Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD MEETING
PUBLIC SESSION
Thursday 30 September 2021
10:00 – 13:30
To be held via Microsoft Teams

AGENDA

TIME	Agenda Item	Title	Purpose		Presenter
Opening Business					
10.00	01/0921	Apologies for absence and quorum	Assurance	Verbal	Chair
	02/0921	Declarations of interest	Assurance	Verbal	Chair
10.05	03/0921	Service User Story Presentation	Assurance	Verbal	DoNTQ
10.25	04/0921	Draft Minutes of the meetings held on: • 29 July 2021	Approve	**Paper**	Chair
	05/0921	Matters arising and Action Log	Assurance	**Paper**	Chair
10.30	06/0921	Questions from the Public	Assurance	**Paper**	Chair
Performance and Patient Experience					
10.40	07/0921	Quality Dashboard Report • Respiratory syncytial virus 2021 preparedness	Assurance	**Paper** Verbal	DoNTQ
11.00	08/0921	Patient Safety Report Q1	Assurance	**Paper**	MD
11.10	09/0921	Learning from Deaths Q1	Assurance	**Paper**	MD
11.20	10/0921	Performance Report	Assurance	**Paper**	DoF
11.40am - BREAK – 10 Minutes					
11.50	11/0921	Finance Report	Assurance	**Paper**	DoF
12.00	12/0921	Medical Revalidation Annual Report	Assurance	**Paper**	MD
Strategic Issues					
12.10	13/0921	Report from the Chair	Assurance	**Paper**	Chair
12.15	14/0921	Report from Chief Executive	Assurance	**Paper**	CEO
12.25	15/0921	Systemwide Update	Assurance	**Paper**	DoSP
12.35	16/0921	Operational Resilience and Capacity Plan (including Winter Plan)	Assurance	**Paper**	Deputy COO
Governance					
12.45	17/0921	Annual SIRO Report	Assurance	**Paper**	DoF
12.55	18/0921	Well-Led Governance Review	Assurance	**Paper**	HoG
13.05	19/0921	Digital Update	Assurance	**Paper**	DoF
13.15	20/0921	Council of Governor Minutes – July	Assurance	**Paper**	HoG

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TIME	Agenda Item	Title	Purpose		Presenter
Board Committee Summary Assurance Reports (Reporting by Exception)					
13.20	21/0921	Audit and Assurance Committee (12 August)	Information	**Paper**	Audit Chair
	22/0921	Appointments and Terms of Service (25 August & 1 Sept)	Information	**Paper**	Chair
	23/0921	Resources Committee (26 August)	Information	**Paper**	Resource Chair
	24/0921	Quality Committee (2 September)	Information	**Paper**	Quality Chair
Closing Business					
13.25	25/0921	Any other business	Note	Verbal	Chair
	26/0921	**Date of Next Meetings** **Board Meetings 2021** Thursday 25 November **Board Meetings 2022** Thursday 27 January Thursday 31 March Thursday 26 May Thursday 28 July Thursday 29 September Thursday 24 November	Note	Verbal	All

	Gloucestershire Health and Care
	NHS Foundation Trust

MINUTES OF THE TRUST BOARD MEETING

Thursday, 29 July 2021

Via Microsoft Teams

PRESENT: Ingrid Barker, Trust Chair
                  Paul Roberts, Chief Executive
                  Angela Potter, Director of Strategy and Partnerships
                  Dr. Amjad Uppal, Medical Director
                  Dr. Stephen Alvis, Non-Executive Director
                  Graham Russell, Non-Executive Director
                  Helen Goodey, Director of Primary Care and Locality Development
                  Jan Marriott, Non-Executive Director
                  John Trevains, Director of Nursing, Therapies and Quality
                  Marcia Gallagher, Non-Executive Director
                  Maria Bond, Non-Executive Director
                  Neil Savage, Director of HR & Organisational Development
                  Sandra Betney, Director of Finance
                  Steve Brittan, Non-Executive Director
                  Sumita Hutchison, Non-Executive Director

IN ATTENDANCE: Laura Bailey, Trust Governor
                  Margaret Dalziel, Deputy Chief Operating Officer
                  Bob Lloyd-Smith, Healthwatch
                  Kate Nelmes, Head of Communications
                  Lavinia Rowsell, Head of Governance/Trust Secretary
                  Anna Hilditch, Assistant Trust Secretary

1.	**WELCOME AND APOLOGIES**

1.1   The Chair welcomed everyone to the meeting. Apologies for the meeting had been received from Hilary Shand.

2.	**DECLARATIONS OF INTEREST**

2.1   There were no new declarations of interest.

3.	**SERVICE USER STORY PRESENTATION**

3.1   The Board welcomed Claire to the meeting, who was joined by Trust colleagues Cathy Ford and Angela Willan. Claire was in attendance to speak about her personal experience of anxiety, and a debilitating skin condition, and her subsequent life changing interaction with the Trust's Recovery Team.

3.2   Claire was 36 and lived with her parents in Gloucester. She informed the Board that she had suffered with anxiety for most of her life and this has prevented her from working and in later years has prevented her from leaving her home at all.

3.3   During lockdown last year, Claire's anxiety along with a chronic skin condition meant she had a period of self-neglect which ultimately led to her being sectioned in May 2020 for treatment. After her discharge, things deteriorated, and Claire was on the verge of being admitted again to hospital. However, in

September 2020 Claire was referred to the Trust and colleagues from across GHC worked collaboratively to help Claire both with her physical and mental health. The Trust has a small team of general nurses who are specifically working to improve the physical health of people with serious mental illnesses. This team engaged with Claire and helped with her anxiety around caring for her skin condition, visiting 3 times a week initially to build a rapport and treat her. Since that time her skin condition has improved vastly, and she has also had input from the community recovery team and a psychologist who is helping Claire with her anxieties. Claire has also benefited from community physio and now goes to exercise classes once a week at GL1 and she is currently spending some time at Wheatridge Court for some rehabilitation as part of her recovery.

3.4   Jan Marriott asked Claire whether there was anything that could have been improved for her when she was struggling. Claire said that she had started attending face to face therapy sessions in May 2021 which she had found really helpful and said that she could have benefited from these earlier on.

3.5   Sumita Hutchison asked Claire which of the services she had received had stood out as making the most difference to her. Claire said that the support she had received from Angela and Cathy had been invaluable. She said that her eczema had been very debilitating but they had built up her confidence so she felt able to accept the help and support of the Recovery Team.

3.6   Neil Savage said that people are sometimes fearful of accessing services or asking for help, and asked Claire what message she would give to other people about seeking help. Claire said that she would encourage anyone to seek help. She said that the service had helped her incredibly and she wouldn't be where she was if it wasn't for the support she had received. Angela Willan informed the Board that Claire had fully engaged with the service and had taken everything on board. She had worked really hard. Claire's goal was to use her experiences to become an Expert by Experience and volunteer, possibly working towards becoming a MH nurse. Claire said that she was really proud of herself to see how far she had come over the past year.

3.7   Graham Russell asked Angela and Cathy whether they had any suggestions to put to the Board for further investment or improvements. Cathy said that they had not been made aware of Claire or her situation until she was at crisis point. The service could have got involved with her much sooner and it was important to ensure that patients didn't fall between the cracks. Claire may have been physically well but her mental health state meant that she was unable to leave the house. Angela Willan advised that different approaches were being trialled and the team was working closely with the Trust's Intensive Health Outreach Team (IHOT).

3.8   The Board thanked Claire for attending and speaking about her experiences. This was a positive story and really demonstrated the progress made since the merger in ensuring parity of esteem and improving physical health for people with mental health conditions, and vice versa. Ingrid Barker said that it really did make the Board focus down on those key areas of performance and patient experience, hearing first-hand about the impact and difference that this made to individuals.

with you, for you

4.	MINUTES OF THE PREVIOUS BOARD MEETINGS

Board Meeting – 27 May 2021

4.1 The Board received the minutes from the previous Board meeting held on 27 May 2021. These were accepted as a true and accurate record of the meeting.

Extraordinary Board Meeting – 15 July 2021

4.2 The Board received the minutes from the Extraordinary Board meeting held on 15 July 2021. Subject to the inclusion of a question from Steve Alvis regarding heat pumps, these minutes were accepted as a true and accurate record of the meeting. **ACTION**

5.	MATTERS ARISING AND ACTION LOG

5.1 The Board reviewed the action log and noted that all actions were now complete or progressing to plan. There were no further matters arising.

6.	QUESTIONS FROM THE PUBLIC

6.1 The Board was asked to note that two questions had been received in advance of the meeting. Ingrid Barker asked that these questions, and the Trust's response to them be read out in full and included within the minutes of the meeting. A formal written response to all the questions received for this meeting would be provided in due course.

Question One - Cllr Jeremy Charlton-Wright

I would like to know whether the awful plans can be redrawn, as the proposed new hospital looks more like a garden centre, and not what a hospital should look like.
The images included are artists impressions to demonstrate the shape of the building – the work to finalise the materials, colours and textures etc have not yet been completed and will be part of the next phase of work. We will undertake this being mindful of the natural heritage of the Forest and with input from staff, patients, local stakeholders, the neighbouring residents and the planners and they will form a detailed part of our planning application pack.

I mentioned about both hospitals being awarded "outstanding" in 2012 for healthcare, but any health service provided, automatically includes the surroundings & facilities, the equipment as well as the healthcare provided by the staff working at each hospital.
As you rightly indicate, the facilities and environment do indeed form part of the CQC ratings and the current environment at both hospitals would not be compliant with modern standards. Overall, we currently have a good CQC rating and we anticipate a further review by CQC within the next 12 months.

When the Dilke was built, it was in the centre of the coal mining industry and so acted as a satellite hospital for the outer lying coal mines such as Brierley, Northern United & other mines around there, as well as New Fancy. This is where the bottom line is - can anyone confirm what will

happen with these two sites (Dilke & Lydney) if they were to close, as the Lydney Hospital is on a prime development site.

The business case confirms that both sites will be declared surplus and a disposal plan put in place by the Trust. We are mindful that the sites have been registered as Assets of Community Value due to their significant local and historic value to the communities. We are committed to exploring use by other public sector bodies and working in partnership with third sector organisations and local stakeholders to ensure that all disposal opportunities that offer ongoing public benefit are explored and that our disposal takes accounts of all the options available.

Can confirmation be given that should both hospitals be closed, then the South of the Forest of Dean won't suffer from a lack of healthcare and facilities that are desperately needed now, and not in four or five years' time, and also that services won't be cut before and that there will be an overlap period before any closure.

Gloucestershire Health & Care has maintained a commitment that the current range of services provided at both Lydney and Dilke Hospital will continue until they transfer to the new community hospital, this remains the Trust's intention. Services delivered at the current health centre and in other locations will remain in Lydney until any new primary care facility is developed.

The Clinical Commissioning Group is working with primary care partners to take forward the development of improved primary care facilities in Lydney and is currently starting to scope out a business case. We will be a key partner to this development for the re-provision of the services that we provide within the health centre currently. Whilst this is still in the early procurement stages and a definitive timetable is not yet known, we anticipate this new centre may open in 2025.

In the interim, should new services be agreed or pilots put in place such as a minor injury service run by primary care then accommodation will need to be considered as part of establishing the pilot.

Question Two – Joy Hibbins, on behalf of the charity Suicide Crisis

I would like to ask a question about the Gloucestershire High Intensity Network (GHIN), a service which has been provided for some patients under Gloucestershire Health and Care NHSFT. I refer to a presentation about GHIN which was given to the Gloucestershire Suicide Prevention Partnership (GSPPF) in October 2019, which I found online recently (the link to the document was provided). My question is about the statements relating to "crisis response plans" on page 28. On page 28, within the GHIN presentation, it says "What information would you need to trust a plan?" and then, underneath "Crisis response plans" it gives the reply: "PSD, CQC and Coroner endorsed". Please can you explain what a "coroner endorsed" crisis response plan is (or was) i.e. what kind of crisis response plan is "coroner endorsed"? If a second question is permitted, I would ask the Trust: Were the GHIN crisis response plans "coroner endorsed"?

Lavinia Rowsell informed the Board that unfortunately, it was not possible to respond to this question at the meeting. The reason for this was that the question in part related to a presentation and work being led by other partner organisations, not GHC, and until the Trust could liaise with them it was not felt appropriate to provide a response on their behalf. A full response would be provided to the questioner in due course.

6.2 No further questions were raised at the meeting.

7. QUALITY DASHBOARD

7.1 This report provided an overview of the Trust's quality activities for June 2021. It was noted that key data was reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led.

7.2 John Trevains informed the Board that overall, the report demonstrated that some fantastic and dynamic work was being carried out and high-quality services were being delivered.

7.3 The report highlighted those Quality issues for priority development to the Board:

- Significant pressures on adult mental health beds persist, a task and finish group led by NTQ has been established to deliver opportunities. RMN recruitment at Wotton Lawn Hospital remains a significant service challenge and further work is being delivered to address this issue in partnership with Operations and Human Resources Directorates. John Trevains assured the Board that good progress was being made.
- There were 4 post-48-hour Clostridium Difficle (C.diff) cases reported in June which is an increase on the figure last month. Regionally and nationally the numbers of C.diff cases are increasing. It is likely that this is associated with increased antibiotic use during Covid-19. Further work is being undertaken to understand in greater detail and this work will be reported upon when results are available. John Trevains offered the Board good assurance that effective reporting processes were in place. Steve Alvis asked whether we were seeing the emergence of resistant strains. John Trevains said that the Trust was working with partners in the county around education in issuing antibiotics, working alongside Public Health and the CCG. This was a piece of work being taken forward by the ICS and John agreed to provide further details about this to Steve Alvis outside the meeting. **ACTION**
- CPA compliance slightly decreased compared to the previous month's figure of 92.4%. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are raising compliance with teams, assisted by Business Intelligence reports, and are setting up weekly schedules with early warnings for reviews that are due. Maria Bond said that it was good to see the progress made in improving CPA compliance, however, the target was 95% and although the Trust was essentially dealing with small numbers, the target was not being achieved and she asked that further

assurance about this position and the recovery plan in place be provided at the next meeting of the Quality Committee. **ACTION**

7.4   Those Quality issues showing positive improvement included:

- The 2 remaining 12 months plus complaints were finalised, reflecting the complex nature of the complaints and the reach over a number of teams, including a legacy complaint from Hereford.
- The Pressure Ulcer (PU) indicators are showing that there have been fewer skin integrity incidents and reduced numbers of pressure ulcers that were considered as avoidable under our care as numbers reduced by 25 between May and June. Early indicators are positive that this is an improving area and that initiatives taken to reduce PU's are effective. Sandra Betney welcomed this update and asked whether the causality behind the reduction in pressure ulcers was known. John Trevains advised that the new initiatives in place would have had a significant impact such as improved first point of contact nursing care, education and quality assessment.
- 'Embedded learning' workshops have now commenced within clinical environments and have been welcomed by front line colleagues. This is a key milestone in our journey to becoming a learning organisation.
- There is ongoing improvement in staff Covid-19 vaccination rates with good progress within the 1stnd dosage of vaccinations for Clinical staff being 82% and 72.8% for 2nd dosage.
- The sickness rolling average indicator was maintained under threshold of 4% this month.

7.5   Maria Bond congratulated John Trevains and his team, noting that the Quality Report continued to improve month on month. She said it was pleasing to see the great improvements reported for children's services discharge planning.

7.6   The Board discussed the continuing pressure on adult MH beds and staffing at Wotton Lawn. John Trevains advised that a system had been established with operational colleagues and reviews were carried out daily looking at patient flow. A standard operating procedure was in place to manage escalation. Paul Roberts informed the Board that Gloucestershire was not an isolated case with regard to staffing challenges or service demand pressures, and this was currently being considered by the National Team. The Trust needed to build this current position into its plans for future investments in mental health, working to develop partnerships with third sector organisations to get better interventions in place so people don't need to be admitted. He said that this was not a quick fix, however, Gloucestershire had managed its capacity well.

7.7   In relation to International Recruitment, the Board noted that in total 30 new physical health nursing colleagues are in the process of joining the Trust. 9 have arrived in the UK and 7 have passed their OSCE to date. New mental health nursing colleagues are joining with additional recruitment underway in this area in July. The Trust has received additional funding to be one of 6 national pilot sites with NHSE and the Queens Nursing Institute to support direct entry into community services for international recruits. The Trust Quality Team

are leading this initiative. Graham Russell asked about the welcome and support package offered to international recruits by the Trust. Neil Savage said that the dedicated support package had some very explicit requirements for pastoral support and the feedback received so far was that this felt supportive and fresh. The Trust also ensured that it linked in with national organisations for additional support.

7.8   Marcia Gallagher noted the reference to "data quality" issues with regard to early intervention in psychosis services. It was noted that this related to the recording of interventions in a timely way, but work was being progressed to address this.

7.9   The Board welcomed this report, noting the developments underway and the good level of assurance provided.

8.   LEARNING FROM DEATHS REPORT – QUARTER 4 2020/21

8.1   The Board received the Learning from Deaths report which provided information about the mortality review process and outcomes found during 2020/21.

8.2   Amjad Uppal reported during 2020/21 there were 829 patients who died whilst receiving care from the Trust; whilst as either a physical health inpatient or in the care of the Trust's mental health or learning disabilities services. The occurrence of deaths was as follows:
- 336 in the first quarter
- 182 in the second quarter
- 177 in the third quarter
- 134 in the fourth quarter

8.3   The Board was assured that none of the deaths were judged likely to have been due to problems in the care provided by the Trust.

8.4   It was noted that the findings from the 2019 MH Homicide case had now been shared with all parties, and it was noted that NHSE had sent in an external review team to carry out an assurance exercise. Amjad Uppal thanked John Trevains for the support that he provided to both families during the investigation.

8.5   Steve Alvis noted the development of a second end of life care room at Charlton Lane and asked whether support was being received from physical health colleagues. Amjad Uppal advised that there was close working with a Palliative Care Consultant. He agreed to provide further details to Steve Alvis outside the meeting. **ACTION**

8.6   Ingrid Barker noted that last year had been an extraordinary year. She said that there were a lot of learning points highlighted within the report and sought some assurance on the implementation and impact of these. Amjad Uppal informed the Board that there would be more emphasis on the learning and reflections from serious incidents moving forward, with a Learning Assurance

group now in place, embedded learning workshops and the cascade of "learning on a page". He said that the Trust was always looking to improve and offered good assurance on the mechanisms for doing this.

8.7 The Board noted that the Learning from Deaths reporting would be presented to the Board in a revised format going forward.

9. PERFORMANCE DASHBOARD

9.1 Sandra Betney presented the Performance Dashboard to the Board for the period June 2021 (Month 3 2021/22). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation.

9.2 Sandra Betney informed the Board that the new proposed National Standards for MH services were currently out for consultation. It was noted that these include 5 waiting list guarantees. Scoping work was taking place and the performance dashboard would be updated to reflect the new standards, once agreed.

9.3 At the end of June, there were 9 mental health key performance thresholds and 9 physical health key performance thresholds that were not met. It was noted that all of these indicators had been in exception previously within the last 12 months. The Eating Disorder (ED) Services account for four of the MH KP indicators. The service continues to face major performance challenges due to a high number of referrals and high vacancy rate. Of the Physical health indicators within exception, four of these relate to CYPS and three to Wheelchair Services.

9.4 With regard to non-exception reporting, the Board noted that there were additional indicators outside of threshold but are either within normal, expected variation, have a legacy 'proxy' threshold, are formally suspended or have a confirmed data quality issue that is administrative only and resolution is assured. These have not been highlighted for exception but are available for operational monitoring within the online Tableau storyboard. However, it has been agreed that 8 proxy indicators will be re-introduced into the performance dashboard as soon as possible as *internal* KPIs using Statistical Process Control (SPC) limits as thresholds. The remaining 16 proxy indicators will be removed from the active performance reporting schedule but will continue to be monitored and may compliment formal indicators as 'context' narrative in the future. By way of keeping exception reports focussed for the Board, the Board was asked to support the decision that administrative, data quality issues are no longer escalated by exception if clinical quality and safety can be assured, unless there are two consecutive periods of data quality concern. This was supported.

9.5 There are currently 3 Workforce indicators in exception this month. Once again, it is of note that sickness absence is compliant in June (3.8% against a 4% threshold). Progress was being made on agreeing which workforce performance metrics would be included within the performance dashboard going forward. This will lead to a phased process that will be deployed over the year which will provide more granular analysis. Next steps will be presented to the Resources Committee in August 2021.

9.6   Marcia Gallagher noted those services currently in exception and asked how the Board could be assured about the scale of the problems being faced and the expected timescales for resolution. Margaret Dalziel advised that all services had recovery plans in place which were monitored via BIMG and governance structures were in place to support the Refocus, Regroup and Recovery programme. Regular meetings took place and corporate support offered.

9.7   Maria Bond welcomed the BI updates within the report; however, she said that she found these difficult to track through in terms of timescales and progress made. Sandra Betney said that she would be happy to review the presentation and format of this section of the report with the BI Team. **ACTION**

9.8   Further to a question about waiting times, the Board noted that waiting time indicators were included within the dashboard. However, waiting list information was collated and shared directly with operational services. It was noted that there were data quality issues currently being worked through and it was therefore not appropriate for exception dashboard reporting, however, some high-level targets could be pulled out.

9.9   The Board agreed that it would be helpful to receive a collective briefing on the issues around data quality currently being experienced, to gain a better understanding of what the key issues were, how the issues were going to be addressed and by when. Sandra Betney agreed to consider the best way of providing this briefing for Board members. **ACTION**

9.10   Following the questions and discussions received on the report, it was also agreed that it would be helpful to consider how the risks and issues associated with the Regroup Refocus Recover programme should be presented to the Board for assurance at future meetings. It was noted that this would be discussed in more detail later in the meeting.

10.   FINANCE REPORT

10.1   The Board received the month 3 Finance Report for the period ending June 2021. It was noted that the final audited accounts were submitted by the 29th June deadline and there were no material movements to the accounts. The year-end surplus remained at £47k. The Trust had received an unqualified opinion from the external auditors on the accounts and the Board offered their huge thanks and congratulations to Sandra Betney and the finance team for this achievement, in what had been a very difficult and challenging year.

10.2   The Trust has an H1 plan of breakeven and the Trust's position at month 3 was a surplus of £42k.

10.3   The cash balance at month 3 is £58.2m

10.4   Capital expenditure was £0.980m at month 3. The Trust has revised the capital plan. The 21/22 plan remains at £15.993m but reflects increases to some buildings scheme costs and reduced backlog maintenance spend. Future years

of the programme have also been amended to reflect rephasing and the inclusion of some leases due to IFRS16. Marcia Gallagher noted that the impact of IFRS16 had been built into the capital programme and was presented in the table under "buildings"; however, she asked that this be presented as a separate line in future reports so it was readily identifiable. **ACTION**

10.5 Marcia Gallagher noted the Trust's plan to breakeven and asked about the impact on this of funding the recently agreed 3% pay award. Sandra Betney advised that this had been flagged nationally by NHS Providers and the consequences to individual Trusts if the pay award was not fully funded. There was likely to be some impact in H1 but nothing had yet been confirmed. Guidance was still awaited on when the pay award would be made.

10.6 Graham Russell noted that the provision for back log maintenance in 2022/23 was 0 and asked for assurance around this figure. Sandra Betney advised that the plan for 2021/22 had been increased to try and push this into the following year. She said that there were no concerns about this currently, with all plans having been assessed at the Capital Management Group, with quality and operational colleagues present.

10.7 The Board noted the Finance Report for month 3 and approved the revised capital programme.

11. CHAIR'S REPORT

11.1 The Board received the Chair's Report which highlighted the activity of the Trust Chair and Non-Executive Directors since the previous meeting of the Board in May. Key areas of focus remain ensuring effective system working, ensuring equality, diversity and inclusion are at the heart of how we work as a Trust and that the voice of the Trust is heard locally and nationally to ensure the needs of our community are understood and inform policy and practice.

11.2 Ingrid Barker was pleased to report that Coln Ward at Cirencester Hospital, was officially named the South West winners in the NHS Parliamentary Awards Care and Compassion category. Coln Ward were nominated by colleagues at the hospital for the way in which they adapted to caring for COVID-19 patients while maintaining the highest levels of care and compassion. The nomination was submitted by Sir Geoffrey Clifton-Brown, MP for the Cotswolds. The Board offered their congratulations to all colleagues involved.

