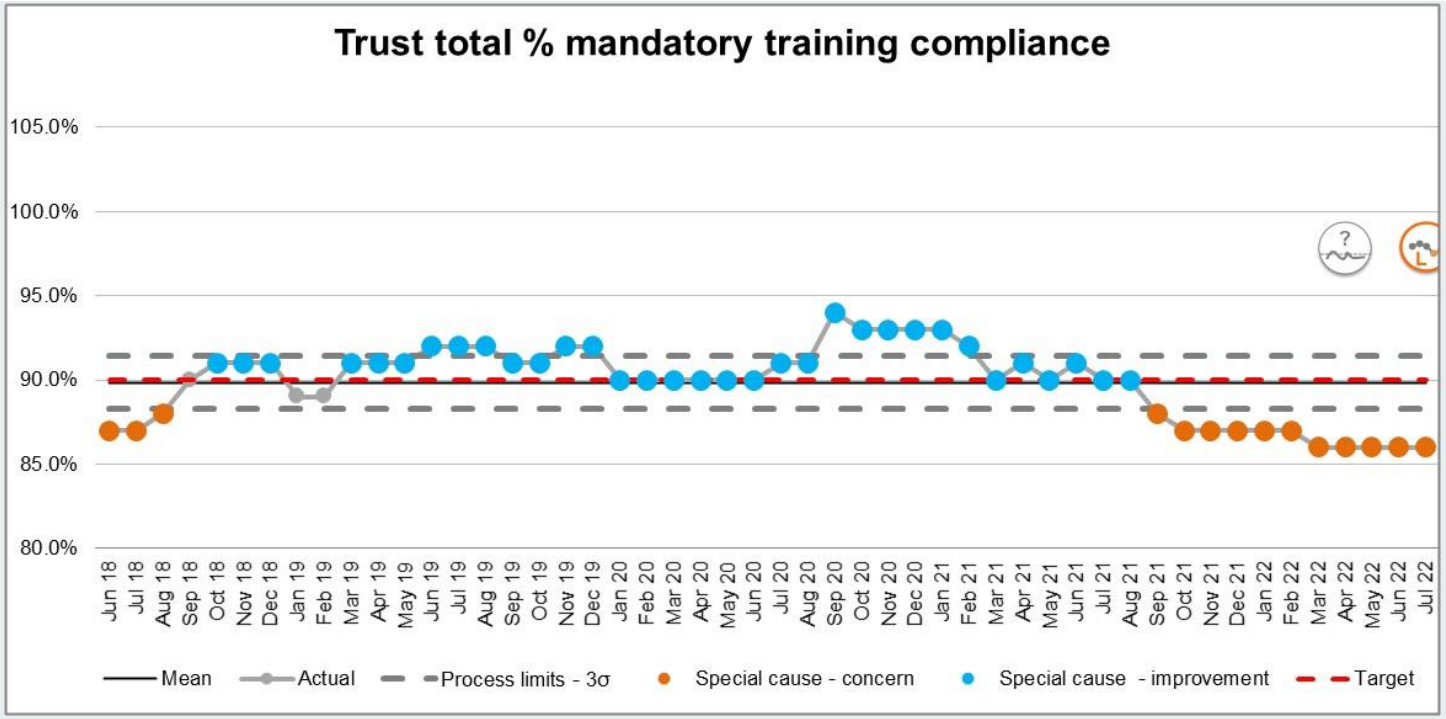
- **Director of Human Resources and Operational Development**

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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Mandatory training compliance remains below the 90% target and has remained at 86% for the last couple of months. Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process. Specific work is being undertaken to identify how best to work with staff groups who fall well below the target for example staffing groups who as a whole do not use computers as part of their role and therefore do not login regularly. Communication is commencing with Stat/Man subject leads as to how to support them to increase uptake of training.

- **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 11 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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:
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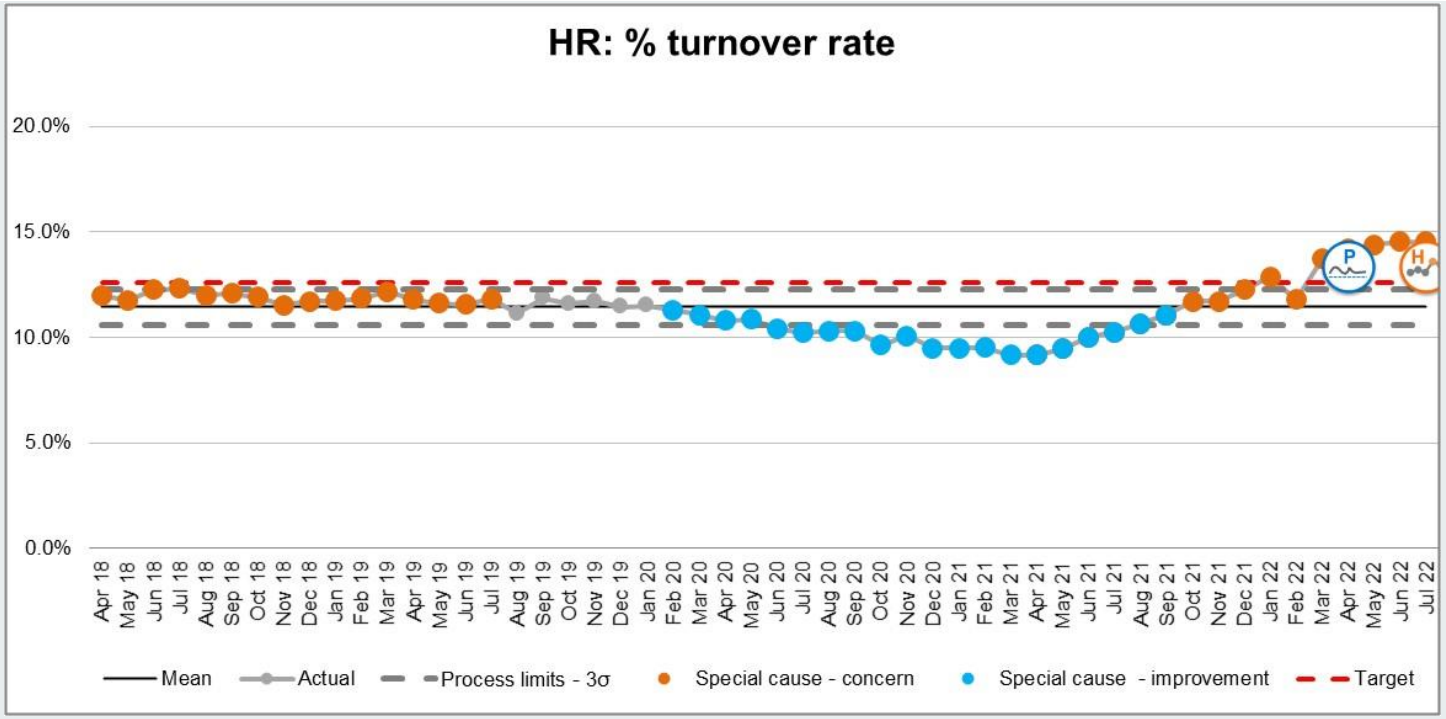
Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Turnover continues to be of key focus across all staff groups. Understanding reasons for staff leaving remains a priority in order to support the development of informed retention initiatives. A retention sub group is being established within the structures of the Workforce Sustainability Programme.

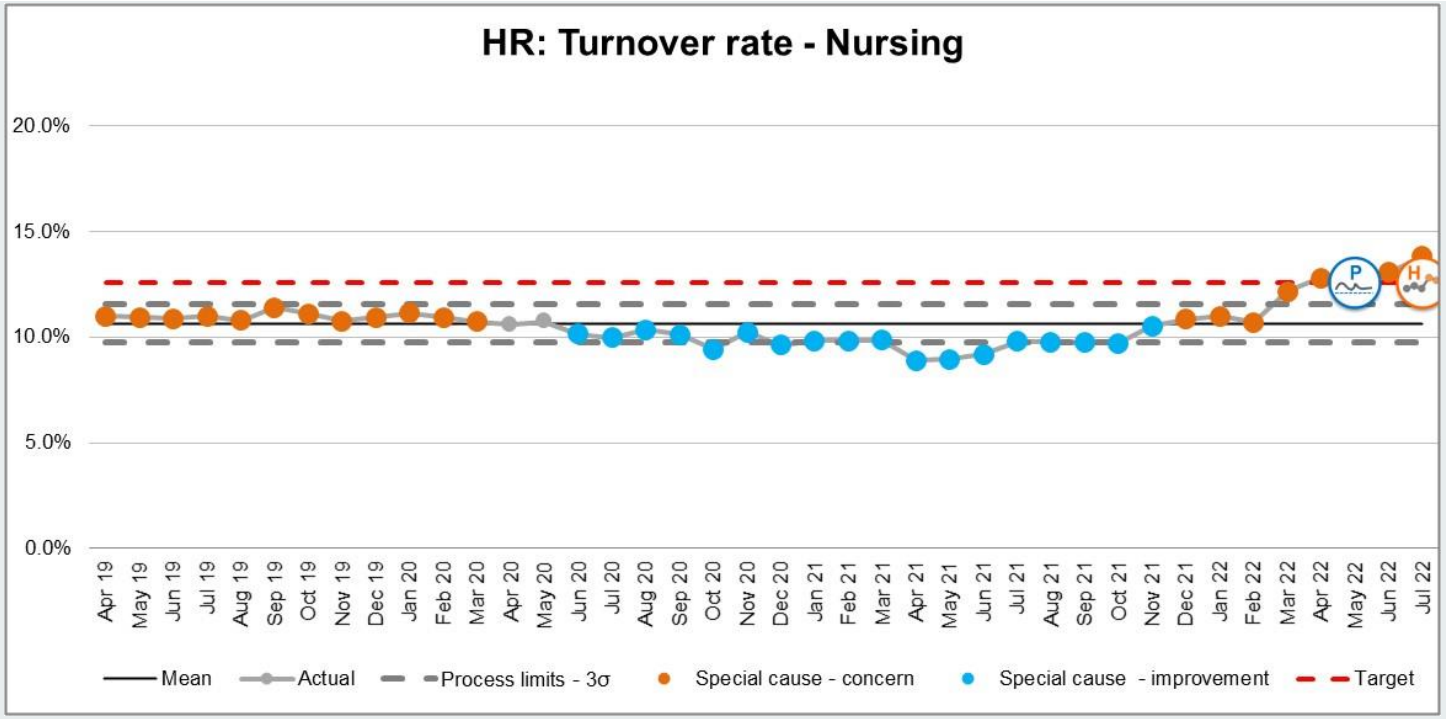
- **Director for People and OD**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Pastoral care and preceptorship for both newly appointed overseas and newly qualified nurses are key in ensuring the Trust invests sufficiently in a structured, quality transition in order to guide and support all new nurses.

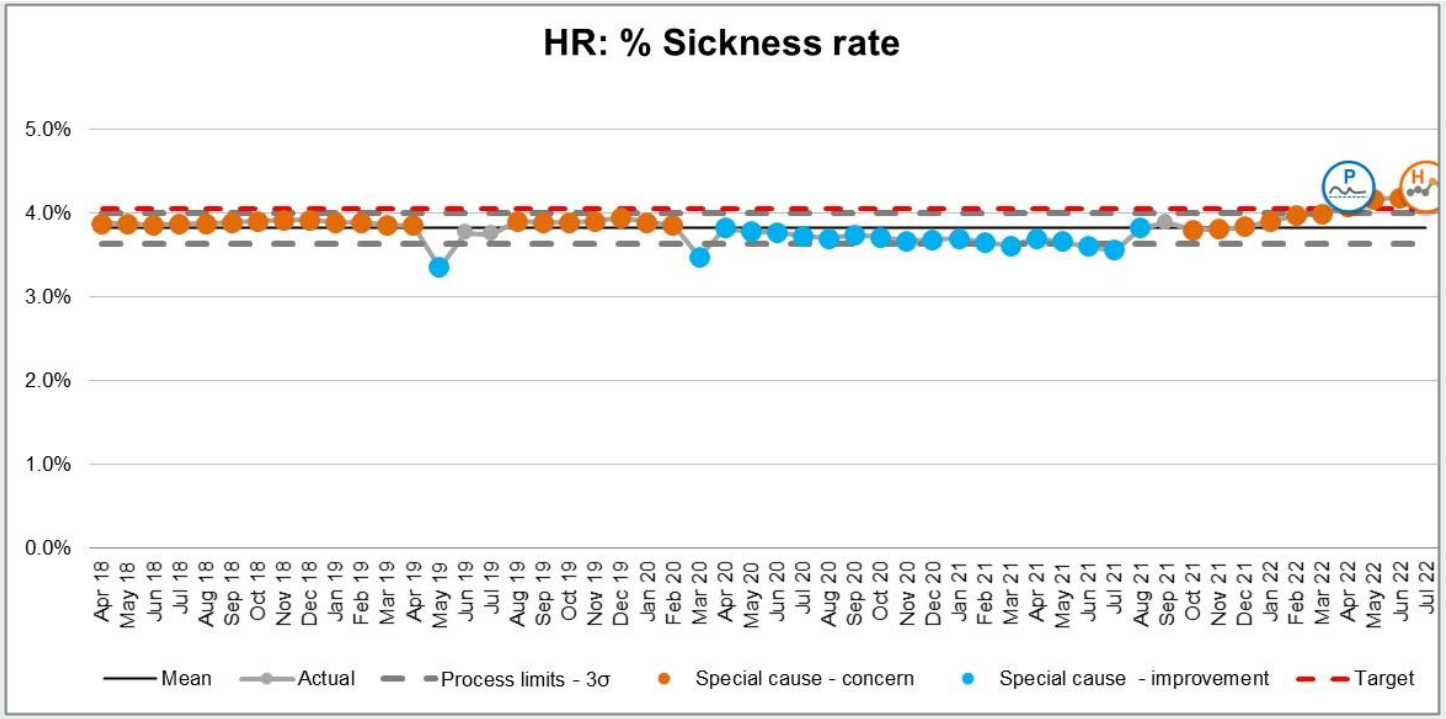
- **Director for People and OD**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Focus in the last month has been given to supporting those staff suffering with Long Covid given the changes with the national policy on sick pay relating to Covid-19. A short term post within the P&OD function is being recruited to, supported by NHSE/I funding with the aim of achieving improved sickness absence levels and developing enhanced support for managers. The Trust's Occupational Health provider Working Well has been supporting NHSE/I with the regional scoping exercise for the new Growing Occupational Health and Wellbeing Together Strategy presenting an opportunity to identify key areas for development across the staff health and wellbeing agenda.

- **Director for People and OD**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a 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

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	11	Enclosure Number:	6
Date	8 September 2022		
Title	Organ Donation Report		
Author /Sponsoring Director/Presenter	Dr Mark Haslam, Consultant in Anaesthesia and Intensive Care Medicine		

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 update the Board in respect of organ and tissue donation activities.

Key issues to note

- The NHSBT report documents ongoing success of Trust processes for identification of potential organ donors, timely referral and provision of support for clinical teams and families by specialist nurses.
- In 2021/2022 the Trust facilitated 9 solid organ donors resulting in 19 patients receiving a life-saving or transforming transplant.
- Of 61 patients who met organ donation referral criteria, 60 were referred (98%). UK referral rate 92%.
- Thirteen families were approached to discuss organ donation, 11 were supported in person by a specialist nurse (85%, UK 93%)
- Consent rate from families approached was 69% (UK 66%).
- In 2021/2022 the Trust made 747 referrals for consideration of tissue donation and facilitated 64 tissue donors.

Implications and Future Action Required

- Targeting 100% referral and in person specialist nurse involvement
- Training/education for junior doctors.
- Continued expansion of tissue donation services.

Recommendation

The Board is asked to receive this report as a source of assurance regarding the quality of organ and tissue donation activities in the Trust.

Enclosures

- Organ Donation Report (full and summary)

Actual and Potential Deceased Organ Donation 1 April 2021 - 31 March 2022

NHS Blood and Transplant

Gloucestershire Hospitals NHS Foundation Trust

Taking Organ Transplantation to 2020

In 2021/22, from 9 consented donors the Trust facilitated 9 actual solid organ donors resulting in 19 patients receiving a life-saving or life-changing transplant. Data obtained from the UK Transplant Registry.

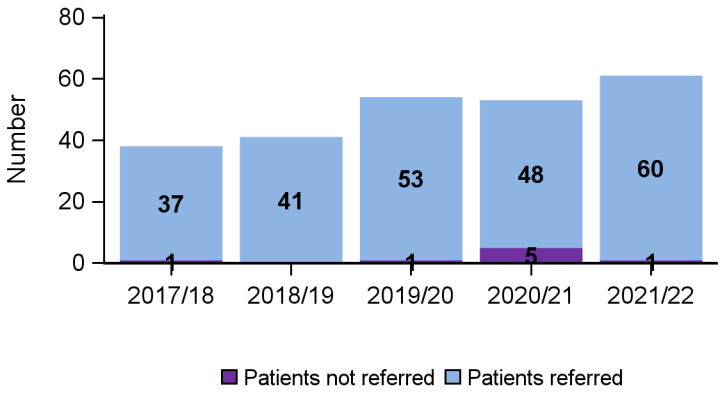
Best quality of care in organ donation

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

Referral of potential deceased organ donors

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

Aim: There should be no purple on the chart

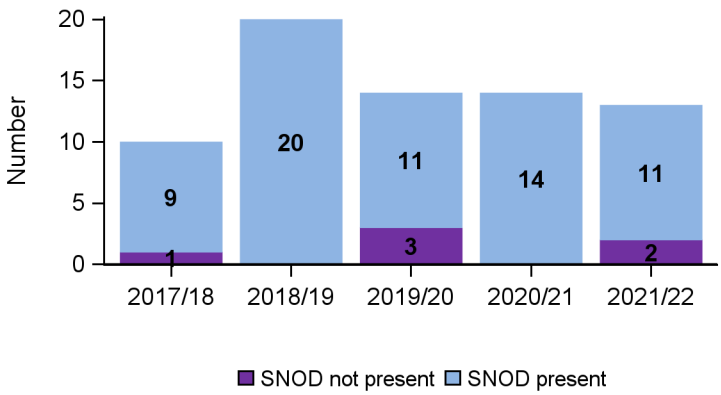


The Trust referred 60 potential organ donors during 2021/22. There was 1 occasion where a potential organ donor was not referred.

Presence of Specialist Nurse for Organ Donation

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

Aim: There should be no purple on the chart



A SNOD was present for 11 organ donation discussions with families during 2021/22. There were 2 occasions where a SNOD was not present.

Why it matters

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

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

	South West*	UK
1 April 2021 - 31 March 2022		
Deceased donors	126	1,397
Transplants from deceased donors	241	3,410
Deaths on the transplant list	20	422
As at 31 March 2022		
Active transplant list	446	6,269
Number of NHS ODR opt-in registrations (% registered)**	2,828,878 (52%)	27,751,289 (43%)

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

Further information

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

Key numbers comparison with UK data, 1 April 2021 - 31 March 2022

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	10	1919	51	5198	61	6767
Referred to Organ Donation Service	10	1894	50	4700	60	6258
Referral rate %		*99%*		*90%*		*92%*
Neurological death tested	8	1530				
Testing rate %		*80%*				
Eligible donors[2]	7	1373	32	2972	39	4345
Family approached	6	1239	7	1445	13	2684
Family approached and SNOD present	6	1188	5	1306	11	2494
% of approaches where SNOD present		*96%*		*90%*		*93%*
Consent ascertained	5	861	4	902	9	1763
Consent rate %		*69%*		*62%*		*66%*
- Expressed opt in	3	522	2	550	5	1072
- Expressed opt in %		*95%*		*90%*		*92%*
- Deemed Consent	2	260	2	267	4	527
- Deemed Consent %		*63%*		*56%*		*59%*
- Other*	0	78	0	83	0	161
- Other %*		*66%*		*47%*		*55%*
Actual donors (PDA data)	5	787	4	602	9	1389
% of consented donors that became actual donors		*91%*		*67%*		*79%*

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

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

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

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

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

NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2021 - 31 March 2022

Gloucestershire Hospitals NHS Foundation Trust

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3.5 Consent
3.6 Solid organ donation

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5. Emergency Department data
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5.2 Organ donation discussions

6. Additional Data
6.1 Supplementary Regional data
6.2 Trust/Board Level Benchmarking

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A.2 Data description
A.3 Table and figure description

Further Information

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

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2022 based on data meeting PDA criteria reported at 9 May 2022.

1. Donor Outcomes

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

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2021 and 31 March 2022, Gloucestershire Hospitals NHS Foundation Trust had 9 deceased solid organ donors, resulting in 19 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2020/21. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

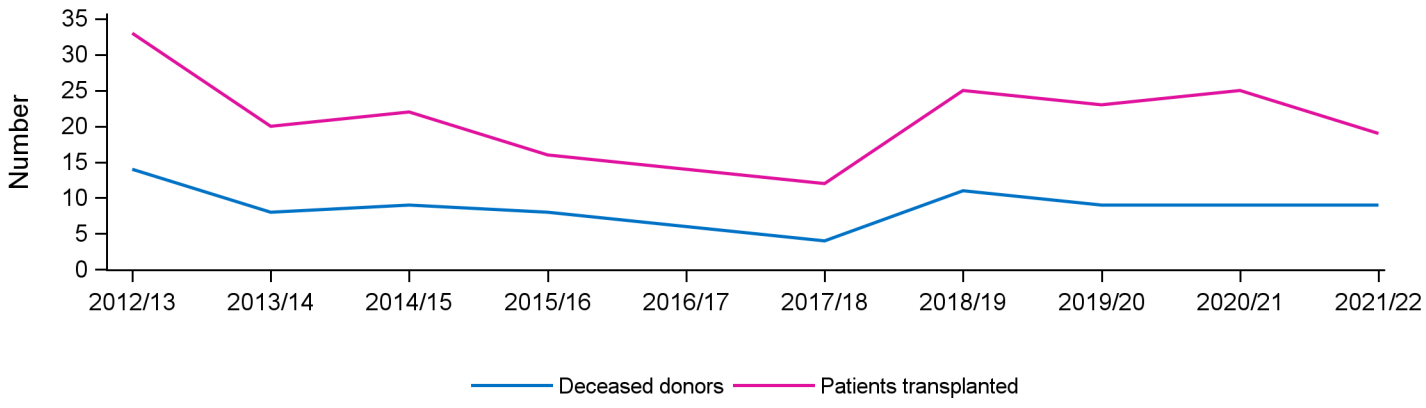
Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2021 - 31 March 2022 (1 April 2020 - 31 March 2021 for comparison)

Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Trust		Average number of organs donated per donor: UK	
DBD	5	(7)	13	(22)	3.0	(3.7)	3.5	(3.3)
DCD	4	(2)	6	(3)	2.0	(3.0)	2.8	(2.6)
DBD and DCD	9	(9)	19	(25)	2.6	(3.6)	3.2	(3.0)

Table 1.2 Organs transplanted by type, 1 April 2021 - 31 March 2022 (1 April 2020 - 31 March 2021 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	9	(12)	0	(2)	3	(6)	0	(2)	2	(2)	0	(0)
DCD	6	(3)	0	(0)	0	(0)	0	(0)	0	(0)	0	(0)
DBD and DCD	15	(15)	0	(2)	3	(6)	0	(2)	2	(2)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2012 - 31 March 2022



2. Key Numbers in Potential for Organ Donation

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

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

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

It is acknowledged that the PDA does not capture all activity. There may be some patients referred in 2021/22 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA.

Table 2.1 Key numbers comparison with national rates, 1 April 2021 - 31 March 2022

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	10	1919	51	5198	61	6767
Referred to Organ Donation Service	10	1894	50	4700	60	6258
Referral rate %		*99%*		*90%*		*92%*
Neurological death tested	8	1530				
Testing rate %		*80%*				
Eligible donors[2]	7	1373	32	2972	39	4345
Family approached	6	1239	7	1445	13	2684
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% of approaches where SNOD present		*96%*		*90%*		*93%*
Consent ascertained	5	861	4	902	9	1763
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- Other %*		*66%*		*47%*		*55%*
Actual donors (PDA data)	5	787	4	602	9	1389
% of consented donors that became actual donors		*91%*		*67%*		*79%*

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

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

* Includes patients where nation specific deemed criteria are not met and the patient has not expressed a donation decision in accordance with relevant legislation

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

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

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

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

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2017 - 31 March 2022

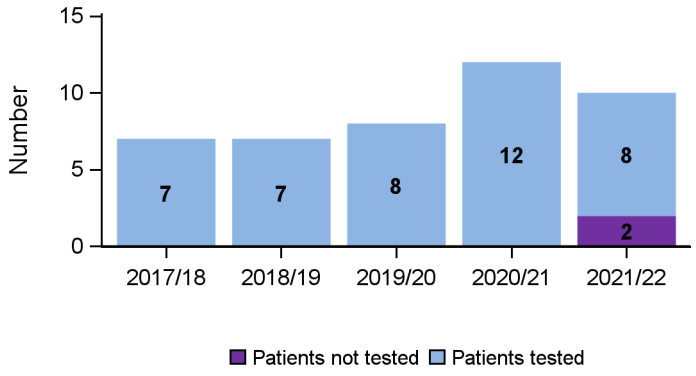


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2021 - 31 March 2022

	Trust	UK
Biochemical/endocrine abnormality	-	21
Clinical reason/Clinician's decision	-	48
Continuing effects of sedatives	-	10
Family declined donation	1	20
Family pressure not to test	-	27
Hypothermia	-	2
Inability to test all reflexes	-	17
Medical contraindication to donation	-	7
Other	1	37
Patient had previously expressed a wish not to donate	-	1
Patient haemodynamically unstable	-	162
Pressure of ICU beds	-	8
SN-OD advised that donor not suitable	-	10
Treatment withdrawn	-	14
Unknown	-	5
Total	**2**	**389**

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

3.2 Referral to Organ Donation Service

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

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

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

Figure 3.2 Number of patients meeting referral criteria, 1 April 2017 - 31 March 2022

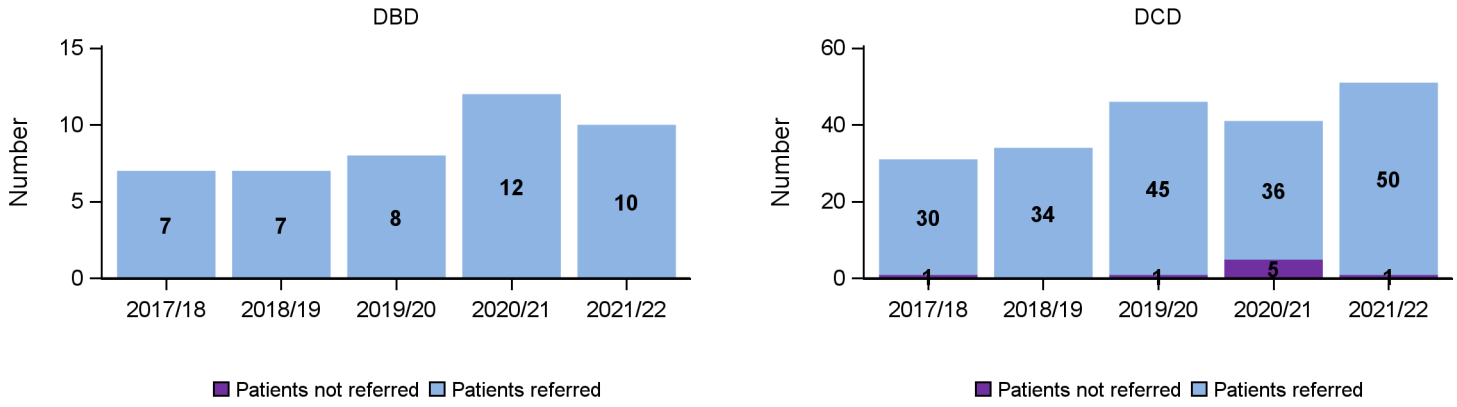


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2021 - 31 March 2022

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	2
Coroner / Procurator Fiscal reason	-	-	-	1
Family declined donation after neurological testing	-	2	-	-
Family declined donation following decision to remove treatment	-	-	-	7
Family declined donation prior to neurological testing	-	1	-	1
Medical contraindications	-	3	-	78
Not identified as potential donor/organ donation not considered	-	12	1	275
Other	-	1	-	51
Patient had previously expressed a wish not to donate	-	1	-	-
Pressure on ICU beds	-	-	-	5
Reluctance to approach family	-	-	-	4
Thought to be medically unsuitable	-	2	-	65
Uncontrolled death pre referral trigger	-	3	-	9
Total	**-**	**25**	**1**	**498**

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

3.3 Contraindications

In 2021/22 there were 17 potential donors in your Trust with an ACI reported, 1 DBD and 16 DCD donors. Please note, the number of potential DBD and DCD donors with an ACI reported may not equal the total stated as a patient can meet potential donor criteria for both DBD and DCD donation.

3.4 SNOD presence

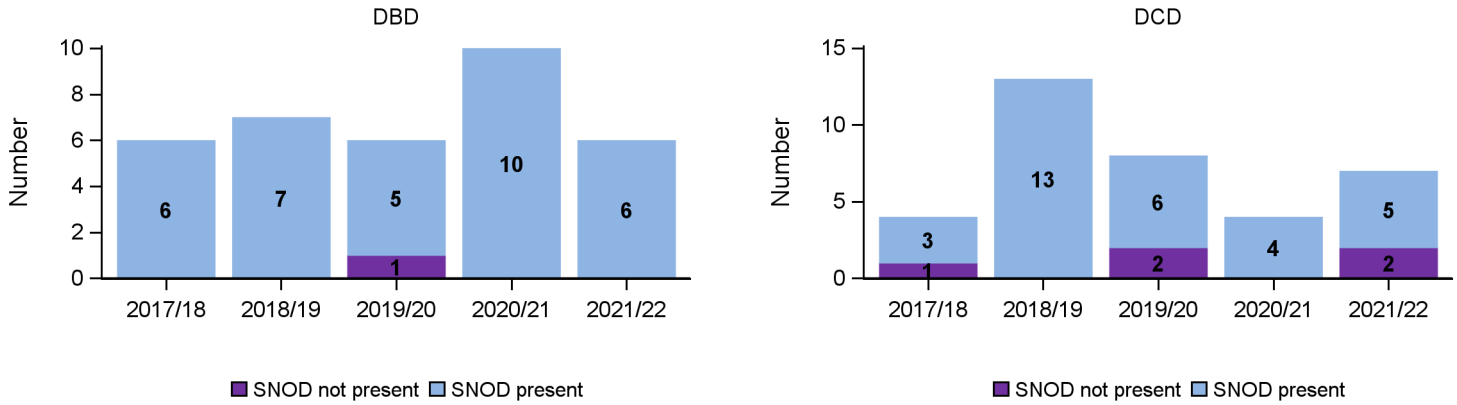
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

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

In the UK, in 2021/22, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 35% and 19%, respectively, compared with DBD and DCD consent/authorisation rates of 71% and 67%, respectively, when a SNOD was present.