11.3 The Board was asked to note two new appointments in the wider NHS system. Gill Morgan had now been formally appointed as Chair Designate for the Gloucestershire ICS following approval by the Secretary of State. Amanda Pritchard had been appointed as the new NHS Chief Executive. Amanda would be the first female NHS leader. The Board welcomed these fantastic appointments. It was noted that Amanda Pritchard had visited Gloucester the previous week and had commented on the "breathtaking" work taking place. This had been a great visit and outstanding feedback had been received.

11.4 Ingrid Barker said that the past few months had continued to be very busy but she was happy to report that the NED quality visits were now back up and running which was excellent.

11.5 The Board noted the content of the Chair's report.

12.	**CHIEF EXECUTIVE'S REPORT**

12.1 Paul Roberts presented this report which provided an update to the Board and members of the public on his activities and those of the Executive Team since the last meeting in May.

12.2 Paul expressed his continued gratitude to colleagues across the Trust for their management of Covid, noting the Trust had a prudent approach to lockdown easing in place.

12.3 Following approval of the Forest of Dean business case on 15 July, conversations had now commenced on next steps, including securing capital and revenue support from system partners and agreeing the NHSE/I approval process. The submission of a planning application will take place shortly, with building scheduled to start in early 2022 subject to system and regulator support.

12.4 Paul Roberts was delighted to report that GHC had now launched its new Trust People Strategy. This is our new five-year strategy confirming our goals, aims and ambitions for our 5,400+ strong workforce, made up of more than 40 different professions. Our ultimate goal over the next five years is: "To be a healthy and happy high-quality workforce, performing well in all local and national performance standards", with the aim to be a "Great Place to Work". A number of actions and programmes are already in place or planned to realise our people ambitions. The Trust's people strategy was co-produced with our colleagues and by reflecting on what we've been told through the staff survey and other engagement events. The strategy is a collaborative effort and reflects what matters most to our colleagues and sets out our ambitious but realistic plans for the next 5 years. Paul Roberts said that the Trust recognises that our people make our Trust the place it is and taking forward and achieving this challenging agenda will be an area of focus for the Board over the coming months.

12.5 There is a mandatory requirement for the Trust to have a public statement by the Board on its recognition of and work towards compliance with the Modern Slavery Act (2015) (the Act). Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. The Trust fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses. Ongoing assurance from relevant leads within Safeguarding, Procurement, Counter Fraud and HR teams that combatting and eradicating modern slavery is ongoing business as usual work. The Board had approved the Trust's updated statement virtually and this had now been published on the Trust's website.

12.6 Paul Roberts wished to formally record that John Campbell, Chief Operating Officer had decided to step down from his role with the Trust in June. John

made a significant contribution to [2]gether and then, following our merger, to GHC. Indeed, his role in ensuring the merger was grounded in our values and our ambitions for the new organisation was more significant than many will realise. Board and Executive Director colleagues were saddened but respectful and supportive of his decision. In terms of next steps, the Board was aware that the Chief Operating Officer role was a significant and important one for the Trust and Paul Roberts advised that a recruitment process had commenced so that an appointment can be made as soon as possible. In the meantime, Hilary Shand has agreed to continue to act up as Interim Chief Operating Officer with the continued support of executive and senior colleagues.

12.7 Paul Roberts informed the Board that he had attended a virtual discussion for the Gypsy, Roma, Traveller community which had provided an opportunity to hear from the community on any inequalities and injustice that they experience. This also provided a good opportunity to hear their perceptions on health and care as well as vaccination uptake. Marcia Gallagher welcomed this report and she asked for further detail on what the Trust was actually doing with this community and the progress that had been made. Paul Roberts advised that this had been a specific session, however, ongoing links with that particular community were already in place through the Trust Strategy and Partnerships Team. He said that people had made assumptions that the take up of the Covid vaccine would be low amongst the population; however, many expressed the views that vaccination was important and there was a good level of take up amongst that community which was excellent.

13. INTEGRATED CARE SYSTEM UPDATE

13.1 This paper provided an overview of a range of activity taking place across the Integrated Care System.

13.2 Sumita Hutchison noted the Home-Start UK report which included the findings from a piece of national research *Home Is Where We Start From* that has focused on measuring the impact of Covid on parents of young children. Poverty, mental health issues and the social development of children were found to be the three main concerns for parents of young families. Sumita asked how the Trust was addressing the findings from this report. Angela Potter said that this would be embedded into the work of the ILPs and the Trust would be working closely with system partners on this piece of work. Helen Goodey added that Covid had been a catalyst for discussions about population health.

13.3 The Board noted that the Stroke beds at the Vale Hospital were extended from 14 to 20 in September 2020. This had appeared to offer system wide benefits with an increase in stroke audit scores, particularly in the acute trust. A formal pilot has been approved to undertake a full review of the impacts, benefits and pathway in order to determine any long term recommended changes. The results of this would be brought back in due course.

13.4 The Board noted the content of this report, welcoming the breadth of coverage.

14. QUALITY STRATEGY

14.1 The purpose of this report was to present to the Board the draft GHC Quality Strategy – a key part of the emerging Trust Five-Year Strategy.

14.2 The Strategy highlights our quality pledge: To place continuous improvement and working together at the heart of everything we do so that we can consistently deliver high quality care and make the changes that matter to people. It contains our three Trust quality ambitions:

- Safe – Everyone can trust our care will cause no harm and can be accessed when they need it.

- Effective – Everyone receives care that is beneficial, based on evidence and efficiently delivered.

- Experience – Everyone has access to person-centered, responsive and respectful care.

14.3 The Board was asked to note that final changes had been made to previously shared versions of the draft strategy to incorporate comments and requests made from individuals, teams, and various engagement sessions, commissioning colleagues, Trust Executives, and the Quality Committee. Once approved, the strategy would be professionally formatted in line with the Trust Strategy with associated infographics. An accessible version of the strategy would also be made available, to include easy read and versions in different languages.

14.4 Steve Alvis noted that the Strategy only referred to providing services to the people of Gloucestershire and asked whether this could be reviewed to take into account those out of county patients who also accessed Trust services. **ACTION**

14.5 The Board fully supported and endorsed the Quality Strategy, noting that there was good read across to the Trust strategy and other enabling strategies, and there had been excellent engagement with colleagues both internally and externally.

15.   ESTATES STRATEGY

15.1 The purpose of this report was to present to the Board the Estates Strategy for final comment and approval.

15.2 The Trust has spent a considerable amount of time engaging with Trust colleagues, system partners and experts by experience to understand what is important from our estate moving forward. This strategy is the culmination of this engagement and co-production and builds on feedback received from members of the Resources Committee.

15.3 Our Estates Vision is "To enable the delivery of outstanding, place-based care by providing high quality settings in the right locations for people". Our Estates strategy sits as one of our six enabling strategies and it fully acknowledges the inter-relationships between them. It also recognises that not all services are delivered from buildings that we own or lease – but are integrated into our communities with staff working out of health centres and community venues

such as libraries or schools or frequently delivering services in people's own homes. Many of our services are delivered in partnership with primary care, social care and the voluntary sector and our estates strategy will be a key way in which we can continue to facilitate wider integration and partnership working.

15.4 The impact of COVID-19, at a time of major transformational change in the NHS provides a platform for Estates processes, projects and partnership to be re-evaluated and thus this strategy will continue to evolve as a live document to reflect changing working practices and thus estate and building need.

15.5 With a solid foundation of the asset base owned, leased or occupied by the Trust, this strategy outlines the roadmap for embedding technology, adopting efficient processes and working with system partners to realise efficiencies. There are potential developments in the pipeline, a need to consider rationalisation of the estate and, most importantly, a framework to create an Estate over the next 5 years that is flexible, value for money and fit for new ways of working.

15.6 Marcia Gallagher said that it was great to see this key enabling strategy. She said that the Estates Strategy was dynamic and ambitious, and therefore asked for assurance around the Trust's capacity to deliver the proposals set out within it. Sandra Betney advised that work had already started to look at those areas where additional resource was required and some proposals would be shared with the Executive Team for consideration in the coming months. An implementation plan to sit alongside the strategy, to include reference to the resources required would be worked up. Sandra Betney offered the Board assurance that the capital programme did reflect the content of the Estates Strategy.

15.7 Graham Russell noted that preparing the Estates Strategy had been a major exercise and thanked colleagues for the work that had gone into this. He said that a draft of the strategy had been received at the Resources Committee. Having reviewed the strategy again, Graham said that he would welcome additional information such as the scale of the estate rationalisation, interplay with Trust finances, future investment requirements and measures of success. Steve Brittan agreed, noting that the strategy felt qualitative rather than quantitative. Angela Potter said that it was difficult to pin down the metrics as the position was constantly changing and there was a huge amount of data collection required. It was agreed that further discussions about the development of quantifiable measures would be delegated to the Resources Committee. **ACTION**

15.8 The Board supported the broad strategic direction and tone of the Estates Strategy, and this was approved subject to further discussion at the Resources Committee.

16. REFURBISHMENT OF STROUD JUBILEE WARD & MIIU BUSINESS CASE

16.1 The purpose of this report was to present the business justification for the refurbishment of Jubilee Ward and the Minor Illness and Injuries Unit at Stroud General Hospital. The proposed Jubilee Ward refurbishment and the complete

redesign of MIIU are part of an ongoing programme to upgrade the hospital's facilities to the standards expected in the 21st century.

16.2 Jubilee Ward and Stroud MIIU are important contributors to local services. Neither has benefitted from significant investment in recent years and this is now impeding the ability to deliver care. This business case demonstrates a pressing case to upgrade the facilities in both units to meet the standards now expected.

16.3 Schemes have been proposed that will deliver substantial benefits for patients, staff and service operations. The schemes will make notable improvements to patient privacy and dignity, enable better isolation and infection control, improve operational effectiveness through better adjacencies and layout and will greatly improve the working conditions for staff. Much improved air handling will result in a better environment for both staff and patients.

16.4 The Board was asked to note that the preferred option was to proceed with both schemes at the same time, instead of undertaking the work in two separate stages. This would avoid the need for multiple decants and was more economical.

16.5 The Business Case had a value of approximately £1.5m [£1.964m less League of Friends contribution (c £400k) less applicable VAT reclaim]. Steve Brittan asked whether the scheme would still be affordable if this funding from the League of Friends was not received, noting that this had not yet been confirmed. Sandra Betney said that it would be but noted that the capital plan did assume that this £400k would offset overall expenditure.

16.6 The Board noted that the refurbishment would require the vacating of both Jubilee Ward (to be relocated at Cirencester Hospital) and MIIU (with some work retained in booked appointments in Stroud and demand diverted to Cirencester and the Vale). Detailed planning was underway to ensure continuity of service and minimal impact on patient care. Margaret Dalziel said that this would have a significant operational impact; however, she assured that Board that the proposals had the full support of Trust clinicians and project support was in place to manage the transition arrangements.

16.7 Steve Alvis asked whether this business case would include improvements to administrative areas as well. Sandra Betney advised this this was not included in this business case; however, a separate piece of work had been carried out looking at the whole estate to consider administrative working areas.

16.8 Maria Bond supported the decision to proceed with both schemes at the same time for the reasons set out in the report. She did express some concern that the process seemed a little rushed in terms of contractor appointments, also noting that the asbestos survey had not yet been carried out. These points were noted.

16.9 The Board agreed that this was a well-articulated and much needed business case. A robust operational plan was in place to manage the relocation of

services during the refurbishment. The Board was happy to approve the business case, as presented. Thanks, were also expressed to the Stroud Hospital League of Friends for their planned donation which was substantial.

17.   SOUTHGATE MOORINGS BUSINESS CASE

17.1   The purpose of this report was to provide a business justification and establish costs for the refurbishment of the ground floor of Southgate Moorings, to enable Board approval to be received for this scheme to progress

17.2   Southgate Moorings (ground floor) requires an upgrade to meet compliance and improve patient and staff experience. The building has 12 years left of a 15-year lease. The ground floor was last refurbished in 2008. The scope of the proposed project includes replacement of the majority of the ground floor's internal fabric, furniture and fittings and mechanical and electrical systems. The project also includes minor improvements externally to secure the waste bins with a new compound for bicycles. The project excludes work to the staff WCs and locker rooms apart from new sustainable lighting.

17.3   The building industry is witnessing significant price rises of between 10-15% across the board leading to increased costs of supply of essential materials. The price rises are not unique to this project, they are also impacting a number of current and planned capital schemes.   As a consequence, lead times for orders are lengthening while prices are increasing. The project has been priced by Speller Metcalfe under a framework, and the total project costs are £1,127,026 inclusive. Given approvals the project could start in September and be complete by Christmas.

17.4   Margaret Dalziel presented an operational overview of the business case, setting out the current position and rationale for the business case.

17.5   The Board noted that an initial indicative budget of £750k was allocated in 21/22 for this scheme. Costs have been returned which exceed the original budget allocation. The project team have undertaken a rigorous challenge process with the services involved to minimise the costs of the scheme. The scope of the scheme has undertaken several revisions to reduce the cost to a point where it cannot be reduced further without impacting on the needs and requirements of the service.

17.6   The Board received the business case, and some queries and reservations were made. These included using the contractor (Speller Metcalfe) without following a competitive tender route. There was also a question around the timing of the business case, noting that it would be helpful to have had more time to consider the Value for Money aspect.

17.7   Marcia Gallagher noted that the business case had not been through a Board Committee in advance of coming to Board, and from a governance perspective she therefore felt uncomfortable this this had received no previous NED scrutiny or oversight. Sandra Betney said that she understood the concerns, however, delegated power to approve business cases sat with the Trust Board, not the Committees so prior viewing at a Committee was not required.

17.8 Paul Roberts said that there was a need to be mindful of any delays to progressing this business case in terms of the impact on CDEL. He said that the Trust was committed to the scheme, but he fully appreciated the issues raised by NED colleagues around governance oversight and value for money. He said that he would reflect further on whether this business case should have been presented to the Board at this point, or whether it should have been presented elsewhere first for scrutiny and NED oversight.

17.9 The Board approved the Southgate Moorings Business Case in principle, subject to a rapid review meeting with Sandra Betney, Steve Brittan and Graham Russell. This would then be followed up for final approval at a meeting with Paul Roberts, Ingrid Barker and Graham Russell (as Vice Chair). **ACTION**

18. AUDIT AND ASSURANCE COMMITTEE ANNUAL REPORT

18.1 The Board received the annual report of the Audit and Assurance Committee for 2020/2021.

18.2 The Audit and Assurance Committee terms of reference require that: *"The Audit and Assurance Committee will update each routine Board meeting on its activity, highlighting decisions made, issues being progressed and concerns requiring further consideration or decision by the Board". "The Committee will report to the Board annually on its work in support of the Annual Governance Statement."*

18.3 This report provided an overview of the Committee's work in the last financial year, from 1 April 2020 to 31 March 2021 in sections which reflect the headings in the Committee's terms of reference. The report also provided an overview of the work of the Committee in overseeing internal control mechanisms in the Trust as reflected in the Annual Governance Statement. No issues had been highlighted as areas of concern. The Committee has operated in line with its terms of reference to meet the functions delegated to it by the Board.

18.4 Marcia Gallagher, Chair of the Audit and Assurance Committee said that she was pleased to present such a positive report to the Board. She expressed her thanks to Sandra Betney and the finance team for their efforts during what had been a very challenging year, noting the earlier reported receipt of an unqualified audit opinion on the 2020/21 Annual Accounts.

19. MINUTES FROM THE COUNCIL OF GOVERNORS MEETING – MAY 2021

19.1 The Board received and noted the minutes from the Council of Governors meeting held on 12 May 2021.

20. BOARD COMMITTEE SUMMARY REPORTS

20.1 Audit & Assurance Committee

The Board received and noted the summary report from the Audit & Assurance Committee meeting held on 26 May 2021.

20.2 Appointments and Terms of Service Committee

Ingrid Barker informed the Board that the ATOS Committee had met twice since the last Board meeting, on 1st and 16th June, with meetings focused on the recruitment process for a new Chief Operating Officer and agreement of the interim arrangements.

20.3 Charitable Funds Committee

The Board received and noted the summary report from the Charitable Funds Committee meeting held on 9 June 2021.

20.4 Resources Committee

The Board received and noted the summary report from the Resources Committee meeting held on 24 June 2021.

The Board was asked to note Chair's action taken outside of the meeting. A new return required this year is the Premises Assurance Model (PAM). The PAM has been developed to provide a nationally consistent basis for assurance for Trust Boards on regulatory and statutory requirements relating to their Estates, Facilities and associated functions. The Trust undertook a self-assessment and overall assessed itself as "good". Prior to submission the self-assessment required Board approval; however, given the timescales this had not been possible at a meeting. A detailed paper and action plans were presented to the Chair of the Resources Committee and assurance was received that the process followed had been robust with evidence based self-assessments undertaken and challenged by colleagues. Actions plans are in hand to ensure those areas not already achieving "good" ratings do so when we re-assess in March 2022. On the basis of the detailed report and assurance provided, the Chair of the Resources Committee had approved the Submission of the PAM assessment.

20.5 Quality Committee

The Board received and noted the summary report from the Quality Committee meeting held on 1 July 2021.

20.6 Mental Health Legislation Scrutiny Committee

The Board received and noted the summary report from the MHLS Committee meeting held on 21 July 2021.

The Committee had noted an increase in detentions of people with an ethnic minority background, which showed an additional increase in 'White – other European' and requested a further understanding of the increase in numbers. The Committee had requested the joint commissioners provide an update at the next meeting on the work they are undertaking to understand and address the issues.

21. ANY OTHER BUSINESS

21.1 For the record, it was noted that the Trust's Quality Account 2020/21 had been formally endorsed by the Board outside the meeting and this had been submitted in line with required timescales.

22. DATE OF NEXT MEETING

22.1   The next meeting would take place on Thursday 30 September 2021.

Signed: …………………………..…..   **Dated: …………………………**

Ingrid Barker (Chair)
Gloucestershire Health and Care NHS Foundation Trust

Gloucestershire Health and Care
NHS Foundation Trust

TRUST BOARD PUBLIC SESSION: Matters Arising Action Log – 30 September 2021

Key to RAG rating:

🟩	Action completed (items will be reported once as complete and then removed from the log).
🟧	Action deferred once, but there is evidence that work is now progressing towards completion.
🟦	Action on track for delivery within agreed original timeframe.
🟥	Action deferred more than once.

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
27 May 2021	16.4	Future Patient Safety Reports to include trends, as well as improved triangulation of data, and contextualisation such as the inclusion of bed numbers.	Amjad Uppal	November	The patient safety team have approached the BI Team to request their input to present comparable information across our entire inpatient estate as this level of data is not currently available for physical health community hospitals which would likely result in an unbalanced report. An update on progress would be provided back to the Board in November.	🟧
29 July 2021	4.2	Extraordinary Board meeting minutes from the meeting held on 15 July 2021 to include the question asked by Steve Alvis regarding heat pumps, and the response received *(after the meeting by email correspondence).*	Trust Secretariat	September	Complete	🟩
	7.3	John Trevains to provide further details about the increase in C.diff cases and the work being taken	John Trevains / Steve Alvis	September	Complete. Discussed further at September Quality Committee – Increase in cases is believed to be a national issue related to	🟩

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
		forward by the ICS to address this to Steve Alvis outside the meeting.			changes in prescribing through Covid Pandemic. Plan - continue monitoring and reporting though QAG, QC & Quality Dashboard.	
	7.3	Maria Bond asked that further assurance about the CPA compliance position and its associated recovery plan be provided at the next meeting of the Quality Committee.	John Trevains	September	Complete. Discussed further at September Quality Committee – James Wright and Quality Assurance team to supply further update on national changes to CPA guidance and explain how this is influencing compliance.	
	9.7	Sandra Betney to review the presentation and format of BI Updates within the performance dashboard report with the BI Team to ensure this was easy to track through in terms of timescales and progress made.	Sandra Betney	September	In progress. Will be included in September Performance Dashboard.	
	9.9	Sandra Betney to consider the best way of providing a briefing for Board members on the issues around data quality currently being experienced, to gain a better understanding of what the key issues were, how the issues were going to be addressed and by when.	Sandra Betney	September	Complete. Included in report on Board agenda.	
	10.4	Finance report to be updated to reflect the impact of IFRS16 as a separate line so it was readily identifiable.	Sandra Betney	September	Complete. Leases are now shown on separate line	

Meeting Date	Item No.	Action Description	Assigned to	Target Completion Date	Progress Update	Status
	14.4	Quality Strategy to be updated to also refer to providing services to those out of county patients who accessed Trust services.	John Trevains	August	Complete.	
	15.7	Further discussions about the development of quantifiable measures and metrics for the Estates Strategy would be delegated to the Resources Committee.	Trust Secretariat / Angela Potter	September	Added to Resources Committee work plan for future discussion.	
	17.9	The Board approved the Southgate Moorings Business Case in principle, subject to a rapid review meeting. This would then be followed up for final approval at a meeting with Paul Roberts, Ingrid Barker and Graham Russell (as Vice Chair).	Sandra Betney / Paul Roberts / Trust Secretariat		Rapid review meeting took place, implementation of Business case now progressing.	

RESPONSE TO QUESTIONS RAISED AT PUBLIC BOARD MEETING – July 2021

Questions Raised: *Joy Hibbins, on behalf of the charity Suicide Crisis*

I would like to ask a question about the Gloucestershire High Intensity Network (GHIN), a service which has been provided for some patients under Gloucestershire Health and Care NHSFT. I refer to a presentation about GHIN which was given to the Gloucestershire Suicide Prevention Partnership (GSPPF) in October 2019, which I found online recently. This is the link to it below. The GHIN presentation starts at page 15 of the online document. I have also attached it as a PDF document:

https://www.gloucestershire.gov.uk/media/2092932/gsppf-oct-19-workshop-presentation.pdf

My question is about the statements relating to **"crisis response plans"** on page 28.

On page 28, within the GHIN presentation, it says "What information would you need to trust a plan?" and then, underneath "Crisis response plans" it gives the reply: "PSD, CQC and Coroner endorsed".

Please can you explain what a "coroner endorsed" crisis response plan is (or was*) i.e. what kind of crisis response plan is "coroner endorsed"?*

If a second question is permitted, I would ask the Trust: Were the GHIN crisis response plans "coroner endorsed"?

Response:

Question 1:

There was a consultation process in the conception of the Gloucestershire High Intensity Network and a variety of stake holders including HM Coroner's office were consulted. It was felt that a multi-agency and person-centred care plan should stand up to scrutiny, including scrutiny in the event of a serious incident and this is what was needed in the county. The purpose was to improve the quality of crisis plans.

Question 2:

The aim of the GHIN approach is to develop person focused, co-produced (with the person) multi-agency care plans with clearly defined roles and responsibilities which are of a standard which would stand up to external scrutiny in the event of an unfortunate incident. We hope this is helpful and you may wish to direct any further queries to HM Coroner's Office on this subject.

August 2021

Gloucestershire Health and Care
NHS Foundation Trust

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: John Trevains, Director of Nursing, Therapies and Quality

AUTHOR: John Trevains, Director of Nursing, Therapies and Quality

SUBJECT: **QUALITY DASHBOARD REPORT – AUGUST 2021 DATA**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐   Endorsement ☐   Assurance ☑   Information ☐

The purpose of this report is to
To provide the GHC Board with a summary assurance update on progress and achievement of quality priorities and indicators across Trust physical health, mental health and learning disability services.

Recommendations and decisions required
Board members are asked to: • **Receive, note** and **discuss** the August 2021 Quality Dashboard

Executive summary
This report provides an overview of the Trust's quality activities for August 2021. This report is produced monthly for Board, Quality Committee and Operational Delivery and Governance Forums for assurance. **Quality issues for priority development** • Pressure on adult mental health beds continues, as does the task and finish group led by the quality team to support opportunities to create capacity. Positively, the situation does appear to be slowly improving and is reflected in the reduction of out of area bed usage reported in this dashboard. • Wheelchair Services, Podiatry, Physiotherapy and Paediatric Speech and Language Therapy remain under enhanced observation by the quality team noting the additional challenges with referrals and wait times.