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

Figure 3.3 Number of families approached by SNOD presence, 1 April 2017 - 31 March 2022



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2022]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2022]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2022]

3.5 Consent

In 2021/22 less than 10 families of eligible donors were approached to discuss organ donation in your Trust therefore consent rates are not presented.

Figure 3.4 Number of families approached, 1 April 2017 - 31 March 2022

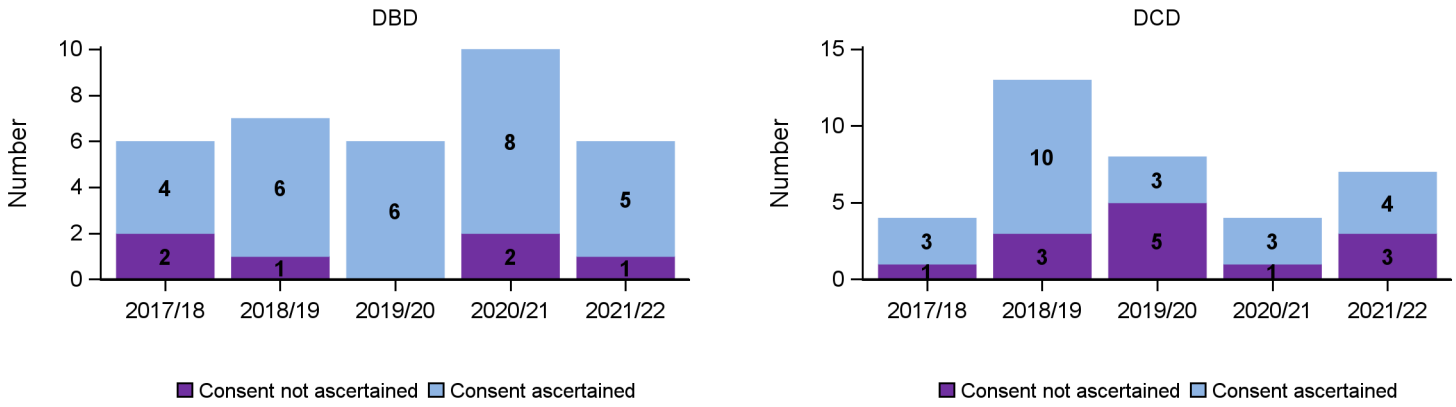


Table 3.3 Reasons given why consent was not ascertained, 1 April 2021 - 31 March 2022

	DBD		DCD	
	Trust	UK	Trust	UK
Family concerned donation may delay the funeral	-	-	-	2
Family concerned other people may disapprove/be offended	-	3	-	1
Family concerned that organs may not be transplantable	-	1	-	4
Family did not believe in donation	-	10	-	13
Family did not want surgery to the body	-	35	-	46
Family divided over the decision	-	13	1	11
Family felt it was against their religious/cultural beliefs	-	39	-	24
Family felt patient had suffered enough	-	26	-	42
Family felt that the body should be buried whole (unrelated to religious/cultural reasons)	-	16	-	9
Family felt the length of time for the donation process was too long	-	15	1	85
Family had difficulty understanding/accepting neurological testing	-	2	-	-
Family wanted to stay with the patient after death	-	2	-	5
Family were not sure whether the patient would have agreed to donation	-	35	-	64
Other	-	20	-	45
Patient had previously expressed a wish not to donate	1	125	-	148
Patient had registered a decision to Opt Out	-	23	-	20
Strong refusal - probing not appropriate	-	13	1	23
Total	**1**	**378**	**3**	**542**

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

3.6 Solid organ donation

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

Table 3.4 Reasons why solid organ donation did not occur, 1 April 2021 - 31 March 2022

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinical - Absolute contraindication to organ donation	-	4	-	6
Clinical - Considered high risk donor	-	3	-	5
Clinical - No transplantable organ	-	5	-	21
Clinical - Organs deemed medically unsuitable by recipient centres	-	25	-	70
Clinical - Organs deemed medically unsuitable on surgical inspection	-	8	-	4
Clinical - Other	-	3	-	10
Clinical - PTA post WLST	-	-	-	135
Clinical - Patient actively dying	-	6	-	14
Clinical - Patient's general medical condition	-	-	-	6
Clinical - Positive virology	-	3	-	5
Consent / Auth - Coroner/Procurator fiscal refusal	-	11	-	11
Consent / Auth - Known wish not to donate	-	1	-	1
Consent / Auth - NOK withdraw consent / authorisation	-	5	-	8
Consent / Auth - Other	-	-	-	2
Logistical - No critical care bed available	-	-	-	1
Logistical - Other	-	-	-	1
Total	**-**	**74**	**-**	**300**

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

4. PDA data by hospital and unit

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

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

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

Table 4.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2021 - 31 March 2022

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Cheltenham, Cheltenham General Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	1	1	-	1	-	1	1	1	1	-	1	-	1
Gloucester, Gloucestershire Royal Hospital													
A & E	0	0	-	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	9	7	-	9	-	7	6	5	5	-	4	-	4
Other, please specify	0	0	-	0	-	0	0	0	0	-	0	-	0

Table 4.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2021 - 31 March 2022

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Cheltenham, Cheltenham General Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	9	9	-	9	6	2	2	-	1	-	1
Gloucester, Gloucestershire Royal Hospital											
A & E	0	0	-	0	0	0	0	-	0	-	0
General ICU/HDU	42	41	98	42	26	5	3	-	3	-	3
Other, please specify	0	0	-	0	0	0	0	-	0	-	0

Tables 4.1 and 4.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Gloucestershire Hospitals NHS Foundation Trust in 2021/22 there were 0 such patients. For more information regarding the Emergency Department please see Section 5.

5. Emergency Department data

A summary of key numbers for Emergency Departments

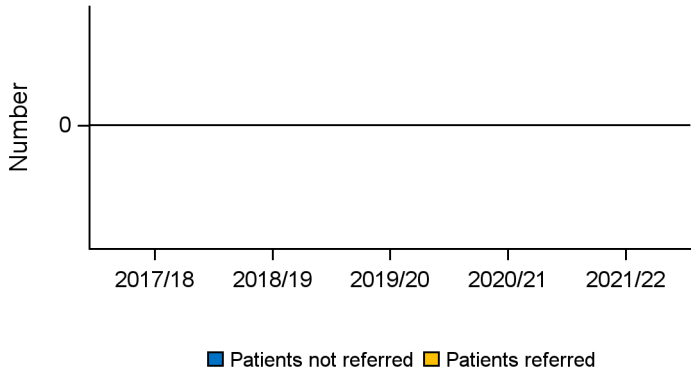
Data in this section is obtained from the National Potential Donor Audit (PDA)

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

5.1 Referral to Organ Donation Service

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

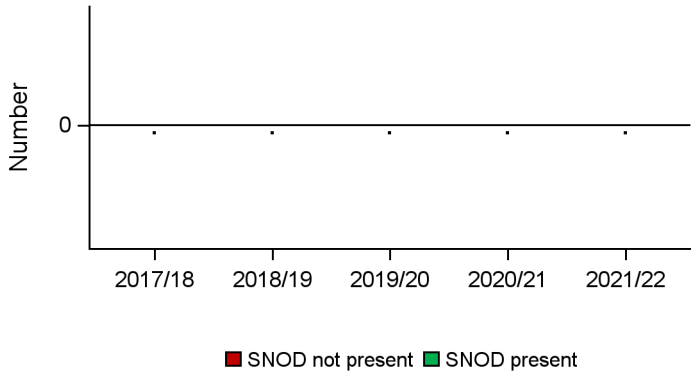
Figure 5.1 Number of patients meeting referral criteria that died in the ED, 1 April 2017 - 31 March 2022



5.2 Organ donation discussions

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

Figure 5.2 Number of families approached in ED by SNOD presence, 1 April 2017 - 31 March 2022



[4] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 9 May 2022]

6. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

6.1 Supplementary Regional data

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

	South West*	UK
1 April 2021 - 31 March 2022		
Deceased donors	126	1,397
Transplants from deceased donors	241	3,410
Deaths on the transplant list	20	422
As at 31 March 2022		
Active transplant list	446	6,269
Number of NHS ODR opt-in registrations (% registered)**	2,828,878 (52%)	27,751,289 (43%)

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

Key numbers and rates on the potential for organ donation

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

6.2 Trust/Board Level Benchmarking

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

Table 6.2 Trust/Board level categories

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

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

Table 6.3 National DBD key numbers and rate by Trust/Board level, 1 April 2021 - 31 March 2022

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	10	8	80	10	100	8	7	6	6	-	5	-	5
Level 1	1044	840	80	1034	99	827	748	679	646	95	470	69	434
Level 2	455	361	79	445	98	355	318	284	274	96	187	66	173
Level 3	286	225	79	282	99	221	208	189	184	97	147	78	128
Level 4	134	104	78	133	99	103	99	87	84	97	57	66	52

Table 6.4 National DCD key numbers and rate by Trust/Board level, 1 April 2021 - 31 March 2022

	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DCD donors
Your Trust	51	50	98	51	32	7	5	-	4	-	4
Level 1	2391	2224	93	2289	1498	818	728	89	513	63	347
Level 2	1451	1261	87	1383	750	335	310	93	197	59	137
Level 3	915	827	90	882	464	184	174	95	130	71	76
Level 4	441	388	88	425	260	108	94	87	62	57	42

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under (prior to 81st birthday)

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: invasive ventilation, Glasgow Coma Scale 3 not explained by sedation, no respiratory effort, fixed pupils, no cough or gag reflex. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – below 37 weeks corrected gestational age'. Previously referred to as brain death
Neurological death tested	Neurological death tests performed to confirm and diagnose death
DBD referral criteria	A patient with suspected neurological death
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to Specialist Nurse – Organ Donation	A patient with suspected neurological death referred to a SNOD. A referral is the provision of information to determine organ donation suitability. NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DBD donor	A patient with suspected neurological death
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188) Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Donation decision conversation	Family of eligible DBD asked to make or support patient's organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual donors: DBD	Patients who became actual DBD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Actual donors: DCD	Patients who became actual DCD donors following confirmation of neurological death, as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested

Referral rate	Percentage of patients for whom neurological death was suspected who were referred to the SNOD
Donation decision conversation rate	Percentage of eligible DBD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations)
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above)

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving invasive ventilation, in whom a clinical decision to withdraw treatment has been made and a controlled death is anticipated within a time frame to allow donation to occur (as determined at time of assessment)
DCD referral criteria	A patient for whom imminent (controlled) death is anticipated following withdrawal of life sustaining treatment (as defined above)
Specialist Nurse Organ Donation or Organ Donation Services Team Member (SNOD)	A member of Organ Donation Services Team including: Team Manager, Specialist Nurse Organ Donation, Specialist Requester, Donor Family Care Nurse
Referred to SNOD	A patient for whom imminent death is anticipated who was referred to a SNOD. A referral is the provision of information to determine organ donation suitability NICE CG135 (England) : Triggers for clinicians to refer a potential donor are a plan to withdraw life sustaining treatment or a plan to perform neurological death tests
Potential DCD donor	A patient who had treatment withdrawn and imminent death was anticipated within a time frame to allow donation to occur.
Absolute contraindications	Absolute medical contraindications identified in assessment which clinically preclude organ donation as per NHSBT criteria (POL188). Absolute medical contraindications to donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/17160/clinical-contraindications-to-approaching-families-for-possible-organ-donation-pol188.pdf
Eligible DCD donor to be assessed	A patient who had treatment withdrawn and imminent (controlled) death was anticipated, with no absolute medical contraindications to solid organ donation.
DCD exclusion criteria	DCD specific criteria determine a patient's suitability to donation when there are no absolute medical contraindications (see absolute contraindications documentation above)
DCD screening process	Process by which an organ may be screened with a local and national transplant centre to determine suitability of organs for transplantation
Medically suitable eligible DCD donor	An eligible DCD donor to be assessed considered to be medically suitable for donation (i.e. no DCD exclusions and not deemed unsuitable by the screening process)
Donation decision conversation	Family of medically suitable eligible DCD donor who were asked to make or support patient's organ donation decision - This includes clarifying an opt out decision.
Consent/Authorisation ascertained	Family supported opt in decision, deemed consent/authorisation, or where applicable the family or nominated/appointed representative gave consent/authorisation for organ donation
Actual DCD	DCD patients who became actual DCD as reported through the PDA (80 years and below). At least one organ donated for the purpose of transplantation (includes organs retrieved for transplant however used for research)
Referral rate	Percentage of patients for whom imminent (controlled) death was anticipated who were referred to the SNOD

Donation decision conversation rate	Percentage of medically suitable eligible DCD families or nominated/appointed representatives who were asked to make or support an organ donation decision - This includes clarifying an opt out decision
Consent/Authorisation rate	Percentage of donation decision conversations where consent/authorisation was ascertained.
SNOD presence rate	Percentage of donation decision conversations where a SNOD was present (includes telephone and video call conversations).
Consent/Authorisation rate where SNOD was present	Percentage of donation decision conversations where a SNOD was present and consent/authorisation for organ donation was ascertained (as above).

Deemed Consent/Authorisation

Deemed consent applies if a person who died in Wales, Jersey or England has not expressed an organ donation decision either to opt in or opt out or nominate/appoint a representative, is aged 18 or over, has lived in the country in which they died for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed consent for a significant period before their death.

Deemed authorisation applies if a person who died in Scotland has not expressed, in writing, an organ donation decision either to opt in or opt out, is aged 16 or over, has lived in Scotland for longer than 12 months and is ordinarily resident there, and had the capacity to understand the notion of deemed authorisation for a significant period before their death. Note that, in Scotland, a patient who has verbally expressed an opt in decision is included as a deemed authorisation, whereas a patient who has verbally expressed an opt out decision is not included.

Consent/Authorisation groups

Expressed opt in	Patient had expressed an opt in decision. Opt in decisions can be expressed in writing or via the ODR in all nations and verbal opt in decisions are also included in Wales, England and Jersey. Verbally expressed opt in decisions are not included in Scotland
Deemed consent/authorisation	Patient meets deemed criteria specific to each nation as described above. In Scotland, this includes patients who have verbally expressed a decision to opt in
Expressed opt out	Patient had expressed an opt out decision. Opt out decisions can be expressed verbally, in writing or via the ODR in all nations
Other	Patient has expressed no decision or deemed criteria are not met. Paediatric patients are included in this group

UK Transplant Registry (UKTR) definitions

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

Appendix A.2 Data Description

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

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

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

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

Appendix A.3 Table and Figure Description

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

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

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

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

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

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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	12	Enclosure Number:	7
Date	8 September 2022		
Title	Fit for the Future 2: Output of Engagement Report		
Author /Sponsoring Director/Presenter	Micky Griffith, Programme Director - Fit for the Future Simon Lanceley Director of Strategy and Transformation		

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

Summary of Report

Purpose:
To review the Fit for the Future 2 Output of Engagement Report.
Objectives:

- To provide a reminder of the FFTF2 proposals
- To review the FFTF2 engagement activities
- To review the FFTF2 engagement quantitative and qualitative responses.
- To confirm next steps

Recommendation

As part of the agreed process for service change proposals, the Board are requested to review and discuss the Output of Engagement Report prior to any recommendations being formulated. This report, combined with the Clinical Senate Panel Review Report and any other information deemed necessary, will be used to determine next steps recommendations.

Enclosures

FFTF2 OoE (Output of Engagement) Report v1.2	This is the main report for review and discussion. Given material shared previously with Board members, **sections 6,7 & 8 are key sections to read.**
OoE presentation	Summary presentation
Appendices 1a-e Responses	These are all the comments received by respondent type and are included for completeness but are **not required** reading
Appendices 3a & b Engagement materials	These are for information only and are **not required** reading

One Gloucestershire
Transforming Care, Transforming Communities

NHS

Output of Engagement Report

Version 1.2

August 2022

Work in Progress: Proposals subject to public involvement

Fit for the Future 2

Developing specialist health services in Gloucestershire

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ICB Strategic Executives	18/08/22	1.2	
GHNHSFT Board	08/09/22		
NHS Gloucestershire Integrated Care Board	28/09/22		
HOSC	25/10/22		

1 Executive Summary

1.1 What we engaged on[1]

The Fit for the Future 2 engagement covered ideas[2] for consideration for six services:

- **Benign Gynaecology**: to continue to locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital **[3].
- **Diabetes and Endocrinology:** to continue to centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital **.
- **Respiratory**: to continue to centralise Respiratory Inpatient beds and establish Respiratory High Care at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital **.
- **Non-Interventional Cardiology**: To centralise Non-Interventional Cardiology inpatient beds at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.
- **Stroke**: to continue the change of location for Hyper Acute Stroke Unit (HASU) and Acute Stroke Unit (ASU) at Cheltenham General Hospital **.
- **Frailty**: rather than a specific service change, we provided information on existing services, ideas for improvements and asked *What do you think are the most important things to be considered in improving Frailty services*?

1.2 Engagement key facts

- Public, patient and staff engagement focussed on six specialist health services: Benign Gynaecology; Diabetes and Endocrinology; Non-interventional Cardiology; Respiratory; Stroke and Frailty/Care of the Elderly.
- Approximately 3,000 Engagement booklets distributed across the county, including at Cheltenham General and Gloucestershire Royal Hospital.
- 50+ engagement events.
- 6 Facebook Live streamed independently hosted events with 9,800 views.
- A comprehensive series of activity for staff including question and answer drop ins and regular newsletters.
- Telephone interviews conducted with members of the public who wanted to share more insights about their personal experience of services.
- Over 1,800 face-to-face conversations with members of the public and staff at engagement events.
- Facebook adverts reached approximately 64,500 individual people. This resulted in 925 people clicking the link through to the Engagement survey.
- Twitter adverts had more than 55,000 impressions with the link to the survey clicked 87 times in total.
- 200+ Fit for the Future 2 (including Easy Read) surveys completed

[1] A copy of the engagement booklets can be found in Appendix 3

[2] Subsequent to the engagement, an options appraisal process has been undertaken and these ideas are now our preferred options and have been submitted to the South West Clinical Senate and NHSE for review.

[3] **Currently under temporary service change

An example of promotional communications is presented below

1.3 Engagement survey quantitative responses

Full details are provided in section 7, but in summary:

- Strong level of support for all service ideas
- Survey respondents answer the questions they are interested in so respondents either skip or indicate no opinion.

Service	Support[4]	Oppose
Benign Gynaecology	92%	8%
Diabetes and Endocrinology	98%	2%
Non-interventional Cardiology	99%	1%
Respiratory	97%	3%
Stroke	84%	16%

[4] Analysis of standard survey

1.4 Engagement survey qualitative themes

Responses to the engagement focussed on the following themes, these included:

1.4.1 *Public and Patients respondents' themes*

- Support for Centres of Excellence approach
- Travel and Transport
- Car parking
- Ward environment

1.4.2 *Staff respondents' themes*

- Benefits of the Centres of Excellence approach
- Travel and Transport
- Car parking for patients
- Health inequalities
- Interdependencies with other clinical services
- Improved integration with primary and community services

As previously stated, all responses to Frailty/Care of the Elderly are qualitative.

All the individual comments are included in Appendix 1.

1.5 Who got involved?

In terms of the reach of the engagement, demographic information is known about those survey respondents who chose to provide 'About You' information in their survey responses. There is a broad representation of groups in responses to the survey. There is extended reach through some of the targeted activities, which ensured a diverse range of voices had an opportunity to be heard.

During the engagement, participants took the opportunity to access information, ask questions and comment on other health and wellbeing related matters. Access to GP and NHS dental appointments were the most frequently occurring non-FFTF2 matters raised during the engagement period.

A detailed summary of feedback received can be found in Sections 6 & 7. All feedback received can be found in the Appendix 1 to this Report.

2 Introduction

2.1 Purpose of this report

The Fit for the Future (FFTF2) Output of Engagement Report is intended to be used as a practical resource for One Gloucestershire Integrated Care System (ICS) partners; to provide them with information about how the public, patients, community partners and staff feel about the FFTF2 ideas for change. One Gloucestershire is a partnership between the county's NHS and care organisations to help keep people healthy, support active communities and ensure high quality, joined up care when needed.

The NHS partners of One Gloucestershire Integrated Care System are:

- NHS Gloucestershire Integrated Care Board (ICB) (NHS Gloucestershire Clinical Commissioning Group until 30.06.2022)
- Primary care (GP) providers
- Gloucestershire Health and Care NHS Foundation Trust (GHC)
- Gloucestershire Hospitals NHS Foundation Trust (GHT)
- South Western Ambulance Services NHS Foundation Trust (SWAST)

This Report will be shared widely across the local health and care community and will be made available to all on the NHS Gloucestershire website https://www.nhsglos.nhs.uk/ and on the online participation platform Get Involved in Gloucestershire https://getinvolved.glos.nhs.net

One Gloucestershire partners are invited to consider the feedback from the Engagement and indicate how it has influenced their thinking. Full details of the next steps for the Fit for the Future Programme can be found in section 3.6

This Report has been prepared by the One Gloucestershire Communications and Engagement Group. This report is produced in both print and on-line (searchable PDF) formats. For details of how to obtain copies in other formats please turn to the back cover of this Report.

2.2 Making the best use of the information provided

This report is divided into sections.

- **Section 3**: provides background information about the Fit for the Future Programme
- **Section 4**: provides details of our approach
- **Section 5**: describes our engagement activities
- **Section 6**: provides demographic information on those responding to our survey
- **Section 7**: provides quantitative and qualitative feedback on the individual service ideas
- **Section 8**: is an evaluation of the Engagement activity.

There are elements of feedback which will be relevant and of interest to all readers; these can be easily found in the report.

All feedback received can be found in Appendix 1 and includes all comments collated through the Fit for the Future 2 Engagement survey.

The theming of the qualitative feedback received through the FFTF2 Engagement survey presented in this report has been undertaken by members of the One Gloucestershire Communications and Engagement Group using Smart Survey.

All feedback received has been read and themes identified; these are presented in section 7.

All qualitative feedback received by representatives of One Gloucestershire partners during the Engagement period is available in the Appendices. The information provided in this report and Appendices will be used by decision makers to 'conscientiously consider'[5] all feedback received.

2.2.1 *Appendices*

Details of the appendices are listed in Section 10.

Following internal review all appendices will be made available on the NHS Gloucestershire website https://www.nhsglos.nhs.uk/ and on the online participation platform Get Involved in Gloucestershire https://getinvolved.glos.nhs.net

We would like to thank everyone who has taken the time to share their views and ideas.

[5] One of the Gunning Principles that have formed a strong legal foundation from which the legitimacy of public involvement is often assessed.

3 Information about the Fit for the Future Programme and Engagement Activities

3.1 Background

Over the last few years, the NHS in Gloucestershire Fit for the Future (FFTF) programme has been involving local people and staff in looking at potential ways to develop specialist hospital services in Gloucestershire. Through this process the 'centres of excellence'[6] approach has been designed. In FFTF2 the conversation about some of these services is broader, covering both:

- the continued development of the 'Centres of Excellence' approach at Cheltenham General and Gloucestershire Royal Hospitals, including inpatient care; and
- support for people in their own home, in their GP surgery or in the community.

As part of our response to the NHS Long Term Plan and commitment to the public in Gloucestershire, when patients require specialist care, we believe they should receive treatment in centres with the right specialist staff, skills, and equipment by delivering care that is fit for the future.

Our FFTF Programme includes looking at how we can develop outstanding specialist hospital care in the future across the Cheltenham General (CGH) and Gloucestershire Royal (GRH) hospital sites. Our "*Centres of Excellence*" vision for the future configuration of specialist hospital services with GRH focussing more (but not exclusively) on emergency care, paediatrics, and obstetrics and CGH focussing more (but not exclusively) on planned care and oncology. Across the UK and the world, it is recognised that an element of separation between planned and emergency care services can improve care for everyone.

[6] Centres of excellence: bringing staff, equipment, and facilities together in one place to provide leading edge care and create links with other related services and staff.

What we mean by *centres of excellence…*

Not all clinical specialties will be centres of excellence in their own right.

Co-locating services that work together to rapidly stabilise, triage, diagnose and treat patients will form the basis of our centre of excellence for emergency care at GRH…

Wherever possible, **planned care and oncology will be provided on a separate site** to ensure our teams and patients have reliable access to diagnostic facilities, inpatient beds, daycase trollies, operating theatres and critical care will form the basis of our centre for excellence for planned care at CGH.

Not a purest strategy, not all emergency care will be provided from GRH and not all planned care will be provided at CGH.

Centres of excellence are not limited to our acute sites. Some services will deliver better outcomes and experience from being co-located off-site with community or primary care services.

Through the FFTF Engagement in 2019 and Consultation in 2020; and during earlier conversations about the NHS Long Term Plan in 2018, the NHS in Gloucestershire has been involving staff, patients, local people and the public in looking at a number of services and developing potential 'solutions. The FFTF 2 Engagement is the latest element of the engagement cycle to develop the Gloucestershire response to the NHS Long Term Plan:

- **2018**: Development of our local NHS Long Term Plan (informed by earlier engagement feedback)
- **2018/19**: Countywide public / community partner /staff engagement - What matters to you?
- **2019**: FFTF1 Engagement: developing specialist hospital services in Gloucestershire. Developing potential solutions.
- **2020**: FFTF1 Consultation: developing specialist hospital services in Gloucestershire. Options for change consulted upon and agreed following conscientious consideration of output of consultation. Implementation underway.
- **2022**: FFTF2: developing specialist health services in Gloucestershire: Engagement about ideas for change.

3.2 What the Fit for the Future 2 Engagement was about

The purpose of the Engagement was to discuss and receive views about ideas about the future provision of six specialist hospital services in Gloucestershire:

- Benign Gynaecology (day-case) *
- Diabetes and Endocrinology (inpatients and community) *
- Non-interventional cardiology (inpatients)
- Respiratory (inpatients) *
- Stroke (inpatients) *
- Frailty/Care of the Elderly (inpatients and community)

* Changes already in place as part of Temporary Service Changes

3.3 What the Fit for the Future 2 Engagement was not about

It was not about:

- Saving money. The priority is quality of care and health outcomes
- FFTF1 - the public consultation in 2020, past decisions and the service changes that are now being implemented
- The Accident and Emergency Department in Cheltenham, which remains a 24-hour A&E (nurse led service overnight 8pm to 8am).

3.4 Engagement activity summary

The Fit for the Future 2 public and staff Engagement started on 17 May 2022 and ran until the survey closed on 31 July 2022. Further conversations will continue over the summer.

A range of engagement and communication channels have been used including:

Gloucestershire Hospitals: Facebook Live (@GlosHospitals)	Targeted engagement to address the homogeneity of participants
'Your Say' area on the One Gloucestershire Health website and Get Involved in Gloucestershire online participation platform	GHNHSFT staff FFTF2 events plus presentations and awareness raising at team, divisional and Trust-wide meetings
NHS Information Bus Tour	Public events
A phased communication campaign for GHNHSFT staff using existing channels (CEO briefing etc.), weekly FFTF2 service focus emails, posters across both hospital sites, booklet drops to teams and Q&A sessions.	Presentations to Integrated Locality Partnerships; ILPs are operational and strategic partnership of senior leaders of providers and local government, supporting integration at PCN level
Healthwatch Gloucestershire	Presentations to local councillors
Presentations to PCN clinical leads	Media releases and stakeholder briefings
Media (print and social) advertising	

Full details of the Engagement activities can be found in Section 5.

3.5 Engagement review period

There is an Engagement review period, where Gloucestershire Hospitals NHS Foundation Trust and NHS Gloucestershire Integrated Care Board will carefully consider all the feedback. This Output of Engagement Report will be reviewed by NHS Gloucestershire, Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT), NHS England and the Gloucestershire Health Overview and Scrutiny Committee (HOSC).

3.6 Decision regarding next steps

Decisions regarding whether the service change ideas which are the subject of the Fit for the Future 2 Engagement are deemed to be a substantial development of the health service in Gloucestershire, or a substantial variation in the provision of those services, will be taken by NHS Gloucestershire Integrated Care Board in partnership with Gloucestershire Health Overview and Scrutiny Committee, taking into account the Output of Engagement Report, the

NHS England Clinical Senate Clinical Review Panel Report and other information that the Integrated Care Board deems necessary to such a decision.

3.7 Process of implementation

If the ideas set out in this Engagement are supported by the Board, and if it were decided based on the information and evidence that no further consultation is required, the current temporary changes would be made permanent immediately. The timescale for other changes would be determined by a number of factors such as estates, staff recruitment and training.

The Fit for the Future Programme implementation structure would remain in place with programme and project managers working with clinical staff within the specialties to develop and then deliver detailed implementation plans. Plans to involve local people in the implementation and evaluation process would be developed.

3.8 Providing feedback

Following internal review, the feedback from the engagement will be published on the online participation platform Get Involved in Gloucestershire https://getinvolved.glos.nhs.uk

4 Our Approach to Communications and Engagement

4.1 Working with others

The planning and delivery of the Fit for the Future engagement has been supported by many external groups:

- The Consultation Institute: We have benefited from advice and guidance throughout membership of the Consultation Institute (tCI) Throughout the last three years tCI have been key partners in developing and assuring our approach to involving people and communities. The Fit for the Future 1 Consultation was Quality Assured by tCI and learning from that, and Fit for the Future 1 Engagement, has been applied to Fit for the Future 2.
- Inclusion Gloucestershire: Assisted with the development of Easy Read materials.
- Healthwatch Gloucestershire (HWG): HWG Readers Panel reviewed an early draft of the full consultation booklet and made suggestions for changes, which were incorporated into the final version. A HWG representative will be a member of the independent Oversight Panel for the second Fit for the Future Citizens' Jury.
- Aneurin Bevan Health Board (ABHB): ABHB facilitated an Information Bus visit to Chepstow Hospital in Monmouthshire to enable residents living close to the Wales England Border, who might access services in Gloucestershire the opportunity to find out more about the consultation.
- District/Borough Councils and Retail partners: Supported the visits of the Information Bus to locations with maximum footfall across the county. Tewkesbury Borough Council also hosted members' seminars to discuss the Fit for the Future 2 Engagement.
- Local media: Gloucestershire Live, BBC Radio Gloucestershire and GFM Radio
- Others: Many other groups and individuals have helped to raise awareness of the Engagement such as Trust Governors, staff-side representatives, hospital volunteers and community and voluntary sector organisations such as homelessness support charities.

4.2 Equality and Engagement Impact Analysis (EEIA)

Equality, diversity, Human Rights, and Inclusion are at the heart of delivering personal, fair, and diverse health and social care services. All commissioners and providers of health and social care services have legal obligations under equality legislation to ensure that people with one or more protected characteristics[7] are not barred from access to services and decision-making processes.

The FFTF2 Engagement has been informed by the experience of managing earlier extensive engagement activities. The approach and detailed plan for communications and consultation was informed by feedback from those engagement activities, including feedback from NHS England Assurance processes.

[7] It is against the law to discriminate against someone because of age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex, sexual orientation. These are called protected characteristics. https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

4.3 Integrated Impact Assessment (IIA)

An integrated impact assessment supports decision making by evaluating the impact of a proposal, informing public debate, and supporting decision makers to meet their Public Sector Equality Duty and their duty to reduce inequalities.

In relation to equality, these responsibilities include assessing and considering the potential impact which the proposed service relocation could have on people with characteristics that have been given protection under the Equality Act, especially in relation to their health outcomes and the experiences of patients, communities, and the workforce. With reference to health and health inequalities, the responsibilities include assessing and considering the impact on the whole of the population served by the relevant statutory bodies and identifying and addressing factors which would reduce health inequalities, specifically with regard to access and outcomes.

The assessment uses techniques such as evidenced based research, engagement, and impact analysis to understand the impact of change on the population, the impact on groups with protective characteristics and the impact on accessibility and quality of services. The aim of the report is to understand and assess the consequences of change whilst maximising positive impacts and minimising negative impacts of the proposed change.

The Fit for the Future (FFTF) programme undertakes the following process to develop its IIA.

1. Undertake a baseline IIA for each service based on the proposals, clinical evidence and potential outcomes prior to the engagement process and include recommendations based on the evidence review to inform an action plan.
2. Update the baseline IIA following public engagement to take account of feedback from the public, patients, staff, and stakeholders. The IIA report contains evidence that decision-making arrangements will pay due regard to equalities and inequalities issues and the Brown principles[8].
3. Where public consultation is undertaken, the PCBC IIA is updated to take account of feedback from the public, patients, staff, and stakeholders.

Our IIA process is made up of 3 factors:

- Equality Impact Assessment
- Health inequalities impact assessment
- Health impact assessment

The ideas presented in the FFTF2 Engagement for all groups were found to be either neutral impact, significant positive impact/moderate adverse impact, or significant positive impact.

Our approach to the Engagement targeted all groups, ensuring proactive engagement amongst older and disabled residents more likely to be service users and ensuring opportunities for people to have their say were provided in both urban and rural venues through the extensive use of the NHS Information Bus.

[8] R. (Brown) v. Secretary of State for Work and Pensions [2008] EWHC 3158 at paras 90-96.

4.3.1 *IIA Summary*

The impact assessment for services consolidating at either the Cheltenham General Hospital or Gloucestershire Royal Hospital is often similar including:

- Centralisation of services can improve patient outcomes, continuity of care, length of stay, patient experience and reduces mortality particularly beneficial to patients with protected characteristics including those with long term conditions or co-morbidities which are prevalent in patients with disabilities and those over 65.
- Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission. The district with the highest proportion of ethnic diversity is Gloucester city meaning that a geographical distribution of services to GRH might have a greater positive impact on these communities
- On the basis that there is a higher proportion of the population in the Gloucester district who are living in deprivation (25%) and who suffer from Type 2 Diabetes (6.8%) there is a potential that patients who access the service from Gloucester will be positively impacted by a movement of services to GRH
- The re-location of services from GRH to CGH will impact some patient and carer travel times either positively or negatively (see section 7 for individual service impacts)
- There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely based on a person's sex.
- There is currently limited data to determine any impact of the changes for women during pregnancy.
- There is currently limited data to ascertain any impact of the changes for those who are from any particular marital status.
- According to the Stonewall survey, 13% of LGBTQ+ people have experienced some form of unequal treatment from healthcare staff because they are LGBTQ+
- There is currently limited data to ascertain any impact of the changes for those who are from any particular religious background.
- There is limited evidence regarding the impact to those who have undergone gender reassignment, however, impacts may mirror those of sexual orientation.
- Caring responsibilities can have an adverse impact on the physical and mental health, education, and employment potential of those who care, which can result in significantly poorer health and quality of life outcomes.
- Consolidation of the inpatient bed base should provide shorter lengths of stay, faster diagnostics and minimised waiting times which will help carers who have to attend hospital regularly.
- Services centralising at GRH will be located nearer to the highest proportion of homeless people in Gloucestershire. Homeless people are more likely to have long term conditions and multiple conditions which means consolidating and co-locating services will provide support for more complex needs such as these.
- Mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages. Relocation of services may therefore be beneficial to this group.
- Gloucestershire Hospitals NHS Foundation Trust admission data demonstrates that more people attend GRH than CGH with mental health related issues. Relocating services to GRH may therefore be beneficial to this cohort.

- The consolidation of relevant specialist services improves training and enhanced understanding of patient conditions, leading to better clinical outcomes and improving access to services with fewer cancellations
- Feedback from staff and patients suggests parking can be a challenge at both sites.
- Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute care. This geographical clustering means that geographical changes to where services are delivered may have a disproportionate impact on those with disabilities in terms of access.

4.4 Communications: Developing understanding and supporting Fit for the Future engagement

A range of communications and engagement methodologies were used during the Fit for the Future 2 Engagement. This section describes the wide-ranging approach taken to promoting the *Fit for the Future 2* Engagement and the range of involvement opportunities.

In summary:

4.4.1 *Media releases and stakeholder briefings*

This included:

- launch materials – media release and stakeholder briefing
- media statements reinforcing key messages and involvement opportunities
- a further open stakeholder letter sent to community stakeholders by email including Patient Participation Groups, local authorities, voluntary and community organisations
- Foundation Trust Membership communications promoting the Engagement

4.4.2 *Stakeholder briefing*

Stakeholder briefing sent on launch day to core stakeholders including MPs, Chairs and Chief Execs of NHS partners, Gloucestershire County Council leadership including HOSC Chair and members (via democratic services), District Councils, Healthwatch Gloucestershire, VCS Alliance.

4.4.3 *Printed engagement booklets*

Approximately 3,000 booklets were widely distributed to a range of public places including Cheltenham General and Gloucestershire Royal Hospitals and GP surgeries. The booklets included the Freepost survey and information detailing the ways people could get involved.

4.4.4 *Get Involved in Gloucestershire online participation platform*

All Engagement materials can be found at: https://getinvolved.glos.nhs.uk/fit-for-the-future-2 *Get Involved in Gloucestershire* is an online participation space where anyone can share views, experiences and ideas about local health and care services.

4.4.5 *Further engagement to address the homogeneity of participants*

Targeted opportunities for Engagement with protected characteristic groups were identified through the Equality and Engagement Impact Analysis. An Easy Read version of the Engagement Booklet and Survey were produced and other alternative formats of all

Engagement materials were available on request. We have a contract in place with telephone (and face to face) interpreters, incl. BSL and for written translation.

4.4.6 *Social media*

Social media was used extensively to support the Engagement and planned activity covered topics such as promotion of how people could get involved, the Information Bus Tour, promotion of the booklet and survey, and promotion of the online Facebook Live clinical discussions.

As part of the social media promotion of the FFTF2 Engagement we ran paid for adverts on Twitter and Facebook for four weeks in total, split into two separate two-week blocks.

On Facebook, the combined total for our two adverts reached 64,410 individual people. This resulted in 925 people clicking the link through to the survey.

On Twitter the two adverts had 55,767 impressions, this means that the advert was seen a total of 55,767 times but not necessarily by different people each time. On Twitter the link to the survey was clicked 87 times in total.

4.4.7 *Media Advertising*

As well as the methods described above, the Engagement was promoted in local media titles including Gloucester Citizen, Gloucestershire Echo, The Forester, Wilts & Glos Standard, Stroud News & Journal, Cotswold Journal and Gloucestershire Gazette.

Title	Locality	Advert details
Gloucestershire Live	Countywide	Quarter page ads in Echo and Citizen for two weeks, plus digital support, including sponsored advertorial and 100k impressions on MPU/DMPU ads across one month
Forest of Dean and Wye Valley Review	Forest of Dean	Quarter page ad for one-week, small number of digital ads
Forester	Forest of Dean	Quarter page ad for one-week, small number of digital ads
Stroud News and Journal	Stroud and Berkeley Vale	Quarter page for one-week, plus 127,000 impressions on digital (across all Local IQ titles) and sponsored Facebook adverts
Cotswold Journal	Cotswolds	Quarter page for one-week, plus 127,000 impressions on digital (across all Local IQ titles) and sponsored Facebook adverts
Wilts and Glos Standard	Cotswolds (e.g., Cirencester, Tetbury)	Quarter page for one-week, plus 127,000 impressions on digital (across all Local IQ titles) and sponsored Facebook adverts
Gloucestershire Gazette	Stroud/Cotswolds (e.g., Dursley, Wotton-under-Edge)	Quarter page for one-week, plus 127,000 impressions on digital (across all Local IQ titles) and sponsored Facebook adverts

4.4.8 *Staff communication and engagement*

Several programmes of internal communication and engagement were rolled out to support staff at Gloucestershire Hospitals NHS Foundation Trust.

Staff Global Briefings to all staff	Date
Staff Global Briefing - Frailty / Care of The Elderly Briefing	25/05/2022
Staff Global Briefing - Diabetes & Endocrinology	01/06/2022
Staff Global Briefing - Non-interventional cardiology Briefing	08/06/2022
Staff Global Briefing - Respiratory Briefing	15/06/2022
Staff Global Briefing – Stroke	22/06/2022
Staff Global Briefing – Benign Gynaecology	29/06/2022
Staff Global Briefing Staff Forum	17/06/2022 & 04/07/2022

In all briefings relevant upcoming events were mentioned including upcoming Facebook lives, where to find and complete the FFTF2 survey and requests to attend clinical staff meetings to discuss FFTF2 and the staff forum

4.4.8.1 Promotional posters and booklet distribution

Posters advertising the Engagement and opportunities to have your say were distributed across the Trust.

Numbers of posters and booklets distributed and locations		
Item	**#**	**Location**
Posters - Staff Rooms	25	GRH staff rooms
	20	CGH staff rooms
FFTF Engagement Booklets	490	CGH waiting rooms
	490	GRH waiting rooms
	20	Sandford Lido
	20	Community venues
	70	Big health event

4.4.8.2 Staff Engagement event: Friday 15 July 2022

A drop-in session where staff could join the virtual briefing where the ideas for FFTF2 were summarised, and staff had the opportunity to pose questions and to share their views.

4.4.9 *Other stakeholder communication and engagement*

4.4.9.1 Elected Representatives

Members of Parliament

Regular MP briefings have taken place prior to and during the Fit for the Future 2 Engagement period.

Gloucestershire County Council (GCC) Health Overview and Scrutiny Committee (HOSC)

County Council Elected representatives and officers have received information about the Fit for the Future 2 Engagement via the GCC Democratic Services Department.

Gloucestershire County Council Health Overview and Scrutiny Committee Members have received regular updates on the FFTF2 programme and Engagement. Engagement materials have been available to elected members and staff. The Output of Engagement report will be presented and discussed with HOSC members in October 2022.

District and Borough Councils

District and Borough Council Elected representatives and officers have received information about the FFTF2 Engagement via their Democratic Services Departments. FFTF2 Members Seminars, similar to those that took place during FFTF1 were offered to District and Borough Members. Tewkesbury Borough Council Scrutiny Committee responded to the invitation and a presentation and question & answer session was held at Tewkesbury Borough Council Offices in June 2022.

Neighbouring Integrated Care Boards and Welsh Health Boards

The FFTF Programme team have been in contact with neighbouring ICBs at the start of our engagement to encourage them and their residents to participate. We have shared information on the programme scope, exchanging of activity information and agreements to build relationships and share information as the preferred option(s) are finalised.

The overall activity numbers for FFTF2 are considerably lower than FFTF1 and the impact on patients registered outside Glos. is similarly reduced. We also look at patients per GP practice and have contacted the practices direct (those >4 patients impacted).

Integrated Locality Partnerships and PCNs

Presentations and discussions took place with Primary Care, Community and Voluntary Sector colleagues through the 6 Integrated Locality Partnership Boards across the county. These sessions enabled people who work together in local areas to hear about the Engagement

REACH Campaign

Information about the FFT2 Engagement and how to get involved was sent to REACH representatives on the launch day of the Engagement. The REACH (Restore Emergency at Cheltenham General Hospital) campaign was launched by Cheltenham Chamber of Commerce.

5 Public Engagement Activities

5.1 Gloucestershire Media: Live social media partnership (@GlosLiveOnline)

Underpinning the approach to the Engagement was a partnership with local media stakeholder Gloucestershire Media. This built on the approach taken during the FFTF1 consultation.

Throughout the Covid 19 pandemic the use of video conferencing has proliferated as a means of effective communication and engagement. The advantages are extensive and include:

- The opportunity to reach a greater audience
- The material is more accessible
- The content is available in perpetuity/matter of public record
- Opportunity to ask questions and engage in two-way dialogue
- Ensures the events are available in perpetuity/matter of public record

Working in partnership with Gloucestershire Live, we broadcast a series of live Q&A sessions throughout the month of June 2022. Working with Gloucestershire Live ensured we reached a greater audience and enabled the sessions to be independently chaired. Each Q&A session was broadcast via Gloucestershire Live's Facebook page as well as Gloucestershire Hospital NHS Foundation Trust's Facebook page.

Each session was led by clinical representation who spoke openly and transparently about the ideas for their service. Additional software was incorporated into the live broadcasts that made public participation simple and straightforward. Questions could be submitted in advance or submitted live during the event. Questions were read out by the chair and responses given.

5.1.1 *Promotion*

The events were heavily promoted by Gloucestershire Live in advance. Methods of promotion included:

- Homepage takeovers of the Glos Live website in advance
- Feature articles both previewing and reviewing content
- Promotional posts on Glos Live's Facebook and Twitter accounts
- Promotional posts via NHS Gloucestershire social media channels

5.1.2 *Impact*

Please click on the links in the table below to visit the session adverts.

Facebook Promo Posts	Total Reach	Total Engagement	Post Clicks	Likes	Comments	Shares
Respiratory	21, 233	1090	758	165	75	15
Frailty	33, 693	2125	1788	156	22	30
Gynaecology	31, 353	1073	955	81	22	11
Stroke	20, 653	1116	974	121	5	11
Diabetes	25, 055	1537	1361	116	28	20
Cardiology	25, 469	1231	1062	114	17	17

Please click on the links in the table below to visit the session adverts.

Twitter Ads (The first out of the 2)	Total Impressions	Likes	Retweets	Comments
Respiratory		9	8	-
Frailty		10	6	-
Gynaecology		3	2	-
Stroke		6	7	1
Diabetes		4	3	
Cardiology		5	5	1

Please click on the links in the table below to visit the session recordings.

Live Q&As	Total Reach	Total Views	Peak Live Views	Total Clicks	Minutes Viewed (Rounded)	Likes	Comments
Live Q&A with Respiratory & Glos Live - Monday 13th June 2022	5K	1.8K	74	1.8K	28	18	4
Live Q&A with Frailty and Glos Live - Tuesday 15th June 2022	4.5K	1.6K	48	1.5K	21	11	12
Live Q&A about Benign Gynaecology Care and Glos Live - Wednesday 16th June 2022(External link)	3.8K	1.3K	36	1.1K	13	4	15
Live Q&A with Stroke services and Glos Live - Friday 17th June 2022	5.6K	1.7K	46	1.3K	17	8	14
Live Q&A with Diabetes/Endocrinology and Glos Live - Wednesday 22nd June	5.8K	1.6K	37	1.3K	22	6	11
Live Q&A with Cardiology services and Glos Live - Friday 24th June 2022	5.7K	1.8K	49	1.3K	20	7	24

Please click on the links in the table below to visit the relevant articles

Articles	Page Views (7 day window)	Average Dwell Time
Respiratory	650	04:03
Frailty	631	04:28
Gynaecology	1000	05:13
Stroke	1100	04:45
Diabetes	2000	04:10
Cardiology	1500	05:23

5.2 Gloucestershire Patient Participation Group Network

All GP practices in England are required to have a patient participation group[9]. The Gloucestershire PPG Network is organised by NHS Gloucestershire. It is designed to provide a space for PPG members from across the county to share their experiences with one another in order for each PPG to learn and continue to provide an effective role in their practice.

NHS Gloucestershire involves PPG members in engagement and consultation work, provides support to PPGs on an individual basis and also provides opportunities for PPGs to learn and develop. In addition, NHS Gloucestershire hosts a quarterly network meeting. However, during the current pandemic this has moved to holding meetings virtually using MS Teams. The PPG Network in May focussed on the Fit for the Future 2.

5.3 NHS Information Bus Tour

The Information Bus aims to facilitate partnership working, offering information and activities which support self-care, health and wellbeing and self-management across the communities of Gloucestershire. The Bus is also used to support engagement with the public to inform service planning and design. An Information Bus Tour to raise awareness of the Engagement to gather views and answer questions took place during May, June and July 2022.

[9] https://getinvolved.glos.nhs.uk/ppg-network

Gloucester City Centre, Armed Forces Day 25 June 2022

During the Engagement 750 people visited the Information Bus. See Section 5.6 for details of all Information Bus Tour dates.

5.4 Fit for the Future 2 Surveys

Two surveys (standard and Easy Read) were developed by the NHS to support the Fit for The Future engagement.

These were available as print, as FREEPOST return copies in the engagement booklets and also on line at: https://getinvolved.glos.nhs.uk/fit-for-the-future-2

More than 200 Fit for the Future survey responses have been received.

5.5 Engaging people with protected characteristics and others identified in the Integrated Impact Analysis

The Engagement took two main routes to reach, gather and record views from people with protected characteristics and others identified in the independent Integrated Impact Analysis:

- promoting the engagement routes and encouraging participation. The consultation survey asks for respondents to provide demographic information (see Part 2)
- proactive engagement with targeted groups. The Engagement team contacted groups across Gloucestershire using existing well established networks and Your Circle https://www.yourcircle.org.uk/, which is a local online directory to help you find your way around care and support and connect with people, places and activities in Gloucestershire.

5.5.1 *People with disabilities*

There is a good response to the survey from people who indicated they have a disability (including mental health problem or learning disability). During the Engagement, members of the consultation team attended Know Your Patch meetings across the county to promote FFTF2 and the Get Involved in Gloucestershire online participation platform. Know Your Patch builds networks for those working with individuals and groups to help people stay independent for longer and to lead full and happier lives. Know Your Patch has a network of organisations in each district in Gloucestershire. These networks meet quarterly for networking and discussion and communicate through email bulletins and updates. These networks help connect VSCE and statutory organisations together for effective partnership working https://knowyourpatch.co.uk/networks/ Information about the consultation was also promoted to the Mental Health and Learning Disability Partnership Boards.

5.5.2 *Over 65s who are more likely to have long term conditions*

There is a good response to the survey from people aged over 65 and, and also from people who indicated they have a disability.

5.5.3 *Frail older people*

The activities described above for over 65s with long terms conditions apply to this group as well. The Information Bus attended an event at Highnam Court organised by Age UK Gloucestershire to promote the Engagement.

5.5.4 *Carers*

There is a good response to the survey from people who indicated that (unpaid) they look after, or give any help or support to, family members, friends, or others because of either a physical or mental health need or problems related to old age.

5.5.5 *People living in low-income areas*

Low income is not a characteristic the survey collects. However, there is information within local data which records indices of deprivation and shows which areas of the county are most likely to be low income areas. Details can be found at https://inform.gloucestershire.gov.uk/deprivation/overview/, which states that:

The Indices of Deprivation 2019 are national measures based on 39 indicators, which highlight characteristics of deprivation such as unemployment, low income, crime and poor access to education and health services. The 2019 indices offer an in-depth approach to pinpointing small pockets of deprivation. Each indicator was based on data from the most recent time point available. Using the latest data available means there is not a single consistent time point for all 39 indicators.

https://inform.gloucestershire.gov.uk/media/2094524/gloucestershire_deprivation_2019_v13.pdf

There are 12 areas of Gloucestershire in the most deprived 10% nationally for the overall IMD. [9 of the 12 are in Gloucester District Council: GL1, GL2 and GL4 postcode areas, 2 in Cheltenham GL50 and GL51 and 1 in the Forest of Dean GL14.

LSOA	District	National Rank (1 most deprived)
Podsmead 1	Gloucester	621
Matson and Robinswood 1	Gloucester	735
Westgate 1	Gloucester	1,183
Kingsholm and Wotton 3	Gloucester	1,456
Westgate 5	Gloucester	1,579
St Mark's 1	Cheltenham	2,178
Moreland 4	Gloucester	2,221
St Paul's 2	Cheltenham	2,368
Cinderford West 1 *	Forest of Dean	2,729
Tuffley 4 *	Gloucester	2,801
Matson and Robinswood 5	Gloucester	2,948
Barton and Tredworth 4	Gloucester	3,126

Employment status is one of the indices of deprivation. Information available on the Inform website the latest available unemployment data for October and November 2020 indicates that Barton and Tredworth ward in the GL1 postcode of Gloucester has the highest claimant rate (Job Seekers Allowance and Universal Credit) in Gloucestershire. https://inform.gloucestershire.gov.uk/media/2102589/unemployment-bulletin-147-oct-20.pdf and https://inform.gloucestershire.gov.uk/media/2103578/unemployment-bulletin-148-nov-20.pdf

The FFTF2 Engagement survey collects top level postcode information (first part of the postcode, e.g., GL16 or GL3) to avoid potential for identifying individual survey respondents. Survey response information can be found in section 6.1.

5.6 Engagement events activity timeline

Activity	Reach/ Contacts	Date
ICS Non-Executive Directors & Lay Member Network	Approx.30 Non-Executive Directors and Lay Members	12 Apr 2022
GHNHSFT Board of Directors	Approx.15 Non-Executive Directors and Executive Directors	14 Apr 2022
PCN Clinical Directors	Approx.15 PCN Clinical Directors and CCG staff	28 Apr 2022
ICS Executives	Approx.10 CEOs, Executives and system leaders	05 May 2022
NHS Gloucestershire CCG Governing Body	Approx.15 CCH Executives and Governing Body members	05 May 2022
HOSC meeting	13 HOSC members – elected representatives	17 May 2022
Forest of Dean Integrated Locality Partnership (ILP)	Approx. 12 Mixed membership, clinical, community and voluntary sector	18 May 2022
Stroud and Berkley Vale ILP	Approx. 12 Mixed membership, clinical, community and voluntary sector	19 May 2022
Integrated Care System Board	Approx. 20 Board Members	19 May 2022
Countywide Patient Participation Group (PPG) Network	Approx. 40 PPG Members	20 May 2022
Cotswold ILP	Approx. 12 Mixed membership, clinical, community and voluntary sector	24 May 2022

Activity	Reach/ Contacts	Date
Kingfisher Treasure Seekers staff meeting	Approx. 12 staff members	24 May 2022
Glos. CCG Transformation Directorate meeting	Approx.40 CCG Staff	25 May 2022
Information Bus Tewkesbury Morrisons	25 visitors	30 May 2022
ICS Frailty Task & Finish Group	Approx.15 Clinical staff (GHNHSFT, GHCFT and CCG)	30 May 2022
ICS Stroke Task & Finish Group	Approx.15 Clinical staff (GHNHSFT, GHCFT and CCG)	31 May 2022
GHNHSFT Council of Governors	Approx.20 Governors and staff	31 May 2022
University of Gloucestershire – Nursing Students	300+ students (face-to-face / virtual)	1 June 2022
NHS Black and Minority Ethnic commissioning staff group	Approx. 10 colleagues	6 June 2022
Information Bus Stroud Tesco	121 visitors	7 June 2022
Cheltenham ILP	Approx. 12 Mixed membership, clinical, community and voluntary sector	8 June 2022
Tewkesbury ILP	Approx. 12 Mixed membership, clinical, community and voluntary sector	9 June 2022
Information Bus, Cheltenham High Street	57 visitors	11 June 2022
Information Bus, Abbeydale Morrisons	55 visitors	13 June 2022
Respiratory Facebook Live Discussion	Peak live views 74	13 June 2022

Activity	Reach/ Contacts	Date
Information Bus, Cirencester Market Square	140 visitors	14 June 2022
Frailty Facebook Live Discussion	Peak live views 48	14 June 2022
Stow-on-the-Wold, Market Square	36 visitors	15 June 2022
Tewkesbury Health and Wellbeing Event	Approx. 75 visitors	15 June 2022
Benign Gynaecology Facebook Live Discussion	Peak live views 36	15 June 2022
Information Bus, Cheltenham High Street	85 visitors	16 June 2022
Big Health Day (Learning Disabilities), Oxstalls Sports Park	100+ visitors	17 June 2022
Stroke Facebook Live Discussion	Peak live views 46	17 June 2022
Diabetes and Endocrinology Facebook Live Discussion	Peak live views 37	22 June 2022
Information Bus, Lydney Town Centre	17 visitors	23 June 2022
Cardiology Facebook Live Discussion	Peak live views 49	24 June 2022
Information Bus, Gloucester City Centre	77 visitors	25 June 2022
Information Bus, Chepstow Community Hospital	6 visitors	29 June 2022
Primary Care Commissioning Committee	Approx. 20 members	30 June 2022
CPG Leaders forum	Approx.20 Clinical staff (Primary Care, GHNHSFT, GHCFT and CCG)	7 July 2022
GHNHSFT Strategy & Transformation Delivery Group	Approx.25 Clinical, operational and transformation team staff	8 July 2022

Activity	Reach/ Contacts	Date
Frailty & Dementia CPG	Approx.15 Clinical staff (Primary Care, GHNHSFT, GHCFT and CCG)	9 July 2022
Circulatory CPG	Approx.15 Clinical staff (Primary Care, GHNHSFT, GHCFT and CCG)	12 July 2022
Health Overview and Scrutiny Committee	Approx. 15 HOSC members – elected representatives	12 July 2022
Tewkesbury Borough Council Seminar	Approx. 20 elected representatives and officers	12 July 2022
Telephone interviews	7 interviewees	13 July – 4 August 2022
GHNHSFT Staff virtual meeting/ drop-in	Approx. 20 Clinical, admin and operational	15 July 2022
Information Bus, Age UK Event, Highnam	Approx. 50 visitors	17 July 2022
Gloucester ILP	Approx. 12 Mixed membership, clinical, community and voluntary sector	19 July 2022
GHNHSFT Staff-side Committee	Approx.10 Clinical, operational and corporate staff	20 July 2022
GHNHSFT Outpatient Nurses meeting	Approx.8 Clinical staff	21 July 2022

6 Responses to the Engagement - Demographic Information

Demographic information about respondents was collected by the Fit for the Future 2 surveys. Monitoring of equality data requires a two-stage process: data collection and analysis. Gathering good equality data supports legislative requirements in that it aids prevention of discrimination. Therefore, it is really important to provide an explanation that the process is worthwhile and necessary.

The Fit for the Future 2 survey included the following statement:

About You: Completing the "About You" section [of the survey] is optional, but the information you give helps to show that people with a wide range of experiences and circumstances have been involved. Your support with this is really appreciated.

The Fit for the Future Easy Read survey included the following statement:

About You: You don't have to fill in this information, but it will help us know that we have asked a lot of different people what they think about our ideas.

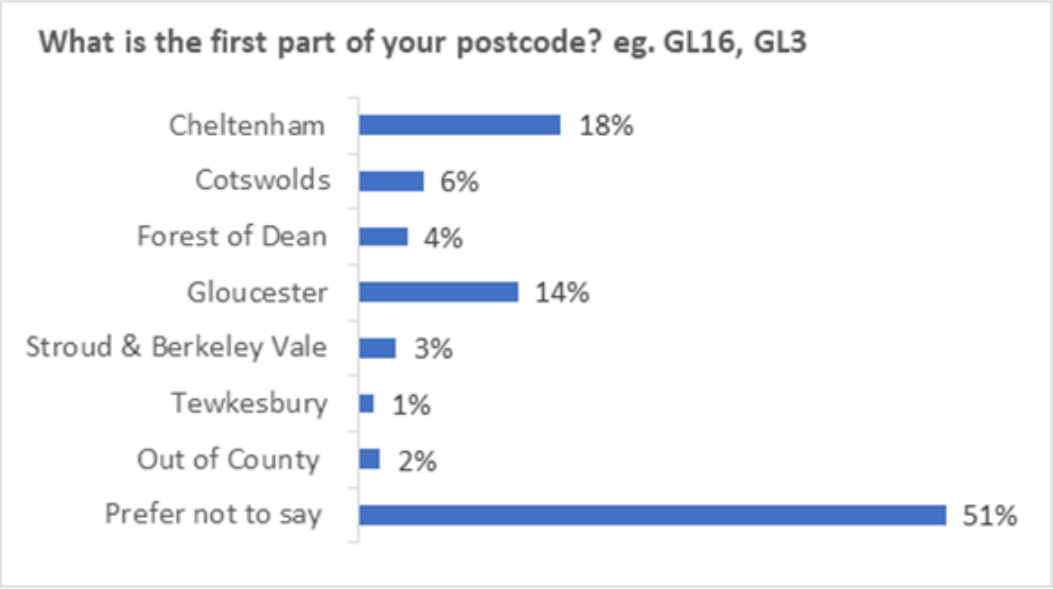
Not everyone who responded to the surveys completed any/all of the demographic questions. However, the data presented in this section indicates that a diverse range of respondents from all protected characteristic groups, and those identified in the Independent Integrated Impact Assessment have provided feedback to the Engagement.

The level of support for each proposal from staff and public is included in section 7.

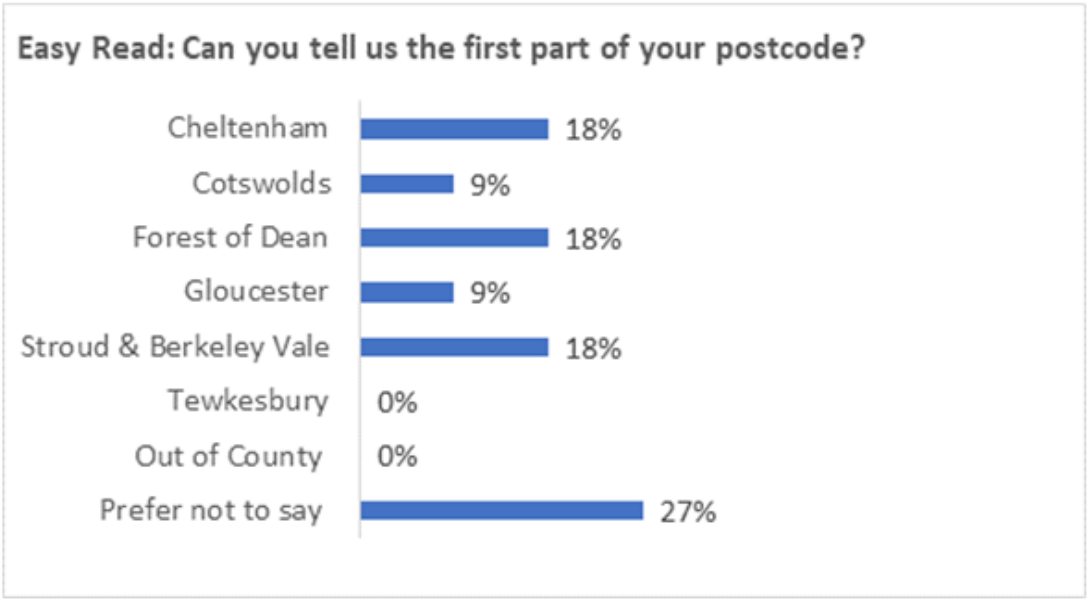
6.1 Location

As stated above, a high proportion of respondents either skipped or preferred not to provide their postcode.