- There are no 12 months plus complaints outstanding and all 7+ month complaint cases have their progress reported upon weekly. However, the previously reported backlog remains and though beginning to improve it requires ongoing attention. All the additional resource (2 new experienced colleagues) is now in place alongside a new more efficient process. Reporting zero 6 month + complaints is a 2021/22 Quality Priority for the Trust.
- RMN recruitment at Wotton Lawn Hospital remains a significant service challenge and further work is being delivered to address this issue in partnership with Operations and Human Resources Directorates. This is alongside recruitment challenges recognised in other services notably Integrated Community Teams.
- CPA compliance has decreased further compared to previous month's data to 86.8%. Trust Recovery Teams continue to report increased caseloads, increased levels of acuity alongside staffing challenges. There is a service recovery action plan in place which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are raising compliance with teams, assisted by Business Intelligence reports, and have set up weekly schedules with early warnings for reviews that are due.

Quality issues showing positive improvement

- The total number of patient safety incidents reported decreased from 1026 in July to 921 in August. The percentage of patient safety incidents meeting moderate, severe and death thresholds has decreased to 5.75%. Further data analysis has identified reductions in self-harm incidents at Wotton Lawn and continued good progress from the Pressure Ulcer Improvement programme linked to the reduction in recorded incidents.
- The Pressure Ulcer (PU) indicators report there have been fewer incidents in all categories of (PU) this month. The number of PU's in category 1&2 has decreased by 4, category 3 have decreased by 1 with Category 4 remaining at 0. Indicators are positive that this is a sustainable improving area and that quality initiatives taken to reduce PU's are effective.
- In total 33 new international nursing colleagues are in the process of joining the Trust. 19 have arrived in the UK and it is anticipated that our remaining new colleagues will have arrived by March 2022. It is excellent to note that the first cohorts of international nurses have all passed their accreditation exams and are very much a valuable addition to our Gloucestershire Health Care nursing family. Our international recruitment approach is developing routes for mental health and direct entry community nurses into District Nursing Teams.
- This dashboard reports strong compliance and sustainable process in place for FFP3 mask training requirements.

Are Our Services Caring?

11 complaints were received in June which is slightly more than the previous month. Actions associated with the complaint's recovery plan continue. When considering the trend lines it is encouraging to note that Q2 19/20 showed 30 complaints

received whist Q2 21/22 shows 20, a similar pattern is seen with concerns. Compliments were slightly less than the previous month at 118. The achievement of the 95% FFT target that was achieved last month has decreased by 1% to 94%. It is expected that the figure will improve as services continue on their recovery trajectories. The results of the Non-Executive Director audit of complaints for Q1 have been included this month for Board assurance. An additional audit undertaken by Price Waterhouse Cooper, as part of the Trust audit programme is currently underway, results will be reported when available providing further independent assurance of the quality of complaint handling.

Are Our Services Safe?

The Board are asked to note that overall incident reporting rates have reduced this month and the percentage of patient safety incidents meeting moderate, severe and death thresholds decreased to 5.75%. Additional data is provided which benchmarks pressure ulcer incidence rates against comparable services in the southwest region. The data provides good assurance that our reported levels of pressure ulcers are lower than comparable services in the southwest. We have a positive reporting structure and the additional data and practice development with the network will inform developments in our local teams. We are reporting 1 Clostridium Difficile case in August. VTE risk assessment compliance continues to be in our required level of achievement.

Are Our Services Effective?

In line with the NTQ 'Quality Mapping' exercise further work is taking place in collaboration with operational colleagues over the next quarter to assess a range of specialised nursing services to include; Lymphoedema, Complex Leg, Tissue Viability, Heart Failure, Diabetes and other smaller Trust nursing services. The aim is to develop quality metrics with the clinical teams to expand the data set currently being afforded via the dashboard and increase the range of reporting and improve the visibility for these smaller services. The work will also inform a range of metrics which will underpin our Trust Quality Priorities for 2021/22 which were outlined in July's dashboard and these priorities will begin to be reported upon in the dashboard from Q3. The targets set within the National Childhood Measurement Programme were achieved, however, the School Age Immunisation (SAI) team were unable to meet their 90% target in relation to the HPV2 cohort, owing to the Covid pandemic, schools being closed from January until the 8th March 2021. The SAI team are working closely with Public Health England (PHE) to agree access to all schools in the area to recover this shortfall. The occupied bed days for "inappropriate" out of area Mental Health placements in August has decreased to 77 days.

Are Our Services Responsive?

Good assurance is available regarding adherence to national PHE admission guidance in order to minimise the risk of nosocomial transmission, whilst supporting an increased demand for Community Hospital beds. In line with system partners and an easing of national lockdown requirements our inpatient units continue to

enable increased visiting. The Vale MIIU reopened mid-August and Stroud MIIU is open to booked appointments only due to refurbishment. Challenges with a range of service access targets is reported within this month's dashboard.

Are Our Services Well – Led

Overall statutory and mandatory training compliance has slightly decreased this month to 85.3% in part due to summer leave and Covid absences impacting attendance. The Tier 1 Oliver McGowan training is progressing well with 21.4% of Trust colleagues now having completed the e-learning session. Appraisal training has shown a decrease this month of 2.4% and further approaches to improve this are being developed. We are offering increased leadership training for staff and funding of £600K has been provided by NHSE/I to create a system-wide Mental Health and Wellbeing Hub to provide support to all health and social care colleagues who work within Gloucestershire ICS organisations. Recruitment to the project has commenced. We are working closely with the Operational recovery and performance lead to ensure that our H&W support are targeted to the areas and services in most need.

Risks associated with meeting the Trust's values

Specific initiatives or targets that are not being achieved are highlighted in the Dashboard. Key quality and safety risks are included in the Dashboard.

Corporate considerations	
Quality Implications	By the setting and monitoring of quality targets, the quality of the service we provide will improve
Resource Implications	Improving and maintaining quality is core Trust business.
Equality Implications	No issues identified within this report

Where has this issue been discussed before?
Quality Assurance Group, updates to the Trust Executive Committee and bi-monthly reports to Quality Committee.

Appendices:	Quality Dashboard Report

Report authorised by: John Trevains	**Title:** Director of Nursing, Therapies and Quality

Gloucestershire Health and Care

NHS Foundation Trust

with you, for you

Quality Dashboard 2021/22

Physical Health, Mental Health and Learning Disability Services

Data covering August 2021

Executive Summary

NHS Gloucestershire Health and Care NHS Foundation Trust

This Quality Dashboard reports quality-focussed performance, activity, and developments regarding key quality measures and priorities for 2021/22 and highlights data and performance. This data includes national and local contractual requirements. Certain data sets contained within this report are also reported via the Trust Resources Committee; they are included in this report where it has been identified as having an impact on quality matters. Feedback on the content of this report is most welcome and should be directed to John Trevains, Director of Nursing, Therapies and Quality (NTQ).

Are our services CARING?

The number of complaints received in August increased to 11, 2 more than July but comparable to year on year data. The total number of complaints open for 10-12 months remains as previous months and these cases are being prioritised . Work on reducing the backlog continues. At time of writing there are no 12 month plus complaints waiting. **9** of the 11 complaints received in August 2021 were acknowledged within the 3-day target timeframe – of the remaining 2, one was acknowledged within 4 days and the other within 5 days. Unfortunately the achievement of the 95% target FFT that was achieved last month has decreased by 1% to 94% this time however, it is expected that the figure will improve as services continue on their recovery trajectories . The results of the non executive director audit of complaints for Q1 have been included this month for Board , the purpose of the audit is to provide assurance that overall, the Trust is investigating and responding to complaints appropriately and in line with national requirements. An additional audit undertaken by Price Waterhouse Cooper, as part of the Trust audit programme is currently underway, results will be reported when available providing further independent assurance of the quality of complaint handling.

Are our services SAFE?

The total number of patient safety incidents reported decreased from 1026 in July to 921 in August. This was the fewest incidents reported in a month for this financial year. The Patient Safety Team validate and analyse changes monthly and note a reduction in self harm incidents at Wotton Lawn and a number of expedited reviews of grade 1 pressure ulcers which is associated with the overall improvement programme. The percentage of patient safety incidents meeting moderate, severe and death thresholds has also decreased to 5.75% which is the lowest reported figure this year .There are currently 7 active SIRIs. Enhanced detail is provided again this month regarding ongoing developments to improve pressure ulcer (PU) management and there are continuing indicators of improvement in this area. Additional data is provided which benchmarks PU incidence rates against comparable services in the southwest region. We are pleased to report that zero C-19 deaths were reported by GHC inpatient services during August. As of 25/08/21, 84% of patient facing GHC staff have received their first vaccination for C-19 and 75.4% have received their second. Systems remain in place to vaccinate all eligible inpatients and vulnerable service users. Preparations are being made to deliver booster vaccinations to appropriate groups. We are reporting 1 Clostridium Difficile case in August and Health Care Acquired Infections (HCAI) reporting has replaced the historical safety thermometer data in the dashboard. HCAI's are being monitored through our Trust Infection Prevention Control Team (IPC) and reported into Quality Assurance Group for executive oversight.

Are our services EFFECTIVE?

Development work continues in collaboration with operational colleagues over the next quarter to assess a range of specialised nursing services .The aim is to develop quality metrics with the clinical teams to expand the data set currently being afforded via the dashboard and increase the range of reporting and improve the visibility for these smaller services. The occupied bed days for "inappropriate" out of area Mental Health placements in August has decreased to 77 days which relates to 9 patients. The surge in demand for inpatient beds continues with increased levels of acuity and dependency observed amongst inpatients which has has resulted in a shortage of bed availability. A task and finish group to improve Adult Mental Health admission and discharge pathways led by the Director of NTQ s demonstrating progress in improving bed access. Vacancies and Covid absences has had an impact on services with wait times for routine appointments within Occupational & Physiotherapy and Podiatry being extended. GHC maintains a vital role in system-wide patient flow and work continues through reablement, community hospital, MIIU's and ICT's to support the wider physical health system. The Child and Adolescent Mental Health Services have completed a small scale evaluation of the waiting list and have implemented a 'Waiting List Support Clinic'. This will be in addition to the triage service and the signposting already in situ to support demand. Service recovery work , led by operational colleagues continues.

Are our services RESPONSIVE?

Good assurance remans in place demonstrating adherence to national IPC admission guidance in order to minimise the risk of nosocomial transmission , set against the challenges of increased demand for Community Hospital beds. The Vale MIIU has re-opened. The Dilke remains closed and Stroud MiiU is open to booked appointments only due to refurbishment .CPA compliance has decreased compared to the previous month's figure to 86.8% with the majority of outstanding cases being within recovery. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are focusing on raising compliance with teams, assisted by Business Intelligence reports, and have set up weekly schedules with early warnings for reviews that are due. The quality team continue to supporting operational colleagues regarding 'access pressures' in services , as reported through resources committee.

Are our services WELL LED?

Statutory and mandatory training compliance has shown a slight decrease this month to 85.3%, this was anticipated over the summer due to annual leave, the position will be closely monitored to ensure that it is recovered in the coming months. Positively, the overall training compliance figure minus staff bank has increased to 93.3% .The current focus on Physical Intervention training shows fluctuation in the improvement levels along with some plateauing of numbers due to holidays and absence, focus will continue on the specific wards with lower compliance and in ensuring that the improvements are maintained. Work continues to improve appraisal rates and conversations are taking place with staff side representatives to evaluate paperwork and to look at ways to improve completion rates . Sickness absence levels have risen marginally above the 4% target for both indicators but Staff health and wellbeing remains a priority. Funding of £600K has been provided by NHSE/l to create a system-wide Mental Health and Wellbeing Hub . The Hub has a "Go Live" Date of 4th October and the first staff member started in September .The first designs for the "brand " have gone out for consultation . Progress against the many challenges is being achieved at pace with this exiting and innovative project .Registered Nurse international recruitment continues with a total of 30 RGN's and 3 RMN's being appointed and it is planned that all of these will be in post by March 2022.
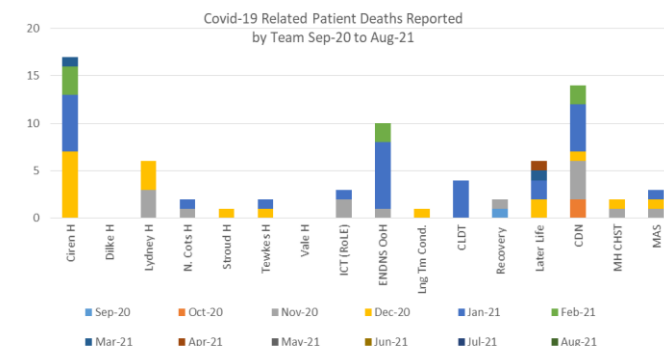
Quality Dashboard

NHS
Gloucestershire Health and Care
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COVID-19 (Whole Trust data, reporting nationally mandated Covid-19 focused safety and activity information)

No	Reporting Level	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A	Exception Report?
No of C-19 Inpatient Deaths reported to CPNS	N-R	66	0	0	0	0	0								0		
Total number of deaths reported as C-19 related.	L-R	161	0	0	0	0	0								0		
No of Patients tested at least once PH	N-R	2004	281	298	306	322	262								1469		
No of Patients tested at least once MH	N-R	775	157	129	169	176	167								798		
No of Patients tested C-19 positive or were admitted already positive PH	N-R	322	0	0	2	2	1								7		
No of Patients tested C-19 positive or were admitted already positive MH	N-R	33	0	0	0	1	2								3		
No of Patients discharged from hospital post C-19 PH	N-R	271	9	0	1	1	1								12		
No of Patients discharged from hospital post C-19 MH	N-R	28	1	0	0	1	1								3		
Community onset (positive specimen <2 days after admission to the Trust)	N-R	30	0	0	2	3	1								5		
Hospital onset (nosocomial) indeterminate healthcare associated -HOIHA (Positive specimen date 3-7 days after admission to the Trust)	N-R	6	0	0	0	0	0								0		
Hospital onset (nosocomial) probable healthcare associated -HOPHA (Positive specimen 8-14 days after admission to the Trust)	N-R	10	0	0	0	0	0								0		
Hospital onset (nosocomial) Definite healthcare associated - HODHA (Positive specimen date 15 or more days after admission to the Trust	N-R	27	0	0	0	0	1								1		
No of staff and household contacts tested	N-R	3123	65	76	342	221	211								915		
No of staff/household contacts with confirmed C-19	L-R	323	0	0	28	25	29								82		
No of staff self-isolating: new episodes in month	L-R		34	40	153	223	199										
No of staff returning to work during month	L-R		29	30	100	210	169										
No staff GHC who received Covid-19 vaccine first dose		4046	17	8	8	7									40		

Additional Information

Patient Reporting: The number of Covid-19 (C-19) related inpatient deaths remains at zero for the fifth consecutive month with zero inpatient deaths meeting criteria for national reporting to CPNS being reported in April - August 2021. The number of community patient deaths reported as C-19 related also continues as zero. C-19 related patient deaths since Sept 2020 by team/hospital site are shown in the chart opposite, previous year data being included for comparison. One Gloucestershire NHS partners agreed to declare a countywide serious incident for HOPHA and HODHA Covid-19 cases in our hospitals in response to NHSE/I guidance. The work identifying the level of harm for each case, as a result of acquiring Covid-19, will be completed by mid-October with Duty of Candour letters being prepared with the aim of sending this by the end of October. Case reviews have commenced and the learning will inform both internal and system wide learning.

Staff Testing : The numbers of staff being tested has reduced and will continue to monitored going forward .

Covid-19 Related Patient Deaths Reported by Team Sep-20 to Aug-21

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

2

Quality Dashboard

NHS
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COVID-19 - KEEPING PEOPLE SAFE – VACCINATION PROGRAMMES

- August data - 84 % "frontline" workforce received first vaccine; with 75.4% having received their second dose. 69% BAME colleagues received first vaccine and 61.4% received their second as at 25/08/2021.
- Vaccine uptake data is monitored weekly and submitted to NHSE/I every 14 days
- Workstream in place led by Working Well to enhance uptake that includes staff conversations to compassionately address vaccine hesitancy
- Proactive and targeted communication in place with intention to reinforce the importance of second dosages.
- Pop up clinics remain in place to support enhanced access for staff
- Systems remain in place to vaccinate all eligible inpatients and vulnerable service users as required with consent.
- Preparations are in place to deliver booster vaccines to identified groups and support the recently announced 12-15 yr old programme

Validated Data as of 25-8-2021

ROLE	TOTAL NUMBER Aug 2021	1ST VACCINE (up to 25/08/21)	%	2nd VACCINE (up to 25/08/21)	%
All doctors/dentists	127	111	87	97	76.4
All qualified nurses, including students	1444	1223	85	1086	75.2
All other professional qualified staff	780	671	86	617	79.1
Support to clinical staff	1872	1549	83	1384	73.9
TOTAL GHC CLINICAL STAFF	**4223**	3554	84	3184	75.4
NHS infrastructure staff	358	245	68	198	55.3
TOTAL GHC WORKFORCE	4581	3799	83	3382	73.8

COVID-19 - KEEPING STAFF SAFE

Personal Protective Equipment (PPE)

At the current time, there are no concerns regarding stock levels of any PPE items. The Trust is fully assured on future supply of all stock items via national supply routes.
The 'controlled pull' model for key PPE product lines to fulfil the Trust's weekly requirements continues to work well. The Trust continues to maintain 14 days supply of all key PPE items at central stores and are maintaining 14 days of supplies at each PPE locality hub.

The Local Resilience Forum (LRF) has now been brought in to the Trust's PPE stores and distribution processes, a collection model has been set up to facilitate access to PPE for social care.

Transparent masks

Following confirmation from NHSEI that there are currently no transparent masks with sufficient assurance on suitability for health and care settings available,
GHC have completed a risk assessment which has enabled us to use transparent masks where need when working with people with acute communication challenges but with additional guidance for colleagues on the considerations that they should have when determining to use transparent masks.

Lateral flow (Asymptomatic testing)

Following the decision at national level to move the provision of lateral flow kits to an 'individual pull' model the Trust have now ceased providing lateral flow kits to individuals. This means that colleagues will now request their own lateral flow kits (7 tests at a time) to be delivered to their home or they can collect them from a test centre or a pharmacy. Colleagues will then report these results via the national reporting tool. The risks are that the process of ordering could result in reduced use of lateral flow tests and that the Trust will also lose its oversight of the reporting process, whilst the benefit is that this will remove the need for storage and distribution of kits within the Trust . However, as yet we don't know when or how the data from national submissions will be provided to GHC. There are currently reserve boxes of lateral flow tests in stock and we will continue to utilise all of these at the most appropriate places prior to their expiry date to avoid waste of resources.

FFP3 fit-testing

The new fit tester/co-ordinator commenced in role in August and is working towards the Trust meeting the requirements as detailed in a letter received from Department of Health and Social Care . Although this directive was to Acute Trusts, GHC will work towards delivering these requirements . This will, at an operational level be co-ordinated by the Fit tester/co-ordinator within the stock team and progress against each requirement will be reported via the Fit Test Oversight Meeting and through to this Quality Dashboard. The refreshed GHC Fit Test Strategy is now in final draft form and includes the Key Success of the programme to date:

• We have successfully tested 1257 staff members for an FFP3 mask throughout the Trust in 2021. This has brought our current overall compliance rate to 95%.
• Through the Covid Stock Management Team, we have created a safe and reliable supply system for masks. This has ensured that we can depend on the ongoing availability of masks that our staff have been tested on.
• The ""Request a Test" process has been created to make receiving a test more accessible to a wider range of staff.
• The Trust has created a role of Fit Test Co-ordinator. The co-ordinator's role is not only to Fit Test throughout the trust to ensure a high compliance rate, but to ensure that Fit Testing continues to be a priority for our staff's safety.

Programme development plan for the next 6 months:

• Strive to test all regular AGP users on two different types of masks. This is so that, if a mask is recalled or the stock becomes unavailable the staff will not have to delay urgent tasks or be unable to give care to patients.
• Ensure that staff tested on two masks are able to regularly alternate what masks they wear.
• Ensure that a range of FFP3 masks are available to users on the frontline and should not exceed 25% usage on any one type of FFP3
• Register FFP3 users and fit test results in ESR and review individual usage every quarter.

Quality Dashboard

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

No		Reporting Level	Threshold	2019/20 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2020/21 YTD	RAG	Exception Report?	Benchmarking Report
	Number of Friends and Family Test Responses Received	N - T		11990	1786	1490	1562	1552	1118								7508			
	% of respondents indicating a positive experience of our services	N - R	95%	94%	92%	94%	94%	95%	94%								94%			
	Number of Compliments	L - R		1478	149	123	129	131	118								650			
	Number of Concerns	L - R		390	41	34	37	37	34								183			
	Concerns escalated to a formal complaint			14	1	3	4	2	2								12			
	Number of Complaints	N - R		83	11	11	11	9	11								53			
	Number of open complaints (not all opened within month)				76	79	82	86	88											
	Percentage of complaints acknowledged within 3 working days		100%	96%	73%	91%	100%	100%	82%								89%			
	Number agreeing investigation issues with complainant				15	17	13	12	20											
	Number of complaints awaiting investigation				4	0	2	3	2											
	Number of complaints under investigation				10	15	21	19	22											
	Number of Final Response Letters being drafted				44	43	45	49	43											
	Number of Final Response Letters awaiting Exec sign-off				3	1	1	1	1											
	Number of complaints closed				7	9	8	7	8								39			
	Number of re-opened complaints (not all opened within month)				5	6	6	6	7											
	Current external reviews				4	4	4	3	3											

|			
N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L – C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure that is treated differently at national and local level, e.g. nationally reported/local target

RAG Key: R – Red, A – Amber, G - Green

CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)

Complaints, concerns and compliments

- The average number of complaints received in August over the past four years is **9**. In August 2021 we received **11 complaints**.
- In August 2021, **8** complaints were closed: **2** were withdrawn, **1** was upheld, **1** was partly upheld, and **4** were not upheld
- **34** concerns were raised in August 2021, which is slightly more than the monthly average of 32 concerns during 2020/21.
- **118** compliments were received in August 2021, which very slightly more than the monthly average of 123 during 2020/21.

Complaints and concerns by quarter (2017 to date)
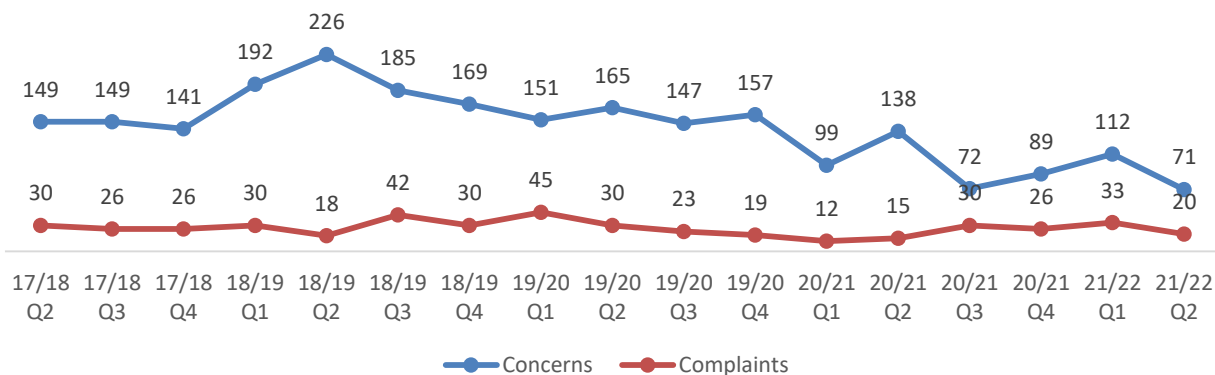
This chart summarises the number of complaints and concerns received by quarter since 2017/18. This offers assurance that services are not receiving a significant increase in complaints in 2021/22. The impact of Covid-19 (national pause, redeployment, services in recovery), PCET staffing challenges, and a cluster of complaints received in November and December 2020, have all contributed to the current increase in complaint response times.

Assurance regarding complaint management
- Each complaint is triaged to check for any immediate actions required. Triage facilitates the identification of themes and hotspots.
- In line with NHS Trusts across England, the largest proportion of our complaints relate to care and treatment and communication/staff attitude.
- The Non-Executive Director Audit of complaints for Quarter 1 2021/22 was reported in July 2021.
- Price Waterhouse Cooper are currently undertaking an audit of complaints closed between 1st April 2021 and 31st July 2021 – results will be reported when available.

Satisfaction with complaints/concern processes
- **7** active re-opened complaints – we openly encourage complaints to challenge responses they are not fully satisfied with
- **40** concerns were closed in August 2021, **2** of which were escalated to a complaint

External review
- There are currently **3** complaints with the PHSO for external review.