Standard Survey



Easy Read


Easy Read: Can you tell us the first part of your postcode?
Cheltenham
18%
Cotswolds
9%
Forest of Dean
18%
Gloucester
9%
Stroud & Berkeley Vale
18%
Tewkesbury
0%
Out of County
0%
Prefer not to say
27%

6.2 Age

Standard Survey

Which age group are you?			
Answer Choices		Response Percent	Response Total
1	Under 18	0.00%	0
2	18-25	3.25%	4
3	26-35	10.57%	13
4	36-45	8.13%	10
5	46-55	23.58%	29
6	56-65	21.95%	27
7	66-75	20.33%	25
8	Over 75	10.57%	13
9	Prefer not to say	1.63%	2
		answered	123
		skipped	83

Easy Read Survey

Which age group are you:			
Answer Choices		Response Percent	Response Total
1	0 - 18	0.00%	0
2	18-25	0.00%	0
3	26-35	12.50%	1
4	36-45	0.00%	0
5	46-55	37.50%	3
6	56-65	12.50%	1
7	66-75	37.50%	3
8	75+	0.00%	0
9	Not saying	0.00%	0
		answered	8
		skipped	3

6.3 Role

Standard Survey

Are you?			
Answer Choices		**Response Percent**	**Response Total**
1	An employee working in health or social care	38.71%	48
2	A community partner	3.23%	4
3	A member of the public	50.00%	62
4	Prefer not to say	8.06%	10
		answered	124
		skipped	82

Easy Read Survey

Are you?			
Answer Choices		**Response Percent**	**Response Total**
1	Someone who works in health or social care	37.50%	3
2	A member of the public	62.50%	5
3	Not saying	0.00%	0
		answered	8
		skipped	3

6.4 Services Accessed

Standard Survey

Have you accessed any of the following services or support in the last 12 months (please tick all that apply)?

	Answer Choices	Response Percent	Response Total
1	Primary Care (GP)	80.95%	85
2	NHS Community Service (e.g. Community Nursing)	6.67%	7
3	Outpatient Hospital Service	57.14%	60
4	Specialist Inpatient Hospital Service	18.10%	19
5	Voluntary or community support related to your health and wellbeing	13.33%	14
6	Urgent care (e.g. 111, Minor Injury and Illness Unit, A&E)	39.05%	41
		answered	105
		skipped	101

Easy Read Survey

Have you used any of these services or had support from them in the last year?

	Answer Choices	Response Percent	Response Total
1	GP	83.33%	5
2	NHS Community Service (e.g. Community Nurse)	0.00%	0
3	Outpatient Hospital Service	33.33%	2
4	Specialist Inpatient Hospital Service	16.67%	1
5	Voluntary or community support for your health	16.67%	1
6	Urgent Care (A&E, Minor Injuries Unit, 111 Service)	33.33%	2
7	Not saying	0.00%	0
		answered	6
		skipped	5

We asked a follow-up question: Please tell us which hospital, community or voluntary service(s) you have accessed (e.g., respiratory, community nursing, support group). Details of the 62 services can be found in Appendix 1.

6.5 Disability

Standard Survey

14. Do you consider yourself to have a disability? (Tick all that apply)

	Answer Choices	Response Percent	Response Total
1	No	63.11%	77
2	Mental health problem	6.56%	8
3	Visual Impairment	2.46%	3
4	Learning difficulties	2.46%	3
5	Hearing impairment	6.56%	8
6	Long term condition	21.31%	26
7	Physical disability	10.66%	13
8	Prefer not to say	2.46%	3
		answered	122
		skipped	84

Easy Read Survey

Do you have a disability - tick the ones that describe you?

	Answer Choices	Response Percent	Response Total
1	No	28.57%	2
2	Mental health problem	28.57%	2
3	Problems with your sight	0.00%	0
4	Learning difficulties	0.00%	0
5	Problems with your hearing	0.00%	0
6	A health problem you have had for a long time like asthma, diabetes, or something else	71.43%	5
7	Physical disability	14.29%	1
8	Not saying	0.00%	0
		answered	7
		skipped	4

6.6 Carers

Standard Survey

Do you look after, or give any help or support to family members, friends, neighbours or others because of either a long term physical or mental ill health need or problems related to old age? Please do not count anything you do as part of your paid employment.

	Answer Choices	Response Percent	Response Total
1	Yes	36.36%	44
2	No	57.02%	69
3	Prefer not to say	6.61%	8
		answered	121
		skipped	85

Easy Read Survey

Do you look after, or give any help and support that you don't get paid for, to other people because they are ill or older?

	Answer Choices	Response Percent	Response Total
1	No, I don't	71.43%	5
2	Yes, I do	28.57%	2
3	Not saying	0.00%	0
		answered	7
		skipped	4

6.7 Ethnicity

Standard Survey

Which best describes your ethnicity?

	Answer Choices	Response Percent	Response Total
1	White British	84.80%	106
2	White Other	3.20%	4
3	Asian or Asian British	2.40%	3
4	Black or Black British	0.00%	0
5	Chinese	0.00%	0
6	Mixed	2.40%	3
7	Prefer not to say	7.20%	9
8	Other (please specify):	0.00%	0
		answered	125
		skipped	81

Easy Read Survey

Please can you tell us which o the groups in our list best describes you? This is called ethnicity.

	Answer Choices	Response Percent	Response Total
1	White British	75.00%	6
2	White Other	0.00%	0
3	Asian or Asian British	0.00%	0
4	Black or Black British	0.00%	0
5	Chinese	0.00%	0
6	Mixed	0.00%	0
7	Not saying	25.00%	2
		answered	8
		skipped	3

6.8 Religion or belief

Standard Survey

Which, if any, of the following best describes your religion or belief?

	Answer Choices	Response Percent	Response Total
1	No religion	29.27%	36
2	Buddhist	1.63%	2
3	Christian (including Church of England, Catholic, Methodist and other denominations)	58.54%	72
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	0.81%	1
7	Sikh	0.00%	0
8	Prefer not to say	7.32%	9
9	Other (please specify):	2.44%	3
		answered	123
		skipped	83

Easy Read Survey

Please tick if you have any of these religions or beliefs

	Answer Choices	Response Percent	Response Total
1	None	42.86%	3
2	Buddhist	0.00%	0
3	Christian	28.57%	2
4	Hindu	0.00%	0
5	Jewish	0.00%	0
6	Muslim	0.00%	0
7	Sikh	0.00%	0
8	Other	14.29%	1
9	Not saying	14.29%	1
		answered	7
		skipped	4

6.9 Sex and Gender

Standard Survey

Are you?			
Answer Choices		Response Percent	Response Total
1	Male	19.51%	24
2	Female	73.98%	91
3	Transgender	0.00%	0
4	Non-binary	0.81%	1
5	Prefer to self-describe	0.00%	0
6	Prefer not to say	5.69%	7
		answered	123
		skipped	83

Easy Read Survey

Can you say about your gender? Tick the one that describes you.			
Answer Choices		Response Percent	Response Total
1	Male	37.50%	3
2	Female	50.00%	4
3	Transgender	0.00%	0
4	Non-binary	0.00%	0
5	Not saying	12.50%	1
		answered	8
		skipped	3

6.10 Sexual Orientation

Standard Survey

Which of the following best describes how you think of yourself?			
Answer Choices		Response Percent	Response Total
1	Heterosexual or straight	87.80%	108
2	Gay or lesbian	2.44%	3
3	Bisexual	0.81%	1
4	Other	1.63%	2
5	Prefer not to say	7.32%	9
		answered	123
		skipped	83

Easy Read Survey

Can you say how you think of yourself?			
Answer Choices		Response Percent	Response Total
1	Heterosexual or straight	71.43%	5
2	Gay or lesbian	14.29%	1
3	Bisexual	0.00%	0
4	Other	0.00%	0
5	Not saying	14.29%	1
		answered	7
		skipped	4

6.11 Pregnancy

Standard Survey

Are you currently pregnant or have given birth in the last year?			
Answer Choices		Response Percent	Response Total
1	Yes	0.00%	0
2	No	73.39%	91
3	Not applicable	22.58%	28
4	Prefer not to say	4.03%	5
		answered	124
		skipped	82

Easy Read Survey

Are you pregnant or had a baby in the last year?			
Answer Choices		Response Percent	Response Total
1	Yes	0.00%	0
2	No	62.50%	5
3	Not saying	0.00%	0
4	This question doesn't apply to me	37.50%	3
		answered	8
		skipped	3

6.12 Interviews

The survey included the following:

If you are interested in participating in a discussion (face to face or virtual) about any of the FFTF2 services, please provide details below (to protect your anonymity, we will separate your contact information from the feedback you have provided in this survey).

27 people responded positively to this question. Each individual was contacted resulting in 7 telephone interviews conducted.

7 Responses to the Engagement: Individual Services

This section sets out the survey feedback received about each of the services.

The Fit for the Future 2 survey included two types of questions:

1. **Quantitative** questions, which offer a choice for the respondent, for example, Benign Gynaecology: Please tell us what you think about the ideas for Benign Gynaecology:
    - *Strongly support*
    - *Support*
    - *Oppose*
    - *Strongly oppose*
    - *No opinion*
2. **Qualitative** questions which invite the respondent to write a comment,

Please tell us why you think this, e.g., the information you would like us to consider:

As mentioned previously, the qualitative feedback from completed surveys and correspondence has been grouped into themes. In this report, we have addressed the themes from Engagement feedback and included some illustrative quotations have been selected from the free-text responses from the survey for each of the proposals and other correspondence received. All free text responses can be found in Appendix 1.

7.1 Benign Gynaecology

The idea that we engaged on was to continue to deliver the majority of Benign Gynaecology Day case surgery at Cheltenham General Hospital.

- **92%** of all respondents either **strongly supported** or **supported** the idea
- **96%** of staff respondents either **strongly supported** or **supported** the idea

7.1.1 *Quantitative Survey responses*[10]

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	28%	45%	39%	16%	84%
A community partner	4%	50%	50%	0%	100%
A member of the public	37%	39%	56%	5%	95%
An employee working in health or social care	27%	33%	63%	4%	96%
Prefer not to say	5%	50%	33%	17%	83%
Grand Total	**100%**	**40%**	**52%**	**8%**	**92%**

[10] Analysis of standard survey

Easy Read Survey

Answer Choices			Response Percent	Response Total
1	Good idea		71.43%	5
2	Quite good		0.00%	0
3	Not sure		0.00%	0
4	Bad idea		14.29%	1
5	Not saying		14.29%	1
			answered	7
			skipped	4

7.1.2 *Qualitative Survey responses*

A summary of the key themes and some example comments (from staff and the public) are presented below.

7.1.2.1 Public and Patients themes

Theme	Survey comment examples
Reduced cancellations	• It releases women from worry over a long period of time. • Fewer cancellations and shorter waiting
New Day Case unit at CGH	• The day case unit at CGH will be good for this, and having it at a site where there is less likely to be cancellations is good • Privacy and lack of fear of constant cancellation are far more important than the inconvenience of a longer journey • Individual rooms especially for those with disabilities etc.
Centres of Excellence	• If the intention is to make Cheltenham the main day-case site, then it would seem an appropriate to relocate this service to Cheltenham. • The case makes sense • Excellent plan benefits outweigh drawbacks
Travel	• Useful to centralise system but transport will always be a problem if you expect day cases to arrive by 7.30am • I find it incredibly difficult to get to Cheltenham general and I am fit and well with my own transport. GRH is far easier to get to it's all about not having the choice
Patient experience	• Women need to feel they are being seen speedily, by a professional who will listen and expedite treatment, in the near future. • Expertise in one place. Better services. Better access to services.

7.1.2.2 Staff themes

Theme	Survey comment examples
Clinical considerations	• Sensible if the procedure is minor and doesn't involve complications, consideration needs to be given to more complex patients with additional needs, who may require inpatient care. minor surgery suitable for CGH • For day case procedures not expecting overnight stays, I feel this appropriate
New Day Case unit at CGH	• Exciting to be having treatment in the new Day unit being built in CGH rather than the very tired unit in GRH
Reduced cancellations	• Reductions in cancellations are a necessity • Get operations done when no beds • Sounds like a robust plan to consolidate services on a single site and reduce the impact of bed availability on cancellations
Car Parking	• More car parking for our patients is needed

7.1.3 *Addressing themes from engagement feedback*

Feedback received and FFTF2 response
New Day Case unit at CGH
It is welcomed that both staff and the public see the benefits from undertaking Benign Gynaecology Day cases at the new Chedworth Day Surgery Unit (opening Jan 2023)
Reduced cancellations
The negative impact of cancellations on this cohort of patients is recognised by both staff and the public and the positive impact that the reduction in cancellations will have if these proposals are confirmed.
Travel
The negative impact of increased travel, particularly for patients travelling from the Forest of Dean to CGH is clearly recognised. Analysis has indicated that ~ 18% of patients will be negatively impacted, with 82% neutral or positive. For this cohort the impact is only for one day and as it is not the intention to bring all day-case gynaecology to CGH, a smaller number will remain at GRH to offer choice based on circumstances. Finally, if follow up clinics or therapy is required post operatively, this can be carried out at a site closest to the patient's home.

7.2 Diabetes and Endocrinology

The idea we engaged on was to continue to centralise the dedicated Diabetes and Endocrinology Inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology Consult service at Cheltenham General Hospital.

The ideas under consideration only relate to changing inpatient services. There would continue to be a choice of outpatient appointments at both acute hospital sites, in the community and virtually when appropriate. The idea for the Diabetes and Endocrinology Service is to maintain the centralised inpatient beds at GRH on Ward 9B of the Tower Block and to continue supporting General Medicine patients who are also admitted onto the Ward. All patients who have an acute diabetic or endocrine episode would continue to be admitted to GRH. The service would continue to provide support to other hospital patients, who also happen to have diabetes, but are under the care of other specialties (service areas), on both hospital sites.

- **98%** of all respondents either **strongly supported** or **supported** the ideas
- **100%** of staff respondents either **strongly supported** or **supported** the ideas

7.2.1 *Quantitative Survey responses*[11]

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	26%	57%	36%	7%	93%
A community partner	4%	50%	50%	0%	100%
A member of the public	38%	44%	56%	0%	100%
An employee working in health or social care	28%	42%	58%	0%	100%
Prefer not to say	5%	40%	60%	0%	100%
Grand Total	**100%**	**47%**	**51%**	**2%**	**98%**

Easy Read Survey

Answer Choices			Response Percent	Response Total
1	Good idea		87.50%	7
2	Quite idea		12.50%	1
3	Not sure		0.00%	0
4	Bad idea		0.00%	0
5	Not saying		0.00%	0
			answered	8
			skipped	3

[11] Analysis of standard survey

7.2.2 *Qualitative Survey responses*

A summary of the key themes and some example comments (from staff and the public) are presented below.

7.2.2.1 Public and Patients themes

Theme	Survey comment examples
Innovation	• I think it's good to centralise a specialty in one place however I do think that you need make more use of technology, e.g., virtual monitoring • Self-help, education and support for new patients and healthy eating should be part of any new service approach • Train other NHS staff (Drs, nurses, AHPs & dietitians) to enable triage process. These trained staff can refer on &/or discuss directly (phone/email) with specialist diabetes personnel to determine care plan.
Clinical considerations	• A protocol for treating Addisons Crisis and patients being "red flagged" for urgent treatment • More support needed for long-term diabetics. • I think life style is very important and self-control of healthy eating is a better option than reliance on medication. Healthy exercise is also vital. • The staff need to be trained and competent, to deal with patients who have complex needs.
Centres of Excellence	• This seems to be the most efficient way to organise services, but continued support to patients with diabetes or endocrine conditions located on other wards is essential. • The case made is good • The Centres of Excellence approach should bring patient benefits
Travel	• Having the team under one roof is a good thing, but the transport problem is still there. • The benefits are partially outweighed by transport for some people • I believe there should be inpatient beds available at both Gloucester and Cheltenham sites.
Patient experience	• Would just like any services focusing on patient care.

7.2.2.2 Staff themes

Theme	Survey comment examples
Clinical considerations	• It has several linkages to acute specialties that it should remain at GRH. • Centralising service will improve outcomes, patient care and experience.
Integration	• It is important to integrate care for people with diabetes • Diabetes specialists/teams in the community to offer specialist care. • Patient education is really important especially in the community or primary care • I am concerned that reconfiguration discussions which are 'site centric' overlook the overwhelming need to move diabetes services into the community to point of near exclusivity.
Workforce	• There are not enough Diabetic Community Nurses to cover the whole county. • The Diabetes team is extremely small and therefore centralising services to GRH site makes sense
Car Parking	• Parking needs to be improved massively.

7.2.3 *Addressing themes from engagement feedback*

Feedback received and FFTF2 response
A protocol for treating Addisons Crisis
There are protocols available on the Trust's intranet for treating Addisonian crisis. The previous Trakcare system has an icon available to all patients with specific healthcare needs, of which steroid dependency is one of them. Whenever a patient is started on replacement steroids the icon will be allocated to them on Trakcare. There have been some issues pulling this through onto the new EPR system, but this is being addressed currently.
Diabetes specialists/teams in the community to offer specialist care
Confirm that community D&E outpatient clinics will not be impacted. Although this particular proposal focuses on inpatient care, The Hospital Trust does work in collaboration with Gloucestershire Health and Care to share information and projects being worked on in health care settings across Gloucestershire. ICS Diabetes and Endocrinology Integration Model Project aims to develop a single point of access to manage patients in the community who may not need to go into Acute Trust. Type 2 diabetic patients would be included within the scope of this project, with the objective being that the vast majority of these patients would be seen in a community clinic by default. In order to facilitate this, the ICS have recruited a community Diabetic consultant. CCG Virtual Ward Round Project - The virtual ward project is currently being scoped out by the ICS and focuses upon Diabetic and Endocrine patients who are discharged from the Hospital to reduce readmissions.

Patient education is really important especially in the community or primary care
The ICS run various patient education programs of people with newly diagnosed type 2 diabetes and for people who are starting on insulin. There are also a number of courses covering diet and lifestyle to assist in the prevention of the development of type 2 diabetes. In terms of type 1 diabetes, we do a lot of one-to-one work and also offer a number of options on learning to carbohydrate count, these are mainly online based.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 4% of patients will be negatively impacted, with 96% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.
Train other NHS staff (Drs, nurses, AHPs, dietitians) to enable triage process.
The future plan is to have two Diabetes link nurses for each ward and ED areas. In addition, there will be updated training every 2 months for healthcare professionals. There is currently and diabetes e-learning available online for staff, which is currently being considered to become mandatory training for all medical staff members. Furthermore, the service already RAG rates patients to determine which inpatients do need to be seen by the specialist team.

7.3 Non-interventional Cardiology

The idea we engaged on was to centralise Non-Interventional Cardiology inpatient beds at Gloucestershire Royal Hospital and provide a Cardiology Consult service at Cheltenham General Hospital.

The ideas we are considering only relate to potential changes to overnight inpatient services. There would continue to be a choice of outpatient appointments at both GRH and CGH, in the community and virtually when appropriate. Our idea is to centralise all Cardiology inpatient beds at GRH and therefore relocate the remaining eight inpatient beds from CGH to GRH.

- **99%** of all respondents excluding staff either **strongly supported** or **supported** the ideas
- **97%** of staff respondents either **strongly supported** or **supported** the ideas

7.3.1 *Quantitative Survey responses*[12]

Respondent type and proportion (%)		Strong support	Support	Oppose	Total Support
Not stated	14%	50%	50%	0%	100%
A community partner	4%	33%	67%	0%	100%
A member of the public	42%	49%	51%	0%	100%
An employee working in health or social care	37%	45%	52%	3%	97%
Prefer not to say	4%	33%	67%	0%	100%
Grand Total	**100%**	**47%**	**52%**	**1%**	**99%**

Easy Read Survey

Answer Choices			Response Percent	Response Total
1	Good idea		71.43%	5
2	Quite good		28.57%	2
3	Not sure		0.00%	0
4	Bad idea		0.00%	0
5	Not saying		0.00%	0
			answered	7
			skipped	4

[12] Analysis of standard survey

7.3.2 *Qualitative Survey responses*

A summary of the key themes and some example comments (from staff and the public) are presented below.

7.3.2.1 Public and Patients themes

Theme	Survey comment examples
Innovation	• Use of technology to reduce referral times, e.g., patient/ GP/ specialist video calls and portable ultrasound and ECG equipment that can be used to provide diagnostic information to specialists
Clinical considerations	• How are patients with other medical issues who also have a need for non-interventional cardiology be treated in CGH? • It seems to make sense to consolidate cardiology beds in one site (GRH). Would be great for additional funding for MRI, CT, services as well as services related to heart failure and genetic heart conditions. • Reduce length of stays. All different specialists under one roof, better for care and training, more likely to get correct specialists.
Centres of Excellence	• I can see the logic in moving the remaining non-interventional beds to be under the care of the centralised inpatient cardiology team. • Concentrating expertise in one hospital is important. • Objectively - absolutely right to optimise cardiac services in one place. Hard sell for past patients who have been treated successfully in Cheltenham, but this should be pushed forward.
Travel	• Transport over the county is appalling • Makes sense but it is the traveling that could be a problem for those without their own
Patient experience	• My first symptoms were over 65 years ago, and I am truly grateful for the NHS support I had since! I still enjoy life.

7.3.2.2 Staff themes

Theme	Survey comment examples
Clinical considerations	• Best located where support services are • Agree cardiology inpatient provisions should be based at GRH • Centralising services on the GRH site will be of great benefit to ongoing cardiac care/services hopefully reduce waiting times for interventions, improving patient outcomes and LOS in the long term and decreasing the need for transfers out of county. • Better pathway to interventional investigations
Interdependencies	• Cardiology should be on the same site as Vascular Services • Cardiology should be based on the site with greatest cover from Vascular and Interventional Radiology

	• I am concerned that this good work in centralising specialist services will be overly reliant on Ambulance Service performance.
Travel	• Travel may cause a difficulty for some people; however, the benefits appear to outweigh the negatives.

7.3.3 *Addressing themes from engagement feedback*

Feedback received and FFTF2 response
Co-location of all cardiology services (FFTF1 and FFTF2)
It is welcomed that both staff and the public see the benefits from centralising all cardiology inpatient services at GRH
Co-location of cardiology with vascular
It is welcomed that staff see the benefits from centralising all cardiology inpatient services at GRH which will be co-located with vascular services.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 10% of patients will be negatively impacted, with 90% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

7.4 Respiratory

The idea we engaged on was to continue to centralise Respiratory Inpatient beds and establish Respiratory High Care at Gloucestershire Royal Hospital and provide a Respiratory Consult service at Cheltenham General Hospital.

As a result of the temporary service changes in response to COVID-19, the Hospital Trust's inpatient respiratory services are currently centralised at GRH. The respiratory high care service (initially established as a COVID response), aims to improve the quality of service for the population of Gloucestershire and enable the team to quickly respond to high acuity (very unwell) patients, including those with COVID-19, who need this level of specialist care.

- **97%** of all respondents either **strongly supported** or **supported** the idea
- **100%** of staff respondents either **strongly supported** or **supported** the idea

7.4.1 *Quantitative Survey responses*[13]

Respondent type and proportion (%)		Strong support	Support	Oppose	Strongly oppose	Total Support
Not stated	12%	36%	64%	0%	0%	100%
A community partner	4%	50%	50%	0%	0%	100%
A member of the public	43%	41%	51%	5%	3%	92%
An employee working in health or social care	34%	48%	52%	0%	0%	100%
Prefer not to say	6%	40%	60%	0%	0%	100%
Grand Total	**100%**	**44%**	**53%**	**2%**	**1%**	**97%**

Easy Read Survey

Answer Choices			Response Percent	Response Total
1	Good idea		100.00%	6
2	Quite good		0.00%	0
3	Not sure		0.00%	0
4	Bad idea		0.00%	0
5	Not saying		0.00%	0
			answered	6
			skipped	5

[13] Analysis of standard survey

7.4.2 *Qualitative Survey responses*

A summary of the key themes and some example comments (from staff and the public) are presented below.

7.4.2.1 Public and Patients themes

Theme	Survey comment examples
Innovation	• More opportunities for self-referral and annual pulmonary rehab
Clinical considerations	• Need to ensure that patients on these wards with other health conditions receive good support from other specialties. • If the last 2.5 years has shown this to work and be beneficial, that's a pretty compelling 'inadvertent pilot'!! • Review by same practitioners maintain continuity of care. This gives the patient confidence in their care.
Ward environment	• On the whole this idea should be supported however the wards in Gloucester Hospital are poorly ventilated and understaffed.
Integration	• Lack of community support is a huge problem • Putting respiratory professionals in GP clinics/hubs rather than only in GRH • Community involvement may be needed, and it is important to introduce them as soon as possible, to maintain quality care.
Travel	• Makes good sense and has been 'trialled' through the pandemic, again we need to acknowledge limited resources, and the distance is manageable but could be costly for some.

7.4.2.2 Staff themes

Theme	Survey comment examples
Clinical considerations	• Anyone with a diagnosis of acute respiratory illness having access to relevant teams to avoid A&E attendance, perhaps contact through the direct admission pathway to avoid the emergency department. • Patient transfers from CGH. • Respiratory is a service that has worked well being centralised to GRH site • It seems to make sense to consolidate beds in one site especially with more consultant emergency cover should the patient become acutely unwell
High Care	• Respiratory high care service is a needed service to be able to meet the requirements of acutely unwell respiratory patients. • Evidence from COVID suggests a higher level of respiratory care needed.
Workforce	• The proposal is exciting, there needs to be consideration of the workforce resource required outside of medics and nursing. • The Respiratory service at the Trust is exceptionally well lead and proactive in its outlook and approach.
Integration	• There is further work to be done with improving integration of services across the ICS with further investment for managing

	respiratory conditions and access to services such as pulmonary rehabilitation and care/support in the community. • Curious as to why some respiratory services couldn't be offered at community level.

7.4.3 *Addressing themes from engagement feedback*

Feedback received and FFTF2 response
Respiratory High Care
The business case includes on average 11 respiratory high care monitored beds – demand is highly variable. Extra beds are to have monitors in the side rooms for times of high demand of infection control needs. Additional resources required to develop this service are 2 x Advanced Clinical Practitioners and 1.5 x band 7 physiotherapists. The medical and nursing support can be provided within existing establishments.
Patients who come in for surgery may develop other problems that need respiratory help
This would be covered by the consultant based at Cheltenham, very sick patients could be looked after in intensive care.
Patients needing transfer
At the point that the ED team think that the patient needs to be admitted they would put them on the Acute take list, arrangements would then be made to transfer the patient (via a Trust inter-site ambulance) to Gloucester. The patient would be taken directly to the Acute Medical Unit, avoiding the ED.
Community support
Cheltenham outpatient clinics will not be changed. We are also developing an Acute Respiratory Infection Virtual Ward. This model will be aimed at patients who would otherwise have been admitted to hospital on a <5 LOS bed stays and have a News2 score of <4. This model also supports patients being discharged from hospital to the care of this ward who would otherwise have had to remain in hospital longer.
Travel and Transport
The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 9% of patients will be negatively impacted, with 91% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

7.5 Stroke

The idea we engaged on is that both the Hyper Acute Stroke Unit and Acute Stroke Unit remain permanently at CGH and the way that patients currently access the service remains the same. The learning over the past two years is that it's easier to manage and deliver a quality service if both units are on the same site (CGH).

- **84%** of all respondents excluding staff either **strongly supported** or **supported** the idea
- **73%** of staff respondents either **strongly supported** or **supported** the idea

7.5.1 *Quantitative Survey responses*[14]

Respondent type and proportion (%)		Strong support	Support	Oppose	Strongly oppose	Total Support
Not stated	12%	36%	46%	9%	9%	82%
A community partner	4%	50%	50%	0%	0%	100%
A member of the public	44%	51%	47%	0%	2%	98%
An employee working in health or social care	35%	36%	37%	0%	27%	73%
Prefer not to say	5%	20%	20%	0%	60%	40%
Grand Total	**100%**	**43%**	**41%**	**1%**	**15%**	**84%**

Easy Read Survey

Answer Choices			Response Percent	Response Total
1	Good idea		100.00%	6
2	Quite good		0.00%	0
3	Not sure		0.00%	0
4	Bad idea		0.00%	0
5	Not saying		0.00%	0
			answered	6
			skipped	5

[14] Analysis of standard survey

7.5.2 *Qualitative Survey responses*

It should be noted that the ideas for stroke received the highest proportion of opposition from survey respondents compared to other services, particularly from staff concerned with the location of stroke at the non-emergency site. Concerns were raised especially regarding co-location with vascular surgery and cardiology.

All survey comments (Appendix 1) were reviewed by the Stroke team and a response is provided below. Arrangements are also underway to arrange meetings between the services.

A summary of the key themes and some example comments (from staff and the public) are presented below.

7.5.2.1 Public and Patients themes

Theme	Survey comment examples
Interdependencies	• Getting a stroke patient to one of these units within the critical 4 hours is another matter given the current demand for ambulances.
Clinical considerations	• I'm very unsure about this. No mention made of thrombectomy • I am concerned that, with the often time critical nature of strokes, the move of in-patient stroke to CGH might lengthen the time before a patient received a necessary thrombolytic agent. • The issues of patient transport need to be addressed, especially walk-ins to GRH which are subsequently transferred to CGH. • Why would you have Stroke based at Cheltenham General when cardiac, interventional radiology and vascular services are all at Gloucestershire Royal Hospital • Happy that CGH has control of stroke admissions. I agree with potential benefits.
Benefits	• Excellent - good analysis of potential drawback • Streamline to get the best optimal service. The better and sooner we treat stroke, the way better the outcomes for patients and their long-term outlook.
Ward environment	• It makes sense to have both the HASU and ASU on the same site, but also that they are separated so as to have the ASU in the quieter area. • Vital to have prompt effective assessment and treatment. Good to have a therapy areas on Woodmancote Ward.
Inter-site transfers	• There will still be transfers required, but there would be anyway if it was all located at GRH. However, as ever the issues of patient transport need to be addressed, especially walk-ins to GRH which are subsequently transferred to CGH. • Same site for both makes sense and if transport between the 2 hospitals if needed is in place, that should cover the unusual cases

Patient experience	• As I've said Cheltonians prefer Cheltenham over Gloucester. • The family should always be involved in all care plans. Because it needs to be an holistic approach.