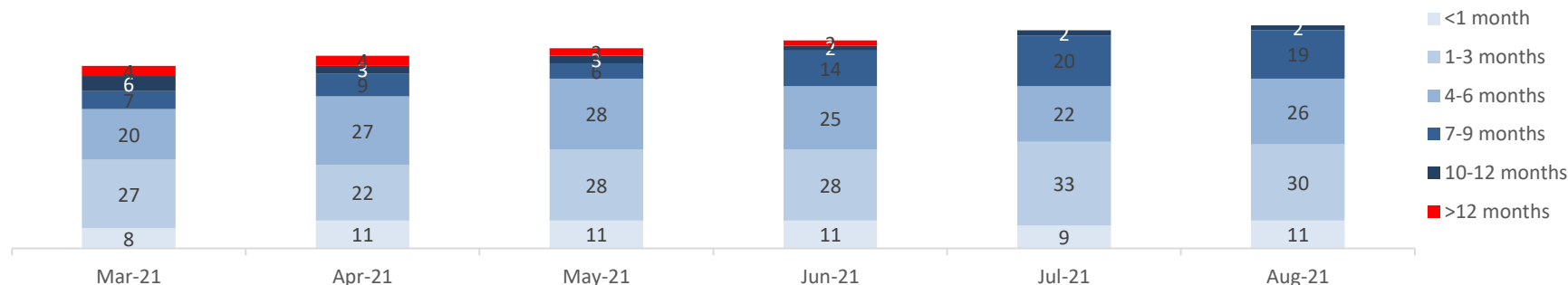**CQC DOMAIN - ARE SERVICES CARING? Patient and Carer Experience Team (PCET)**

Timeframes
- PCET remains in active recovery following the national pause in the complaint management process between April and June 2020.
- **9** of the 11 complaints received in August 2021 were acknowledged within the 3-day target timeframe – of the remaining two, one was acknowledged within 4 days and the other within 5 days.

- Of the **88** open complaints, **18** do not have agreed response times. Of these:
  - **13** are in the very early stages of the complaint process and issues have not been agreed and so timeframes have not yet been set.
  - **5** are complaints being managed by other NHS organisations, for which we are providing input/comments.

- Of the **70** complaints with agreed response dates:
  - **18** are within the agreed timeframe
  - **52** have exceeded the initially agreed timeframes, and there are a range of reasons for these delays including:
    - Agreeing issues for investigation with complainants
    - Delays in the investigation process (e.g. allocating investigators, timeliness of investigation report, and availability of staff for interviews)
    - Delays in the drafting and review of final responses (e.g. capacity, quality of investigation, availability of staff to review draft responses)
  - Work is underway to address delays in the complaints process in order to minimise them where possible

The chart below shows the length of time complaints have been open (please note that it can take up to approx. 8 weeks to agree issues with complainants depending on complexity and availability). The PCET are focusing efforts on completing responses for those open for the longest period. A weekly meeting provides high-level oversight of the complaints tracker. Fortnightly updates to the Director of NTQ are in place and regular briefings to the Board and Quality Committee provide assurance of recovery.

Additional resource has been secured via redeployed colleagues and 2 existing members of the team have agreed to temporarily increase their working hours. Additional investment has resulted in recent recruitment to 2 additional substantive posts, and one fixed term 12-month contract to support complaint response times. Further support has been supplied by senior NTQ colleagues to assist with final response letter completion and to increase triangulation with patient safety and Freedom to Speak Up learning. The Trust Quality Improvement Team are undertaking a LEAN assessment to identify process improvements and areas for efficiency.

Open complaints by length of time open (by month)

Month	<1 month	1-3 months	4-6 months	7-9 months	10-12 months	>12 months
Mar-21	8	27	20	7	6	4
Apr-21	11	22	27	9	3	
May-21	11	28	28	6	3	
Jun-21	11	28	25	14		2
Jul-21	9	33	22	20		2
Aug-21	11	30	26	19		2

ARE SERVICES CARING? Non-Executive Director audit of complaints Q1 2021/22

INTRODUCTION
The agreed aim of the audit is to provide assurance that standards of complaint management are being met in relation to the following aspects:
• The timeliness of the complaint response process
• The quality of the investigation and whether it addresses the issues raised by the complainant
• The accessibility, style and tone of the response letter
• The learning and actions identified as a result

PROCESS
• Three complaint files closed in the quarter are randomly selected by the nominated Non-Executive Director auditor (NED)
• The Patient and Carer Experience Team (PCET) completes section 1 of the audit tool and provides the auditor with copies of the initial complaint letter, the investigation report, and the final response letter
• Having studied the files, the auditor completes sections 2-4
• The auditor compiles a report of their findings, to be presented at the Quality Committee and Trust Board

SUMMARY OF FINDINGS
• Audit findings are summarised within the table on the following slide
• The Q1 2021/22 audit provides assurance that overall, the Trust is investigating and responding to complaints appropriately. Of the 3 complaints that were audited, 2 related to Herefordshire based services
• Delays in responses have been recognised and work continues to address the backlog of complaints. A Recovery Plan is in place using QI methodology to improve processes. Additional resource and capacity within PCET have been delivered. Waiting response times are monitored via fortnightly report to the Director of Nursing, Therapies and Quality report and monthly Quality Dashboard.

FUTURE AUDITS
• The Trust Secretary's office will continue to allocate the audits to NED colleagues
• An ongoing programme for NED audit of complaints has been established
• Audit reports will continue to be presented within the Quality Dashboard for the Quality Committee and for Trust Board

RECOMMENDATIONS
• To note the contents of the report
• To note the assurances provided regarding the Trust's management of complaints

Quality Dashboard

ARE SERVICES SAFE? Non-Executive Director audit of complaints Q1 2021/22					
	Time scale of response	**Quality of investigation**	**Accessibility, style and tone of letter**	**Learning actions identified**	**Comments**
Complaint 1 • Family raised concerns regarding communication about their relative's care and treatment during an inpatient stay and changes to visiting restrictions due to the pandemic	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and the Trust's recovery following national pause in complaints	**FULL ASSURANCE** • Thorough investigation acknowledging failings appropriately • Issues clearly identified with evidence to support conclusions • Need to ensure the acknowledgement of distress families experience of not living locally and being able to visit their relatives	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic • Compassionate	**FULL ASSURANCE** • Learning identified and shared	
Complaint 2 • Family raised concerns about care and support provided during an assessment appointment (Herefordshire)	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and the Trust's recovery following national pause in complaints	**LIMITED ASSURANCE** • Investigation limited as the member of staff involved was unable to be interviewed as they no longer work for the Trust • Issues clearly identified with evidence to support conclusions	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic • Compassionate	**FULL ASSURANCE** • Investigation findings shared with Worcestershire Health and Care NHS Trust to consider and take forward	• Outlined actions to be considered regarding learning if the staff member was still employed by the Trust
Complaint 3 • Family raised concerns about the care and support provided to their child by CAMHS (Herefordshire)	**LIMITED ASSURANCE** • Delayed • Very apologetic regarding the long delay due to the national pandemic and the Trust's recovery following national pause in complaints	**FULL ASSURANCE** • Thorough investigation • Issues clearly identified with evidence to support conclusions	**FULL ASSURANCE** • Apologetic and sincere • Clear and succinct • Apologetic regarding the long delay due to the national pandemic • Compassionate and acknowledged perceptions of the family's experience	**FULL ASSURANCE** • Investigation findings shared with Worcestershire Health and Care NHS Trust to consider and take forward	• Timing of providing information to a young person regarding options for ongoing support from adult mental health services

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CQC DOMAIN - ARE SERVICES SAFE? INCIDENTS (Whole Trust data)

	Reporting Level	Threshold	20-21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021-22 YTD	R / A / G	Exception Report?	Benchmarking Report
Number of Never Events	N - T	0	0	0	0	0	0	0								0			N/A
Number of Serious Incidents Requiring Investigation (SIRI)	N - R		39	4	3	1	2	1								11			N/A
Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm	N - R		1	1	1	0	0	0								2			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding falls leading to fractures	N - R		3	0	1	0	0	0								1			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers	N - R		2	0	0	0	0	0								0			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides	N - R		15	3	1	1	1	0								6			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide	N - R		10	0	0	0	0	0								0			N/A
Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides	N - R		0	0	0	0	0	0								0			N/A
Total number of Patient Safety Incidents reported	L - R		12474	985	1185	1070	1026	921								5187			N/A
% incidents resulting in low or no harm	L - R		93.41%	92.99%	91.05%	92.34%	93.37%	94.28%								92.72%			N/A
% incidents resulting in moderate harm, severe harm or death	L - R		6.59%	7.01%	8.95%	7.66%	6. 63%	5.75%								7.29%			N/A
% falls incidents resulting in moderate, severe harm or death	L - R		2.75%	1.10%	2.17%	2.78%	0.00%	1.75%								1. 53%			N/A
% medication errors resulting in moderate, severe harm or death	L - R		0.83%	0.00%	1.64%	0.00%	0.00%	1.64%								0. 69%			N/A
Embedding Learning meetings taking place to review the outputs of completed SIRI reports and consider practice implications.* **Covid Disruption**	L - R		N/A	0	1	0	1	0	0	0	0	0	0	0	0	2			N/A

N - T | National measure/standard with target
N - R | Nationally reported measure but without a formal target
L - C | Locally contracted measure (target/threshold agreed with GCCG)

L - I | Locally agreed measure for the Trust (internal target)
L - R | Locally reported (no target/threshold) agreed
N – R/L – C | Measure that is treated differently at national and local level, e.g. nationally reported/local target

RAG Key: R – Red, A – Amber, G - Green

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CQC DOMAIN - ARE SERVICES SAFE? – additional information

One SIRI was declared in August 2021, regarding commissioning of dental equipment. This resulted in disruption to service provision and due to potential risks was considered as an SI, we are fully assured no patient harm occurred but we are keen to fully investigate to prevent reoccurrence . All incidents were escalated in line with SIRI reporting requirements. The Patient Safety Team continue to monitor regional and national trends in terms of suicide rates and work towards our Trust's zero suicide ambitions . The tables below represent SIRI reporting over the past 5 years. These reports are stimulating good clinical discussions across operational governance forums and the Trust's Quality Assurance Group. Particular attention was paid at these meetings to thematic analysis of issues.

No. of MH Serious Incidents
(current quarter to date)
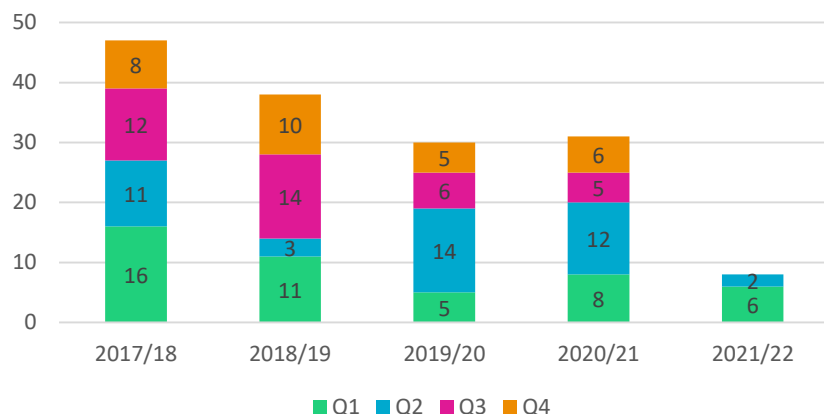
No of PH Serious Incidents
(current quarter to date)
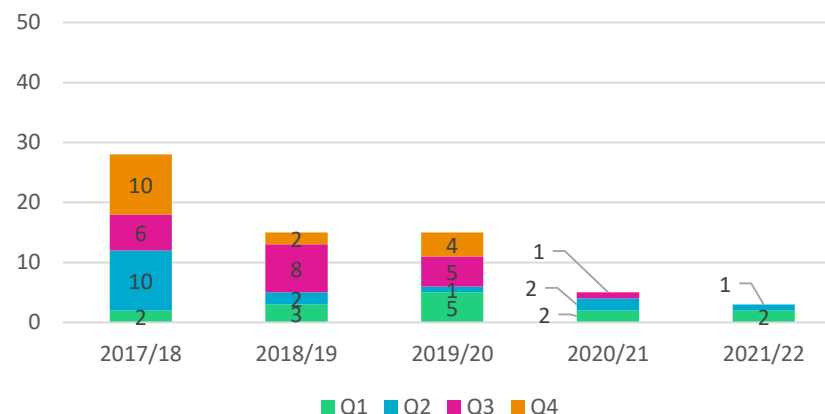
There are 7 active SIRIs, at the time of writing, a Final Report had been submitted to commissioners on 1 September, leaving 6 in process. One active SIRI investigation is likely to complete outside of statutory time frames. An extended submission date for the final report has been agreed with commissioners and remains in place, this is due to compassionate engagement with the family of the deceased at a pace to suit them rather than suit the process. The preliminary investigation has been completed and an internal review held; the final report is being completed. One active SIRI has been formally paused by commissioners whilst GHC awaits detailed information from Gloucester Hospitals NHSFT.

Regarding all patient safety incidents:

• The total number of patient safety incidents reported decreased from 1026 in July to 921 in August. This was the fewest incidents reported in a month for this financial year. The Patient Safety Team validate and analyse changes monthly and note in this reporting period a reduction in self harming incidents at Wotton Lawn and a number of expedited reviews of grade 1 pressure ulcers which is associated with the overall improvement programme.
• The percentage of patient safety incidents resulting in moderate or severe harm and death decreased from July (6.72%) to August (5.75%).
• 2 falls resulted in moderate and above levels of harm in August.
• 1 medication incident resulted in moderate and above levels of harm in August.

Quality Dashboard

NHS Gloucestershire Health and Care NHS Foundation Trust

CQC DOMAIN - ARE SERVICES SAFE? Trust Wide Physical Health Focus

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	RAG	Exception Report?	Benchmarking Report
VTE Risk Assessment - % of inpatients with assessment completed	N - T	95%	97.0%	97.2%	98.7%	98.7%	100%	98.4%								98.6%	G		
Number of post 48 hour Clostridium Difficile Infections (C Diff)	N	1		1	2	3	3	1								10	R		
Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable	N	0			0	0	0	0								0	N/A		
Number of MRSA Bacteraemia	N	0			0	0	0	0								0	N/A		
Total number of developed or worsened pressure ulcers	L - R	61	797	84	64	70	61	56								335	R		
Total number of Category 1 & 2 Acquired pressure ulcers	L - R	56	698	75	60	59	57	53								304	R		
Number of Category 3 Acquired pressure ulcers	L - R	0	70	8	1	9	4	3								2	R		
Number of Category 4 Acquired pressure ulcers	L - R	0	29	1	3	2	0	0								6	R		

ADDITIONAL INFORMATION - Health Care Acquired Infections (HCAI) & Pressure Ulcers (PU)

HCAI

- 1 post 48-hr Clostridium Difficile (C. Diff) cases was detected in August. The case was identified at Abbey View ward at Tewkesbury Hospital . A post incident review (PIR) meeting for the clinical team, facilities, pharmacist and IP&C has been arranged as per protocol to discuss if there are any lapses in care that may have contributed to patient acquiring a C diff infection, or lapses in care of management of C diff. The IPCT discuss any themes or lessons to be learned with the Consultant Medical Microbiologist. The Infection Prevention and Control team are continuing to review the C. Diff policy and associated documentation following a change to initial first line treatment with the aim of achieving a One Gloucestershire approach to the management of C.Diff.

Pressure Ulcers

- The Trust has reported fewer skin integrity incidents this month. The active work with teams continues in terms of improving practice to meet significant rising demand in pressure area care referrals from primary care and care homes. Following the success of the Gloucester Quality Improvement (QI) Pressure Ulcer (PU) plan the Forest & Tewkesbury, Newent & Staunton (TNS) QI PU approach is currently in the 'do' stage of the Plan, Do, Study, Act improvement methodology (PDSA) cycle. Leadership from operational managers and clinicians in Gloucester and Forest remains at a high level and the Datix team have provided historical data from these areas that has supported the development of a baseline for improvement focusing on category 2 damage.
- Further to the success of the 'Datix dashboard oversight' these are now available to all community ICT managers and their senior teams. This has resulted in timely review of Datix incidents and thematic review for teams as well as assurance and governance oversight for the trust.
- Educational webinars highlighting PU categorisation continue and these will be uploaded onto care to learn in September. The Tissue viability page has been relaunched on the trust's intranet and includes pressure ulcer resources. Tissue viability and District Nursing leads from neighbouring trusts are scoping a community benchmarking collaborative with initial data sharing planned in September.
- The 20 minute open invite for a focussed District Nurse discussion on safe and effective pressure area assessment, monitoring and management will be repeated in September following requests from colleagues. The focus will continue to be sharing the national and local themes observed in relation to PU incidence and severity, encouraging debate and involvement in improvement.
- Additional clinical support has been made available to review the most severe pressure ulcer damage: Category 3,4, suspected deep tissue injury and unstageable pressure ulcer Datix reports are all reviewed for any errors in categorising PU's at the end of each calendar month. The monthly reports can be rerun and enable accuracy of submission and numbers.

N - T	National measure/standard with target	L – I	Locally agreed measure for the Trust (internal target)
N - R	Nationally reported measure but without a formal target	L – R	Locally reported (no target/threshold) agreed
L - C	Locally contracted measure (target/threshold agreed with GCCG)	N – R/L – C	Measure that is treated differently at national and local level, e.g. nationally reported/local target

RAG Key: R – Red, A – Amber, G - Green

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CQC DOMAIN - ARE SERVICES SAFE?
Pressure Ulcers – August 2021 Additional Information Trust Wide

Skin integrity incidents

August PU CoHo
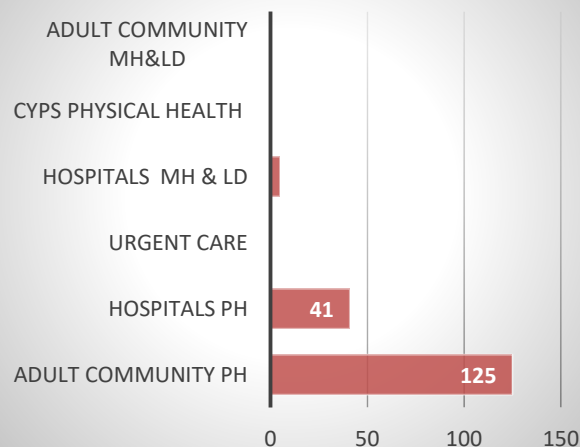
August PU ICT
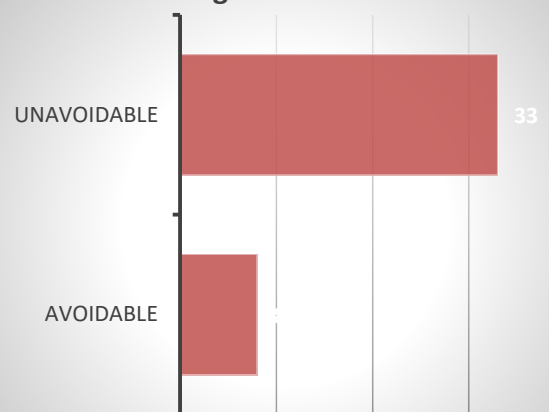

Bar chart showing skin integrity incident reports per service.
- Adult community PH: 125
- Hospitals PH: 41
- Urgent care & specialist services:1
- Hospitals MH & LD: 5
- Adult comm. Mental Health & LD 0

- CYPS Physical Health 1

Bar chart showing PU's developed or worsened under GHC care (acquired) in our Community Hospitals in August 2021
- Community PH hospitals pressure ulcers that have developed or worsened under our care (acquired under our care). *Reviewed* as being unavoidable or avoidable because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 33 unavoidable
- 8 avoidable
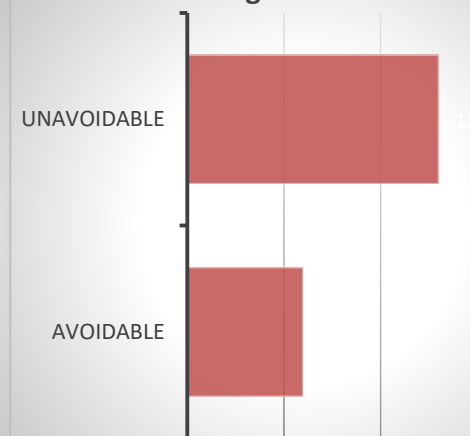
Bar chart showing data reported in community PH in August 2021
- Snapshot of Community PH pressure ulcers that have developed or worsened under our care (acquired under our care). *Reviewed by handlers* as being unavoidable or avoidable. These decisions may have been made because of co morbidities, patient choice (for example patients may decline to use equipment or clinical advice.)
- 13 unavoidable
- 6 avoidable

CQC DOMAIN - ARE SERVICES SAFE? Pressure Ulcers – June 2021 datapoint - Additional Information

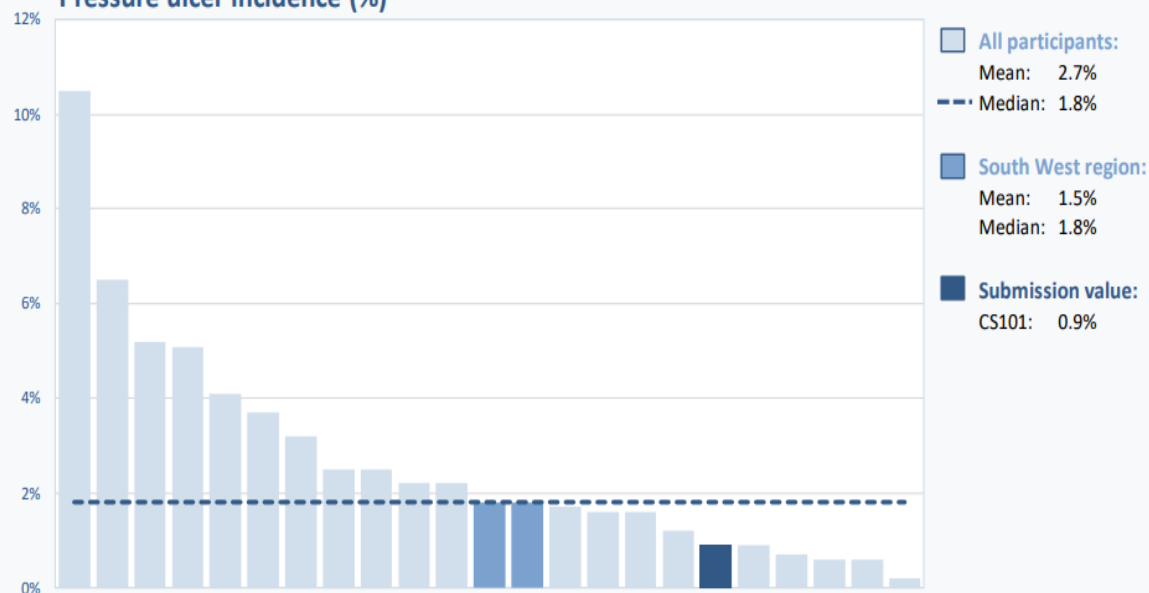### District / Community nursing:
Pressure ulcer incidence (%)

All participants:
Mean: 2.7%
Median: 1.8%

South West region:
Mean: 1.5%
Median: 1.8%

Submission value:
CS101: 0.9%

Submission CS101: Gloucestershire Health and Care NHS Foundation Trust
Pressure ulcers remain a concerning and mainly avoidable harm associated with healthcare delivery. Pressure ulcer incidence can give an indication of the quality of care.
At 0.9% the submission's response was below average. This compares to a median value from all participants of 1.8%.

Benchmarking Data:

The table provides benchmarking information from the NHS Benchmarking Network High Performance Report. It provides a systematic review of high performance from Network projects and a review of the Network outputs that support the exchange of good practice and innovation.

The GHC Pressure Ulcer Lead is part of a benchmarking network made up from services in Oxford, Buckinghamshire & Bristol. The aim of the group is to develop practice and share data on pressure ulcer incidents and severity.

We are now moving our improvement work into business as usual. The data table provides good assurance that our reported levels of pressure ulcers are lower than comparable services in the southwest. We have a positive reporting structure and the additional data and practice development with the network will inform developments in our local teams.

Quality Dashboard

CQC DOMAIN - ARE SERVICES RESPONSIVE?