7.5.2.2 Staff themes

Theme	Survey comment examples
Clinical considerations	• The purpose-built ward at CGH is suitable • I share the concern about receiving the correct treatment, diagnosis and transfers to Cheltenham. • The new model for HASU works well having limited beds and a focus on patients being moved on quickly
Interdependencies	• Stroke services need to be located where ED, Interventional Radiology, Vascular and cardiology are on the main acute site. • Acute stroke is an emergency service, and it should be based at a site where there is 24 hour ED • What happens to overnight Strokes when ACUC moves to GRH, and the medical cover goes with it? • Removing the service from the main ED and delaying crucial intervention such as thrombolysis.
Workforce	• It has hugely helped with staffing and team moral being on the same site. • I point out that, especially for understaffed therapy teams, HASU and ASU being on the same site saves huge amounts of resources as the therapists can help out on each ward depending on staffing and patient demands. • I would also say that the service should have more funding for therapists and assistants and would benefit from an activities coordinator, social work support and complex discharge coordinator
Ward environment	• The current HASU ward is not fit for purpose • Larger clinical area for HASU - more room for beginning rehabilitation of patients • Woodmancote is more modern, lighter and purpose built for Stroke rehabilitation. • Woodmancote is well suited to the therapy needs of patients considering the track hoists and large therapy room and Cheltenham hospital is a good environment for these patients with nice outdoor areas that can be accessed.
Health inequalities	• Stroke services should be at biggest acute hospital in the city where socioeconomic circumstances make stroke most common

7.5.3 *Addressing themes from engagement feedback*

Feedback received and FFTF2 response
Stroke services need to be located where ED, Interventional Radiology, Vascular and cardiology are on the main acute site.
There is currently no interventional radiology input from Gloucester or Cheltenham. The interventional radiology for strokes is carried out at Southmead and there is no intention that that will change. If, and when, GHNHSFT starts providing thrombectomy for strokes, we will revisit our service configurations, but currently and the for the next few years, this is not an issue. The vascular issue is around access to carotid dopplers and carotid endarterectomy for the high TIAs. Surgery is not performed on the same day and best practice is within seven days. The vascular unit at GRH includes patients from Swindon which is acceptable. Cardiology input is for telemetry and tapes and echoes. We will continue to have cardiac investigations on both sites. Furthermore, echoes are never immediate to help guide next steps of treatment. It's not emergency care. We rarely share stroke patients with cardiology. We may occasionally ask for advice on rhythm disturbance, but we have not had a patient that suddenly had a heart attack and needed resuscitating.
Medical cover at CGH
Out of hours there is 24/7 medical registrar cover at CGH. This registrar provides cover for the acute take as well as supporting the stroke service. Once the acute take centralises at GRH the responsibilities of this post will reduce. The medical registrar works closely with the specialist nurses and the Advanced Care Response Team. There is a Consultant Specialist regional on call rota for thrombolysis/thrombectomy queries. At weekends there is a Stroke Consultant on site at GRH from 8am – 12.00
Strokes at GRH
If a patient with stroke symptoms 'walks in' at GRH Emergency Department, they receive a priority assessment and there is immediate communication with the stroke team. If appropriate the patient is transferred to CGH for rapid stroke assessment. There is a consult model in place for GRH, which means that stroke staff will provide advice and support to other specialties (service areas) on the GRH site. There is now an agreed protocol for managing COVID positive stroke patients in CGH.
Ambulance travel times
As with FFTF1, the FFTF2 programme has worked closely with the South Western Ambulance Service NHS Foundation Trust (SWASFT) and Operational Research in Health (ORH) Limited to model the "blue light" ambulance travel impact. The impact has been assessed for both the ambulance incident response times and the Call to Hospital. The findings for HASU are as follows: • The impact to response performance of making the proposed changes are generally small, at 18 seconds for both the C2 mean and C2 90th percentile in Gloucestershire CCG. • Average ambulance utilisation across the model increases by 0.1 percentage points; this is expected as despite travel time to CGH being 3m 37s longer on

average, only 1.2% of transported patients in NHS Gloucestershire are affected by the change.

- The total time from time of call to handover at hospital increases by 7m24s for HASU patients. This measure is impacted by many factors including resource availability, changes in travel times and stacking of vehicles at hospital during handover.
- A series of simulation runs were then carried out, adding additional ambulance deployments at Staverton to identify the additional resources required to mitigate the performance impacts.
- An additional 14 ambulance hours per week at Staverton are needed to restore performance, delivered through the extension of shifts. In terms of scale, this is approximately 10% of the overall additional ambulance hours required for FFTF1.

Ward environment

As part of proposed moves for Cardiology in May 23, the HASU will be able to relocate into the Cardiology ward at CGH, which will provide 21 beds. This ward looks out on to a courtyard garden providing better space for recovery. It will also provide better space for therapy services. Cheltenham has better car parking access for wheelchair users.

Travel and Transport

The negative impact of increased travel is clearly recognised. Analysis has indicated that ~ 15% of patients will be negatively impacted, with 85% neutral or positive. Our Integrated Impact Assessment would indicate that the benefits (patient outcomes) outweigh the negative travel impact.

Inter-site transfers

The Trust currently has a contract with an independent company to provide patient transfers by ambulance. The transfers include transporting patients from the GRH to Hartpury Suite (Cath Lab) at CGH, supporting patient discharge to their place of residence or to other providers and transferring patients between the two hospital sites.

As part of FFTF Phase 1, work was carried out to identify the inter hospital demand to support the centralisation of emergency general surgery and the acute medical take at GRH, and the transfer of vascular services and interventional cardiology services to GRH. This work has been updated to reflect the current experience during the temporary service changes and the proposed service changes within FFTF Phase 2, i.e., the centralisation of respiratory, cardiology, diabetes and endocrinology services at GRH and the centralisation of stroke services at CGH.

7.6 Frailty / Care of The Elderly

The decision was made to include Frailty / Care of The Elderly as part of the FFTF Phase 2 Engagement to seek the views of our population regarding the whole frailty pathway.

On the basis that detailed proposals will not be developed at this time the decision has been made to withdraw Frailty/Care of The Elderly from the NHS England clinical review panel process and external scrutiny (as agreed with NHSEI).

The Frailty Clinical Programme Group has led a series of workshops in 2021 with the aim to develop a Frailty Strategy for Gloucestershire. A Task and Finish (T&F) group has been established to undertake a diagnostic review of current service configuration, develop a case for change and a preferred option for the future configuration of frailty services. This includes the Frailty Assessment Unit (at GRH and any proposals for CGH), Frailty and Care of the Elderly ward and bed numbers at CGH and GRH, direct admit pathways and Same Day Emergency Care (SDEC) offer and integration with existing Community Frailty Services and development of any new services. Membership of this group includes clinical and management representatives from GHNHSFT and GHCFT, CCG commissioning leads, GPs, VCSE and lay representation.

The T&F group will receive and review all the feedback received during the Fit for the Future 2 Engagement. Themes from the feedback relating to Frailty and Care of The Elderly were grouped into the following areas:

- Hospital services
- Information sharing
- Integration between services
- Out of hospital care
- Prevention agenda
- Responsiveness of services
- Other

As and when service development proposals are progressed these will be assessed with regard to our statutory duties and, where required, will be subject to the standard FFTF assurance process.

8 Evaluation

8.1 Considerations and learning points for future engagement and communication activities

Our approach to evaluating the effectiveness of our consultation activities locally is to apply a well-known quality improvement methodology, using an iterative process: Plan, Do, Study, Act (PDSA cycle) https://improvement.nhs.uk/documents/2142/plan-do-study-act.pdf

Engagement (and Consultation), Experience and Inclusion Evaluation Framework developed by The Science and Technologies Facilities Council has developed a useful engagement evaluation framework, https://stfc.ukri.org/files/corporate-publications/public-engagement-evaluation-framework/ We have adapted this to support the STUDY element in our Engagement, Experience and Inclusion PDSA Cycle.

Dimension	Definition	Response
Inputs	Engagement (and Consultation), experience and inclusion inputs include the time, skills and money that are invested into delivering engagement activities.	A comprehensive Fit for the Future Communications and Engagement plan was developed to support the consultation activity. This plan set out the approach to communications and consultation. The plan was evaluated using an Engagement and Equality Impact Assessment
Outputs	Engagement (and consultation), experience and inclusion outputs are the activities we undertake and the resources that we create.	Over 50 public and staff Engagement events were held. The mix of face-to-face and online events were held. Approximately 3000 information booklets were produced and distributed in local communities. Feedback received did include comments on the Fit for the Future2 process itself. Feedback received was a mixture of positive and negative comments. An example of learning from feedback of this kind from the earlier Fit for the Future 1 Engagement and Consultation was to work with Inclusion Gloucestershire to produce and Easy Read version of Engagement materials.

Dimension	Definition	Response
Reach	Reach has two main elements: The number of people engaged, this includes attendance at events, completion of surveys, social media interaction etc. The types or diversity of people engaged.	Total face-to-face contacts was more than 1000 individuals. More than 200 Fit for the Future 2 surveys completed. Facebook adverts reached approximately 64,500 individual people. This resulted in 925 people clicking the link through to the Engagement survey. Twitter adverts had more than 55,000 impressions with the link to the survey clicked 87 times in total. We do not routinely collect demographic information about individuals participating in events/drop-ins etc. Demographic information was collected through our survey, but these questions were optional and consequently were not always completed. However, the demography of the county is considered during Engagement planning and events/meetings targeted to reach a wide range of communities of interest and those groups identified though the independent Integrated Impact Assessment.
Outcomes	Outcomes are the way that audiences respond to the engagement, experience and inclusion activity – completed event evaluation forms, independent observation reports	We have received no written complaints regarding the Engagement approach. The respondents who participated in the follow up telephone interviews with a member of the Engagement Team indicated that they valued the approach taken.

Dimension	Definition	Response
Processes	Processes are the way we work to plan, develop and deliver our engagement, experience and inclusion activities. They include our approaches to quality assurance and following good practice.	Inclusion Gloucestershire: Assisted with the development of Easy Read materials. Healthwatch Gloucestershire (HWG): HWG Readers Panel reviewed an early draft of the Engagement booklet and made suggestions for changes, which were incorporated into the final version. The Readers Panel completed a second review of a more fully worked up version of the full Engagement Booklet – again all feedback was considered. Aneurin Bevan Health Board (ABHB): facilitated an Information Bus visit to Chepstow Hospital in Monmouthshire to enable residents living close to the Wales England Border, who might access services in Gloucestershire the opportunity to find out more about the consultation. Know Your Patch (KYP) Coordinators: KYPs allowed us to share information to promote the Engagement. District/Borough Councils and Retail partners: Supported the visits of the Information Bus to locations with maximum footfall across the county. Tewkesbury Borough Council hosted members' seminars to discuss the Fit for the Future 2 Engagement. Local media: ran articles promoting the Engagement. Paid for advertising was also undertaken. Others: Many other groups and individuals have helped to raise awareness of the Engagement such as Trust Governors, staff-side representatives, hospital volunteers and community and voluntary sector organisations.

8.2 ACT - following Fit for the Future 1

The following actions were undertaken following feedback received during the Fit for the Future 1 Engagement to support future communications and engagement associated with Fit for the Future Programme:

Inclusion Gloucestershire participants identified the following areas for us to consider to improve engagement further (extract from Inclusion Gloucestershire Engagement Report):

- Less information, less jargon and easy read copies of all information.
- From our experience, people who represent the seldom heard groups tend to need more time and preparation to support them to engage. It would have been helpful to have had at least two weeks research time prior to each area workshops.
- Some people from the BME communities were not able to engage in the workshops due to a language barrier. Going forward it might be more beneficial to liaise with community leaders to hold specific workshops within the BME communities with community support for interpreters. We know that there are many barriers for people from the BME communities accessing health care. For many, they don't know how to ask for the health care that they need or struggle to understand treatment options.
- For One Gloucestershire to go out to community groups such as the Inclusion Hubs for those who need to go at a slower pace and for a wider group of people to be included in the process.

8.3 ACT - following Fit for the Future 2 Engagement

The following actions will be undertaken in response to Fit for the Future 2 to support future communications and engagement, we will:

- Consider the introduction of 'incentives' for participation: financial would be prohibitive on a countywide scale, we have previously tried prize draws but these made no difference to response rates.
- Think about how to maximize impact of postage options, e.g., inclusion of NHS information with other door to door communications distributed by ICS partners, such as District Council "Council Tax News" or "The Local Answer".
- Think about how the input of past, current, and future users of services under engagement and consultation and patient experience can be emphasized more in engagement and consultation materials.
- Using our One Gloucestershire Integrated Care System Citizens' Panel approach investigate 'Sampled' market research as an alternative option to consider in future – but note that sample size of this kind would be a smaller number of responses than general survey response rate.
- Continue to pursue further opportunities to promote participation in less well represented districts.
- Consider additional methods for signposting to outcomes of earlier engagement and consultation activity.
- Continue to work with Inclusion Gloucestershire and others to develop Easy Read documents to a high standard and review methods to increase awareness of Easy Read.

- Consider producing engagement information and surveys for individual services separately; respondents to 'multi-service' engagement are often only interested in one or two services.
- Develop and further raise awareness of ***Get involved in Gloucestershire*** across Gloucestershire with the aim of encouraging local people to register to keep up to date with involvement opportunities.
- Establish a 'lay/public' reference group to be involved with reviewing implementation plans for changes approved by decision makers – * A Working with People and Communities Advisory Group is a new part of the ICS Governance arrangements.
- Continue to recognize the value of analysis of free text/qualitative feedback and actively seek innovations to maximize the impact of this important engagement and consultation data.
- Make available decision-making documents in the public domain on the One Gloucestershire ICS Website and the Get Involved in Gloucestershire online participation space and share these with participants to the consultation (for whom we have contact details
- Continue to investigate innovative opportunities to communicate with local people, building on the new media online/social media partnerships developed during the FFTF programme to date.

9 Copies of this report

Following internal review, copies of this report will be made available on the on the online participation platform Get Involved in Gloucestershire https://getinvolved.glos.nhs.uk

Print copies of the report will be made available from the NHS Gloucestershire Integrated Care Board Engagement and Experience Team by calling:

Freephone 0800 0151 548

or email: glicb.gig@nhs.net

To discuss receiving this information in large print or Braille please ring **0800 0151 548.**

To discuss receiving this information in other formats please contact:

এই তথ্য অন্য ফর্মাটে পেতে আলোচনার জন্য দয়া করে যোগাযোগ করুন

如需以其他格式接收此信息，请联系

V případě, že potřebujete obdržet tuto informaci v jiném formátu, kontaktujte prosím

આ માહીતી બીજા ફોરમેટસમાં મળાવાની ચર્ચા કરવામાટે કૃપાકરી સંપર્ક કરો

Aby uzyskać te informacje w innych formatach, prosimy o kontakt

По вопросам получения информации в других форматах просим обращаться

Ak si želáte získat túto informáciu v inom formáte, kontaktujte prosím

FREEPOST RRYY-KSGT-AGBR,
PALS, NHS Gloucestershire Clinical Commissioning Group, Sanger House, 5220 Valiant Court, Gloucester Business Park Gloucester GL3 4FE

10 Appendices

Appendix 1a: Survey responses - Public

See separate document

Appendix 1b: Survey responses - Staff

See separate document

Appendix 1c: Survey responses – Easy Read

See separate document

Appendix 1d: Survey responses – Community Partners

See separate document

Appendix 1e: Survey responses – Prefer not to say

See separate document

Appendix 2: Glossary

See overleaf

Appendix 3a: FFTF2 Engagement Booklet

See separate document

Appendix 3b: FFTF2 Easy Read Booklet

See separate document

Appendix 2: Glossary

ACUC (Acute Medical Take)	The Acute Medicine team coordinates initial medical care for patients referred to them by a GP or the Emergency Departments and decides on whether they need a hospital stay (also referred to as 'the acute medical take')
A&E	Accident and Emergency department (also known as Emergency Department (ED)
Aneurin Bevan Health Board (ABHB)	The local health board of NHS Wales for Gwent, in the south-east of Wales
Addison's crisis	A life-threatening situation that results in low blood pressure, low blood levels of sugar and high blood levels of potassium
BME	Black and minority ethnic
Centres of Excellence (CoEx)	The development of the two main hospital sites. Part of the Fit for the Future Programme
CGH	Cheltenham General Hospital
COVID-19/ Coronavirus	COVID-19 is a new illness that affects lungs and airways. It is caused by a virus called coronavirus.
NHS Gloucestershire Integrated Care Board (ICB)	Previously known as Gloucestershire CCG is responsible for planning and investing in many local health and care services, including the majority of hospital care and stroke services.
Gloucestershire Health & Care NHS Foundation Trust (GHCFT)	Formed in 2019 by the merger of 2gether Trust and Gloucestershire Care Services to provide joined up physical health, mental health and learning disability services
Gloucestershire County Council (GCC)	Responsible for a large number of services, including education, health and transport.
Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)	Provides a wide range of specialist acute services
GRH	Gloucestershire Royal Hospital
Hyper acute stroke unit (HASU)	Provides the initial investigation, treatment and care immediately following a stroke
Healthwatch Gloucestershire	An independent service which exists to speak up for local people on Health and Social Care
Health overview and scrutiny committee HOSC	A committee of the relevant local authority, or group of local authorities, made up of local councillors who are responsible for monitoring, and, if necessary, challenging health plans.
Inclusion Gloucestershire	A charity run by disabled people for disabled people (a user-led organisation) with a vision to help achieve an inclusive society
Integrated Impact Assessment (IIA)	The purpose of the Integrated Impact Assessment is to explore the potential positive and negative consequences of the proposals. It includes a Health Impact Assessment (HIA), Travel and Access Impact Assessment, Equality Impact Assessment (EqIA) (in which the impacts of the proposals on protected characteristic groups and deprived communities are assessed) and Sustainability Impact Assessment.

Integrated Locality Partnerships (ILPs)	Partnerships made up of senior leaders of health and social care providers and local government.
Know Your Patch	Networks based in each district of Gloucestershire for anyone involved in the adult social care field, supporting older and vulnerable people to maintain independence and wellbeing
NHS Long Term Plan (LTP)	Sets out priorities for the NHS over the next ten years
One Gloucestershire Integrated Care System (ICS)	The working name given to the partnership between the county's NHS and care organisations to work in partnership in improving health and care, to help keep people healthy, support active communities and ensure high quality, joined-up care when needed in Gloucestershire
Patient Participation Group (PPG)	A group of patients, carers and GP practice staff who meet to discuss practice issues and patient experience.
PCN Primary Care Networks	Groups of GP practices working closely together - along with other healthcare staff and organisations - providing integrated services to the local population
South West Ambulance Service Foundation Trust (SWASFT)	Provides a wide range of emergency and urgent care services across South West England
The Consultation Institute (tCI)	A not-for-profit organisation specialising in best practice public consultation and stakeholder engagement
VCS Alliance	Acts as an independent voice for the voluntary and community sectors within Gloucestershire

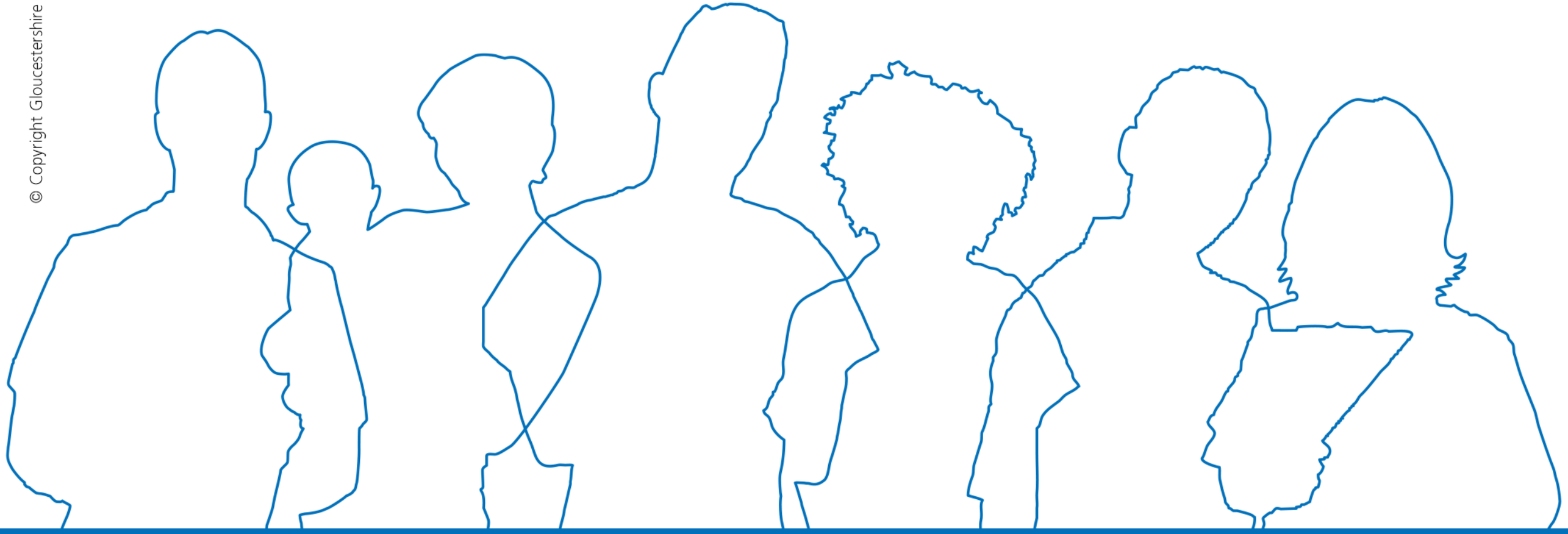
Gloucestershire Hospitals
NHS Foundation Trust

Public Board of Directors

8 September 2022

Fit for the Future Phase 2

Output of Engagement Report



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Session Purpose and Objectives

Purpose:

To review the Fit for the Future Phase 2 Output of Engagement Report.

Objectives:

- To provide a reminder of the FFTF Phase 2 (FFTF2) proposals
- To review the engagement activities
- To review the quantitative and qualitative responses.
- To confirm next steps

Output of Engagement Report - content

- FFTF background
- Our engagement approach
- Engagement activities
- Responses – demographics
- Responses – services
    - Quantitative
    - Qualitative
        - ➢Engagement themes
        - ➢Addressing themes
- Evaluation

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FFTF2 options…

Gloucestershire Royal Hospital

- Diabetes and Endocrinology (In-Patient)
- Respiratory (In-Patient & High Care)
- Non-Interventional Cardiology (In-Patient)

Cheltenham General Hospital

- Benign Gynaecology (Day Case)
- Stroke (In-Patient)

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FFTF2 Engagement - Key Facts

- 50+ engagement events
- 3,000 Engagement booklets distributed
- 6 Facebook Live streamed
- Over 1,800 face-to-face conversations with members of the public and staff
- 200+ surveys completed
- NHS Information Bus Tour
- Internal communication campaign
- Presentations to Primary Care Networks, Integrated Locality Partnerships, Clinical Programme Groups
- Presentations to Health Overview & Scrutiny Committee and local councillors.

Quantitative Feedback

Service	Support		Oppose	
	All	Staff	All	Staff
Benign Gynaecology	92%	96%	8%	4%
Diabetes and Endocrinology	98%	100%	2%	0%
Non-interventional Cardiology	99%	97%	1%	3%
Respiratory	97%	100%	3%	0%
Stroke	84%	73%	16%	27%

Qualitative Feedback – key themes

Gloucestershire Hospitals NHS Foundation Trust

Public and Patients

- Support for Centres of Excellence approach
- Travel and Transport
- Car parking
- Ward environment
- Innovation
- Clinical considerations

Staff

- Benefits of the Centres of Excellence approach
- Clinical considerations
- Travel and Transport
- Car parking for patients
- Health inequalities
- Interdependencies with other clinical services
- Improved integration with primary and community services

Stroke – key themes

84% support (public, patients, staff)

73% support (staff only)

- "Stroke services need to be located where ED, Interventional Radiology, Vascular and cardiology are, on the main acute site"
- Need greater clarity on the medical cover that will be provided at CGH
- Need to define pathway for stroke patients that arrive at GRH
- Need to consider ambulance travel times for patients in West of the county
- Need to consider impact on Inter-site transfers.

Frailty

- Included as part of the engagement to seek the views of our population regarding the whole frailty pathway.
- Detailed service change proposals are not developed so service not subject to NHS England clinical review panel process and external scrutiny
- Frailty T&F group will receive and review all the feedback received.

  Themes were grouped into the following areas:

  - Hospital services
  - Information sharing
  - Integration between services
  - Out of hospital care
  - Prevention agenda
  - Responsiveness of services

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NHS Foundation Trust

Next Steps…

Month	Activity

September	• Outcome of Engagement Report reviewed by:
	  • ICS Strategic Execs
	  • GHFT Board
	  • GHFT Governors
	  • One Gloucestershire Integrated Care Board (ICB)
	• South West Clinical Senate Report received & circulated with covering narrative

October	• Outcome of Engagement Report reviewed by Health Overview & Scrutiny Committee (HOSC) - 25th • Outcome of Engagement Report + SW Clinical Senate report reviewed by GHFT Trust Leadership Team - 18th
November	Outcome of Engagement Report + SW Clinical Senate report + HOSC feedback + TLT feedback + other inputs (e.g. Consultation Institute, legal advice) considered by: • GHFT Board • HOSC • ICB, to determine whether the proposals are deemed to be a substantial development of the health service in Gloucestershire, or a substantial variation in the provision of those services. Decision will be taken by NHS Gloucestershire Integrated Care Board in partnership with Gloucestershire HOSC.

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KEY ISSUES AND ASSURANCE REPORT
Finance and Digital Committee, 25 August 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
Financial Performance Report	The Trust had reported a deficit of £6.5m, which was £4.6m away from plan. The position was driven by a number of factors, including: • Underperformance on out of county contracts (£1.2m) • Divisional pay pressures and overspend on temporary workforce (£2.5m) • Non-pay pressures due to clinical supplies, outsourcing and laboratory reagents (£3m) • Corporate underspends (£1.4m) • Wellbeing day release in month three (£1.3m) The position continued to highlight a significant challenge for the Trust, and a Financial Recovery Plan was in development, which would include: • A review of all income in order to maximise on all possible, including commercial • A forensic review of the financial ledger would be undertaken • A review of WTE workforce from 2019-20 to 2022-23 and recommendations on reassessment • Review of ESRF funding and costs • Divisional recovery plans to be included • A review of temporary staffing controls • Continue to identify additional schemes to meet the overall financial sustainability programme and income targets	The Financial Recovery Plan would be presented to the Committee in September.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
HFMA Financial Sustainability Audit Self-Assessment	NHSEI had advised Trusts to undertake an internal audit review of financial sustainability arrangements. BDO had been commissioned to undertake the review for the Gloucestershire ICS, with work commencing in late August 2022. The Trust had undertaken an initial self-assessment, which was included in the report to the Committee for information. Colleagues from Finance, People and OD, PMO and Corporate Governance had contributed to the self-assessment. The output from the scoring of the self-assessment was 4, which indicated that controls and assurances were in place, with room for improvement.	Audit and Assurance Committee would receive the Terms of Reference for the audit to be undertaken by BDO. The self-assessment would be submitted following the Audit and Assurance Committee in early September.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
None.		

Items not Rated

None.

Impact on Board Assurance Framework (BAF)

The finance risk would continue to be reviewed to include the financial recovery plan.

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.

KEY ISSUES AND ASSURANCE REPORT
Finance and Digital Committee, 28 July 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
Financial Plan Report	An estimate of additional costs and funding for passthrough drugs and devices had been included in the 2022-23 financial plan, based on anticipated outturn information and growth. The expectation had been that any under recovery of income would be offset by underspends within expenditure budgets. During the month three review of the financial position, an error in income assumptions for 2022-23 had been identified, as assumptions had been overstated due to unseen double counts within contractual values. The issues related to complexities of specialised commissioning and ICS contracts, with an overall net impact of £8.9m. The Committee was assured that immediately after the error was identified, the team was briefed and mitigations put in place. Options available to offset £7.3m of the £8.9m shortfall were presented, with the Committee acknowledging the resulting net pressure of £1.5m which would reduce flexibility in the overall financial position.	The Committee supported the move to a ledger-based medium term financial plan, and supported mitigations to eliminate the risk of repetition.
Financial Performance Report	The following key points were highlighted: • The Trust had reported a year-to-date deficit of £4.1m, which was £2m adverse to plan. This included one off benefits of £5m. • The Trust was maintaining its planned forecast breakeven position. • The ICS was required to breakeven for the year, with all organisations within the system forecasted to deliver the breakeven position. There were risks associated with the forecasts, however. The system had reported a year-to-date deficit position of £2m, which was a result of the Trust's deficit and a small surplus at GHC. • Pay and non-pay pressures continued. • Activity had reduced, resulting in a £1m pressure on variable contract income and out of area commissioners, and created a system risk of non-achievement of Elective Recovery Fund targets. • Agency staffing costs continued to increase. NHSEI would be applying an agency cap to the system, of £20.2m. The Committee was advised that if current spending continued, the Trust alone would spend £24.4m on agency, which was above the total system cap proposed for all organisations within the system.	The Committee acknowledged the significant challenge to the Trust, and would receive additional information on the Trust's recovery plan at September's meeting.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Capital Programme Report	At the end of month three, the Trust had delivered goods, works done or services received to the value of £8.4m, which was £1.5m behind plan. The key driver for the position was to the Strategic Site Development project. A revised forecast profile for the project had been calculated, with differentials recoverable over the coming months.	None.
Digital and EPR Programme Report	The Committee was advised that work continued to progress key digital workstreams and projects within the Trust.	The Committee considered the impact on staff during this

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.

	The planned upgrade of TrakCare/TCLE had been cancelled and was replanned for autumn. This would impact the project to surface blood transfusion results into EPR. The Trust had not met the standard for this year's Data Protection Toolkit submission, due to the target for Information Governance training not being achieved.	particularly busy period, and the potential to reconsider the reprioritisation of programmes. The Committee noted progress against the five-year Digital Strategy.
Cyber Security	The Committee was assured by the actions and support provided to system partners as part of the CITS service level agreement. The team continued to progress the cyber security audit action plan, which focused on reducing risk and updated systems.	The cyber security risk would be fully reviewed to ensure the score was accurate in relation to the risks involved.
ICS Reporting and Framework	The Committee was advised of three components that would form the reporting required to the ICB and the financial governance arrangements. A review of internal month end processes and timetables to identify areas for efficiency and improvement. The Committee reflected on the benefit and capacity concerns related to the structure, and was keen to reduce any additional levels of bureaucracy.	A review of the committee, delivery and operational group structure was underway to identify efficiency of information flow. System reporting requirements would be considered.
Financial Sustainability Report	The Financial Sustainability target for the Trust was £19m; £7.5m is remained unidentified and contributed £1.8m to the deficit position. The plan was phased towards future months and the Committee was advised that the efficiency ask would be higher as the year progressed.	None.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
National Cost Collection Pre-Submission Report	The Committee was satisfied with the pre-submission report.	None.

Items not Rated

Risk Register	ICS Update	Information Governance Report	Contract Forward Look	Proposed New Ledger

Investments

Case	Comments	Approval	Actions
IGIC Contract Award	Approved by GMS Board on 26 July.	Approved	Board of Directors approval would be sought.

Impact on Board Assurance Framework (BAF)

A risk rationalisation and review exercise would take place during August and September with executives and the Committee Chair. The financial reporting error would be reflected in the BAF risk. The cyber security risk would be fully reviewed and updated.

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	13	Enclosure Number:	8
Date	8 September 2022		
Title	Financial Performance Report		
Author /Sponsoring Director/Presenter	Hollie Day Craig Marshall Karen Johnson		

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 4 to the Trust Board.

Month 4 overview

- The Trust is reporting a year-to-date deficit of £6.7m deficit which is £4.6m adverse to plan. This includes one-off benefits of £5m.
- The Trust is maintaining the planned forecast breakeven position.
- The ICS is required to breakeven for the year. At month 4, all organisations within the system are forecasting to deliver to a breakeven financial position at year-end in line with the plan, however there are risks in these forecasts.
- The ICS year-to-date (YTD) deficit position of £4.5m is the result of a £4.6m adverse to plan position from GHFT, and a small YTD surplus position at GHC.

2022/23 Capital

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m. As of the end of July (M4), the Trust had goods delivered, works done or services received to the value of £11.9m, £2.7m behind plan.

Key issues to note

The deficit is driven by:

- Underperformance on out of county contracts of £1.2m
- Divisional pay pressures of £2.5m pay overspend due to use of temporary staff to cover vacancies, provide RMN support and meet unscheduled care demands
- Non pay pressures of £3m due to clinical supplies, outsourcing and laboratory reagent costs.
- Corporate underspends of £1.4m
- 50% of well-being day released in M3 £1.3m

Next Steps

The financial position at month 4 continues to highlight a significant challenge. The Trust is now developing a Financial Recovery Plan which will be presented to Finance and Digital Committee in September 2022.

It is recommended that the Financial Recovery Plan includes:

- Review all income to maximise where possible including commercial income
- Undertake a forensic review of the ledger
- Review the significant increase in WTE from 19/20 to 22/23 and makes recommendations for where growth should be re-assessed
- Review ESRF funding and costs
- Incorporate divisional recovery plans including highlighting the difficult decisions required to improve the financial position
- Undertake a review of temporary staffing controls with a view to reducing spend.
- Continuing to identify additional schemes to meet the overall financial sustainability programme and income targets.

Conclusions

The Trust is reporting a year to date deficit of £6.7m deficit which is £4.6m adverse to plan. Divisional forecasts have been developed with operational colleagues. These will form part of the Financial Recovery Plan with mitigations and key actions identified for formal reporting to Finance and Digital Committee in September 2022.

Recommendation

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

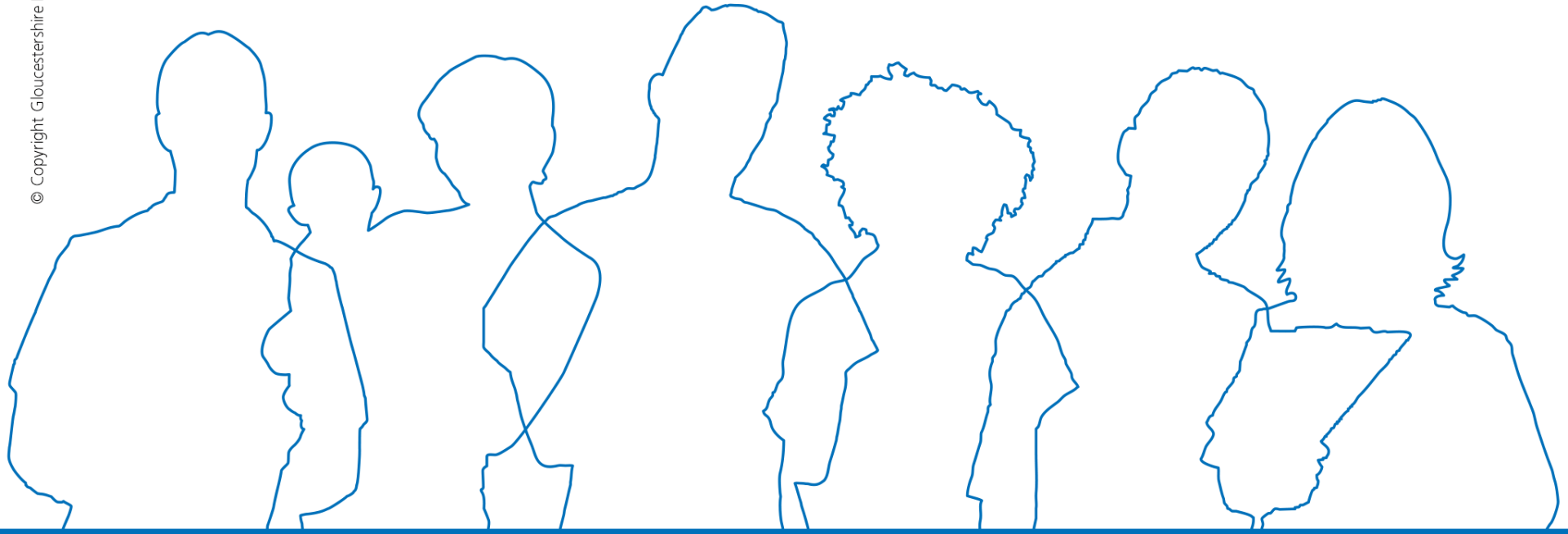
Enclosures

- Finance Report

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Financial Performance Report
Month Ended 31st July 2022



Director of Finance Summary

System Overview

The ICS is required to breakeven for the year. At month 4, all organisations within the system are forecasting to deliver to a breakeven financial position at year-end in line with the plan, however there are significant risks in these forecasts.

The ICS year-to-date (YTD) deficit position of £4.5m is the result of a £4.6m adverse to plan position from GHFT, and a small £0.1m YTD surplus position at GHC.

Key risks in the ICS's financial position are:

- Elective activity and recovery performance
- Under-delivery of savings and efficiency plans
- Inflation – pay and price
- Ambulance handover delays
- Demand and growth pressures

Month 4

M4 Financial position is reporting a deficit of £6.7m which is £4.6m adverse to plan.

The deficit is driven by :

- Underperformance on out of county contracts of £1.2m
- Divisional pay pressures of £2.5m pay overspend due to use of temporary staff to cover vacancies, provide RMN support and meet unscheduled care demands
- Non pay pressures of £3m due to clinical supplies, outsourcing and laboratory reagent costs.
- Corporate underspends of £1.4m
- 50% of well-being day released in M3 £1.3m

The Financial Sustainability Plan (FSP) target for the Trust is £19m, of which £7.8m is still unidentified and is phased to be delivered in the latter part of the year meaning the efficiency requirement will become higher as the year progresses. The M4 position includes FSP delivery of £4.5m YTD.

Director of Finance Summary

The financial position currently includes the following assumptions in regards to mitigations:

- No contingent reserves available for release
- No assumed ESRF income
- No adjustment for future benefits from sustainability schemes – currently the balance of non-divisional identified schemes is showing as an unmitigated overspend

We will continue to work with system partners to explore opportunities to manage the financial position across the system.

Forecast Outturn

The Trust is maintaining the planned forecast breakeven position.

Divisional forecasts have been developed with operational colleagues. These will form part of the Financial Recovery Plan with mitigations and key actions identified for formal reporting to Finance & Digital Committee in September 2022.

Summary M4 activity position

Total activity in M4 was 94% of the same period in 19/20. Inpatient, day cases and outpatient activity have all reduced from prior month. This level of activity presents a risk to the system regarding the attainment of ESRF funding which the overall system is predicated on (net contribution c£15m).

All GHFT Activity

	Point of Delivery	2022/23 Apr-22	2022/23 May-22	2022/23 Jun-22	2022/23 Jul-22	2019/20 YTD	2022/23 YTD	2019/20 % Recovery
Total	ED Attendances	11,616	12,551	12,092	12,596	53,704	48,855	91%
	Non Elective	4,835	5,452	5,270	5,290	23,580	20,847	88%
	Inpatients	797	950	918	858	4,117	3,523	86%
	Day Cases	5,688	6,329	5,979	5,976	26,208	23,972	91%
	Outpatients	58,183	67,894	62,239	60,644	262,220	248,960	95%
TOTAL UNITS OF ACTIVITY		81,119	93,176	86,498	85,364	369,829	346,157	94%

M4 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of July 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 July the Group's consolidated position shows a deficit of £6.7m which is £4.6m adverse to plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 4 Financial Position	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	206,629	200,909	(5,720)	0	0	0	206,629	200,909	(5,720)
PP, Overseas and RTA Income	2,099	1,533	(566)	0	0	0	2,099	1,533	(566)
Other Income from Patient Activities	3,464	4,066	602	0	0	0	3,464	4,066	602
Operating Income	12,692	13,698	1,005	21,512	17,821	(3,691)	13,461	14,775	1,314
Total Income	**224,885**	**220,206**	**(4,679)**	**21,512**	**17,821**	**(3,691)**	**225,653**	**221,283**	**(4,370)**
Pay	(133,461)	(132,527)	935	(7,168)	(7,235)	(67)	(140,629)	(139,762)	867
Non-Pay	(90,374)	(92,385)	(2,011)	(13,373)	(9,944)	3,429	(83,003)	(85,585)	(2,582)
Total Expenditure	**(223,835)**	**(224,912)**	**(1,077)**	**(20,541)**	**(17,179)**	**3,362**	**(223,633)**	**(225,347)**	**(1,714)**
EBITDA	**1,049**	**(4,706)**	**(5,755)**	**971**	**642**	**(330)**	**2,021**	**(4,064)**	**(6,085)**
EBITDA %age	**0.5%**	**(2.1%)**	**(2.6%)**	**4.5%**	**3.6%**	**(0.9%)**	**0.9%**	**(1.8%)**	**(2.7%)**
Non-Operating Costs	(3,186)	(2,067)	1,119	(971)	(642)	330	(4,157)	(2,709)	1,448
Surplus / (Deficit)	**(2,137)**	**(6,773)**	**(4,636)**	**(0)**	**(0)**	**(0)**	**(2,136)**	**(6,773)**	**(4,637)**
Fixed Asset Impairments	0	0	0					0	0
Surplus / (Deficit) after Impairments	**(2,137)**	**(6,773)**	**(4,636)**	**(0)**	**(0)**	**(0)**	**(2,136)**	**(6,773)**	**(4,637)**

* Trust position excludes £12m of Hosted Services income and costs. This relates to GP Trainees
** Group position excludes £16.7m of inter-company transactions, including dividends

M4 Variance Summary

Gloucestershire Hospitals
NHS Foundation Trust

	£000	£000	£000	£000
	Total	Income	Pay	Non Pay
Income shortfall - out of area	(1,186)	(1,186)		
Income shortfall - pass through drugs & devices below plan	(410)	(1,701)		1,291
Income shortfall mitigated by release of GMS VAT provision	0	(2,967)		2,967
Reserves*	1,019	(851)	2,238	(368)
GMS inflation net of £520k reserves released to cover costs	(144)	(5)	0	(140)
Divisional Positions (excl pass through)	(5,422)	1,718	(2,458)	(4,682)
Corporate (net of assumption that digital spend will increase)	1,418	159	1,155	104
Other	89	106	0	(18)
TOTAL	**(4,636)**	**(4,727)**	**935**	**(845)**

M4 Financial position is reporting a deficit of £6.7m which is £4.6m adverse to plan. Summary breakdown of YTD variance position is shown in the table above. The variance is driven by:

- Income below plan due to underperformance of activity on out of area contracts £1.2m.
- Pass-through drugs and device income and expenditure is below plan with a net adverse impact of £410k due to the overhead margin.
- Reserves of £1m are supporting the Trust position predominantly due to the release 50% Health and Wellbeing annual leave days accrual in M3.
- GMS pressure of £144k. This is net of £644k costs that have been partially offset by the release of £520k non-pay reserve to cover inflation costs.
- Divisional positions are £5.4m overspent YTD (excluding underspend on pass-through).
- Corporate areas are £1.4m underspent YTD. The position includes an accrual for digital staffing costs which assumes that the budget will be fully spent by the end of the year.

Next Steps

The financial position at month 4 continues to highlight a significant challenge. The Trust is now developing a Financial Recovery Plan which will be presented to Finance and Digital Committee in September 2022.

It is recommended that the Financial Recovery Plan includes:

- Review all income to maximise where possible including commercial income
- Undertake a forensic review of the ledger
- Review the significant increase in WTE from 19/20 to 22/23 and makes recommendations for where growth should be re-assessed
- Review ESRF funding and costs
- Incorporate divisional recovery plans including highlighting the difficult decisions required to improve the financial position
- Undertake a review of temporary staffing controls with a view to reducing spend.
- Continuing to identify additional schemes to meet the overall financial sustainability programme and income targets.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals
NHS Foundation Trust

Funding
The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m.

The programme can be divided into the following components; Operational System Capital (£25.0m), STP Capital – GSSD (£21.3m), National Programme (£3.3m), Right of Use Assets (£15.4m), IFRIC 12 (£0.8m) and Government Grant/Donations (£1.3m)

YTD Position
As of the end of July (M4), the Trust had goods delivered, works done or services received to the value of £11.9m, £2.7m behind the plan.

A breakeven forecast outturn has been reported to NHSI in the M4 Provider Financial Return (PFR).

22/23 Programme Funding Overview

Gloucestershire Hospitals
NHS Foundation Trust

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m.

The programme can be divided into the following components; Operational System Capital (£25.0m), STP Capital – GSSD (£21.3m), National Programme (£3.3m), Right of Use Assets (£15.4m), IFRIC 12 (£0.8m) and Government Grant/Donations (£1.3m)

in £000's	Plan	Forecast	Variance
Operational System Capital	25,014	25,014	0
National Programme	3,350	3,350	0
STP Capital - GSSD	21,280	21,280	0
Donations via Charitable Funds	1,281	1,281	0
IFRIC 12	817	817	0
Right of use assets adjustment	15,355	15,355	0
Total Capital	**67,096**	**67,096**	**0**

22/23 Programme Spend Overview

Gloucestershire Hospitals NHS Foundation Trust

As of the end of July (M4), the Trust had goods delivered, works done or services received to the value of £11.9m, £2.7m behind the plan. The expenditure by programme area is shown below.

		In Month			Year to date			Forecast Outturn		
Programme Area	**Funding**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Medical Equipment	Operational System Capital	54	87	(33)	685	880	(195)	1,894	2,219	(325)
Digital	Operational System Capital	850	626	224	1,834	1,905	(71)	5,709	5,634	75
Estates	Operational System Capital	460	228	231	1,161	493	668	16,398	16,552	(154)
IDG Contingency	Operational System Capital	0	0	0	0	0	0	1,013	609	404
National Programme - Digital	National Programme	87	250	(162)	290	526	(236)	3,350	3,350	0
STP Programme - GSSD	STP Capital - GSSD	3,095	2,247	849	10,227	7,852	2,375	21,280	21,280	0
Donations Via Charitable Funds	Donations via Charitable Funds	95	0	95	170	0	170	1,281	1,281	0
IFRIC 12	IFRIC 12	68	68	0	272	272	0	817	817	0
Right of Use Asset	Right of use assets adjustment	0	0	0	0	0	0	15,355	15,355	0
Gross Capital Expenditure		**4,710**	**3,505**	**1,204**	**14,638**	**11,928**	**2,710**	**67,096**	**67,096**	**0**
Less Donations and Grants Received	Donations via Charitable Funds	(95)	0	(95)	(170)	0	(170)	(1,281)	(1,281)	0
Less PFI Capital (IFRIC12)	IFRIC 12	(68)	(68)	(0)	(272)	(272)	(0)	(817)	(817)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	Operational System Capital	27	27	0	106	106	0	318	318	0
Total Capital Departmental Expenditure Limit (CDEL)		**4,573**	**3,464**	**1,109**	**14,302**	**11,762**	**2,540**	**65,316**	**65,316**	**0**

Not surprising, given the project makes up more than a third of the programme, that the Gloucestershire Hospitals Strategic Site Development project is the main contributor to this variance.

As reported last month the difference in the profile within the plan has been caused by poor advice from the contractor's supply chain when the plan was submitted. A revised forecast profile for the project was calculated with the contractor confident with the differential being recovered over the subsequent months with the 'spending over plan' months beginning from November.

A breakeven forecast outturn has been reported to NHSI in the M4 Provider Financial Return (PFR)

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £6.7m deficit which is £4.6m adverse to plan.
- Note the next steps including the development of a Trust Financial Recovery Plan.
- Note the Trust capital position.

Authors:	**Hollie Day, Associate Director of Financial Management** **Craig Marshall, Project Accountant**
Presenting Director:	**Karen Johnson, Director of Finance**
Date:	**Sept 2022**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	13	Enclosure Number:	8
Date	8 September 2022		
Title	Digital and EPR Programme Update		
Author /Sponsoring Director/Presenter	Nicola Davies, Digital Engagement & Change Mark Hutchinson, Executive Chief Digital & 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

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. Highlights of the report:

- Work is progressing to deliver ePMA in adult inpatient areas, ED and theatres in the autumn.
- EPR Paper-Lite Outpatients scoping in progress - 170 clinicians / OP staff have provided feedback so far.
- Work continues to progress the cyber action plan put in place in 2021.
- Support is required reminding staff to complete mandatory IG training in September.

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 report.

Enclosures

Digital & EPR Programme Update

PUBLIC BOARD OF DIRECTORS – SEPTEMBER 2022

DIGITAL & EPR PROGRAMME UPDATE

1. Purpose of Report

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

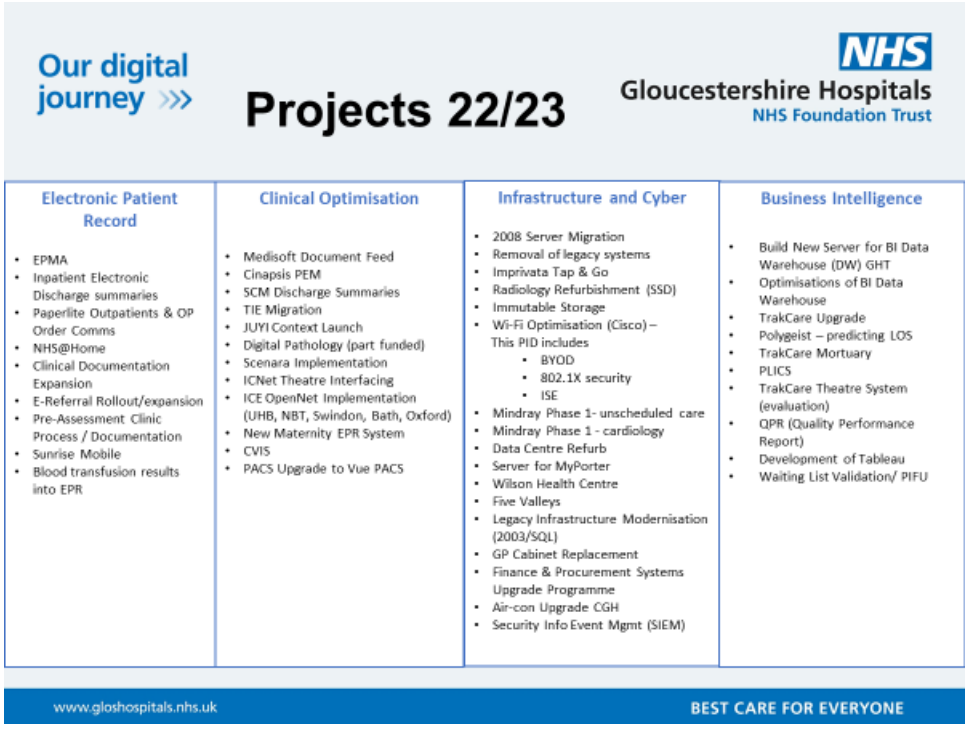
The projects are categorised as four digital delivery areas:

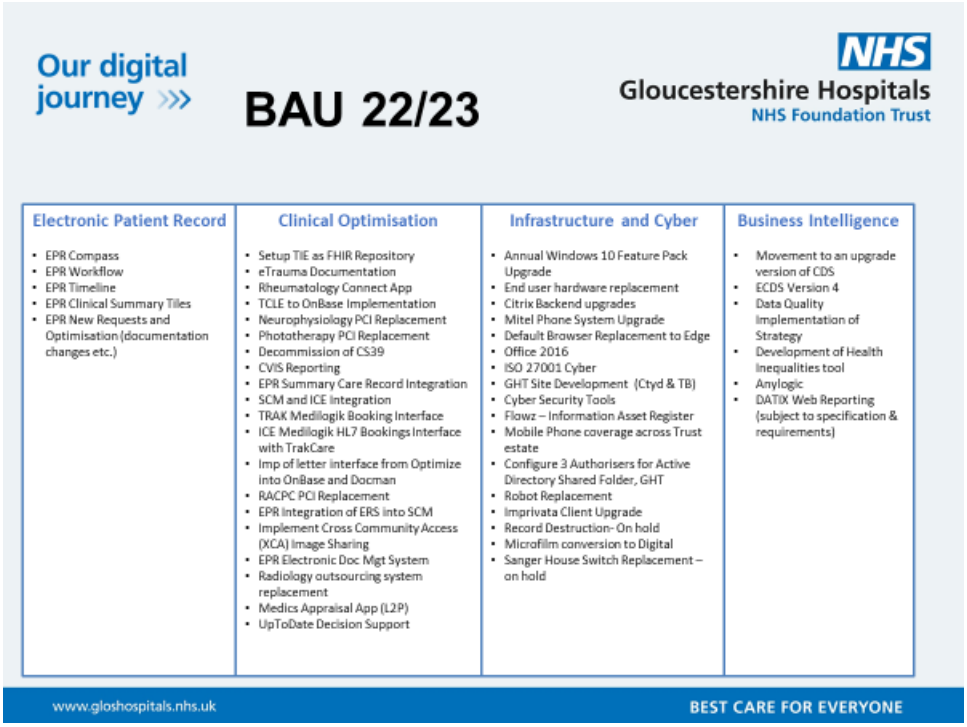
- Electronic Patient Record (Sunrise EPR)
- Clinical systems optimisations
- Infrastructure and Cyber
- Business Intelligence

A full list of projects prioritised for 2022/23 is below. Projects prioritised for 2022/23 must meet the following requirements*:

- Meet existing Digital Strategy and contribute to the journey to HIMSS level 6.
- Provide significant patient care and/or safety benefits – reduce risk.
- Develop and enhance EPR for users as part of a continuous improvement, responding to clinical demand.
- Support wider organisational journey to outstanding.

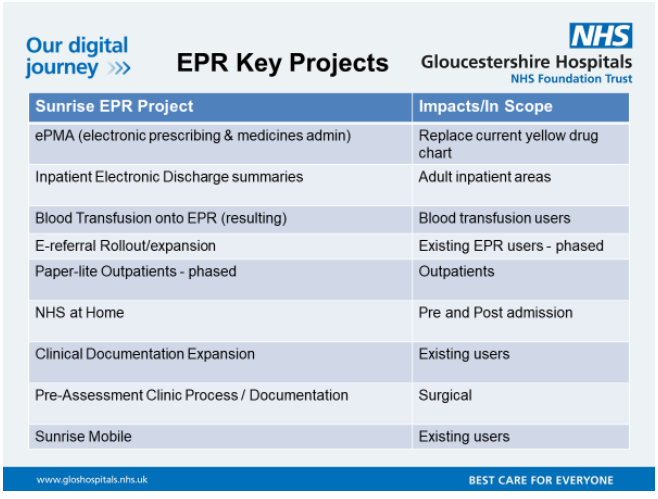
**Or be self-funded to cover all costs including implementation and project management.*





2. EPR Project Updates

This section provides an update on Sunrise EPR and interdependent digital projects. The programme plan below details the EPR functionality planned for 2022/3. The tables below show the update, by exception, and status of these programmes.



ePMA	To implement an ePMA System that will enhance the entire medicine management process when interfaced with the Pharmacy stock control software (EMIS).	Delivery Date	RAG Status
Project Update (by exception)	• Extended the scope of testing with approval of project board • Pharmacy resourcing concerns • Training materials and eLearning in development for delivery late August / early September • Project Board meeting weekly with daily stand-up calls and testing calls • Weekly engagement meetings in place with clinical staff • New medications carts with PCs being delivered to ward areas throughout August	**Sept 2022 (phased)**	**R**

Transfusion Medicine	Implement the Transfusion Module in TCLE (Blood Transfusion results into Sunrise EPR)	Delivery Date	RAG Status
Project Update (by exception)	• Proceeding to plan; no issues.	**Nov 2022**	**G**

EPR Paper-Light Outpatients & Order Comms	To provide clinical documentation for outpatient specialities; patient list solution for accurate viewing of patients in clinics; order comms (requests and results) for outpatients.	Delivery Date	RAG Status
Project Update (by exception)	• Face to face clinical engagement has commenced • More than 180 responses received to an online survey as part of initial engagement process. Responses now being collated and analysed.	**Spring 2023**	**G**

Internal Referrals on EPR	To replace the existing online Internal Referral service using EPR; a phased roll out by Division, starting with Medicine.	Delivery Date	RAG Status
Project Update (by exception)	• Proceeding to plan; no issues.	**Sept 2022**	**G**

Pre-Assessment Digital Workflows	To development and deliver a Pre-Assessment Electronic Patient Questionnaire, Web link and Admin Portal; to review current and develop future state processes and procedures.	Delivery Date	RAG Status
Project Update (by exception)	• Questionnaire live and in use • Monitoring in place for first 2 weeks	**LIVE**	**B**

Maternity EPR (BadgerNet)	To implement a departmental Maternity Electronic Patient Record within Maternity Services at GHNHSFT to enable the electronic documentation of Maternity Notes and a PHR for pregnant people registered with Gloucestershire Maternity Services.	Delivery Date	RAG Status
Project Update (by exception)	• Proceeding to plan; no issues.	**March 2023**	**G**

3. Digital Programme Updates

The reports below provide more detail on the status of projects within the Programme of Work categories. These projects are reported to the Digital Care Delivery Group. This update is correct as reported to Digital Care Delivery Group August 2022 meeting. The current status of projects:

EPR	Clinical Optimisation	Infrastructure & Cyber	Business Intelligence
5	12	9	9

Complete or in closure	On Hold	Red Rated	Amber Rated	Green Rated
2	0	4	19	12

Since the last report three projects have been completed and closed and no projects have gone into closure.

Projects Closed this Period

- Wilson Health Centre NEW GP Surgery
- Appraisal & Re-validation System (Phase 1 – Procurement)
- Waiting List Validation

4. Countywide IT Service (CITS) Monthly Report

A performance report from Countywide IT Services (CITS) is submitted to Digital Care Delivery Group every month in arrears. Highlights for June.

- Operations Team resolved a large outage in GP-IT where 21 practices lost all services; these were restored with a workaround within 2 hours. Full remediation was completed over the weekend.
- The team continues to support moves and refurbishments across the hospital, as well as major improvements to GP surgeries across the county.
- Planning is underway for IT support, including implementation of additional kit for the new ED extension in September.

5. Cyber Security Update

This update provides assurance on cyber security actions and support provided to GHT, CCG and GHC as part of the wider service level agreement in CITS. A monthly overview summary report is provided to ICS Digital Execs and GHT's Digital Care Delivery Group.

A small cyber security team dedicated to monitoring and responding to cyber threats provides cyber security support to GHT, CCG and GHC as part of the wider service level agreement in CITS.

Key highlights this month:

- The team continues to work to the agreed cyber audit action plan, reducing risk and updating systems - work is progressing at pace.
- The upgrade to Office 21H2 has made significant progress with 99% of devices available to be upgraded completed across GHT, ICB and GPs.
- GHT network switch upgrades almost complete.
- One high severity alert - risk closed on the NHS cyber alert service portal within this reporting period.

6. Data Security and Protection Toolkit (DSPT) version 4 2021/22

This year's 2021/22 version 4 DSPT submission has been rated as a non-compliant 'standards not met' because the trust has not achieved 95% of staff completion of annual IG refresher training.

A more detailed action plan and short life action group is in place in collaboration with Deputy Director for People & OD to improve the 86% final compliance figure achieved within June to a position of 95% by the end of September. A risk has been drafted and was covered separately within the digital risk report to Digital Care Delivery Group.

7. Information Governance Incidents

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

Six incidents have been reported to the ICO during the 2022/2023 financial year reporting period to date.

A summary of the incidents together with a description of controls in place are included in the trust's annual report.

-Ends-

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KEY ISSUES AND ASSURANCE REPORT
Audit and Assurance Committee, 26 July 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 Assurance Report	Five new risks had been added, with one downgraded and one removed. The Committee was advised that a number of risk-related activities are underway, including: • Continued work on the Board Assurance Framework, including reconciliation with the Trust Risk Register. • A review of the Committee structure and its delivery and operational groups to ensure the Trust's work is effective and relevant, adding value and protecting staff time. • A review of clinical governance to ensure divisional compliance.	The Committee was concerned in relation to the significant level of non-compliance of divisional achievement of Key Performance Indicators, and was not assured by the actions against some of the risks, some of which were absent. Additional relevant actions to address KPIs would be requested from executives to ensure the management of intolerable risk. Additional information on assurance and/or concerns to be addressed in future reports.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit Review: Research and Development	The review had been given a moderate assurance rating for both Design and Operational Effectiveness. There were three medium priority recommendations related to ensuring a fully updated Standard Operating Procedure, thorough documentation for obtaining capacity and capability approval, and supporting the Research and Development Strategy with an action plan.	Progress on management responses to the recommendations within the report would be received in due course.
External Audit Progress Report	The Annual Report and Accounts 2021-22 had been approved and signed in June. Work on Value for Money was progressing well and was due to be completed in mid-August. The Committee was assured that the audit work on GMS was in progress and would be completed in August. The Committee was informed of a delay to the charity audit; fieldwork was now in progress, and was anticipated to be completed for signing by October.	A clear communication plan to set out effective information flow around audits would be used in future, however the Committee acknowledged that audit was in a much-improved position from last year. The Charity account remained an area of concern where improved coordination was required.
Counter Fraud Report	***Draft Annual Report*** The annual work plan for 2021-22 had been successfully completed, despite continued disruption to direct contact with staff as a result of Covid. ***Fraud, Bribery and Corruption Risk Assessment*** The Trust had reported a red-rated assessment for the two last years, and was actively seeking to improve during the course of 2022-23. ***Draft Counter Fraud Workplan 2022-23*** A total of 200 days activity had been agreed. The workplan for 2022-23 demonstrated progress towards amber and green for a number of areas. ***Bank Mandate Fraud Report*** A review of processes identified that whilst verification searches were undertaken, they are not officially recorded or centrally stored. Bank mandate fraud was not currently included on any of the Trust's risk	Distribution of learning to all managers in all service divisions would be reviewed, in order to support improvements in Trust systems. Commentary would be included where long delays have been reported.