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A G	Exception Report?	Benchmarking Report
Time to initial assessment for patients arriving by ambulance (95th percentile)	N - T	<15 m	00:14	0.14	0.12	0.16	0.15	0.13								0.14	G		
Referral to Treatment physical health																		
Podiatry - % treated within 8 Weeks	L - C	95%	96.00%	96.60%	96.60%	96.80%	91.3%	76.3%								91.52%	G		
ICT Physiotherapy - % treated within 8 Weeks	L - C	95%	89.80%	97.00%	95.50%	93.80%	90.8%	91.1%								93.64%	A		
ICT Occupational Therapy Services - % treated within 8 Weeks	L - C	95%	93%	96.10%	96.70%	96.90%	93%	94.0%								96.34%	G		
Paediatric Speech and Language Therapy - % treated within 8 Weeks	L - C	95%	94,8%	97.1%	95.50%	96.50%	71.2%	58.8%								83.82%	R		
Paediatric Physiotherapy - % treated within 8 Weeks	L - C	95%	96.00%	99.10%	99.50%	98.90%	98.2%	98.0%								98.74%	G		
Paediatric Occupational Therapy - % treated within 8 Weeks	L - C	95%	97.8%	95.70%	98.90%	97.70%	99.4%	99.4%								98.22%	G		
Single Point of Clinical Access (SPCA) Calls Offered (received)	L - R	3,279	28960	3101	2920	1339	1305	1190								10036	R		
Wheelchair Services Adults : New referrals assessed within 8 weeks	L - C	90%	TBC	82.70%	82.20%	65.40%	50.0%	72.3%								70.52%	R		
Wheelchair Services : Under 18's new referrals assessed within 8 weeks	L - C	90%	TBC	62.50%	92.3%	80.00%	93.7%	92.8%								84.26%	A		
Mental Health Services																		
CPA Review within 12 Months	N - T	95%	91.80%	94.9%	92.80%	92.20%	89.09%	86.8%								91.32%	R		
Admissions to hospital gate kept by CRHTT	N - T	95%	99.50%	95.20%	100%	100%	96.5%	100%								98.34%	G		

Additional information

Physical Health

Podiatry – Treatment times have been impacted in month due to an increase in referrals rates, supporting annual leave requests against a pressure of increased sickness absence and a number of staff having to self isolate. New members of the team start in September and will help mitigate against the increased challenges noted in this reporting period.

Community OT and PT (ICT) - The service is experiencing a high demand for OT and PT emerging from the Home First (HF) and Reablement pathways combined with the MDT referral desk activity. Available workforce are managing immediate demand which supports hospital discharges and admission prevention, but people are now waiting longer for routine and long term assessments. There is an expected increase of 7.0 wte funding for therapy resources to support the HF model, but this may not be sufficient to address the backlog developing in the routine care waiting lists. Additional work is being undertaken with the service leads to fully understand the effect and this will inform the recovery action plans. **Paediatric SLT :** There are significant gaps in service due to maternity leave and vacant posts. Additional recruitment is planned as part of the overall recovery plan. The service continues to offer a blended model of delivery based on clinical need and risk assessment and is also setting up an advice line and training for schools, and increasing the resources available to schools on their website in anticipation of increasing demand in the new academic year. Face to Face delivery will start again at Rikenel following the completion of works and new clinic space being made available
.

Wheelchair Services : The current waiting time for adults is below target although improved marginally this month, whilst the time for under 18's is above target . The service has been balancing planned annual leave with episodes of staff sickness within the same time period ,this has reduced the capacity of staff available for assessment in order to balance triage and urgent requirements of the service. All urgent referrals have been seen.

Mental Health

CPA compliance has decreased compared to the previous month's figure to 86.8% and there are currently 124 CPAs outstanding. 82 cases are within recovery. The Recovery service continues to experience high caseloads, high levels of acuity and a high turnover of staff in the Tewkesbury team. However, the staff shortage in Cheltenham due to short-term sickness have been resolved. There is a Service Recovery Action Plan (SRAP) which includes the review of non-compliant cases with regard to scheduling reviews and ensuring the clinical system is updated with reviews that have taken place. Team managers are focused on raising compliance with teams, assisted by Business Intelligence reports, and have set up weekly schedules with early warnings for reviews that are due. NTQ have requested a trajectory to be produced for return to compliance.

CQC DOMAIN - ARE SERVICES EFFECTIVE? (Whole Trust data)

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A G	Exception Report?	Benchmarking Report
Community Hospitals																			
Bed Occupancy - Community Hospitals	L - C	92%	88.9%	89.6%	90.0%	94.3%	95.1%	91.6%								92.12%	G		90.4%
Early Intervention in psychosis EIP: people experiencing a first episode of psychosis treated with a NICE-approved care package within two weeks of referral	N - T	60%	85.7%	90%	90%	75%	80.0%	100.00%								84.6%	G		
Ensure that cardio-metabolic assessment & treatment for people with psychosis is delivered																			
Inpatient Wards	N - T	95%	80%																
GRiP	N - T	92%	85%																
Community	N - T	90%	78%																
Improving access to psychological therapies (IAPT): Proportion or people completing treatment who move to recovery (from IAPT database). Waiting time to begin treatment (from IAPT minimum dataset	N - T	50%	52.9%	54.2%	54.%	52.2%	50.2%	51.6%								52.4%	G		
Admissions to adult facility of patient under 16yrs	N - R		1	0	0	1	0	0								1	N/A		
Inappropriate out of area placements for adult mental health services	N - R	Occupied bed days	1742	82	100	199	187	77								568	G		
Children's Services – Immunisations			2019/20 Academic Year	ACADEMIC YEAR 2020/21 - Target 90% of all 2 immunisations by end of academic year (July 2021) and new cohort 1st immunisations															
HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation)	N - T	90%*	73.1%	30.7%	42.9%	74.4%	86.9%	90.7%								90.7%	G		
Childrens Services - National Childhood Measurement Programme			2019/20 Academic Year	Academic Year 2020/21 - Target 95% of children measured by end of academic year - Cumulative target (July 2021)				Academic Year 2021/22										
Percentage of children in Reception Year with height and weight recorded	N - T	95%*	69.7%	36.0%	64.5%	87.8%	96.8%	96.8%								96.8%	G		
Percentage of children in Year 6 with height and weight recorded	N - T	95%*	73.9%	9.0%	76.3%	84.5%	96.1%	96.1%								96.1%	G		

Additional Information

Children's Services - National Childhood Measurement Programme (NCMP) has met target.

HPV – The target of 90% of the 1st Immunisation was achieved in August . The School Age Immunisation (SAI) team were unable to meet their 90% target in relation to the HPV2 cohort. Owing to the Covid pandemic, and schools being closed from January until the 8th March 2021, over 700 Year 9 - 1st doses were not delivered until March. For the 2nd HPV vaccination to be given there is the requirement for a 6 month interval between HPV 1 and HPV 2 vaccinations hence this interval had not passed by the end of August.

EIP – The recommendation of the Mental Health Taskforce, NHS England outlines its commitment to ensuring that, by 2020/21, at least 60% of people experiencing first episode psychosis receive treatment. The standard has been carried forward to 21/22. There was a data cleansing process completed in month which has refreshed the compliance rates for Jul and Aug and now show our compliance with this standard.

Out of area bed days - The occupied bed days for inappropriate out of area Mental Health placements in August was 77 days which relates to 9 patients (7 x acute & 2 PICU admission beds). This work has been supported by the admission and discharge pathway task & finish group.

Additional KPIs - Physical Health

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A G	Exception Report?	Benchmarking Report
Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target)		95%*	93.1%	35%	61.7%	83.2%	92.1%	92.1%								92.1%	G	N	
Number of Antenatal visits carried out			530	47	51	51	54	30								233	R	Y	
Percentage of live births that receive a face to face NBV (New Birth Visit) within 7- 14 days by a Health Visitor		95%	94.1%	93.4%	96.6%	93.3%	93.4%	94.5%								94.2%	A	Y	
Percentage of children who received a 6-8 weeks review.		95%	95.9%	98.3%	97.2%	97.6%	97.8%	94.6%								97.1%	G		
Percentage of children who received a 9-12 month review by the time they turned 12 months.		95%	72.6%	74.0%	84.7%	82.3%	84.2%	80.6%								81.2%	A	Y	
Percentage of children who received a 12 month review by the time they turned 15 months.		95%	83.7%	83.9%	79.6%	82.8%	86.8%	91.6%								85.1%	A	Y	
Percentage of children who received a 2-2.5 year review by 2.5 years.		95%	72.5%	72.0%	74,4%	81.5%	84.0%	84.1%								78.9%	R	Y	
Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence).		58%	56.0%	61.3%	59.2%	60.1%	54.2%	56.1%								58.1%	G		
Breastfeeding- % of mothers who are still breastfeeding at 8 weeks who were breastfeeding at 2 weeks		80%	81.3%	81.7%	81.5%	85.4%	82.2%	81.2%								82.4%	G		
Chlamydia Screening of Gloucestershire residents aged 15-24 (minimum positivity rate)		3108	970			No Data													
Number of positive Chlamydia screens		169	632																
Average Number of Community Hospital Beds Open reduced by 8 due to social distancing measures.		196*	174,9	186.	187	188	187	181								181	R		
Average Number of Community Hospital Beds Closed		0	21.1	2	1	0	1	7								9	R		

Additional Information

Antenatal Visit: Delivery of sessions was impacted in month due to changes in the scheduling by midwifery services. Some activity in Stroud has not been updated and reflect the change in visit numbers above. The data should be corrected for October.

New Birth Visiting (NBV) – There is a robust triage process to identify those children who are 'hard to reach' to ensure equity of access. The service is working with Maternity Voice Partnership to increase engagement with service users and pre-appointment reminders are being sent to carers/parents. NBV are offered face to face (F2F) with a telephone/virtual consultation available on request. There is a gradual improvement in month, however, the increase in babies remaining in Neonatal Intensive Care Units (NICU) impacts on the teams ability to engage within the timeframe and results in a breach of the threshold. In month there were 14 babies in NICU.

Percentage of children who received a 6-8 week review within 8 weeks by a Health Visitor - Overall a minor variation in month with 6 families not available in timeframe but have since been seen, 8 babies were seen late due to rescheduling of priorities.

Percentage of children who received a 9-12-month review by the time they turned 12 months - The parents of all children within this age group were offered the opportunity to receive a 9-12mth and 2 year review. For all children classified as universal with low risk, virtual appointments via Attend Anywhere are being offered for developmental reviews as the estate available for face to face is reduced. Some families are still request face to face contact and decline the virtual offer. In these cases there is a small wait list, resulting in assessment being completed outside of agreed threshold.

Percentage of children who received a 12-month review by the time they turned 15 months - There has been an increase in this indicator of 5.6% on last month. These contacts are optional for parents and catch up developmental clinics have been completed where parents have rebooked the review, now they are more comfortable to do so.

Percentage of children who received a 2-2.5-year review by 2.5 years - All universal partnership (UP) and universal partnership plus (UPP) are seen face to face in the home setting for a full family health needs assessment. The service will be returning the 2-year ASQ (Ages & Stages Questionnaire) to face to face activity with an additional intervention called the Early Language Identification Measure (ELIM).

Community Beds open and no of occupied bed days - The occupied bed days reduction result from the need to reduce occupancy in Jubilee Ward, in readiness for the planned move to Preston Ward. This forms part of the planned refurbishment programme.

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NHS Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

	Reporting Level	Threshold	2020/21 Outturn	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	2021/22 YTD	R A G	Exception Report?	Benchmarking Report
Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place of work	N - R / L - T	61%	▮																
Staff Friends and Family Test - Percentage of staff who would recommend the Trust as a place to receive treatment	N - R / L - T	67%	▮																
Mandatory Training	L - I	90%	85.8%	87.5%	88.7%	88.3%	89%	85.3%								87.7%	A		
% of Staff with completed Personal Development Reviews (Appraisal)	L - I	90%	70.4%	71.2%	72.4%	73.0%	72.5%	70.1%								71.82%	R		
Sickness absence average % rolling rate - 12 months	L - I	<4%	4.80%	4.3%	3.9%	3.8%	3.9%.	4.1%								4%	G		
Sickness absence % monthly rate	L - T	<4%	New	3.5%	4.4	4.3%	3.9%	4.07%								4.03%	A		

Additional information

Mandatory training, appraisal and absence

- The work that services/teams have been undertaking to re-instate training compliance levels has shown good improvement over recent months although the Trust's overall training compliance figure has shown a slight dip this month, this was anticipated due to annual leave and the position will be closely monitored. Positively ,overall training compliance figure **minus staff bank** has increased to 93.3%, which is above the Trust overall compliance target. Progress with improving the appraisal rate continues to focus on reminding managers to complete and record the process with work being undertaken with staff side to assist progress and suggest any new initiatives .
- Sickness absence has risen by .02% and .08% on the previous month , to be above the 4% target set for both the rolling and snapshot sickness rates.

Resuscitation and Restrictive Physical Intervention training

- The focus on Physical Intervention training shows fluctuation in the improvement levels this month, There is some plateauing of numbers due to holidays and absence and therefore the focus going forward will continue to be both on the specific wards with lower compliance and in ensuring that the improvements are maintained and recovered.
- Progress on this workstream reports monthly to QAG. The Trust target is 90% compliance and the % figures to target are shown in the table opposite .

June 21	PBM Theory			PBM Full			PMVA Breakaway			PMVA Full		
	June	July	Aug	June	July	Aug	June	July	Aug	June	July	Aug
Wotton Lawn Hospital							83%	81%	82%	77%	80%	75%
Charlton Lane Hospital	89%	90%	89%	92%	91%	84%						
Berkley House	71%	71%	67%	88%	86%	86%						

Health and Wellbeing Hub

Funding of £600K has been provided by NHSE/I to create a system-wide Mental Health and Wellbeing Hub in order to provide support to all health and social care colleagues who work within Gloucestershire ICS organisations, recruitment has commenced and we have sent out , and received feedback on the first designs for "Brand" and Webpage. We are working closely with the Operational recovery and performance lead to ensure that our H&W support and OD interventions are targeted to the areas and service in most need. It is encouraging to report that we have increased the number of members of our H&W hub to circa 20 people from across the organisation and are introducing the role of H&W champion across the Trust..

Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

CQC DOMAIN - ARE SERVICES WELL LED?

Safe Staffing Inpatient – August 2021

Ward Name	Code 1 Hours	Code 1 Exceptions	Code 2 Hours	Code 2 Exceptions	Code 3 Hours	Code 3 Exceptions	Code 4 Hours	Code 4 Exceptions	Code 5 Hours	Code 5 Exceptions
Dean	0	0	17.5	3	0	0	0	0	0	0
Abbey	175	23	32.5	3	0	0	0	0	0	0
Priory	195	26	70	8	0	0	0	0	0	0
Kingsholm	70	9	15	2	0	0	0	0	0	0
Montpellier	187.5	22	50	5	0	0	0	0	0	0
Greyfriars	220	27	0	0	0	0	0	0	0	0
Willow	15	1	105	14	0	0	0	0	0	0
Chestnut	90	12	15	2	0	0	0	0	0	0
Mulberry	30	4	7.5	1	0	0	0	0	0	0
Laurel	0	0	7.5	1	0	0	0	0	0	0
Honeybourne	0	0	0	0	0	0	0	0	0	0
Berkeley House	52.5	6	290	30	0	0	0	0	0	0
Total In Hours/Exceptions	1035	130	610	69	0	0	0	0	0	0

Definitions of Exceptions

Code 1 =	Min staff numbers met – skill mix non-compliant but met needs of patients
Code 2 =	Min staff numbers not complaint but met needs of patients e.g. low bed occupancy, patients on leave
Code 3 =	Min staff numbers met – skill mix non-compliant and did not meet needs of patients
Code 4 =	Min staff numbers not compliant did not meet needs of patients
Code 5 =	Other

There were no code 3-5 exceptions in August.

MENTAL HEALTH & LD

Ward	Average Fill Rate	Vacancy WTE HCA	Vacancy WTE RMN	Sickness
Dean Ward	117.20%	0	5.18	8.69%
Abbey Ward	103.76%	0	10.48	6.00%
Priory Ward	113.39%	0	11.18	13.64%
Kingsholm Ward	102.53%	.89	3.18	3.38%
Montpellier	93.63%	1.18	3.08	6.62%
PICU Greyfriars Ward	132.80%	0.58	4.08	5.67%
Willow Ward	106.16%	2.51	1.5	5.67%
Chestnut Ward	102.87%	4.16	.62	2.26%
Mulberry Ward	113.98%	0	5.62	7.05%
Laurel House	99.73%	1.08	0.42	1.60%
Honeybourne Unit	100.27%	0.61	2.3	6.37%
Berkeley House	96.95%	8.82	.92	7.48%
Totals (Aug 2021)	**106.94%**	19.83	48.56	**6.20%**
Previous Month Totals	109.31%	26.32	49.47	9.32%

PHYSICAL HEALTH

Ward	Average Fill Rate	Vacancy WTE HCA	Vacancy WTE RGN	Sickness
Coln (Cirencester)	118.54%	0	4.23	2.92%
Windrush (Cirencester)	118.55%	0	3.54	6.18%
The Dilke	108.11%	.44	4.17	3.78%
Lydney	98.59%	0	4.17	7.76%
North Cotswolds	113.86%	0	.63	11.91%
Cashes Green (Stroud)	117.02%	5.6	1.93	8.13%
Jubilee (Stroud)	88.15%	2.68	.24	7.41%
Abbey View (Tewkesbury)	87.55%	2.2	.75	7.55%
Peak View (Vale)	115.10%	.37	2.47	4.47%
Totals (Aug 2021)	**107.27%**	11.29	22.13	**6.68%**
Previous Month Totals	110.01%	8.89	19.66	7.54%

Staffing Data – Absence/Vacancy Data Quality Notice

Shift fill rates remain high to support safer staffing numbers across a number of wards. A dedicated inpatient recruitment programme is being developed with support of the Matrons and Deputy Service Managers. The quality team are collaborating with colleagues to improve data access to team managers, matrons etc. This will enable teams and services to have the appropriate data to support local recovery plans.

Recruitment Mental Health, Learning Disability Inpatients & Physical Health

International Recruitment: 3 x RMNs have been appointed for Wotton Lawn and 1 has now arrived in the UK. RMN recruitment remains at a slow pace but we are continuing to actively interview. 30 RGN's have been appointed, of these, 19 have arrived in the UK and It is anticipated that the remaining staff will be here by March 2022, there are 7 planned arrivals for the remainder of 2021.

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REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Paul Ryder - Patient Safety Manager, Nicola Mills - Clinical Incident and Learning Manager

SUBJECT: **QUARTER 1 2021/22 PATIENT SAFETY REPORT (INCLUDING SIRIS)**

If this report cannot be discussed at a public Board meeting, please explain why.	Yes

This report is provided for:			
Decision ☐	Endorsement ☐	Assurance ☑	Information ☐

The purpose of this report is to:

This report provides the Board with high level information with regardto patient safety incidents reported through the Trust's Datix Incident Reporting System. Analysis and comment is provided where appropriate.

Recommendations and decisions required

The Board is asked to:

1. **Receive, review** and **note** information relating to quarterly patient safety incident reporting.

Executive summary

This report provides:

• A summary of mental health and physical health Patient Safety Incidents reported during Quarter 1 (1st April to 30 June 2021).
• A summary of the prevalence of patient safety incidents by categories including level of investigation.

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- Provision of data for Mental Health and Learning Disability Hospitals, physical health Community Hospitals, plus MIIUs and community teams for mental health and physical health by quarter, demonstrating change.
- Each quarter, the Patient Safety Team (PST) will examine in further detail a different category reporting a significant number of incidents. Q1 2021/22 provides an update of the PUQ's Project focusing on timely triage of pressure damage in community ICTs.
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q1 to Gloucestershire Clinical Commissioning Group (GCCG).
- Progression of the developing governance arrangements for the management of mental and physical health patient safety incidents.

Risks associated with meeting the Trust's values

Effective systems must be in place to manage all patient safety incidents and reduce risk.

Corporate considerations	
Quality Implications	Increased numbers of reported incidents is seen to indicate and open and transparent reporting culture.
Resource Implications	Quarterly reporting and analysis is resource and labour intensive.
Equality Implications	None.

Where has this issue been discussed before?
Quality Assurance Group – August 2021 Quality committee – Sept 2021

Appendices:	PowerPoint presentation (slide deck) Q1 2021/22 PSR

Report authorised by: Amjad Uppal	Title: Medical Director

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Gloucestershire Health and Care
NHS Foundation Trust

AGENDA ITEM: 08.1/0921
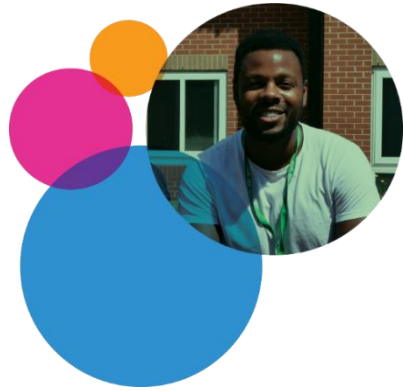
Q1 Patient Safety Report 2021/22

Paul Ryder, Patient Safety Manager
Nickki Mills, Clinical Incidents Manager

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Q1 PSR 2021/22

This report provides the Board with:

- A summary of mental health and physical health Patient Safety Incidents reported during Quarter 1 2021/22 (1 April to 30 June 2021).
- A summary of the prevalence of patient safety incidents by categories including levels of investigation where relevant.
- Provision of data for Mental Health and Learning Disability Hospitals, physical health Community Hospitals, plus MIIUs and community teams for mental health and physical health by quarter, demonstrating change.
- Each quarter, the PST will examine in further detail a different category reporting a significant number of incidents. Q4 2020/21 looked at pressure damage in community ICTs and the developing "PUQs Project". Q1 2021/22 provides a helpful update to this project following a PDSA Cycle 4 evaluation.
- An overview of Serious Incidents Requiring Investigation (SIRIs) and Never Events declared in Q1 to Gloucestershire Clinical Commissioning Group (GCCG).
- Progression of the developing governance arrangements for the management of mental health and physical health patient safety incidents.

Summary of all Patient Safety Incidents reported in the last rolling 4-quarter period

	Q2 (%)	Q3 (%)	Q4 (%)	Q1 (%)
No Harm	2148 (65.5)	2104 (62.7)	2072 (63.0)	1967 (60.71)
Low Harm	963(29.4)	1018 (30.3)	990 (30.1)	1016 (31.36)
Moderate Harm	130 (4.0)	198 (5.9)	188 (5.7)	218 (6.73)
Severe Harm	23 (0.7)	27 (0.8)	30 (0.9)	23 (0.71)
Death	15 (0.5)	8 (0.24)	8 (0.24)	16 (0.49)
Total	3279	3355	3288	3240

Number of No and Low Harm Incidents Reviewed in the last rolling 4-quarter period

	Q2	Q3	Q4	Q1
No Harm	2148	2104	2072	1967
Low Harm	963	1018	990	1016
Total	3111	3122	3062	2983
Reviewed (%)	184 (**5.9%**)	299 (**9.6%**)	374 (**12.2%**)	411 (**13.8%**)

The Patient Safety Team aim to review 10% of the No and Low Harm Patient Safety Incidents. This has not always been achieved due to redeployment of some of the team due to Covid-19, the recovery plan of SIRIs and competing workstreams, such as completing SIRI investigations. Significant progress has been achieved during Q3 and Q4 2020/21 and this is carried successfully into Q1 2021/22.

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Q1 PSR 2021/22

No harm and low harm incidents

Of the 1967 no harm incidents, and the 1016 low harm incidents, the Patient Safety Team aimed to review a blind sample of 10% (PST intended to review more than 298 incidents in Q1). This target was set during the reconfiguration of the Patient Safety Team following merger in October 2019 and due to the impact of Covid work the team have not previously met this target.

In Q1 a total of 411 low and no harm incidents were reviewed (13.8%). The Patient Safety Team have met this ambitious target for the last 2 quarters running

Q1 PSR 2020/21

Never Events, Serious Incidents and other reportable incidents

	Q2	Q3	Q4	Q1	Rolling Total
Never Events	0	0	0	0	0
Failure to publish Declaration of Compliance or Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	0	0	0	0	0
Publishing a Declaration of Non Compliance pursuant to Clause 4.26 (Same Sex accommodation)	0	0	0	0	0
Serious Incidents	14	6	8	8	36

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Q1 'Sub Serious Incident' Incidents (moderate and above harm)

During Q1 the Patient Safety Team convened 25 72-hour Initial Investigation meetings (including incidents that have gone on to be declared as a SIRI which are featured on slides 18 and 19).

6 mental health incidents and 2 physical health incidents met the criteria for a Serious Incident Requiring Investigation (SIRI).

One physical health incident (palliative patient with a diagnosis of Metastatic Osteosarcoma) under the care of the District Nurses for palliative support and symptom control. The patient's pain was not managed well at home which resulted in a transfer to the acute trust (the patient did not want this) but needed to due to the lack of clarity on the drug chart. This situation was felt to be avoidable and has been managed as a Clinical Incident needing additional comprehensive investigation which will conclude in due course.

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Q1 'Sub Serious Incident' Incidents (moderate and above harm)

One mental health incident where the patient was referred to the First Point of Contact Centre (FPCC) and then to Gloucestershire Recovery in Psychosis (GRiP), but sadly died on the day of their initial assessment by suspected suicide. This has been managed as a Clinical Incident needing additional comprehensive investigation and will conclude in due course.

Local learning from these incidents, including evidence of good practice, will be shared via Incidents on a Page following the internal reviews.

Detailed analysis of high frequency incidents

Service provision has seen further disruption due to another national lockdown as a result of the Covid-19 pandemic, however Q1 continues to demonstrate more established incident reporting trends. The data an "Top 10" categories have been refreshed for Q1 an is presented in the following slides.

The high frequency incidents within Mental Health inpatient continue to focus on deliberate self-harm, prevention and management of violence and aggression, and incidents relating to the violent conduct of distressed patients during the acute phase of their illness.

Physical Health hospitals, and older persons wards including Charlton Lane Hospital, report higher rates of falls and some skin integrity incidents.

Similar divergence is also seen with the Community Teams: mental health community team incidents are more evenly spread across their Top 10 categories, whereas physical health community teams report large numbers of skin integrity incidents (54.2%).

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High Level Analysis of Mental Health Inpatient Incidents - By Rolling Financial Quarter

Top 10 Categories Reported	Deliberate Self-Harm				Physical Intervention & RT				Falls				AWOL				Violence & Aggression				Medication				Clinical Care				MERT				Accidents and Injuries				Suicide Attempts			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Wotton Lawn Hospital (excluding PICU)	391	311	426	154	240	269	204	114	16	24	18	10	50	57	72	77	55	23	38	39	13	10	20	21	4	4	5	5	42	10	4	4	2	4	2	6	11	16	7	5
Berkeley House	278	280	251	290	169	125	83	76	7	6	1	1	0	0	0	0	0	0	0	3	2	2	2	2	1	0	3	1	1	2	1	0	7	14	6	8	0	0	0	0
Wotton Lawn - Greyfriars PICU	4	16	28	9	110	83	50	98	1	1	1	3	7	10	18	1	34	6	5	6	0	6	5	0	0	6	1	1	1	8	2	2	0	3	0	1	0	0	9	1
Charlton Lane Hospital (functional)	4	5	0	7	17	10	20	28	31	30	26	55	0	2	0	0	1	0	1	1	13	12	11	8	55	8	4	6	2	4	3	7	8	6	6	3	1	2	0	1
Charlton Lane Hospital (organic)	1	0	3	1	22	29	17	18	62	122	51	32	1	0	1	0	16	7	7	5	0	1	3	3	2	0	0	0	4	5	3	0	4	1	1	1	0	0	0	0
Laurel House & Honeybourne	0	0	0	0	0	0	0	0	0	2	1	4	2	3	4	3	3	0	3	1	4	2	2	13	0	0	0	1	0	0	1	1	1	1	0	3	0	0	1	0
Montpellier Low Secure Unit	1	0	0	0	0	0	0	4	0	0	1	2	4	0	1	1	0	0	1	1	0	1	1	1	1	0	0	0	1	0	1	0	2	1	0	0	0	0	0	0
Total	679	612	708	461	558	516	374	338	117	185	99	107	64	72	96	82	109	36	55	56	32	34	44	48	63	18	13	14	51	29	15	14	24	30	15	22	12	18	17	7

The increase in reported falls for functional CLH wards relates to them taking more patients with organic illnesses when the organic (dementia) wards remain at capacity. Deliberate self-harm is much reduced at Wotton Lawn as several higher frequency self-harmers have been discharged home. Laurel House and Honeybourne Units have seen an increase in medication incidents, but the Patient Safety Manager has not been able to discuss the detail of these incidents with the Units' Matron.

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High Level Analysis of Community Hospital Incidents – by Rolling Financial Quarter

Top 10 Categories Reported	Falls				Skin Integrity				Admissions, Discharges & Transfers				Medication				Clinical Care				Infection Control				Accidents & Injuries				Communication & Handover				Appointments, follow up & referrals				Equipment & Medical Devices			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Cirencester Hospital	11	26	25	17	35	25	26	39	5	4	0	7	5	4	2	1	3	2	6	3	3	24	7	3	4	4	0	2	3	6	0	4	1	3	0	4	0	0	0	3
Dilke Hospital	34	31	31	27	13	9	9	12	3	2	0	9	5	2	4	2	3	2	0	0	3	3	1	1	6	5	2	3	0	1	0	4	0	0	0	3	0	0	0	0
Lydney Hospital	15	18	26	16	16	10	18	16	0	1	3	4	7	1	5	3	1	3	4	4	0	12	0	0	1	2	0	0	2	0	0	3	0	0	0	1	1	2	0	1
North Cots Hospital	10	19	17	23	4	10	13	7	0	1	1	2	0	1	1	3	0	2	0	0	0	1	0	2	0	1	0	0	1	0	4	3	0	1	2	6	1	1	0	0
Stroud Hospital	21	52	29	28	39	38	30	39	13	14	7	6	7	4	1	1	4	7	3	1	1	4	1	3	6	4	3	5	2	0	7	5	2	1	1	3	0	1	0	3
Tewkesbury Hospital	12	20	40	15	13	21	11	13	1	1	3	3	2	2	2	1	2	1	2	3	0	3	1	1	2	0	1	0	4	0	1	3	0	0	2	0	0	1	1	0
The Vale Hospital	23	28	20	27	10	14	13	10	1	6	0	1	3	5	5	10	2	5	6	12	0	2	0	2	4	8	5	6	1	0	0	2	0	1	0	0	0	1	1	2
Total	126	194	188	153	130	127	120	136	23	29	14	32	29	19	20	21	15	22	21	23	7	49	10	12	23	24	11	16	13	7	12	24	3	6	5	17	2	6	2	9

Incident reporting is of a similar order and differences are representative of the changing inpatient population.

The prevalence of falls at Stroud hospital in Q3 is notable and is seen to drop back to a level more consistent with reporting from other hospitals in Q1.

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High Level Analysis of Community Mental Health Incidents – by Rolling Financial Quarter

Top 10 Categories Reported	Clinical Care				Deliberate Self-Harm				Admission, discharge & transfer				Information Governance				Medication				Communication & handover				Appointments, follow up & referrals				Suicide attempts				Death/ SIRI				MERT			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
AMHP	0	5	1	0	0	0	0	0	3	3	1	1	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
AOT	0	1	0	0	1	0	1	0	0	1	0	0	0	0	0	0	1	2	3	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	1	0	0	0
CYPS/CAMHS LD, T2, T3	0	5	3	0	1	0	8	0	0	0	0	1	0	1	2	6	0	0	0	0	0	0	0	2	0	5	2	1	0	0	0	0	0	0	0	0	0	0	0	0
CLDT	1	0	0	0	0	0	0	0	0	0	1	0	1	1	0	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CPI	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
CRHTT	5	5	3	2	4	4	2	11	3	2	1	12	0	0	0	0	0	2	1	0	1	1	3	2	3	1	1	0	1	1	0	2	2	0	1	1	0	0	0	2
Eating Disorders	1	1	2	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	1	0	1	3	2	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Later Life	1	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	1	0	0	0	0	1	0	0	0	0	1	1	1	1	0	0	0
MHICT	2	0	1	1	2	0	0	2	0	1	2	0	1	0	7	2	0	0	0	0	0	0	0	0	2	0	1	0	0	0	0	3	0	1	0	1	0	0	1	0
Memory Assessment	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MH Liaison	0	2	1	3	1	4	1	0	1	2	0	1	0	0	2	0	1	0	1	0	1	5	0	0	0	2	1	0	0	2	2	1	1	0	1	1	0	0	0	0
Recovery	4	1	0	0	3	0	1	3	0	2	1	1	0	0	0	0	2	2	3	7	0	2	1	1	0	1	1	0	2	1	1	0	4	1	2	2	1	2	1	3
Specialist Services	1	0	0	0	0	1	0	1	0	0	0	1	0	1	1	2	3	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	1
Total	16	21	12	6	13	9	13	17	7	12	6	18	2	4	13	11	9	8	9	8	4	11	7	7	9	9	6	1	4	4	3	6	8	4	5	8	3	2	2	6

Mental Health community teams clearly report far fewer patient safety incidents than their inpatient colleagues (n=323 for Q1). There is limited analysis available from this data with no apparent concerns.

High Level Analysis of Community Physical Health Teams Incidents (not ICT/ENDN) – by Rolling Financial Quarter

Top 10 Categories Reported	Diagnosis, Imaging & Testing				Clinical Care				Medication				Communication & handover				Information Governance				Equipment & Medical Devices				Appointments, follow up & referrals				Skin Integrity				Admissions, discharges & transfers				Accidents and Injuries			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
Complex Care at Home	0	0	0	0	2	1	2	1	2	2	2	4	0	1	0	4	0	1	2	0	0	1	1	3	0	0	0	0	4	5	13	5	0	0	2	1	0	0	0	0
Complex Leg (CLWS)	0	0	0	0	2	1	4	3	0	0	0	0	1	0	0	1	0	0	0	0	1	0	1	0	0	0	0	1	3	2	6	0	1	1	1	1	0	0	0	0
CYPS/PH Community Specialist	0	0	1	0	1	9	1	2	1	5	6	9	2	3	3	3	5	2	4	3	9	12	5	10	3	4	0	0	1	2	2	2	1	5	0	1	3	2	0	2
CYPS/PH Public Health Nursing	0	0	0	0	1	5	0	1	0	6	0	0	4	5	7	10	0	3	5	3	0	0	1	0	1	4	4	3	0	0	0	0	2	2	2	2	0	1	0	0
Dental & Sexual Health	22	14	5	16	8	11	9	4	10	8	5	2	5	5	7	4	7	10	4	7	0	1	2	2	2	0	1	2	0	0	0	0	0	0	1	0	0	0	0	0
Intravenous Therapy Team	0	0	0	1	1	3	0	0	1	0	2	0	0	0	0	0	1	0	0	0	2	0	0	1	0	0	0	1	0	0	0	0	0	1	1	1	0	0	0	0
Long Term Conditions	0	1	0	0	0	0	2	4	6	3	3	1	3	1	0	0	3	2	3	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
MiiUs	7	26	31	18	1	13	9	13	1	0	1	1	2	3	3	2	0	0	0	1	1	0	0	2	9	10	4	12	0	0	0	0	1	2	3	3	0	3	0	1
Rapid Response	2	0	0	0	1	1	5	5	2	1	1	1	0	0	0	0	1	1	0	0	2	0	0	0	0	0	2	3	3	6	4	2	0	1	0	3	0	0	0	2
Spec Therapy & Equip Services	0	0	0	0	2	2	1	0	0	0	0	0	1	0	0	0	2	1	3	0	1	3	1	5	0	0	1	1	1	0	1	1	0	0	0	1	1	3	0	2
Tissue Viability	0	0	0	0	2	0	3	1	0	0	0	0	0	0	0	2	1	0	0	0	5	1	2	2	0	0	0	0	0	4	1	0	1	4	2	4	0	0	0	0
Total	31	41	37	35	21	46	36	34	23	25	20	18	18	18	20	26	20	20	21	16	21	18	13	25	15	18	12	23	12	19	27	10	6	16	12	18	4	9	0	7

There is a notable upturn in reporting of Diagnosis, Imaging and Testing within MiiUs during Q4. All 30 incidents report no harm and describe a sub-category of Wrong Diagnosis, or Delayed Diagnosis. The Patient Safety Team has completed a deep dive report of Diagnostic Imaging at MiiUs and this required additional analysis.

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High Level Analysis of Community Physical Health Teams Incidents for ICT/ENDN – by Financial Quarter

Top 10 Categories Reported	Skin Integrity				Medication				Clinical Care				Admissions, discharges & transfers				Equipment & Medical Devices				Appointments, follow up & referrals				Communication & handover				Falls				Safeguarding concerns				Accidents and Injuries			
	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1
ENDNS – Out of Hours DN	4	6	7	9	5	5	10	12	8	9	6	2	2	0	1	2	1	0	0	0	0	0	5	2	1	1	2	0	0	1	0	1	0	1	1	0	1	0	0	0
Chelt ICT	52	81	93	93	15	11	13	21	8	9	13	6	12	8	6	15	6	6	5	10	5	4	1	7	5	11	6	14	2	9	1	5	1	0	0	0	0	0	0	0
Cotswold ICT	84	76	107	111	6	7	10	11	7	10	9	13	8	8	6	11	9	7	7	15	6	2	4	3	1	0	2	2	0	2	4	3	2	2	1	3	0	0	1	0
Forest ICT	71	79	89	83	2	3	8	3	5	8	3	5	3	2	5	2	5	10	9	12	5	8	3	4	5	9	2	14	0	1	0	0	1	1	1	0	1	2	0	1
Glos ICT	110	121	116	130	9	21	20	10	10	15	8	12	8	16	16	5	5	11	13	20	3	6	5	4	8	6	9	4	1	0	2	4	1	3	0	0	1	2	2	1
Stroud ICT	48	58	55	52	8	3	8	8	6	3	4	5	4	6	12	2	5	6	3	14	2	2	0	3	2	1	4	4	3	3	3	6	0	0	0	0	0	0	0	1
TWNS ICT	67	70	59	73	8	11	12	5	11	9	2	4	3	5	2	4	4	5	2	0	6	3	0	1	1	1	0	2	1	1	1	1	0	0	0	2	1	0	0	2
Total	436	491	526	551	53	61	81	70	55	63	45	46	40	45	48	41	35	45	39	71	27	25	18	24	23	29	25	40	7	17	11	20	5	7	3	5	4	4	3	5

Gloucester ICT report higher frequencies of incidents due to the size of the population served.

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High Level Analysis of Community Physical Health Teams Incidents for ICT/DN – by Financial Quarter

The consistently high volume of Skin Integrity incidents reported within the District Nursing Service is clear to see on the previous slide.

A separate paper has been prepared for QAG by Belle Hyslop, PST Clinical Incident Lead and Investigator, detailing the "PUQs Review Process".   A brief overview was provided for the Q4 2020/21 Patient Safety Report, and a progress update is provided for Q1 2021/22 Patient Safety Report on the following slide.

Moderate and above Pressure Ulcer (PUs) Review Process by PST

The Pressure Ulcer Question template underwent PDSA cycle 4 evaluation and has been approved by QAG as the GHC process by which Category 3+ pressure ulcers are reviewed by ICT Community nursing teams and, subsequently, by the Patient Safety Team.

1. **Headline results for PST :**
   - Impact of COVID evident in Dec 20-Jan 21 was an increased number of incidents and reduced closure rate. Likely to be due to PST handling rises in the other types of moderate and severe incidents being reported.
   - PST *doubled the amount reviewed* and closed or escalated in the 6 months to December 2020 – June 2021.
   - PST have Finally Approved *5 times more* moderate pressure ulcers than in April 2020.

2. **Headline results for Operations:**
   - *64% reduction* of pressure ulcers awaiting PUQ review since September 2020.
   - **Consisten**t monthly reduction since Feb 21 in total numbers of pressure ulcers awaiting PUQ completion.

3. **Next steps**:
   - Integration of PUQs into Datix will ensure that the Datix becomes a one stop-shop for reporting, investigation documentation and further develop link with learning and assurance work.
   - Development of a similar document to support the review of pressure ulcers in Community hospital inpatient setting.

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Developments within the Patient Safety Team

- The National Patient Safety Specialists programme continues to inform the development of our localised Patient Safety Incident Response Plan (PSIRP) to meet the guiding principles of the Patient Safety Incident Response Framework (PSIRF). This work is held within the Trust's Patient Safety Group.

- The Patient Safety Team and key medics associated with the SI process, including Medical Director, Deputy Medical Directors and other doctors who chair SI review meetings, will attend 2 days' Root Cause Analysis training in September 2021 with an external accredited provider.

- Assurance processes following the development of recommendations and/ or actions resulting from Serious Incidents have re-started in the form of monthly follow up meetings with the Community Service Managers and Hospital Matrons. Commissioners actively support this process and have been invited to attend the meetings.

- Dave Anderson (previously Physiotherapy Manager at Charlton Lane hospital) was successful at interview and was appointed as a Clinical Incident Lead & Investigator. He took up his new post on 12 July 2021 and is undergoing local induction and initial training.

- Patient Safety Team is being notified of **all** mental health and physical health patient safety incidents categorised as moderate and above. This has gathered pace in recent months and the 10% target was exceeded in both Q4 2020/21 and Q1 2021/22.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Zoë Lewis, Mortality Review Officer
Gordon Benson, Quality Lead (Mortality, Engagement & Development)

SUBJECT: **LEARNING FROM DEATHS 2021/22 QUARTER 1**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐ Endorsement ☐ Assurance ☑ Information ☐

The purpose of this report is to:

The purpose of this report is to Inform the Trust Board of the mortality review process and outcomes during Quarter 1 2021/22.

It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board *National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*, published March 2017.

Recommendations and decisions required

The Board is asked to:
- **Note** the contents of this Learning from Deaths report.
- **Note** the KPIs and feedback from Medical Examiner input.
- **Consider** additional data/information which would enhance the content and format of the report.

Executive summary

- This report summarises Quarter 1 2021/22 activity regarding Learning from Deaths.

- During Quarter 1 2021/22 there were 129 patients who died whilst receiving care from Gloucestershire Health and Care NHS Foundation Trust (GHC) whilst either a physical health inpatient or in the care of our mental health or learning disabilities services. At the time of writing none of these deaths are judged likely to have been due to problems in the care provided by the Trust.

- In addition, during Quarter 1 2021/22,13 care record reviews and 3 comprehensive investigations were completed relating to deaths occurring prior to the reporting period. One of the comprehensive investigations, representing 6.25% of the patient deaths before the reporting period, is judged to be more likely than not to have been due to problems in the care provided to the patient. Learning from this incident was previously reported to QAG in May 2021 as part of the Clinical Incidents & Alerts presentation.

- The report contains, for the first time, KPIs and feedback from the Medical Examiner input which was rolled out in community hospitals from May 2021. This provides independent assurance relating to the quality of End-of-Life care and invaluable feedback from families.

- The format of this report is currently under review, and this is the first iteration as a slide deck. Required mandated information is contained within but the authors are conscious that there is still a high narrative content. The learning elements in subsequent reports will all be summarised via the 'Learning on a Page' document, which will enhance the format and reduce narrative. The Group are asked to identify additional data, graphs, or information which they feel will improve both the quality and accessibility of this report.

Risks associated with meeting the Trust's values

There are no identified risks associated with learning from deaths associated with the Trust's values.

Corporate considerations	
Quality Implications	Required by National Guidance to support system learning
Resource Implications	Significant time commitment from clinical and administrative staff
Equality Implications	None

Where has this issue been discussed before?
Mortality Review Groups Quality Assurance Group 20th August 2021 Quality Committee 2nd Sept 2021

Appendices:	None

Report authorised by: Dr Amjad Uppal	Title: Medical Director

Purpose

The purpose of this report is to Inform the Quality Committee of the mortality review process and outcomes during Quarter 1 2021/22.

It is a regulatory requirement for all NHS Trusts to identify, report, investigate and learn from deaths of patients in their care, as set out in the National Quality Board National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care, published March 2017.

The Committee is asked to note the contents of this report.

Scope

The following categories of patient are considered in scope for a mortality review process (including application of the serious incident process where appropriate);

- All inpatient deaths in community hospitals;

- All inpatient deaths mental health inpatient units or who had been discharged from in-patient care within the last month;

- All deaths of those with learning disabilities under our care;

- All patients with a diagnosis of psychosis or eating disorders during their last episode of care, who were under the care of services at the time of their death, or who had been discharged within the 6 months prior to their death;

- All patients who were under a Crisis Resolution and Home Treatment Team (or equivalent) at the time of death;

- All perinatal/maternal deaths (perinatal mental health service for us);

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Scope (cont.)

- All deaths of patients where a complaint or significant concern about the quality of care provision has been raised (within 12 months of the date of death);

- All deaths of patients receiving care from a service where an 'alarm' has been raised with the Trust through whatever means (for example via an elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator). This will include situations where another organisation has reviewed a death and suggests that our Trust reviews its care processes;

- Deaths where learning will inform the provider's existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically.

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Overview

- During Q1 2021/22, 129 Gloucestershire Health and Care NHS Foundation Trust (GHC) patients died. This comprised the following number of deaths, which occurred in each month of that reporting period:
  37 in April;
  59 in May;
  33 in June.

- By 21 July 2021, 14 case record reviews and 1 comprehensive investigation had been completed in relation to the 129 deaths included above. The number of deaths in each month for which a case record review or an investigation was carried out was:
  8 in April;
  7 in May;
  0 in June.
  .

- 0, representing 0.0% of the patient deaths during the reporting period, are judged more likely than not to have been due to problems in the care provided to the patient.

- The numbers above do not include open comprehensive investigations and care record reviews.

Overview (cont.)

- Additionally, during Q1 2021/22,13 care record reviews and 3 comprehensive investigations were completed relating to deaths occurring prior to the reporting period.

- 1, representing 6.25% of the patient deaths included above, are judged more likely than not to have been due to problems in the care provided to the patient.

- For learning relating to comprehensive investigations, including the above incident, please refer to the Clinical Incidents & Alerts reports.

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Learning Disability

- The University of Bristol's contract with NHS England to provide the Learning Disabilities Mortality Review (LeDeR) came to an end in May this year. NHS England has subsequently published a new policy which sets out the core aims and values of the LeDeR programme and the expectations placed on different parts of the health and social care system in delivering the programme from June 2021. The new policy can be found here.

- From June 21, the Integrated Care System will take over responsibility for making sure LeDeR reviews are completed and LeDeR reviewers will need to have a NHS employment contract.

- From this winter, LeDeR reviews will also include people with just an autism diagnosis. The name will change to *Learning From Lives And Deaths – People With A Learning Disability*, however the Acronym will remain as LeDeR.

- Cheryl Hampson remains as our Gloucestershire's Local Area Contact, Cheryl.hampson@gloucestershire.gov.uk

- A new website has been launched which includes a new webportal for reporting deaths, which can be found at https://leder.nhs.uk/

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Learning Disability (cont.)

- Prior to the recent changes, LeDeR in Gloucestershire had caught-up with the back-log of cases to review, however, due to recent changes, LeDeR report that there is currently a 3 month lag.

- In light of this, and to provide assurance, LD MRG have decided to carry on for the time being with the current process of GHC LD operational teams completing care record review paperwork for discussion by LD MRG. LD MRG will review this decision if / when LeDeR catch-up in order to avoid duplication of work.

- LeDeR has recently published its 2020 annual report, which includes 10 recommendations to NHS England / NHS Improvement, NHS Race and Health Observatory, Department of Health and Social Care, NICE, Local Authorities, ICSs and Primary Care Networks. The report can be found at: https://leder.nhs.uk/images/annual_reports/LeDeR-bristol-annual-report-2020.pdf

- LeDeR has made no direct recommendations to GHC.

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Medical Examiner Input

The role of the Medical Examiner (ME) is set out in the Coroner & Justice Act (2009) following recommendations from the Shipman Inquiry (2004) and subsequently the Francis report (2013). The ME has a duty to review deceased patient records and speak to their relatives to ensure that the wording used on the medical certificate of cause of death (MCCD) accurately describes the circumstances leading to the death and is acceptable for release to the Registration Service. This includes:

- Support and challenge the certifying doctors to ensure the best quality and most accurate MCCD and associated mortality data.
- Provide proportionate scrutiny of all non-coronial deaths.
- Enabling the bereaved to raise any concerns through the ME system in a safe and transparent way.
- Supporting the appropriate direction of deaths to the coroner allowing the ME to act as a specialist resource.