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.

	registers. The Committee was satisfied with the management action plans in place to rectify these two areas, and was otherwise assured that the Trust was compliant. The Committee was assured by the Trust's green-rated Counter Fraud Functional Standard Return.	
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Internal Audit Progress Report	The HFMA financial sustainability self-assessment toolkit was due for completion by the end of September. The Committee was advised of the planned approach, whereby individual organisations within the ICS would complete the review and a full report would be prepared to determine any key themes, best practice and cross-comparison across the health system. The Committee stressed the need to ensure the review added value to the Trust.	The internal audit review into Culture would take place at the end of the year to take into consideration recommendations from the well-led CQC report.
Internal Audit Review: Data Security and Protection Toolkit	A positive report was received, with a moderate assurance opinion given for overall risk management, and a high opinion level for confidence. The Committee noted the different assurance levels used for this particular report. The moderate assurance opinion related to three areas that had been categorised as not demonstrating compliance with the toolkit.	The Committee was pleased with the report and passed on its congratulations to the team. The team was working hard to ensure full compliance against the toolkit.
Single Tender Actions Report	A total of sixteen waivers had been received at a value of £2,095,847.56. Two retrospective waivers had been received within the reporting period.	The Committee was assured by the waiver management process, and noted that additional training had been received to continue to support the timeliness of single tender actions.
Losses and Compensations Report	The Committee was assured by the management of the process of losses and compensations, and approved the write off of 214 invoices totalling £2,241.87.	The Patient Property Policy was in development and would be approved at Quality and Performance Committee. A briefing on the progress of the Policy would be brought to the Committee in November. The private patient debt write-off process would be reviewed to ensure its appropriateness.
GMS Update	Annual accounts were due to be approved and signed at September's Board meeting. There was some outstanding work related to evidence sampling. The Committee was advised of work ongoing to reconcile risks across the Trust and GMS to ensure collective review of the Group's performance.	None.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
Risk rationalisation was discussed. Additional assurance would be sought from Executives via a thorough review of the incorporated risks to ensure integration and triangulation, with clarity around strategic and organisational risks.		

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	15	Enclosure Number:	10
Date	8 September 2022		
Title	Emergency Preparedness, Resilience and Response Report		
Author /Sponsoring Director/Presenter	Dickie Head, Head of EPRR Qadar Zada, Chief Operating 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

To provide assurance with regard to the Trust's performance in achieving the set Core Standards for Emergency Preparedness, Resilience and Response (EPRR).

Please note with the report a live document until submission certain statistics and statements remain to be finalised. Anything highlighted will be updated before submission to board.

Key issues to note

- To comply with NHSE/I Assurance there is a requirement to submit a report covering EPRR to the Board. The attached report at Appendix 1 fulfils that requirement and provides an overview to DOAG as to the state of EPRR.
- The process for 2022-23 returns to the standard EPRR Toolkit. After last year's number of Core Standards was reduced the number the Trust is required to report on this year has returned to the standard 63. The Trust has also been required to conduct a Deep Dive focused on Shelter and Evacuation. Core Standards and Deep Dive are found in Appendix 1.

The Trust self-assesses that:

- 57 Core Standards out of 63 are Fully Compliant and 6 are Partially Compliant.
- Therefore, the Trust self-assesses that it has achieved Substantially Compliant status for 2022-23.

Overview

Continued impact of COVID19, NHS pressures, and Business Continuity Incidents. The effect COVID19 has had on conducting training and exercising continued throughout much of the reporting period resulting in less activity than the Trust would expect to see in a normal year. Allied to the impact of COVID19 is the impact on the Trust of enduring NHS pressures which have resulted in the requirement to frequently go in to Business Continuity Incident (previously called Internal Critical Incident). The impact these have had on maintaining the day-to-day business of EPRR cannot be underestimated, especially with regard to exercises and training – much of which has been forced to be cancelled at the last minute.

However, the overall awareness, relevance and application of EPRR good practice continues to increase and improve across the Trust. The Trust has continued to build on this step-change in the practical application of EPRR working practices. The COVID19 pandemic has seen a rise in the awareness and application of EPRR, an unforeseen consequence that will have a positive impact when handling future crises. The Trust has strived to ensure such lessons are embedded through a combination of a set of Trust-wide common processes and procedures; a high tempo of EPRR Assurance and associated meetings; a stronger process for debriefing incidents; and a continued focus on key priorities across the Trust.

Priorities

EPRR priorities. In Nov 21 the COO and Hd of EPRR developed a set of priorities that took into account assessed gaps in EPRR. The priorities are below with a brief assessment of progress made.

Fire: From Sep 21 – Jul 22 the Trust has seen:

- 147 training sessions covering Fire Drills; Fire Evacuations; Fire Warden Training; Table Top Exercises; and Fire Walks.
- 1387+ staff received training from the GMS Fire Team
- 93% of Fire Wardens have been trained Trust-wide.
- All Fire Risk Assessments have been completed by GMS Fire Team – with actions now being followed up by individual wards.

These are significant achievements under challenging circumstances. The GMS Fire Team is now on a firmer footing than 12 months ago with the appointment of a new Fire Safety Manager in July 22. The improvements in Fire activity and assurance that took place in 20-21 have been reinforced.

Chemical Biological Radiological Nuclear explosive (CBRNe): Implementing the new concept adopted in 2021 has been extremely challenging with a combination of high turnover of ED staff alongside a significant amount of training being cancelled due to operational and staffing pressures. A renewed focus and change in approach is assessed to bring an increase in those attending training.

Lockdown: The Trust site Lockdown Policy has been revised, and new Action Cards have been revised and distributed, ensuring at the lowest operational level procedures are in place. However, while the Trust is well practiced in the process of a deliberate Lockdown, because of the inability to conduct a full rehearsal, exercise, and test of procedures during COVID19 it is assessed the Trust still requires further practice in reactive Lockdowns, particularly at the operational level.

Incident Control Centre (ICC) / GOLD / Silver On-Call Training. ICC formally checked on frequent basis. Work on secondary ICC underway – likely in CGH.

Digital Contingency. Significant process in Business Continuity Planning and disaster recovery processes. Hard copies of digital business continuity plans in all wards.

Winter Readiness. Planning started in Jun 22. EPRR team reviewed plans in Mar 22.

Conclusions

This reporting period continued on from an extraordinarily tough year. Indeed, it has only been as we transitioned in to Summer that there was a sense of moving on from the challenges of COVID19 and a potential return to the norm. However, in general, this has not been the case. Pressures across the wider NHS, the ICB, and the Trust have continued. In particular it has been the frequent return to Business Continuity Incidents due to operational

pressures combined with staffing issues and pressures that has impacted the most on EPRR output. This has been felt most in the arena of training and exercising.

To balance this the Trust is regularly solving significant challenges at speed which means there is an extremely resilient and agile approach embedded in to the organisation that counteracts some of those gaps earlier identified. If the Trust were a sports team, one would assess that it is not getting much time on the training ground, but getting plenty of match play against tough opposition instead. As a result, while perhaps a little tired, we remain match fit.

Implications and Future Action Required

- Following the publication of the new Minimum Occupational Standards the Trust will further develop its own EPPR Strategy and Plan.
- Priorities will continue to be reassessed.
- Assurance processes are now well established within the Trust however it is in the more formal areas of Business Continuity that gaps will be addressed.
- Despite initial success in delivering the new CBRNe plan the impact of staffing pressures mean a renewed engagement and approach in this critical area.
- Despite the impact of the pandemic and subsequent pressures on the Trust the drive towards Full Compliance continues.

Recommendation

The Board to receive the report for assurance. The report would be submitted to the ICB by 14 October 2022.

Enclosures

- EPRR Assurance Report
- Core Standards Appendix

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
EPRR REPORT 2022-23 TO BOARD

EPRR/Assurance/2022-23/GHNHSFT Response

30 Aug 2022

References:

A. Emergency Preparedness, Resilience, and Response (EPRR) Annual Assurance Guidance for 2022-23 from NHSE dated 29 Jul 2022
B. Emergency Preparedness, Resilience, and Response Annual Assurance Process for 2022/23 - dated 29 July 2022
C. NHS core standards for emergency preparedness, resilience, and response guidance v6.0 dated 29 July 2022

Introduction

1. In line with Refs A and B the Gloucestershire Hospitals NHS Foundation Trust (GHFT) is mandated to submit an annual Emergency Preparedness, Resilience and Response (EPRR) assurance return to the NHS Gloucestershire Integrated Care Board (ICB). Ref C is the recently updated NHS Core Standards for EPRR.

2. The process for 2022-23 continues the standard process using the EPRR Toolkit which was reviewed and updated by NHSE in June 22.

3. In contrast to the reduced 46 Core Standards assessed last year during the COVID19 pandemic the number has increased to the standard 63. The Shelter and Evacuate policy has been subject to a Deep Dive – which sits separate to the assurance process. The detail covering the Core Standards and Deep Dive are found in Appendix 1.

4. To comply with NHSE Assurance there is a requirement to submit a report covering EPRR to the Board. This report fulfils that requirement.

5. While NHSE Assurance is a critical element of EPRR output, the report also covers other elements that are fundamental to an efficient and safe Trust but sit outside the confines of the Assurance Toolkit.

NHSE Annual Assurance Compliance 2022-23

6. In spite of the challenges posed by the continuing pressures of COVID19 that impacted the Trust until Apr 22 the Trust has strived to continue to update and revise policies, procedures, training, action plans and action cards. To mitigate the impact of this disruption the Trust has focused on key risks in priority areas, while also reacting to challenges and incidents throughout the year. While internal auditing has understandably been challenging, it is assessed that this has been mitigated by the Trust regularly using internal and external EPRR networks on a weekly, daily and even hourly basis, as well as the frequent implementation of EPRR plans due to incidents throughout the reporting period.

7. The Trust self-assesses that it is Partially Compliant in six Core Standards laid out in Table 1 below. The Trust assesses all other Core Standards as Fully Compliant.

a.	b.	c.	d.
No.	**Core Standard**	**Comment and Next Steps**	**Status**
CS22	EPRR Training	The introduction of new Minimum Occupational Standards (MOS) in June 22 means that at present the Trust is not fully compliant. Progress has already been made in this area prior to the new MOS. Plan will be complete by end Sep 22.	PARTIALLY COMPLIANT
CS23	EPRR exercising and testing programme	The last reporting period has been an extremely challenging time to implement such a regime. Mitigation has been the regular use of EPRR processes through the regular standing up of Business Continuity Incidents and real-life incidents (storms, heatwaves, and more localised EPRR issues). Despite the challenges a number of exercises have taken place (see Para 20) which has been an improvement on the last two years. However, a deliberate programme has not been in place. Plan will be in place by end Sep 22.	PARTIALLY COMPLIANT
CS 46	Business Impact Analysis/Assessment (BIA)	The formal use of Business Impact Analysis/Assessment has not been a regular process across the Trust. The intent is to introduce the concept following a review of how best to integrate this into our present processes	PARTIALLY COMPLIANT
CS49	Data Protection and Security Toolkit	This is a remit laid on all Trust members to complete. Digital have a plan in place to ensure increased compliance.	PARTIALLY COMPLIANT
CS51	BC Audit	While the Trust assesses being mostly compliant in this core standard due to the large amount of internal auditing that has taken place within divisions, no independent external audit has taken place, hence a Partially Compliant assessment. An independent audit will be implemented and aligned with our own internal audit programme, which will also be revised.	PARTIALLY COMPLIANT
CS58	Decontamination capability availability 24/7: Rotas of appropriately trained staff availability 24/7	A revised CBRNe plan was brought in to place last year. At one stage there were very high completion rates of Level 1 training – over 75% - across ED. However, a combination of high staff turnover which has reduced the pool of trained staff and the challenge of training in a period of extraordinary staff pressures has resulted in a drop in capability. A revitalised approach has been adopted from July 22 onwards with an uptick in those attending Level 2 training, and with Level 1 integrated in to onboarding of staff in to the department. A Core Team of trained CBRNe responders are still held as a reserve to reinforce ED staff in the case of an extended incident. These are now categorised as a Special Operations Response Team (SORT).	PARTIALLY COMPLIANT

Table 1
Partially Compliant Core Standards 2022-23

8. **The Trust self-assesses that 57 Core Standards out of 63 are Fully Compliant and 6 are Partially Compliant - a 90% compliancy level.**

Therefore, the Trust self-assesses that it has achieved Substantially Compliant status for 2022-23.

Overview

9. **Continued impact of COVID19, NHS pressures, and Business Continuity Incidents**. The effect COVID19 has had on conducting training and exercising continued throughout much of the reporting period has been significant. Additionally, we have seen the impact on the Trust of enduring NHS pressures resulting in the requirement to frequently go in to Business Continuity Incident (previously called Internal Critical Incident). The impact these have had on maintaining the day-to-day business of EPRR cannot be underestimated, especially with regard to exercises and training – much of which has been forced to be cancelled at the last minute.

10. However, the overall awareness, relevance and application of EPRR good practice continues to increase and improve across the Trust. We have continued to build on this step-change in the practical application of EPRR working practices. The COVID19 pandemic has seen a rise in the awareness and application of EPRR, an unforeseen consequence that will have a positive impact when handling future crises. The Trust has strived to ensure such lessons are embedded through a combination of a set of common processes and procedures; a high tempo of EPRR Assurance and associated meetings; a stronger process for debriefing incidents; and a continued focus on key priorities.

Annual Programme, Plan, and Priorities

11. **EPRR priorities.** The EPRR priorities developed in 2020 were reassessed in Nov 21 and refined to include Digital Contingency and Winter Readiness. The priorities are below with a brief assessment of progress made.

a. **Fire**: Through the continued close working of the EPRR Assurance Group with the GMS Fire Team the reset that took place last year has continued. A plan was developed that has delivered an outstanding level of training and activity in spite of the aforementioned challenges. From Sep 21 – Jul 22 the Trust has seen:
   - 147 training sessions covering Fire Drills; Fire Evacuations; Fire Warden Training; Table Top Exercises; and Fire Walks.
   - 1387+ staff received training from the GMS Fire Team
   - 93% of Fire Wardens have been trained Trust-wide.
   - All Fire Risk Assessments have been completed by GMS Fire Team – with actions now being followed up by individual wards.

   These are significant achievements under challenging circumstances. The GMS Fire Team is now on a firmer footing than 12 months ago with the appointment of a new Fire Safety Manager in July 22. The improvements in Fire activity and assurance that took place in 20-21 have been reinforced.

b. **Chemical Biological Radiological Nuclear explosive (CBRNe) Aim: Establish a SWAST compliant CBRNe/Special Operations Response Team (SORT) team and rota:**
   i. Considerable work has gone in to redesigning the CBRNe concept and approach. Following benchmarking with peer Trusts a concept was settled on that builds on the capability already in place but with ED staff providing the Initial Operational Response and a Special Operations Response Team reinforcing when necessary. A Table-top exercise was conducted in Jan 22 to rehearse the concept. Implementing the system has been extremely challenging with a

combination of high turnover of ED staff alongside a significant amount of training being cancelled due to operational and staffing pressures. At present we have 47% of all ED staff trained across both sites in Level 1 (Awareness) which remains a good standard; however only 6 ED staff are trained in Level 2 (Suits and Tents) and 3 staff are trained in Level 3 (Incident Response). A revitalised approach has been adopted from July 22 onwards with an uptick in those attending Level 2 training, and with Level 1 integrated in to onboarding of staff in to the department. *The concept was tested in a pre-warned LIVEX on 23 Sep 22 and adjustments to the process have been made as the Trust strives to reach Full Operational Capability.*

ii. The creation of a bespoke Decontamination Room which is planned to be complete by Dec 22 as part of the Emergency Department new build will greatly enhance not only the reaction time but also the resilience and capability of the Trust's CBRNe response.

c. **Lockdown: Establish and Exercise Trust-wide and Local Lockdown Plan.** Lockdown Action Cards are now in place across the Trust. While the Trust is well practiced in the process of local reactive lockdowns often for security reasons, the opportunity to rehearse a deliberate Lockdown has remained extremely challenging due to the combination of COVID19 and recent operational pressures. An exercise was conducted for the first time in 3 years on 16 Aug 22, lessons identified have been implemented.

d. **Incident Control Centre (ICC) & GOLD/SILVER On-Call Training** With the GRH ICC now well established, subject to routine inspection and, when required, activated (as has been twice for precautionary reasons during recent incidents) - the Trust is assured of a robust capability. Attention has turned to the creation of a second ICC in CGH with work progressing and an anticipated Initial Operating Capability by Nov 22.

e. GOLD and SILVER staff now receive a formal induction from the EPRR team that covers the key aspects of SILVER and GOLD responsibilities as well as the use of the ICC and the Virtual On-Call Dashboard. In addition, an external training programme is now in place for members of BRONZE (Site), SILVER and GOLD that has delivered Major Incident Training; Applied Suicide Intervention Skills Training; Joint Emergency Services Interoperability Programme training; CBRNe Awareness training; Structured Debrief training; and Strategic Leadership in Crisis and Emergency training. These courses have been delivered to a spread of senior staff. Following the recent publication of the Minimum Occupational Standard for EPRR in June 22, the Trust will now conduct a Training Needs Analysis for key staff and implement a new EPRR Strategy working where we can with the ICB working where we can to achieve synergies.

f. The Trust Incident Management Team (IMT), which has been running since the beginning of the COVID19 pandemic, is still functioning.

g. **Digital Contingency** The reporting period has seen considerable focus by the Digital team on emergency planning. Business Continuity Planning has been the main focus. The early part of the year saw an upgrade for SUNRISE EPR in preparation for ED going live, as well as reviewing Business Continuity arrangements in the event one digital system fails. An audit of Business Continuity devices has taken place on all wards ensuring a hard copy of Digital processes is in every ward's Business Continuity folder.

Internally the Digital team has been running a number of workshops in order to review and strengthen their own business continuity and disaster recovery processes. Electronic Prescribing and Medicines Administrations is due to go live in the Autumn which will continue to enhance Business Continuity. Considerable progress has been made in this area.

h. **Winter Readiness.** The COO instigated a Winter Planning phase in Jun 22. EPRR is integrated in to this process. Systems are in place and will be rehearsed to ensure the Trust can respond to Adverse Weather

Internal Assurance and Audit Processes

12. The COVID19 pandemic continued to present challenges up until Apr/May 22 for internal assurance and auditing. Despite this the EPRR Assurance Group has maintained a high tempo of activity conducting formal fortnightly meetings, and connecting informally on a daily basis. EPRR leads and their deputies at Deputy Divisional Level have continued to lead the way ensuring key activity has continued. Internal audits have been conducted either within their own teams or when possible across Divisions providing objectivity. The challenges have eased although the impact of the many Business Continuity Incidents on such activity must not be underestimated.

Governance

13. EPRR governance continues to be delivered by a series of Committees and Working Groups including:
    a. EPRR Assurance Meeting
    b. Fire Safety Management Committee
    c. Security Management Group
    d. EPRR Group

    The frequency at which these groups meet brings an ability to horizon scan and respond to arising issues often before they become significant challenges. The EPRR Assurance Meeting is regarded as the 'battle-winner' in delivering EPRR outputs.

14. The above groups escalate issues and risks in to the rest of the Trust governance framework on a regular basis including:
    a. Exception reports from the Security and Fire groups to the Health and Safety Committee.
    b. Risks reviewed regularly and escalated to Risk Management Group
    c. EPRR Report to Trust Board through DOAG, Trust Leadership Team, Audit and Assurance Committee, Board
    d. NHSE EPRR Assurance through DOAG, Trust Leadership Team, Audit and Assurance Committee, Board.

Business Continuity

15. Maintaining Business Continuity has been an integral part of the COVID19 pandemic. Systems have been stress tested on a routine basis. Where improvements have been required these have been put in place sometimes within hours. However, there is no doubt that the formal processes in this arena require more work hence why 3 Core Standards are assessed as Partially Compliant.

Linkages and Collaborative Working

16. The Trust's EPRR team has continued to develop and build networks across Gloucestershire and the South West. Relationships with the ICB remain strong, open, and transparent. The Trust EPRR team feels well supported by a forward thinking NHSE SW EPRR team. Relationships in the Local Resilience Forum and Local Health Resilience Partnership are with both formal and less formal meetings at 100% attendance, and the leads for EPRR/ Organisational Resilience in GHC and GHFT have put a regular fortnightly meeting in to place to encourage mutual support where appropriate. Internally linkages remain active and continue to develop with a focus on ensuring GMS and Appleona are linked in to Trust operational processes.

Learning from Incidents

17. During the period of the COVID19 pandemic, an enduring an major incident itself, other incidents of a varying nature have taken place ranging from power outages, interruptions to essential support systems, extreme weather, and security incidents. Where appropriate and when learning can take place a process is now in place for turning Lessons Identified in to Lessons Learned through the newly adopted Structured Debrief Process. The EPRR team has conducted training in this approach and will ensure it continues as a Trust-wide policy when accessing learning from significant incidents.

Planning

18. While revision of plans has been difficult, a number have been addressed, including a review of Op CONSORT, an updated Lockdown Policy, and Extreme Heat plans and Action Cards following the Jun, Jul and Aug 22 heatwaves.

Training, Testing, and Exercising.

19. This aspect of EPRR has been particularly challenging during the pandemic. The focus on Fire Training, has ensured that the habit of conducting training has continued throughout this period.

20. In addition, there has been an increase in exercises being conducted either within or alongside the Trust. These have included:

- Dec 21: Op CONSORT
- Nov 21: Ex HIGH TOWER - SABA car park incident training
- Jan 22: CBRNe Table top exercise – Ex CALCANIA
- Jan 22: Ex SPRUCE – No notice - Mass Cas exercise with CCG/ICB
- May 22: Ex LEMUR- power outage
- May: 22 SWAST Maj incident comms test
- Jan and Jun 22 Ex INFANS PREPARE: Baby Abduction Table Top Training
- Jul 22: Ex TOUCAN - ICB comms ex
- Aug 22: Ex INFANS REACT
- *Sep 22: Mass Casualty exercise 23 Sep*

Horizon Scanning

21. The Trust continues to horizon scan across a wide spectrum for threats or challenges including adverse weather; travel restrictions including strikes;

Statutory Inquiry

22. The Trust has activated a team in preparation of the Statutory Inquiry. A Trust COVID19 Tool remains ready to be used that has collated data and decision making. Dir of Finance is the project lead with Hd of EPRR in support. We await further guidance and direction in the Autumn.

Next Steps and Summary

23. This reporting period continued on from an extraordinarily tough year. Indeed, it has only been as we transitioned in to Summer that there was a sense of moving on from the challenges of COVID19 and a potential return to the norm. However, in general, this has not been the case. Pressures across the wider NHS, the ICB, and the Trust have continued. In particular it has been the frequent return to Business Continuity Incidents due to operational pressures combined with staffing issues and pressures that has impacted the most on EPRR output. This has been felt most in the arena of training and exercising.

24. To balance this the Trust is regularly solving significant challenges at speed which means there is an extremely resilient and agile approach embedded in to the organisation that counteracts some of those gaps earlier identified. If the Trust were a sports team, one would assess that it is not getting much time on the training ground, but getting plenty of match play against tough opposition instead. As a result, while perhaps a little tired, we remain match fit.

25. The Board should continue to be assured that the Trust remains in a sound position in terms of EPRR. As stated last year it is a credit to the staff and to the leadership team that the organisation finds itself in such a place despite the pressures placed upon it.

Dickie Head

Head of Emergency Preparedness, Resilience and Response GHNHSFT

Appendix 1. NHSE/I Assurance Toolkit 2022-23

Ref	Domain	Standard name	Standard Detail	Acute Providers	Supporting Information - including examples of evidence	Organisational Evidence	Link to Evidence	Link to Evidence	Link to Evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's EPRR work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. Green (fully compliant) = Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance														
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	• AEO = Qadar Zada Chief Operating Officer • Deborah Lee, Chief Executive where necessary • Dickie Head, Head of Emergency Preparedness, Resilience, Response, and Recovery	..\04 Evidence\01 Governance\Chief Operating JD_Feb 2021 (2).docx			Fully Compliant				
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	• Updated July 2021 • Head of EPRR Quarterly meetings with Finance Team	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/emergency-preparedness-resilience-and-response-policy/	..\04 Evidence\01 Governance\GHNHSFT_EPRR Policy Final 270721.docx		Fully Compliant				
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, EPRR board report should be published in a way that is accessible to the public.	• EPRR Report presented annually. • 2021/22 reported September 2021 • See CS 6 Lessons ands Learning identified embedded	..\04 Evidence\01 Governance\20210831 EPRR Assurance - PUBLIC BOARD_202122.docx			Fully Compliant				
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	• BMG System Work Plan				Fully Compliant				
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	•EPRR Structure Head of EPRR , Senior Manager EPRR , Band 5 secondment 22hours •Monthly meetings with Finance Team and Annual Budgetary Review. • EPRR Leads across each of the divisions Bi Week Assurance meetings	https://www.gloshospitals.nhs.uk/media/documents/StructureChart-MAR_10_22-FINAL.pdf			Fully Compliant				
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	• Incident response feedback forms completed by On Call Bronze / Silvers / Golds • Debriefs are held after incidents embedded document • Structured debriefs adopted and EPRR Team Trained Structured Debrief • Debrief forms are held on the Shared Folder • Reports from incidents and exercises are shared with the relevant areas • Attendance Acute SW EPRR Forum quarterly sharing of best practice lessons learned	S:\Restricted\NHS EPRR\01 EPRR\11 On Call\03 Internal Incidents\03 2022\July 2022\Air Handling\Debrief_Air Handling FINAL010822.pdf	S:\Restricted\NHS EPRR\01 EPRR\11 On Call\03 Internal Incidents\03 2022\July 2022\Air Handling\Air Handling Theatres Feedback 190722 - ACM.docx		Fully Compliant				
Domain 2 - Duty to risk assess														
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	• Reviewed by the risk department and Head of EPRR and at the EPRR G quarterly meeting • Risks escalated and reviewed when necessary at Trust Risk Management Group • LRF Risk Register review monthly at monthly WOT Meetings Risk Register held on Resilience Direct	S:\Restricted\NHS EPRR\01 EPRR\07 Meetings\07 H&SC Exception Reports\3. Jun 22\H&SC Subgroup Fire Exception Report Jun 22.pptx	S:\Restricted\NHS EPRR\01 EPRR\07 Meetings\07 H&SC Exception Reports\3. Jun 22\H&SC Subgroup Security Exception Report Jun 22.pptx		Fully Compliant				
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	• Link to EPRR Policy document • Weekly contact with Head of Corporate Risk, Health & Safety • All key groups have risk registers. • Escalation process in place. • Exception reports raised to Health and Safety Committee	Copy of EPRRG Risks ? DH	S:\Restricted\NHS EPRR\01 EPRR\10 EPRR Policy and Strategy\GHFT EPRR Policy\GHNHSFT_EPRR Policy Final 270721.docx	S:\Restricted\NHS EPRR\01 EPRR\10 EPRR Policy and Strategy\GHFT EPRR Strategy\EPRR Strategy as at Aug 22.pptx	Fully Compliant				
Domain 3 - Duty to maintain Plans														
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	• Collaborative working arrangements with the LRF • Active participation in Task and Finish groups • DH Lead for SW EPRR group quarterly meetings and relevant Task and Finish groups as and when necessary • Version control table embedded in documents • Bi weekly meeting GHC DH / MS • Collaborative planning Police, Fire SWAST - Major Events e.g. Cheltenham Festival				Fully Compliant				
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Major Incident Response Plan held on the Trust Intranet • last updated January 2021	https://intranet.gloshospitals.nhs.uk/departments/corporate-division/emergency-major-incident-planning/major-incidents/			Fully Compliant				
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	• UKHSA PHE Adverse Weather plan Heatwave plan updated 2022 on the intranet • Regular comms cascade per met office warnings to Site team and On Call. • Recent Heatwave Incident debriefed and embedded learning in Trust Plans • LRF Access to 4x4 • Snow Control Room Lead •Accommodation Lead • Plans and alerts: Operation Link, Met Office Weather Alert etc. • COO has instigated winter planning in July 2022	Adverse Weather (gloshospitals.nhs.uk)			Fully Compliant				
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.	• Pandemic Plan held on Trust intranet extensively practiced and reviewed during ongoing COVID incident • FFP3 Procedure document held on Trust intranet	https://www.gloshospitals.nhs.uk/media/documents/GHFT_Pandemic_COVID19_Plan_Working__v0.9_ofOe5SB.pdf	https://nhs.sharepoint.com/sites/RTE_ghnhsft_policies/Shared%20Documents/A2223.pdf		Fully Compliant				
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Adaptation of a generic plan				Fully Compliant				
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	• Mass Prophylaxis Centre Planning Framework NHSE/I • Generic Respiratory Plan	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\04 Evidence\06 Response\NHSE-NHSI South West Mass Prophylaxis Centre Planning Framework- FINAL.pdf	https://intranet.gloshospitals.nhs.uk/departments/corporate-division/infection-control/monkeypox/		Fully Compliant				
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	• Mass casualty plan held on the Trust Intranet • Sept 2022 Mass Casualty Exercise	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/major-incident-response-plan/			Fully Compliant				
16	Duty to maintain plans	~~Evacuation and shelter~~	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	DEEP DIVE				Not applicable				
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• Lockdown Policy - in place. • Lockdown Action Card in place and socialised across the Trust • Baby Abduction exercise including Lockdown 16th August 2022	S:\Restricted\NHS EPRR\01 EPRR\06 Plans and Frameworks\06 Lockdown\GHNHSFT Lockdown Policy Final 270721.docx			Fully Compliant				
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	• OP Consort Action Card / Plan in place • Table Top Exercise 1/10/21	..\04 Evidence\03 Plans\IR.013 Operation Consort Current 300522 V4.0.pdf			Fully Compliant				
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	**Major Incident Response Plan** • Plan Appendix 6 Police Casualty Bureau setup mutual agreements • Plans in place with local funeral directors • LRF County Wide Mortuary Plan • Police acting for HM's Coroner will make arrangements for temporary storage of bodies . • Meeting arranged to walk the floor GHTFT / Police • Pathology Business Plan outlines procedures in place for Mortuary Capacity last updated 29/04/21 updated every 2years	Major incident response plan (gloshospitals.nhs.uk)	..\04 Evidence\09 Business Continuity\Business Continuity Plan (Contingency) Pathology.docx		Fully Compliant	Plan Table Top Exercise 2023/24 last Exercise Summer Rose arranged LRF			
Domain 4 - Command and control														