Medical Examiner input within community hospitals commenced from 17 May 2021; this section aims to provide an overview of activity against identified Key Performance Indicators (KPIs) key activity and learning from the first 4 weeks of implementing the service. Subsequent reports will report on full quarter's data.

Medical Examiner KPIs

1. **Percentage of deaths generating MCCD resolved with the input of the ME service**.

    a. GHC inpatient deaths which do not go through this pathway should be subject to Datix.

    b. These will be identified monthly at the point of the Mortality Review meetings.

    Outcome = 100%

    - *4 at the Dilke, 29/5, 1/6 and 13/5 (x2)*
    - *2 at Tewkesbury, 20/5, 6/6*
    - *1 at Lydney 23/5*
    - *2 at Cirencester 23/5 and 14/6*
    - *1 at Stroud 20/5*
    - *3 at North Cotswolds 23/5, 29/5 and 14/6*

2. **Number of times a MCCD is rejected by Registrar and reason this occurs.**

    Outcome = 0

    However, ME service records show that the ME in one case suggested a revised wording which would have 'bounced' at the Registration Office as Renal Failure was unqualified in part 1 of the MCCD.

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Medical Examiner KPIs (cont.)

3. **Percentage of potential Coroner referrals resolved with the input of the ME service.**

   a. These will be identified monthly at the point of the Mortality Review meetings.

   Outcome - **Only** *1 patient death was reported to the ME service that required Coroner involvement*. *The ME suggested a 100A for sacral sore. We are still defining numerators and denominators for the metric.*

4. **Complaints made by bereaved relatives due to perceived delays to completion and release of MCCD (end to end timescales examined)**
   - the discussion with the ME or their officer has added further distress.
   - information was not clear or helpful, lacking in compassion, professionalism etc.
   - the cause of death did not match their understanding of what their relative died from.

   Outcome = 0
   For each reported death, the ME service turned around the process within 24 hours and no concerns were raised by families.

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Feedback & Learning from ME Input

Specific feedback from families to the ME service is provided below by hospital ward and site.

- **Dilke**
  Case 1 - Feedback from Niece: "*Care at the Dilke was brilliant with him*".
  Case 2 - Feedback from Son: "*The staff were marvellous – like home from home*".

- **Lydney**
  Feedback from daughter:" Brilliant *care given – could not fault anyone*".

- **Coln Ward, Cirencester**
  Feedback from son: "*Staff kept mum comfortable, and she had said everyone was nice to her*".

- **Cashes Green, Stroud**
  Feedback from daughter: "*wonderful care*"

- **North Cotswolds Hospital**
  Feedback from sister: "*Lovely care - all staff did very well and were so polite and caring*".

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Gloucestershire Health and Care
NHS Foundation Trust

REPORT TO: TRUST BOARD PUBLIC SESSION – 30 September 2021

PRESENTED BY: Sandra Betney, Director of Finance & Deputy Chief Exec.

AUTHOR: Chris Woon, Deputy Director of Business Intelligence

SUBJECT: COMBINED PERFORMANCE DASHBOARD AUGUST 2021 (MONTH 5)

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☒   Endorsement ☐   **Assurance** ☒   Information ☐

The purpose of this report is to

This performance dashboard report provides a high-level view of key performance indicators (KPIs) in exception across the organisation.

Performance covers the period to the end of August (Month 5 of 2021/22). It is of note that the performance period remains aligned to our operational priority to recover services from the pandemic (within Regroup Reconnect Recover) and support forthcoming operational planning and transformation developments. RRR briefings are provided to the Business Intelligence Management Group (BIMG). There is now a new section within the performance dashboard (from page 2-11) providing highlights on operational recovery.

Where performance is not achieving the desired threshold, operational service leads are prioritising appropriately to address issues. Where appropriate, Service led Performance Exception Action Plans (PEAP) will be presented to BIMG and will more widely account for performance indicators in exception. Example of this include CAMHS (June & Sept), Eating Disorders (June), CYPS Community (July) and Wheelchair Services (August).

In addition, a separate paper has been provided outlining the high-level learning from the recent Measuring What Matters Board Seminar on 16th June 2021. A timetable monitoring
progress will be integrated into the Performance Dashboard for future months.

Recommendations and decisions required
The Board are asked to:

- **Note** the aligned Performance Dashboard Report for August 2021/22.
- **Acknowledge** the ongoing impact of the pandemic and service recovery on operational performance.
- **Note** the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service action plans are being developed to address areas requiring improvement
- **Advise** if the layout of the new look report (incorporating operational recovery is helpful and whether further amendments to detail can be made)

Executive summary

Recovery Update
Operational recovery continues, with many services settling back to business as usual. All services are being tracked and coded as red, amber or green. This month there are 15 services in red recovery support indicating they are at present, unlikely to return to pre-pandemic state within 12 months (using a comparator of November 2019 as the pre-pandemic metric). These teams, many of which are undergoing service transformation and business case construction, continue to receive support both in addressing demand through recovery plans, Service Development and Improvement Plans (SDIP) and Performance Exception Action Plans (PEAP). We continue to support staff in their own health and wellbeing recovery post-pandemic. There are 27 services identified as amber RAG status, indicating a predicted recovery within 12 months. These teams remain under review to explore change and progression.

From this month we have implemented a recovery performance oversight process which incorporates business intelligence, workforce data, quality surveillance intelligence, service narrative and governance and risk information. Key information this month: District Nursing is included as red – due to sustained increase in referral activity (+10% pre-pandemic) and workforce challenges, the Memory Assessment Service is expected to move to amber status due to assured performance recovery plans and reduced numbers waiting (20% less than pre-pandemic). CYPS SaLT is already red for recovery due to workforce challenges and demand, has completed a PEAP and exception briefing to detail its position against reduced 8week KPI compliance for the past 2 months (58.9% this month from 71.3% in July and 96.5% in June).

Performance Update
As shown within the spark charts, it is of note that all the indicators within this report have been in exception within the last 12 months.

Mental Health & Learning Disability Service (National & Local) Performance
The Board's attention is requested to review the 6 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Eating Disorder (ED) Services account for three indicators and CPA two. The ED service continues to face major performance challenges due to a high number of referrals and high vacancy rate which is further outlined within the

narrative. NHSE/I have proposed the replacement of CPA which is being considered within the Nursing, Quality & Therapies directorate.

Physical Community Health Service (National & Local) Performance
In addition, attention is drawn to a further 14 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Within these, eight are within CYPS, two Musculoskeletal and two are within Wheelchair Services. As planned, there will be a review of our Statistical Process Control baseline methodology for Q3 across indicators.

Trust Wide Service Performance
There are currently 4 Workforce indicators in exception this month. Sickness absence is no longer compliant in August like it was in the last three periods.

There is a phased plan to deploy further workforce performance metrics within the performance dashboard over the next year. This is expected to begin next month with headline performance indicators for Vacancy (Sept), Annual Leave (Oct) and Turnover/ Stability (Nov). More granular analysis will be provided as automated data sources are developed. Additional monitoring items will inform this and be discussed within the new People Committee.

Non-exception reporting
It is further noted that there are additional indicators outside of threshold but are either within normal, expected variation, have a legacy 'proxy' threshold, are formally suspended or have a confirmed data quality issue that is administrative only and resolution is assured. These have not been highlighted for exception but are available for operational monitoring within the online Tableau storyboard.

It has been agreed by Board (July) that 8 proxy indicators will be re-introduced into the performance dashboard from October as *internal* KPIs using Statistical Process Control (SPC) limits as thresholds. These thresholds are just being finalised.

Risks associated with meeting the Trust's values
> Where appropriate and in response to significant, ongoing and wide-reaching performance issues; an operational Performance Exception Action Plan (PEAP) which outlines any quality impact, risk(s) and mitigation(s) will be monitored through BIMG.

Corporate considerations	
Quality Implications	The information provided in this report can be an indicator into the quality of care patients and service users receive. Where services are not meeting performance thresholds this may also indicate an impact on the quality of the service/ care provided.
Resource Implications	The Business Intelligence Service provides the support to operational services to ensure the robust review of

	performance data and co-ordination of the combined performance dashboard and its narrative.
Equality Implications	Equality information is monitored within BI reporting.

Where has this issue been discussed before? BIMG 16/09/2021

Appendices:	None

Report authorised by: Sandra Betney	**Title:** Director of Finance / Deputy CEO

Gloucestershire Health and Care NHS Foundation Trust – **TRUST BOARD PUBLIC SESSION – 30 Sept 2021**
AGENDA ITEM: 10 – PERFORMANCE DASHBOARD M5 – COVER REPORT   Page 4
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Performance Dashboard Report & BI Update

Aligned for the period to the end August 2021 (month 5)

This performance dashboard provides a high level view of Key Performance Indicators (KPIs) in exception across the organisation for the period. Indicators within this report are underperforming against their threshold or are showing special cause variation (as defined by Statistical Process Control SPC rules) and therefore warrant escalation and wider oversight. To note, confirmed data quality or administrative issues that are being imminently resolved will inform any escalation decision unless there has been consecutive, unresolved issues across periods. A full list of all indicators (in exception or otherwise) are available within the dynamic, online server version of this Tableau report.

Where performance is not compliant, operational service leads are prioritising appropriately to address issues. Additionally, and where appropriate, and in response to significant, ongoing and wide-reaching performance issues; an operational Performance Exception Action Plan (PEAP) which outlines appropriate risk, mitigation and actions will be monitored through BIMG. For example, specific updates have been provided by operational services in across Q1 and Q2 2021 for areas with consistent performance challenges; Children and Young People's Services (CYPS including CAMHS), Eating Disorder Services and Wheelchair Services.

Business Intelligence Summary Update
Although high demands continue, Business Intelligence services continue to prioritise key infrastructure development tasks and has ensured the continuity of business critical items during the period. Some development projects outside of BI's control - such as the server migration project, school aged immunisation project and maintenance of the SystmOne data warehouse - are delaying some planned objectives.

The following high profile tasks continue to be the focus;
- Server migration to allow for reconfiguration and resolve licensing concerns - complications have delayed closure but expected by Q3
- Service level recovery and operational planning is being supported and prioritised through robust business partnering
- The project *'SystemOne Simplicity; Improving accuracy, consistency and quality assurance' is* established to improve Community Health (PH) reporting within our clinical systems and new BI environment. This predominantly focuses on clinical system data capture, governance adjustments and data warehouse remapping. A timeline of key milestone objectives is expected from the Project Management Office.
- Further Board Performance Workforce Performance Indicators are in development. Operational ESR workforce reporting is being deployed but further data source items need to be incorporated offering further service level granulation. The first development phase will include;
     - Monthly Vacancy Rate (expected Sept)
     - Monthly (Cumulative) Annual Leave Consumption (expected Oct)
     - Turnover and Stability (expected Nov)
- Progress has been made with the KPI review having completed National indicators and 60% of local indicators. Conclusion is expected in October 2021.

The following tasks continue to be 'in the development pipeline' in line with the service's 2021/22 Business Plan;
- Dashboard visualisation capability further developed to include; SPC, automated benchmarking observation, PEAP alerts and data quality alerts (Extended to 2022/23).
- BI Infrastructure Development; further development of the data warehousing infrastructure and technical solutions to ensure robst and reliable BI (2021/22 Q2)
- Core Reporting Delivery; To further develop our established BI reporting and ensure efficient use of information to inform decision making (2021/22 Q3)
- Maintain Data Warehouse; Further develop and maintain efficient data warehouse that maximised data quality and raised analytical productivity and efficiency (2021/22 Q4)
- Delivering System Data Flows; Introduce new data sources into data warehouse such as Allocate and Care to Learn and futher develop existing flows in line with Trust Strategy (2021/22 Q4)
- Legacy Reporting Migration; To conclude legacy reporting requirements (2021/22 Q4)
- Progressive Insight Delivery; To develop next level BI reporting needs and integrate information for cohesive insight (2021/22 Q4)

Operational Recovery Update

Data sources: Recovery services report, performance exceptions and governance data relates to August 2021 (Month 5)

Service RAG summary + all RED rated services

Operational Service Recovery RAG Rating Key		Aug Status	July status
Service recovery plan in place to support recovery to pre-Covid levels. Identified as low risk		57	48
Service recovery plan in place to support recovery to pre-Covid levels within 12 months. Moderate level of risk Identified which may involve workforce, estates or service design challenges		15	27

Service area	Specialism	Service	RIO/ S1	Current RAG
Long Term Conditions	PH	Respiratory - Home Oxygen Service	S1	
Long Term Conditions	PH	Respiratory - Core	S1	
Long Term Conditions	PH	Pulmonary Rehab	S1	
Long Term Conditions	PH	Diabetes	S1	
Long Term Conditions	PH	Heart Failure	S1	
Long Term Conditions	PH	Cardiac Rehab	S1	
Therapy & Equip	PH	Adult MSK	S1	
Adult PH	PH	District Nursing	S1	
Adult PH	PH	ICT Occupational Therapy	S1	
Adult PH	PH	ICT Physiotherapy	S1	
Adult Specialist MH	MH	Eating Disorders	RIO	
Adult Specialist MH	MH	ASC	RIO	
Adult Specialist MH	MH	ADHD	RIO	
Children & Young People	PH	SALT - core	S1	
Children & Young People	PH	Immunisation Service	RIO	
Children & Young People	MH & LD	CAMHS LEVEL 2/3	RIO	
Children & Young People	MH & LD	CAMHS LD	RIO	

Services rated AMBER rated this month

Service areas	Specialism	Service	RAG	Rationale
Long Term Conditions	PH	McMillan		Estates -clinical space
Therapy & Equip	PH	SALT - IP & community		Service review underway
NEW Therapy & Equip	PH	Adult MSKAPS		New model and workforce transition
Adult Community	PH	Lymphoedema service		Workforce Challenge
Adult Specialist MH	MH	MHICMAS		Service review
Adult Specialist MH	MH	Accommodation Team		Service review
Adult Specialist MH	MH	AOT		Workforce Challenge
Adult Specialist MH	MH	Recovery		Workforce Challenge
Adult Specialist MH	MH	OP CMHT		Workforce Challenge
NEW Adult specialist MH	MH	Later Life services		Workforce Challenge
Children & Young People	PH	OT - core		Demand & Capacity and Workforce Challenge
CYPs	PH	Children in Care		Demand & Capacity
Children & Young People	MH & LD	CAMHS VCS		Workforce Challenge
Children & Young People	MH & LD	CAMHS LD		Demand & Capacity

Adult MH & LD Directorate RAG Summary

	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21
RED	4	4	3
AMBER	5	5	6
GREEN	14	14	15

Directorate Current Recovery Red Services & Performance Exceptions

Community Mental Health Services Directorate		
Memory Assessment Service (MAS)	Recovery amber service (decreased from red this month)	Referrals have fallen this month Total waiting is 20% fewer than pre-pandemic The number waiting over 52 weeks has increased this month, trend over last quarter. Service improvement plan is well established and provides assurance and grip. This service was reduced to amber at this month's recovery and performance review and will not be reported in depth unless the RAG changes
Eating Disorders	Recovery red service	Now fully established but new staff need time to embed into their role and deliver the required clinical functions to enable recovery. The service is presently assessing only urgent referrals and is closed to non-urgent activity. An SDIP is in place and reviewed formally in August. Referrals have increased April to August and higher than previous 2 years The overall total waiting at the end of August is 17.5% higher than the same position at the end of June 21. There are early plans to recommence some day treatment services (in Nov 21) which enables both improved patient pathway and prevention of admission as well as staff enrichment in clinical function and improving patient outcomes. There is early work to divert some of the future low level referrals to VCS and other providers, but it is noted this will not remove from the existing waiting list for non-urgent assessment.
Care programme Approach (CPA)	Performance exception	Formal review necessary within 12 months. Performance for August is 86.8% (124 cases) against a threshold of 95%. A Service Recovery Action Plan now in place. Referral numbers remain above average but could be a symptom of pressure in other teams such as MH recovery teams, related to this patient acuity at referral is noted to be higher.
Autistic Spectrum Conditions (ASC)	Recovery red service	Referrals above levels of previous 3 years. Wait times increasing with 317 people now over 52 weeks (256% higher than pre-pandemic levels). Service may benefit from inclusion in CMHT programme but this is to be progressed. This service was historically been under resourced for the delivery model commissioned and the population health need. They have embraced virtual working and are completing some assessments virtually with good effect and positive patient feedback.
Attention Deficit Hyperactivity Disorder (ADHD)	Recovery red service	Referrals fallen as expected in August but remains higher than previous financial years. Total waiting list this month is 66% higher than pre-pandemic levels. Service may benefit from inclusion in CMHT programme but this is to be progressed. This service was historically been under resourced for the delivery model commissioned and the population health need. They have embraced virtual working and are completing some assessments virtually with good effect and positive patient feedback.

Directorate Decisions Agreed this Month

Service	RAG change proposed	Notes	Decision by COO
Memory Assessment Service	Move red to amber	20% reduction in referrals compared to pre-covid. Pilot project in SBV working effectively, team back from redeployment, moved to virtual model, good service grip. Recovery is established and predicted fully within 12 months	☒Approved ☐Not-approved
Dementia education	Move amber to green	Service lead identifies this is a stretched service due to commission arrangements – esp with care homes, no covid impact, not in recovery. Links to MAS improvement plans and virtual ways of working as well.	☒Approved ☐Not-approved
Later life team	First status – amber	This service had not been RAG rated previously. The team feel there is some distress esp in Tewks and Chelt teams, but SD clear this needs an independent review. Likely to be amber due to staff working from home, but WW support to bring back is in place. Caseloads require review – SD will commence. Hold at amber until further intel gathered.	☒Approved ☐Not-approved
Recovery team	Hold RAG at amber	Team lead is of the belief this is a red service but SD clear this needs an independent review. Likely to be amber due to staff working from home, but WW support to bring back is in place. Caseloads require review – SD will commence. Hold at amber until further intel gathered. SD needs to discuss with deputies and look objectively at activity and workforce data before would support step up to red. Service lead is shared with later life and has been working from home. Issues regarding leadership identified as well as discharge behaviours, SD wishes to explore before further step up.	☒Approved ☐Not-approved

Children's and Young People Directorate RAG Summary:

	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21
RED	4	4	4
AMBER	6	6	4
GREEN	17	17	19

Directorate Current Recovery Red Services & Performance Exceptions

Children's and Young Peoples Services (CYPS) Directorate		
CYPS Speech & language Therapy	Recovery red service + Performance exception	58.9% compliance to 8 week target against a threshold of 95%. There are significant workforce challenges within this service and combined with a referral peak in June 2021 the service is under pressure. Total waiting list this month = 1777. The team have adopted virtual assessments and find these are well received by children and families. They have also created advice and support functions for schools to access to advice and signpost.
Health Visiting	Performance exceptions	New Birth Visits 94.5% compliance against target of 95%. 9 – 12 month reviews, 80.6% compliance against 95% target. 12 month review, 91.6% against 95% target. 2 – 2.5 year developmental review, 84.1% compliance against 95% target. PEAP in place
Childhood Immunisations Service	Recovery red service	The team continue to recover the 19/20 and 20/21 programmes which were impacted by school closures during the pandemic as well as commencing the 21/22 academic year programme this month. They have successfully run catch up clinics through the summer and have just a few schools left to complete the 19/20 programme by the end of the month. They have received additional resource to manage the expanded flu vaccination programme which brings an additional 35,000 children into eligibility and developed new roles to support this. The recovery team continues to work with this service to support the demands of their programmes.
CAMHS (core)	Recovery red service	Expected reduction in referrals this month during school holidays. Some data quality work required to streamline recording and reporting which may account for some of the long waits. Greater number of waiters for treatment than pre pandemic (723 this month versus 466 pre-pandemic (Nov 2019)). There are safe waiting list calls in place for those waiting for treatment and options to re-prioritise children if necessary or provide simple advice and information. Working with recruitment the service are accelerating their on-boarding processes and to create new roles such as the Clinical Associate Psychologist role.
CAMHS LD	Recovery red service	Average referral rate April to August 2021 is higher than previous 2 financial years. A number of long waiters requiring specific therapy interventions which run bi-annually (Sorrow & Joy group), many families are offered this multiple times before accepting the offer when the time is right for them. The current number waiting for treatment = 97. The team note they accepted 2 new schools from Spring this year and did receive new resource to manage this new demand, but the demand came before those new staff were fully established resulting in increased service pressure. The team have new roles in place such as the family support practitioner to help support in new ways and follow up treatment plans.

Directorate Decisions Agreed this Month

Service	RAG change proposed	Notes	Decision by COO
School Nursing	Move amber to green	Hard to recruit vacancies now filled, improved preceptorship and training programme established, no KPI breaches, no redeployed staff. BAU was always challenging, settled back now. On target for vision screening programmes.	☒Approved ☐Not-approved
CAMHS L2 parenting	Move amber to green	F2F groups back up and running and using virtual offers very effectively. Many of the long waiters have been offered groups but have declined. Cannot 'force' attendance and parents need to attend when the time is right, need to keep the offer on the table for them hence not discharged. Running more groups at present which is causing an over-spend but is addressing backlog.	☒Approved ☐Not-approved

Adult Physical Health & Therapies Directorate RAG Summary

	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21	
RED	3	2	4	NB. No previous RAG for Falls Assessment Service or Blue badge – brought into Aug data
AMBER	7	9	4	
GREEN	9	8	13	

Directorate Current Recovery Red Services & Performance Exceptions

Adult Physical Health Directorate		
MSK Physio	Recovery red service + Performance exception	57.2% compliance to 95% target for 8 week RTT. This service endured significant workforce challenges following redeployment during both waves of the pandemic. +52 week waits may be a recording anomaly – the team are reviewing Total waiting in August 2019 – pre pandemic was 2782, this month it is 2638. There is a steady reduction in 0-8 week waits, but a rise in 18-36 week waits. There is a robust recovery plan in place which includes waiting list initiative work and new ways of working – especially virtual assessment and self-care resources on the website.
MSKAPS	Performance exception	51.5% compliance against 95% target within 8 weeks
Wheelchair service	Performance exception + Moved to recovery amber this month	72.3% compliance to 8 week RTT for new referrals. Robust improvement plan in place which has provided assurance and improvement across all expected domains.
NEW – Adult Speech & Language Therapy	Performance exception	KPI breach related to vacancies. The service are struggling to prioritise community demand due to requirements to cover GHFT in-patient workload, this commonly takes priority to enable urgent assessment and / or discharge facilitation. At present this is recovery rated amber and may require some cross system conversations about risk share for the diverse activity required. .
District Nursing	Recovery red service	Referral increases have not settled post-pandemic with a 10% increase in referrals being reported across the county with some clinically interventions being significantly increased in the 20/21 FY (phlebotomy is of note). Workforce recruitment and retention remains a concern, especially at staff nurse (band 5). The recovery team are working with the service to better understand the potential for recovery.
NEW - ICT Occupational Therapy	Recovery red service	Rising waiting times for routine referrals. This is reported to be induced by the front door demand to support Home First, Reablement and the MDT referral desk. This activity is commonly urgent; prevents unnecessary admission or facilitates discharge. This however means resources are unavailable to meet the routine referral demand, often for long term conditions. There are discussions with GCC & CCG re additional resources for HF & Reablement to address this.
NEW - ICT Physiotherapy	Recovery red service	Rising waiting times for routine referrals. This is reported to be induced by the front door demand to support Home First, Reablement and the MDT referral desk. This activity is commonly urgent; prevents unnecessary admission or facilitates discharge. This however means resources are unavailable to meet the routine referral demand, often for long term conditions. There are discussions with GCC & CCG re additional resources for HF & Reablement to address this.