20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	• Gold and Silver on call rotas are in place 24/7 • Access by all On Call Mangers to "On Call Information Portal " Shared folder containing Plans, Contact List , Action Cards etc	..\..\..\10 EPRR Policy and Strategy\GHFT EPRR Policy\GHNHSFT_EPRR Policy Final 270721.pdf		Fully Compliant	
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	• Roles and Responsibilities covered in Trust EPRR Policy • Gold and Silver on call rotas are in place 24/7 • Following recent occupational standards review required • Training Programme in pace for Gold, Silver and Bronze	S:\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\06 EPRR Assurance Training Record\02 2022\02 GHTFT_On Call Training and Exercise Tracker 130521.xlsx	..\..\..\02 Training and Exercising\06 EPRR Assurance Training Record\02 2022\02 GHTFT_On Call Training and Exercise Tracker 130521.xlsx	Fully Compliant	
Domain 5 - Training and exercising										
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	• TNA identified 2022 and programme is planned	S:\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\06 EPRR Assurance Training Record\02 2022\EPRR Master Record of Training 202122 (2).xlsx		Partially Compliant	Rolling Training Programme needs putting in place work with ICB
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	• Comms MI exercise carried out SWAST June 2022 then monthly there after • Exercise Toucan July 2022 NHSE/ I Comms Cascade • Table Top Exercises on going Fire • Vertical and horizontal Evacuation Fire • Electronic Patient Record exercise as and when rolled out in divisions • Electronic Patient Prescribing Exercise Early September 2022 test areas then roll out across the Trust End September 2022 • Live Lockdown exercise "Baby Abduction" August 2022 • Live Mass Casualty Exercise September 2022 • Business Continuity live events responded to in 2022	S:\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\03 Live Exercises\Year 2022\ED_CBRN(e)_TTX_Calcaria_190122\ED_CBRN(e)_TTX_Calcaria_190122.pptx		Partially Compliant	
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	• ESR Records all mandatory training for staff	S:\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\06 EPRR Assurance Training Record\02 2022\EPRR Master Record of Training 202122 (2).xlsx		Fully Compliant	Training Programme in the development stage
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	• Exercise and training records reported to the board • Trust wide training report evidence	..\..\..\02 Training and Exercising\07 Trust Wide Training report\Training Compliance Report_GHT 31 July_2021.docx		Fully Compliant	
Domain 6 - Response										
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	• Primary ICC located GRH site with secondary location available CGH • Facility for all On Call to access "Virtual ICC Desk" this gives the option to access ICC files extra remotely • ICC checked on a monthly basis to ensure hardware and software all working • During the 1st wave response to COVID the IMT was operating virtually 7 days • COVID 2nd wave IMT are now operating 5 days a week • Link to ICC Action Cards	Evidence AC set up ICC		Fully Compliant	
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	• Yes • All Plans and Policies Held on Trust Intranet • Virtual ICC desk gives access to electronic files "On call Information Portal" • Paper copies of key plans held in the ICC, ED • Version Control documented within plan			Fully Compliant	
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	• Business Continuity Plans in Place across all area which are reviewed and updated ongoing in responses to incidents • These are held on the Trust Intranet and at a local level in Business Continuity Folders - these BC folders are audited quarterly and socialised at Team Huddles			Fully Compliant	
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	• The Trust has a list of trained Loggist • During COVID the IMT have maintained a Trust Decision Log • Logging of localised incidents events is part of Trust procedures • Embedded in "On Call" training	Embed loggist list		Fully Compliant	• Trust requirement to set update training dates
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	• Standard templates METHANE, SBAR available and embedded in Trust incident response • BI Team complete and have access to SITREP Template • METHANE SBAR briefed to Bronze, Sliver and Gold			Fully Compliant	
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Y	Guidance is available to appropriate staff either electronically or hard copies	• Guidance is available on the Trust Intranet and paper copies held in key areas	https://intranet.gloshospitals.nhs.uk/departments/corporate-division/emergency-major-incident-planning/major-incidents/		Fully Compliant	
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Y	Guidance is available to appropriate staff either electronically or hard copies	• Electronic copies held on Trust Intranet • Hard Copies in Primary ICC, Site Office GRH and CGH ; ED GRH and ED CGH	Major incidents (gloshospitals.nhs.uk)		Fully Compliant	
Domain 7 - Warning and informing										
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	• Plans are in place to manage EPRR issues including robust ways to work with the media, Partners and stake holders • OOHs service the Trust does not have a formal OOHs service it should be noted in terms of mitigation that goodwill is offered by the team (which means the organisation has never been without comms support OOHs) while solutions are being explored.			Fully Compliant	
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England and NHS Improvement's regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE/I (if appropriate).	Follow up with comms team Action Card Development			Fully Compliant	•Action Cards sent a template 08/08/22 • Meeting James 11/08/22
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	• **Communication and Engagement** - Our Brilliant Basics this sets out the Trust • The Communication and engagement model • Operational priorities delivery • SPOC list in place	..\04 Evidence\07 warning and Informing\Our Brilliant Basics.docx		Fully Compliant	
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	• **Engagement and Involvement Strategy**	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\04 Evidence\07 warning and Informing\Engagement and Involvement Strategy - Final.pdf		Fully Compliant	
Domain 8 - Cooperation										
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a representative with Delegated Authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	• Active Trust attendance at LHRP meetings	\\glos.nhs.uk\ghnhst\Restricted\NHS EPRR\01 EPRR\04 LHRP\BMG		Fully Compliant	
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	• Active Trust attendance at LRF meetings	\\glos.nhs.uk\ghnhst\Restricted\NHS EPRR\01 EPRR\05 LRF\WOT		Fully Compliant	
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	• LHRP Mutual Aid Agreement • Signed Trust MOU 4x4	..\04 Evidence\08 Cooperation\Gloucester LHRP aid agreement V1.3 060319.docx	..\..\..\06 Plans and Frameworks\04 4 x 4\01 GW MOU\MOU GHFT W&G 4x4 290921.docx	Fully Compliant	
40	Cooperation	Arrangements for multi area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all				Not applicable	
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency				Not applicable	
42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas				Not applicable	
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	• Vulnerable People Plan held on Trust Intranet	https://intranet.gloshospitals.nhs.uk/documents/1178/Vulnerable_People_Plan.pdf		Fully Compliant	
Domain 9 - Business Continuity										
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	• BC Policy and documents accessed via Trust Intranet	https://intranet.gloshospitals.nhs.uk/documents/4877/GHFT_BCM_Contingency_Plan_1_June__2017_v4.doc	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\04 Evidence\09 Business Continuity\GHFT_BCM_Contingency_Plan_1_June__2017_v4 (14).doc	Fully Compliant	
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	• Business Continuity Plans held on the Trust Intranet • Identifies BC Planning Cycle • Identification of risks • BC Contingency plan • BC Action CArds • Link to action cards whinin the plan • Business Continuity Actoin Cards by division area held on Trust Intranet	https://intranet.gloshospitals.nhs.uk/departments/corporate-division/emergency-major-incident-planning/business-continuity-management/	Business Continuity Management Contingency Plan (gloshospitals.nhs.uk)	Fully Compliant	Plan not reviewed since 2017 to be actioned end of August

46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.		https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/business-impact-assessment-and-continuity-plan-template/		Partially Compliant	DH Leigh / Plan
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	BCP Plans held on the Trust Intranet • Gold and Silver Actioin Cards • Staffing • Generic / General Loss of Power , Natinal Threats, Catering , Heating , Hot Water etc • Communication Action Cards • Fire • Evacuation and Shelter Plan	https://intranet.gloshospitals.nhs.uk/departments/corporate-division/emergency-major-incident-planning/business-continuity-management/		Fully Compliant	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief Evidence Post exercise/ testing reports and action plans	• Fire Evacuation Horizonal and Vertical • Fire Table Top • Live Baby Abduction Exercise Aug 2022 • Live Mass Casualty Exercise Sept 2022	S:\Restricted\NHS EPRR\01 EPRR\07 Meetings\01 EPRR Meetings\02 EPRR Assurance Group (Bi Weekly)\06 Meetings\Bi Weekly 2022\03 Fire Brief\Copy of EPRR Fire Briefing July 22.xlsx		Fully Compliant	
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	• Approaching Standard - See data Security sheet 86% at present 95% to achive • Drive at the moent to encourage staff to update their mandatory training	See Data Security Sheet		Partially Compliant	
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	• Business Continuity Plan held on the Trust Intranet • Business Continuity Plans by department held on the Trust Intranet • Reports to the Board?	https://intranet.gloshospitals.nhs.uk/policies-and-guidelines/business-continuity-management-contingency-plan/		Fully Compliant	
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	• On going audits of EPR and EPMA as and when they are August / Sept 2022 • On going audit of EPRR Assurance documentation "Topic of the Month" Lockdown, BC Computers and Printers, Red Folders etc			Partially Compliant	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	• Culture of continuous improvement • Internal incident feedback forms • Debrief reports • Lessons Learned embedded	S:\Restricted\NHS EPRR\01 EPRR\11 On Call\03 Internal Incidents\00 Admin\On Call Feedback Current.docx	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\04 Evidence\09 Business Continuity\Debrief Air Handling FINAL010822.pdf	Fully Compliant	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	• Majority of clinical consumables are via NHS-SC • There is a back up system in place for this, which includes our out of hours response • When contracting outside of NHS-SC and services, we use the NHS standard T&C's as a default, and push for copies of the business continuity plans, when a critical contract. These are provided to the contract Manager • Managed service contracts such as Roche for Pathology etc., place the responsibilities on the managed service provider • Sustainable Procurement Policy embedded • Procurement Shared Services embedded link	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\04 Evidence\09 Business Continuity\Sustainable_Procurement_Strategy__Policy_2015-18_Final.docx	https://www.gloshospitals.nhs.uk/about-us/our-trust/gloucestershire-procurement-shared-service/	Fully Compliant	
54	Business Continuity	Computer Aided Dispatch	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning					
Domain 10 - CBRN										
55	CBRN	Telephony advice for CBRN exposure	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements	•Yes •Telephone numbers for Public Health England Centre for: Radiation and Environmental Hazards • Environment Agency • DEFRA Decontamination Service • SWAST NILO; TOXBASE; • Met Office Chemical Meteorology Serve • GHFT Radiation Protection Supervisor are in the CBRNe Plan and held physically in Sisters' Office in ED in both GRH and CGH.			Fully Compliant	
56	CBRN	HAZMAT / CBRN planning arrangement	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Y	Evidence of: • command and control structures • procedures for activating staff and equipment • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • interoperability with other relevant agencies • plan to maintain a cordon / access control • arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	•Current Plan is in place with revised plan drafted containing Policy, SOPs, and Action Cards. •New training packages Levels 1, 2, and 3 also reinforces the structures and implementation of best practice	S:\Restricted\NHS EPRR\01 EPRR\06 Plans and Frameworks\11 CBRN\CBRN(e)_Policy_&_SOP\GHNHSFT_CBRN(e)_Incident_Plan_V0.1_(DRAFT)_060521-Current.docx		Fully Compliant	
57	CBRN	HAZMAT / CBRN risk assessments	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Y	• Impact assessment of CBRN decontamination on other key facilities	• Diagnosis and early management of organo-phosphate chemical incident guidance held on Trust Intranet • The Trust works collaboratively with the Fire Service in response • Three pumping appliances would attend the scene • Environmental Protection Unit (EPU) and the CBRN Shower unit which can Strip, Wash, Dry and Clothe 200 people in quick succession •All contaminated water is collected • Once the Environmental Officer and Water Authority are clear on the chemical dilution and ratio, if applicable , the water is then passed through the natural water course • Worst case scenario the water is contained , tanked and disposed at the treatment plant off site • Impact assessment embedded in document	https://www.gloshospitals.nhs.uk/media/documents/Chemical_and_organophosphate_incident_clinical_management.pdf	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\04 Evidence\10 CBRN\CBRN(e)_Business_Impact_Assessment_Continuity_Plan_260821.docx	Fully Compliant	
58	CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Y	Rotas of appropriately trained staff availability 24 /7	• A system is in place that involves the training of ED staff in the Initial Operational Response; selected staff members in the use of suits and erection of a decontamination tent; and the management of a CBRNe incident. • In addition a Special Operations Response Team is on a Recall to Duty , using a flash call to all team members, which has been tested and resulted in a recall rate that surpassed requirements.	S:\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\06 EPRR Assurance Training Record\02 2022\ED_CBRN(e)_MASTER Training_Record_CURRENT_060722.xlsx		Partially Compliant	
59	CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Y	Completed equipment inventories; including completion date	• Inventories for both CGH and GRH stores are held and checked on regular basis. • All electrical devices are Pap-tested by medical engineering. • High-voltage electricity and water tested regularly by Appleona evidence held with Appleona • PRPS suits maintained and serviced by RESPIREX engineers.	Copy of Certificates		Fully Compliant	
60	CBRN	PRPS availability	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Y	Completed equipment inventories; including completion date	• Yes • Financed through EPRR Budget	S:\Restricted\NHS EPRR\01 EPRR\06 Plans and Frameworks\11 CBRN\CBRN(e)_Assurance Documents\PRPS_GEN2_Shelf_Life_Extension_GRH_CGH_180521.docx		Fully Compliant	
61	CBRN	Equipment checks	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Y	Record of equipment checks, including date completed and by whom.	• Trust Lead for CBRNe conducts visual inspections including: Kit; equipment and decontamination tent for wear and tear. • Spot checks conducted by Hd of EPRR on irregular basis.	CBRN Assurance document		Fully Compliant	
62	CBRN	Equipment Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment	Y	Completed PPM, including date completed, and by whom	• PPM for Suits is held. • Other equipment is RAG rated	CBRN Assurance document		Fully Compliant	
63	CBRN	PPE disposal arrangements	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Y	Organisational policy	•At last changeover of suits (2019) old suits were retained for training purposes. • Arrangement is in place with GMS to dispose of PPE.	S:\Restricted\NHS EPRR\01 EPRR\06 Plans and Frameworks\11 CBRN\CBRN(e)_Policy_&_SOP\GHNHSFT_CBRN(e)_Incident_Plan_V0.1_(DRAFT)_060521-Current.docx		Fully Compliant	
64	CBRN	HAZMAT / CBRN training lead	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Y	Maintenance of CPD records	• Yes. • Held at SWAST Hazardous Area Response Team • Train the Trainer Feb 2022 delivered by SWAST	Held at SWAST Hazardous Area Response Team		Fully Compliant	
65	CBRN	Training programme	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • A range of staff roles are trained in decontamination techniques • Lead identified for training • Established system for refresher training	• A system is in place that involves the training of ED staff in the Initial Operational Response; selected staff members in the use of suits and erection of a decontamination tent; and the management of a CBRNe incident.	S:\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\06 EPRR Assurance Training Record\02 2022\ED_CBRN(e)_MASTER Training_Record_CURRENT_060722.xlsx		Fully Compliant	
66	CBRN	HAZMAT / CBRN trained trainers	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Y	Maintenance of CPD records	• Train Trainers session completed by SWAST Feb 2022	S:\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\06 EPRR Assurance Training Record\02 2022\EPRR Master Record of Training 202122 (2).xlsx		Fully Compliant	
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Y	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	• CBRNe Training sheets • CBRNe Attendance Sheet • CBRNe Feedback forms • CBRNe Future bookings	\\glos.nhs.uk\ghnhst\Restricted\NHS EPRR\01 EPRR\02 Training and Exercising\02 CBRN		Fully Compliant	
68	CBRN	FFP3 access	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.	Y		• Impact of COVID19 • The Trust has trained staff extensively across the Trust in the use of PPE • Link to training documentation embedded • All Trust clinical staff have received training over last year.	Supporting documentation\Copy of Copy of Surgery fit test compliance up to Aug 2021 v2.xlsx		Fully Compliant	Sent for revised back up 03/08/22

Approaching Standard

20/07/2022

00/08/22

Data Security and Protection Toolkit (DSPT) version 4 2021/22

The Trust's 2020/21 version 3 self-assessment published 30 June 2021 had a status of Standards met. The challenges previously reported in achieving 95% of all staff to have completed the annual IG refresher

1. Continue all staff comms campaign to maintain and raise awareness
2. Review and improve ease of access to training
3. Continue targeted comms through divisions to areas of high non compliance
4. Drive through Exec reviews and Divisional boards
5. Review of new starter induction particularly for rotating doctors staff groups

This plan has a target for meeting compliance by 31.09.2022 and has been accepted by NHS Digital resulting in a status update of Approaching Standards.

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

Ref	Domain	Standard	Deep Dive question	Further information	Acute Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Link to Evidence	Self assessment RAG Red (not compliant) = Not evidenced in evacuation and shelter plans or EPRR arrangements. Amber (partially compliant) = Evidenced in evacuation and shelter plans or EPRR arrangements but requires further development or not tested/exercised. Green (fully compliant) = Evidenced in plans or EPRR arrangements and are tested/exercised as effective.	Action to be taken	Lead	Timescale	Comments
Deep Dive - Evacuation and Shelter												
Domain: Evacuation and Shelter												
DD1	Evacuation and Shelter	Up to date plans	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.		Y	• Evacuation and Shelter Plan version 7.1 updated July 2021	..\..\03 Evidence\11 Deep Dive\GHNHSFT_Shelter_and_Evacuation_Plan_v7.1-Final_270721_9LRPJJv.pdf	Partially Compliant	Review plan against latest guidance			
DD2	Evacuation and Shelter	Activation	The organisation has defined evacuation activation arrangements, including the decision to evacuate and/or shelter by a nominated individual with the authority of the organisation's chief executive officer.		Y	• Detailed in Shelter Plan **7 Activation triggers**		Partially Compliant				
DD3	Evacuation and Shelter	Incremental planning	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.		Y	• Detailed Shelter Plan **10 Patient Management**		Partially Compliant				
DD4	Evacuation and Shelter	Evacuation patient triage	The organisation has a process in place to triage patients in the event of an incident requiring evacuation and/or shelter of patients.		Y	• Detailed in the Shelter Plan ref **10 Patient Management - Table3 Triage Priorities**		Partially Compliant				
DD5	Evacuation and Shelter	Patient movement	The organisation's arrangements, equipment and training includes the onsite movement of patients required to evacuate and/or shelter.		Y	• Detailed in the Shelter Plan **11 Equipment to support the movement of patients** • Training undertakedn by Fire Team ResQ sheets and Sled2eo		Partially Compliant				
DD6	Evacuation and Shelter	Patient transportation	The organisation's arrangements, equipment and training includes offsite transportation of patients required to be transferred to another hospital or site.		Y	• Detailed in the plan **12 Onward Management of Patients**		Partially Compliant				
DD7	Evacuation and Shelter	Patient dispersal and tracking	The organisation has an interoperable patient tracking process in place to safely account for all patients as part of patient dispersal arrangements.		Y	• Detailed in the Shelter Plan **Appendix 1** Patient Tracking Form pre numbered forms held in ward boxes		Partially Compliant				
DD8	Evacuation and Shelter	Patient receiving	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.		Y	• LHRP Mutal **Aid Plan 4,5,6,7 Appendix A,B**	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\03 Evidence\03 Plans\2019_Gloucester_LHRP_aid_agreement_V1.3_060319 (1).docx	Partially Compliant				
DD9	Evacuation and Shelter	Community Evacuation	The organisation has effective arrangements in place to support partners in a community evacuation, where the population of a large area may need to be displaced.		Y	• LRF Mutal Aid Plan	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\03 Evidence\03 Plans\LRF_Evacuation and Shelter V1.9 final.pdf	Partially Compliant				
DD10	Evacuation and Shelter	Partnership working	The organisation's arrangements include effective plans to support partner organisations during incidents requiring their evacuation.		Y	• Police Casualty Bureau set up in ED Appendix 6	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\03 Evidence\03 Plans\Major_Incident_Response_Plan_-_V8_February 2021.pdf	Partially Compliant				
DD11	Evacuation and Shelter	Communications-Warning and informing	The organisation's evacuation and shelter arrangements include resilient mechanisms to communicate with staff, patients, their families and the public, pre, peri and post evacuation.		Y	Detailed in Shelter Plan **16 Communication**		Partially Compliant				
DD12	Evacuation and Shelter	Equality and Health Inequalities	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.		Y	Detailed in Shelter Plan **19 Equality Impact Assessment**		Partially Compliant				
DD13	Evacuation and Shelter	Exercising	The evacuation and shelter arrangements have been exercised in the last 3 year. Where this isn't the case this will be included as part of the organisations EPRR exercise programme for the coming year. Please specify.		Y	• Fire Team have conducted live fire evacuation exercise	S:\Restricted\NHS EPRR\01 EPRR\03 Assurance\2022\03 Evidence\11 Deep Dive\Copy of EPRR Fire Briefing July 22.xlsx	Partially Compliant				

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Estates and Facilities Committee, 28 July 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**
None.		
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
GMS Chair Report	The Committee was provided an overview of the delivery of the business plan for 2022-23, particularly around the national cleaning standards rollout, the continuation of work to address 146 workforce vacancies, and the financial performance of GMS which was currently below budget year-to-date. GMS Board had discussed inflationary costs and reviewed some indicative increases which included a 70% increase in gas prices, 42% increase in fuel, and an 8% increase in cleaning products.	Inflationary cost details would be shared with the Director of Finance to ensure clarity.
Contract Management Group Exception Report	Funding for paediatric safer areas had been granted. Funding for dementia wards had not been granted; further information had been requested to understand why. The Trust was reviewing the heatwave business continuity incident, which had highlighted issues with the Trust's ageing estate; there had been a number of outages of air handling units and chillers, and power outages.	The Committee would receive an update on contract discussions with Saba, and resolution progress.
Workforce Action Plan	Plans to close the vacancy gap continued to progress, in collaboration with the Trust's Deputy Director for People and Organisational Development. Any proposals against the plan would be brought to the Committee for review. The Committee was concerned in relation to the pay award for Agenda for Change staff and how this could be applied and funded for non-Agenda for Change staff.	The Committee would receive the plan on the implementation of pay award funding for non-A4C staff at the next meeting.
Electrical Resilience Strategy	The Committee received an update on the Electrical Resilience Strategy, noting that an £8m investment was required to ensure full compliance.	The action plan was in discussion with the Trust to finalise and confirm capital planning for implementation.
Risk Report	The Committee was assured that all risks now formally belong to the Group, with a clear executive reporting process. Two new risks had been included on the register.	GMS and the Trust would collectively review risks and agree the operational lead for each. This would process would begin with the highest scored risks.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Sustainability Report	The report detailed a number of achievements over the last year, including the increase in video and tele-conferencing which contributed towards reduced travel; the Trust as a carbon negative supplier for sandwiches and wraps; the creation of a wildlife garden at GRH; and the introduction of the new Social Value Model in all tender processes. The report also detailed a number of projects for 2022-23 including a new recycling/domestic waste contract and a new staff parking policy. The Committee was apprised of the ICS Green Plan, which did not replace the Trust's plans but confirmed common and collaborative actions and timelines across the local health system.	The team would consider a staff communication plan on sustainability initiatives.
GSSD Progress Report	The Committee was satisfied that the project was progressing well, and noted that the Trust was proud of the ongoing work.	A visit for non-executive directors would be arranged 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.

		Cheltenham site.
Items not Rated		
Integrated Care System Update		
Impact on Board Assurance Framework (BAF)		
Risk rationalisation would be taking place with Executives and Committee Chairs throughout August and September.		

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item	17	Enclosure Number	12
Date	8 September 2022		
Title	Guardian of Safe Working Hours Quarterly Report		
Author /Sponsoring Director/Presenter	Author: Dr Jess Gunn Sponsor: Dr Alex d'Agapeyeff		

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

Key issues to note

- There were 61 exception reports logged.
- There were no fines levied.
- 23 Datix reports were submitted during this quarter, relating to junior doctor shortages
- The total expenditure on agency and bank locum cover, across all specialties', over the last quarter was: £7,252,083.00
- A further £3527.38 was paid to junior doctors as a result of a total of additional hours worked and 5.45 hours were allocated as TOIL.

Conclusions

The number of exception reports has reduced significantly this quarter and has also fallen compared with the same quarter in 2021. The cause of this is likely multifactorial but may be a positive consequence of increasing expenditure on locum staff to support existing staff members.

Recommendation

The Board should be ASSURED that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly

Enclosures

- GOSW Quarterly Report

Quarterly Guardian Report on Safe Working Hours for Doctors and Dentists in Training

For Presentation to the Main Board

1. Executive Summary

1.1 This report covers the period of 1.04.22 – 30.06.22. There were 61 exception reports logged.

1.2 During this period, 0 fines were levied.

2. Introduction

2.1 Under the 2016 terms and conditions of service (TCS) for junior doctors, the trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The guardian oversees exception reports and assures the board of compliance with safe working hour's limits. The Terms and conditions have been updated in 2019, with further requirements being monitored.

2.3 The structure of this report follows guidance provided by NHS Employers.

High level data

Number of doctors / dentists in training (total):	417
No. of trust doctors	70
Total Junior doctors	487
Amount of time available in job plan for guardian:	2PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors: (first/additional trainees to maximum 0.5 SPA)	0.25/0.125 PAs

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1-2& GPT**	**IMT & ST3-8**	**Additional training and trust grade vacancies**
ED	U/a	u/a	u/a	u/a	**Numbers unavailable at the time of writing report**
Oncology	0	0	1	0	**1x trust doctor ST1 grade**
T&O	0	0	6	0	**6 x Trust Dr (ST1)**
Surgery	0	0	0	2	**1x urology clinical fellow** **1x upper GI/ colorectal trust doctor** **Anaesthetics- number unavailable at the time of writing report**
General Medicine	u/a	u/a	u/a	u/a	**Numbers unavailable at the time of writing report**
Paeds	0	0	1	3	**3x trust registrar** **1x trust doctor**
Cardiology	0	0	0	1	**1x trust doctor in interventional cardiology**

(vacant training grade post to which tabulated numerical value corresponds)*

Total Junior Doctor Vacancies – currently unable to provide absolute number due to missing data.

4. Locum Bookings

4.1 Data from finance team and HR:

The total expenditure on agency and bank locum cover, across all specialties', over the last quarter was: £7,252,083. 00

The breakdown of this locum expenditure over the last quarter, according to department, is as follows:

		April	May	June
Medicine	Agency	879,612	615,772	954,087
	Bank	507,148	557,986	520,071
Surgery	Agency	265,927	289,705	375,114
	Bank	211,421	191,582	244,681
Diagnostics & Specialist	Agency	163,133	155,670	190,723
	Bank	94,423	74,972	57,972
Womens & Childrens	Agency	225,891	177,457	234,364
	Bank	85,035	102,209	77,128

5 Additional Costs

5.1 Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £3527.38 (186.75 additional hours worked.)

Total number of hours given as TOIL as result of exception reporting of additional hours worked: 5.45 hrs

5. Exception Reports

	Exceptions Raised		
Specialty	**Working Hours**	**Educational Opportunities**	**Service Support Available**
General/GI Surgery	0	0	50
Urology	2		0
Trauma/ Ortho	10		0
ENT	0		0
MaxFax	0		0
Ophthalmology	0	0	0
Orthogeriatrics	0	0	0
General Medicine	29 + 2x ISC	2	6
Geriatric Medicine	5	0	0
Neurology	0	0	0
Cardiology	1	0	0
Respiratory	1	0	0
Gastro	0	0	0
Renal	0	0	0
Endocrine	0	0	0
Acute medicine/ ACUA	1	1	0
Emergency Department	0	0	0
Obstetrics and Gynaecology	0	1	0
Paediatrics	1	0	0
Psychiatry	0	0	0
Anaesthetics	0	1	0
Oncology	0	0	0
Haematology	0	0	0
GP	0	0	0
Other	**0**	**0**	**0**
Total	**52**	**5**	**6**

6. Fines this Quarter

6.1 This quarter there have been no fines levied.

7. Issues Arising

7.1 There were 2 reports listed as ‘immediate safety concern’. The nature of these concerns related to workload and reported lack of medical staff/ junior doctors to provide out of hours surgical cover in CGH on one occasion and on the acute medical take.

Further information was obtained about the nature of these events and this was escalated to the relevant senior staff to assist with resolution. Subsequent to this, at the time of writing, no further ISC reports or concerns about ongoing or unresolved issues have been received.

8. Actions Taken to Resolve Issues

8.1 As above.

9. Correlations to Clinical Incident Reporting

9.1 There were 23 datices submitted over the last quarter, from medical, paediatric and surgical specialties, directly relating to medical/ doctor staff shortages.

The reported consequences of these staff shortages include:

- Lack of junior doctors to support consultants doing ward rounds, and review in patients out of hours, with a consequent delay in undertaking ‘jobs’ required to progress patient care, including requesting tests, prescribing discharge medications, writing discharge summaries and liaising with other specialties and patients’ relatives. This has a detrimental effect on patient ‘flow’ through the hospital and a significantly negative effect on patient experience.

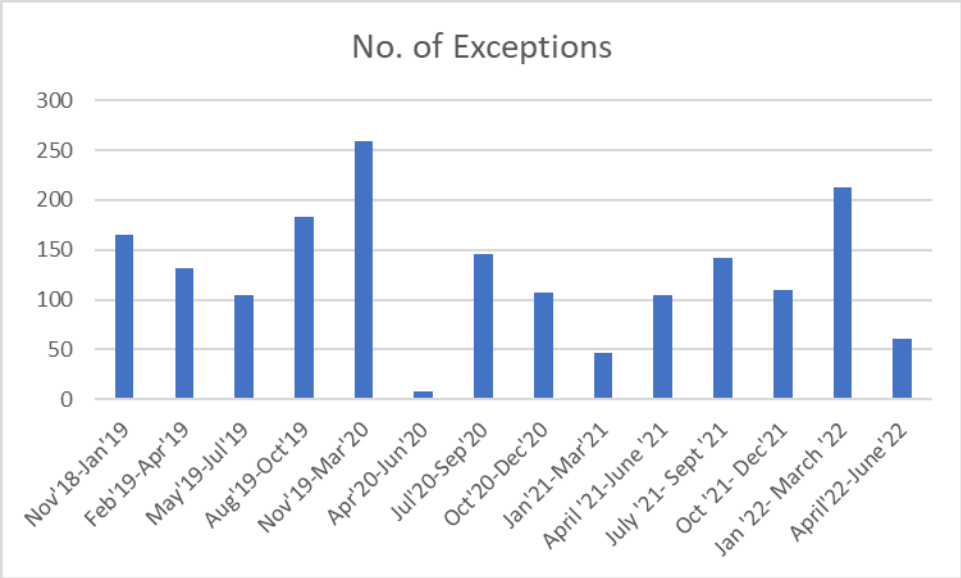
- Delays in patients being seen and assessed when presenting to ED, SDEC, SAU etc with consequent impact on patient care, patient experience and flow through the hospital.

These datices universally concluded that the actual level of harm arising from these events was ‘none-no harm caused’. However, 17% of these scenarios were recognised as having a high risk rating and 13% a moderate risk rating. At the time of writing 56% of these events did not have a risk rating ascribed to them.

10. Junior Doctors Forum

10.1 The Junior Doctor’s forum meets every other month and is a useful forum for juniors to raise any issue of concern and keep informed of current business issues within the trust.

11. Trajectory of exception reports



This graph shows the number of exception reports per quarter.

12. Summary

11.1 A total of 61 exception reports have been made from the beginning of April 2022 until the end of June 2022. No fines were levied.

The overall rate of exception reports has fallen and is lower than the same quarter in 2021. This may be a positive consequence of spending on staff members through bank and agency to support the work of existing staff.

Author: **Dr Jess Gunn, Guardian of Safe Working Hours**

Presenting Director: **Prof Mark Pietroni**

Date 24.8.22

Recommendation

- ☐ To endorse
- ☐ To approve

Appendices

Link to rota rules factsheet:
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20August%202016%20v2.pdf

Link to exception reporting flow chart (safe working hours):

http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Safe%20working%20flow%20chart.pdf