Directorate Decisions Agreed this Month

Service	RAG change proposed	Notes	Decision by COO
Reablement	Move amber to green	Doesn't run a waiting list so no recovery to be addressed	☒Approved ☐Not-approved
Home First	Move amber to green	Doesn't run a waiting list so no recovery to be addressed	☒Approved ☐Not-approved
Adult MSKAPS	Move green to amber	Struggling to switch from virtual working through pandemic to hybrid delivery in new model. Will take a few months to settle into new approach. Need to pull data to review impact of service closure – may not be a concern but need to look at as amber and then review. Small team with some sickness and people using leave to support difficult home situations so impacting upon capacity.	☒Approved ☐Not-approved
Integrated equipment Service	Move amber to green	Small but stable (x 5 staff) just recruited to new full-timer so is now resourced for demand. Struggling to switch behaviours of referrers to expect the service to undertake all of the decision making and ordering process – as was brought in during covid to support staff – but now back to BAU. Need to sort out education packages to help referrers become more confident in decision making – new starter will allow this. Plans in place and stability rapidly returning.	☒Approved ☐Not-approved
Blue badge scheme	First status – green	Service had not been RAG rated previously. No concerns evident. FYI rate as green	☒Approved ☐Not-approved
ICT Referral centres	Move amber to green	Doesn't hold a waiting list manages demand at front door therefore no waiting list to recover.	☒Approved ☐Not-approved
ICT Occupational Therapy	Move amber to red	Demand at front door and within Home First and reablement is drawing OTs away from routine LTC work, thus waiting lists rapidly rising. Need data extract and reporting to sight organisation to patient impacts. Some vacancies also a concern	☒Approved ☐Not-approved
ICT Physiotherapy	Move amber to red	Demand at front door and within Home First and reablement is drawing Physios away from routine LTC work, thus waiting lists rapidly rising. Need data extract and reporting to sight organisation to patient impacts. Significant vacancies also a concern.	☒Approved ☐Not-approved

UCASS Directorate summary:

	Recovery RAG July 21	Recovery RAG Aug 21	Recovery RAG Sept 21
RED	5	5	6
AMBER	6	4	1
GREEN	4	6	8

Directorate Current Recovery Red Services & Performance Exceptions

Urgent Care & Specialist Services (UCASS)		
Respiratory – Home Oxygen Assessment Service (HOAS)	Recovery red service	This month all pathways within the respiratory team are coded red due to the interdependency on the same workforce. The respiratory team is identified for a service support review approach next month. There has been a positive reduction in the total waiting in HOAS this FY compared to 2019/20 however the number of waits over 52 weeks is currently 31, compared to 23 in Aug 20 and 14 in Aug 19. Total waits is rising – 141 this month, 132 in July and 127 in June. Discussions with CCG re wider sources of prescribing and monitoring for Oxygen is underway.
Respiratory – Pulmonary Rehab (PR)	Recovery red service	Activity this FY to date is broadly tracking 2019/20 levels but the service is still managing the surge in referrals since between December 2020 and March 2021. The number of people waiting over 52 weeks is at 205 currently against a total of 588. In August 2020 this was 51 over 52 weeks among a total of 621, in August 2019 this was 17 among a total of 308. People are waiting longer – this month 205 of the 588 waiters have been +52 weeks, in August 2019 this was 17 out of 308 total waiters. Group sessions have now restarted, but they are running with reduced numbers due to covid. The team also use virtual delivery options, but at present this is only accepted by 20% of referrals, the rest are choosing to wait for face to face sessions.
Diabetes service	Recovery red service	Referral increase during pandemic. Whilst the average waiting time remains comparable to pre pandemic levels, it has risen quickly back to pre-pandemic levels since a low in June 2020. In August 2021, there were 14 people waiting 8 – 18 weeks for a first contact, this is the highest it has been for the last 2 years. Successful recruitment to dietician and education posts is positive. Whilst the team are resilient and coping well, there are limits to what GHC alone can do to address the demand the service is feeling as population health needs change.
Heart Failure	Recovery red service	Business case in progress for additional resource to meet demographic growth demand 2021/22 referrals are consistently higher than the previous 2 years This month 263 people are waiting for the service, all are currently below 36 week wait. There are plans to recruit to a senior clinician to use Cynapsis to prevent unnecessary / inappropriate referrals and support clinical decision making in primary care.
Cardiac Rehab	Recovery red service	Impacted by the inability to run face to face exercise programmes during the pandemic and latent demand emerging as primary care returns to BAU. Referrals in 2021/22 are above 20/19 but below the previous FY average. The number waiting has reduced to 35 this month from a peak of 97 in July 2020. 0-8 week waits have also reduced 61 in June to 26 this month, there is positive progress in this service.

Directorate Decisions Agreed this Month

Service	RAG change recommended	Notes	Decision by COO
Respiratory services:	Respiratory Core + HOAS + Pulmonary rehab to all to be red status.	HOAS is recovering but using the same workforce as the other 2 functions under the respiratory umbrella. Work needed to define functions across the service and consider is addressing 1 aspect is contributing to waiting lists in other functions. Until fully scoped and appraised recommend all 3 are red	☒Approved ☐Not-approved
Homeless Healthcare	Move amber to green	Lead now in place, estates issues resolved. Stable.	☒Approved ☐Not-approved
Bone health	Move amber to green	Well managed, no waiting lists. Current workload is manageable but less than pre-covid, Rag would change if demand increased back to pre-covid levels but hasn't been seen yet	☒Approved ☐Not-approved

Hospitals Directorate summary:

Hospitals Directorate		
All sites	Performance exception	1 C. Diff case in August 21, whilst this is not above threshold, there have been 5 cases in the last 3 months. Re-admission within 30 days of discharge following a non-elective admission 8.1% against threshold of 8% Average Number of Community Hospital Beds Open – 181 compared to traditional bedstock of 196

There are currently no recovery programmes in place in the hospitals directorate.

KPI Breakdown

Mental Health - National Requirements Gloucestershire
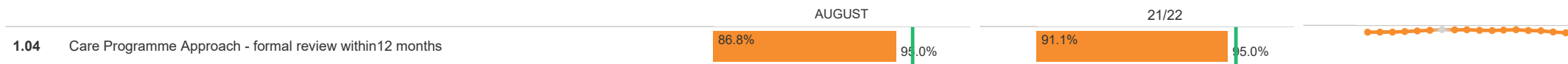
		AUGUST	21/22	
1.04	Care Programme Approach - formal review within12 months	86.8% ▮ 95.0%	91.1% ▮ 95.0%	

Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously within the last twelve months*.

1.04: CPA (Care Programme Approach) – Formal review within 12 months [Community MH Services]
Performance for August is 86.8% (124 cases) against a performance threshold of 95% and is below Statistical Process Control (SPC) limits.   Most of the cases are within Recovery (82) and Eating Disorders (6) services.

The mean number of days between the CPA review due date and the end of August is 84 days. The median is 40 days. Cases in exception are being validated with the services.

The Recovery service continues to struggle with high caseloads, high levels of acuity and a high turnover of staff in the Tewkesbury team. The staff shortage in Cheltenham due to short-term sickness have been resolved.

We have received National NHSE/I guidance outlining a CPA position statement which proposes replacing the Care Programme Approach using new principles. The NQT Directorate are considering alternative options to manage this going forward.

KPI Breakdown

Mental Health & Learning Disabilty - Local Contract
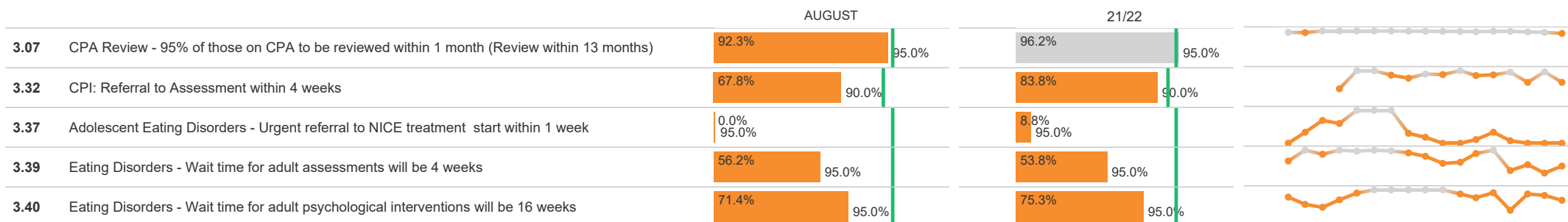
		AUGUST		21/22	
3.07	CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months)	92.3%	95.0%	96.2%	95.0%
3.32	CPI: Referral to Assessment within 4 weeks	67.8%	90.0%	83.8%	90.0%
3.37	Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week	0.0% 95.0%		8.8% 95.0%	
3.39	Eating Disorders - Wait time for adult assessments will be 4 weeks	56.2%	95.0%	53.8%	95.0%
3.40	Eating Disorders - Wait time for adult psychological interventions will be 16 weeks	71.4%	95.0%	75.3%	95.0%

Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously within the last twelve months.*

3.07: CPA (Care Programme Approach) – Formal review within 13 months [Community MH Services]
Performance for August is 92.3% against a performance threshold of 95% and is below Statistical Process Control (SPC) limits.   This indicator is a subset of 1.04 and of those non-compliant records there were 70 where the CPA review is not recorded as having taken place within 13 months. Of these, 45 are within the Recovery Service. Cases in exception are being validated with the services.

The Recovery service continues to struggle with high caseloads, high levels of acuity and a high turnover of staff in the Tewkesbury team. The staff shortages in Cheltenham due to short-term sickness have been resolved.

We have received National NHSE/I guidance outlining a CPA position statement which proposes replacing the Care Programme Approach using new principles. The NQT Directorate are considering alternative options to manage this going forward.

3.32: CPI: Referral to assessment within 4 weeks [Community MH Services]
August performance is reported at 67.8% against a performance threshold of 90% and is below SPC the lower control limit. There were 9 non-compliant cases in August. Two patients cancelled multiple appointments and one client was waiting for a group to be re-started after COVID restrictions had been lifted

The remaining 6 clients were seen within 5 to 8 weeks with delays being due to staff vacancies and annual leave. The service continues to have vacancies with a particular issue in the South. A further advert, with a different approach, has recently gone out to attract applicants by inviting expressions of interest and offering some flexibility around the 'make up' of posts. The Service have a meeting planned to discuss workforce related issues and consider ways of creatively managing the current challenges.

3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]
August performance is reported at 0% against a performance threshold of 95%. There were 5 non-compliant cases in August.

3.39: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]
August performance is reported at 56.2% against a 95% performance threshold. There were 7 non-compliant cases reported in August.

3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks [Community MH Services]
August performance is reported at 71.4% against a 95% performance threshold. There were 2 non-compliant cases reported in August.

Note on 3.37, 3.39 & 3.40 – Eating Disorders waiting times
The service now has very few remaining vacancies and are commencing workforce planning meetings to discuss how to proceed within the CMHT (Community Mental Health Transformation) programme.

The current wait profile for the service at the end of August indicates that 86.9% (458) of all patients waiting for assessment, are waiting over 4 weeks, and waiting times will continue to increase until

newly recruited staff are working at full capacity.

Capacity mapping for the service has indicated that the team is significantly under established to meet business as usual demands. This has been discussed and highlighted with commissioners and further investment has been secured as part of the CMHT (Community Mental Health Transformation) submission.

Demand remains high overall with a 24% increase in referrals during 2020/21 compared to 2019/20 and a significant increase in urgent referrals for under 18s (28% in 2020/21 compared to 17% in 2019/20) and this is continuing with 30.9% of referrals received in August being flagged as urgent. The main impact of this referral increase appears to be the detrimental effect that the pandemic, lockdown and school closures have had on Children and Young Peoples' wellbeing and mental health. This is validated by the replication in demand across other teams treating CYP.

The service is accepting routine referrals, which are being triaged and placed on a waiting list, however, assessment and treatment will continue to be paused throughout September 2021 which will impact on future reported waiting times and has led to several referrals being expedited due to the patients deteriorating condition. The service is working on reducing the urgent assessment waiting lists and hoping to bring the urgent assessment waiting times back in line with KPI's during October 2021.

Day treatment remains closed at this stage with staff capacity used to accommodate the increase in urgent referrals and is likely to remain closed until at least November 2021, however the service is working up a model to re-open this service and support reducing pressures in other areas such as RHED (High-risk) team and demand on specialist out of county in-patient beds and local acute medical beds.

The service has a development and improvement plan which focuses on all areas of recovery and will now begin to focus on how the future investment will be spent ensuring that the needs of the local population can be met and working towards bringing KPI's back in line.

KPI Breakdown

Physical Health - National Requirements

		AUGUST		21/22		
26	Re-admission within 30 days of discharge following a non-elective admission	8.1%	8.0%	6.9%	8.0%	
31a	HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2	88.0%	90.0%	69.5%	33.3%	
84	% of live births that receive a face to face New Birth Visit within 7- 14 days by a Health Visitor	94.4%	95.0%	94.2%	95.0%	
85	% of children who received a 6-8 weeks review	94.5%	95.0%	97.0%	95.0%	
86	% of children who received a 9-12 month review by the time they turned 12 months	80.6%	95.0%	81.2%	95.0%	
87	% of children who received a 12 month review by the time they turned 15 months	91.5%	95.0%	85.0%	95.0%	
88	% of children who received a 2-2.5 year review by 2.5 years	84.0%	95.0%	78.8%	95.0%	
91	% of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence)	56.1%	58.0%	58.1%	58.0%	

Performance Thresholds not being achieved in Month - *All indicators have been in exception previously in the last twelve months.*

26. Re-admission within 30 days of discharge following a non-elective admission
The readmission rate for Community Hospitals in August is 8.1% compared to the threshold of 8.0%. This is within SPC chart upper and lower control limits based on 2018/19 and 2019/20 data but as a National indicator is highlighted. There were 11 readmissions during August out of a total of 135 admissions. The service has identified that these patients were transferred from the wards to GHT because of a deterioration in their condition that required a higher level of assessment and or intervention and returned to trust community beds following this.

31a: HPV Immunisation coverage for girls aged 12/13 years old - Immunisation 2
August performance was 88.1% compared to a target of 90%. 3,027 of the year 9 girls school cohort 3,437 have been vaccinated to the end August.

The School Age Immunisation (SAI) team were unable to meet their 90% target in relation to the HPV2 cohort. The contributing factor to not meeting this target is that, owing to the Covid pandemic, and schools being closed from January until the 8th March 2021, over 700 Year 9 1st doses were not delivered until March.

For the 2nd HPV vaccination to be given there is the requirement for a 6 month interval between HPV 1 and HPV 2 vaccinations. This interval had not passed by the end of August and this is the contributing factor to an 88.1% uptake for HPV 2. In addition, the Service were unable to access one Secondary School within Gloucestershire in a high deprivation area whose cohort was 154 young people. These students were invited to our community clinics however, due to the nature of the school this offer was not accessed. The SAI team have worked closely with PHE to resolves this access issue and this has been resolved for the 2021/2022 academic year.

84: Percentage of live births that receive a face-to-face New Birth Visit within 7- 14 days by a Health Visitor [Children and Young People Service]
94.5% of the eligible children who received a New Birth Visit (NBV) in August 2021 was within 7-14 days of birth against a threshold of 95%. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator. The increase in babies remaining in NICU (Neonatal Intensive Care Unit)/ hospital is impacting on access for timely delivery resulting in the breach. Of the 29 exceptions, 14 babies were in NICU/ hospital. 1 declined the service and were unable to be seen to be seen in timeframe.

85: Percentage of children who received a 6-8 week review within 8 weeks by a Health Visitor [Children and Young People Service]
94.6% of the eligible children who received a 6-8 week review in August 2021 was within 8 weeks of birth against a threshold of 95%. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator. 16 families (64% of exceptions) were not available in timeframe but have since been seen. 8 babies were seen late due to rescheduling of visits to support priorities in service.

86: Percentage of children who received a 9–12-month review by the time they turned 12 months [Children and Young People Service]
80.6% of eligible children received the 9-12 month visit by a Health Visitor in August 2021 compared to a threshold of 95%. 97 out of 501 children did not receive the visit within timeframe of 9-12 months. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

The parents of all children in this cohort were offered the opportunity to receive a 9-12 month review. For all children classified as universal with low risk, virtual appointments via Attend Anywhere are being offered for developmental reviews as the estate available for face to face is reduced. Some families are still request face to face contact and declining the virtual offer. In these cases there is a small wait list, resulting in completion out of timeframe. This accounted for 41.2% of exceptions. 50% of exceptions declined or did not attend the appointment.

87: Percentage of children who received a 12-month review by the time they turned 15 months [Children and Young People Service]
91.6% of eligible children received the 9–12-month visit (by the time they were 15-months old) by a Health Visitor in August, compared to a target of 95%. 40 out of 476 reviews in August were not completed within the target timeframe of 15 months. This is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

Catch up developmental clinics have been completed where parents have rebooked the review, now they are more comfortable to do so. 85% of exceptions were declines or did not attend the appointment.

88: Percentage of children who received a 2-2.5-year review by 2.5 years [Children and Young People Service]
84.1% of eligible children received the 2-2.5-year mandated contact by a Health Visitor in July, compared to a target of 95%. 75 out of 471 reviews were not completed within the target timeframe of 2-2.5 years. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

All universal partnership (UP) and universal partnership plus (UPP) are seen face to face in the home setting for a full family health needs assessment. The service will be returning the 2-year ASQ (Ages & Stages Questionnaire) to face to face activity with an additional intervention called the Early Language Identification Measure (ELIM). 89% of exceptions were declines or or did not attend the appointment.

Additional Commentary for 84, 85, 86, 87 and 88
The health visiting service is a universal service and so all families in Gloucestershire are offered the mandated contacts and are included in the denominator but not all may wish to engage in all contact types.

The Health Visiting Service have a number of performance exceptions, which are reported further in the service's Performance Exception Action Plan (PEAP) tabled at BIMG. The service is trying to increase the offer of face-to-face capacity as estates allows, they are continuing to offer parental choice of virtual appointments and are working with Early Years to target the most vulnerable children.

Robust triage aims to identify those children who are 'hard to reach' but classified as universal to increase equity of access. The service is working with Maternity Voices Partnership to increase engagement with service users and pre-appointment text message reminders are being sent to parents/carers. The service in the month of August had reduced capacity due to 7.2% sickness rate, 2.5wte vacancy and 3.72wte maternity, and 3.3wte capacity moved across to support District Nursing.

91. % of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence) [Children and Young People Service]
Breastfeeding prevalence was 56.1% in August compared to a threshold of 58%. Performance has averaged 57.8% in the previous 3 months to July 2021. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

The service suggests this indicator is not a true reflection of its delivery around Breastfeeding rates. The number of children being breastfed at 6 weeks after birth depends how many started being breastfed in the first place (i.e. Breastfeeding Initiation), and Breastfeeding Initiation is a midwifery indicator. Hence in contract monitoring with Commissioners, it is acknowledged that this indicator is outside of GHC Health Visiting service influence.

The related indicator which measures maintenance of breastfeeding by looking at the percentage of mothers who are still breastfeeding at 8 weeks since breastfeeding at 2 weeks, is at 81.2% with a target of 80%. The service will continue to promote breastfeeding antenatal and support the wider system to increase initiation rates.

91. % of infants being totally or partially breastfed at 6-8wks (breastfeeding prevalence). [Children and Young People Service]
Breastfeeding prevalence was 56.1% in August compared to a threshold of 58%. Performance has averaged 56.8% in the previous 3 months to July 2021. Performance is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a national indicator.

KPI Breakdown

Physical Health - Local Requirements
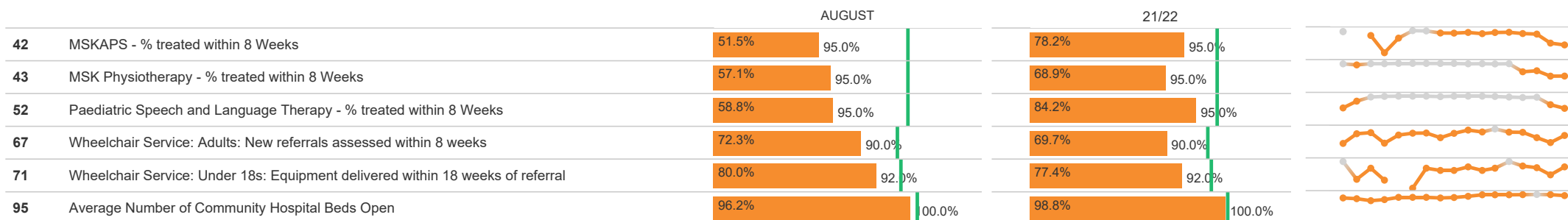
		AUGUST		21/22		
42	MSKAPS - % treated within 8 Weeks	51.5%	95.0%	78.2%	95.0%	
43	MSK Physiotherapy - % treated within 8 Weeks	57.1%	95.0%	68.9%	95.0%	
52	Paediatric Speech and Language Therapy - % treated within 8 Weeks	58.8%	95.0%	84.2%	95.0%	
67	Wheelchair Service: Adults: New referrals assessed within 8 weeks	72.3%	90.0%	69.7%	90.0%	
71	Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral	80.0%	92.0%	77.4%	92.0%	
95	Average Number of Community Hospital Beds Open	96.2%	100.0%	98.8%	100.0%	

<u>**Performance Thresholds not being achieved in Month**</u> - *Note all indicators have been in exception previously in the last twelve months.*

42. MSKAPS - % treated within 8 Weeks [Adult Community Services]
August performance was 51.5% compared to a threshold of 95%. 108 out of 223 patients seen in August were seen outside the 8-week target of timeframe of referral to first contact. This is below SPC lower control limit based on 2018/19 and 2019/20 data.

Some instances are due to patient choice where the patient has not booked their next appointment within the expected timeframe. A reminder is sent by the service, approximately 3 weeks after the initial communication. Other, additional influencing factors include staff annual leave, staff self-isolation, sickness and awaiting the start dates of recent recruits.

The Business Intelligence team is currently working with the service to capture clinically significant telephone contacts within the referral to treatment (RTT) pathway. The service is predicting that recovery will be achieved from October as the new model and staffing settles.

43. MSK Physiotherapy - % treated within 8 Weeks [Adult Community Services]
August performance was 57.2% compared to a threshold of 95%. 558 out of 1,303 patients seen in August were seen outside the 8-week target of timeframe of referral to first contact. This is below SPC chart lower control limit based on 2018/19 and 2019/20 data.

The service continues to work through their recovery plan and again has seen an increase in patient contacts in August despite accommodating annual leave. Further recruitment is underway with new colleagues expected to start in October. Sickness, maternity & adoption leave continue to impact capacity.

52. Paediatric Speech and Language Therapy - % treated within 8 Weeks
August performance was 58.9% compared to a target of 95%. 81 out of 187 young people seen in July were seen outside of the 8-week target timeframe of referral to first contact. This is below SPC chart lower control limit based on 2018/19 and 2019/20 data.

There are significant gaps in service due to 5.4 WTE on maternity/adoption leave, and 8.15 WTE vacant posts (including 5 WTE posts being recruited to as part of the recovery plan). The service continues to offer a blended model of delivery based on clinical need and risk assessment. The service is also setting up an advice line and training for schools, and also increasing the resources available to schools on their website in anticipation of increasing demand in the new academic year.

67: Wheelchair Service: Adults: New referrals assessed within 8 weeks [Adult Community Services]
13 out of 47 new adult referrals were assessed outside of the 8-week threshold in August. Performance is 72.3% and below the threshold of 90%. The service has been balancing planned annual leave with episodes of staff sickness within the same time period. This has reduced the capacity of staff available for assessment in order to balance triage and urgent requirements of the service.

71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral [Adult Community Services]
1 out of 5 equipment were not delivered within 18 weeks of referral in August. Performance was 80% compared to a threshold of 92%. This was due to the client requiring an additional assessment for moulded seating, the handover date was agreed at the assessment and fixed by the Specialist Seating Rep's availability – this meant we were 3 days outside the time frame. Average performance in the previous 6 months to July was 80%.

Additional Commentary for 67 & 71

The Wheelchair Service continues to collaborate with the Business Intelligence team (BI) to address data quality issues and has in place a robust plan to establish further quality checks to verify and further improve this data. This work, alongside actions agreed following an external audit, is reflected in the improved performance data.

95: Average Number of Community Hospital Beds Open [Hospitals]
The average number of beds open in Community Hospitals in August was 181. When compared to the traditional bed stock of 196 beds and reduced bed stock of 188 beds), the indicator is below SPC Chart lower control limits based on 2018/19 and 2019/20 data.

This is due to the need to reduce occupancy in Jubilee Ward, In readiness for the planned move to Preston Ward, Cirencester for the refurbishment programme. The service reduced the number of beds gradually throughout the month before all patients had been transferred over to Preston Ward.

Admissions to Jubilee Ward ceased from 2nd August and discharges progressed, so that on the day the ward moved to there were only 6 patients. When at Preston Ward the service increased their patient numbers by two a day until they reached 13 patient occupying beds on the 27th August.

KPI Breakdown

Trust Wide Requirements
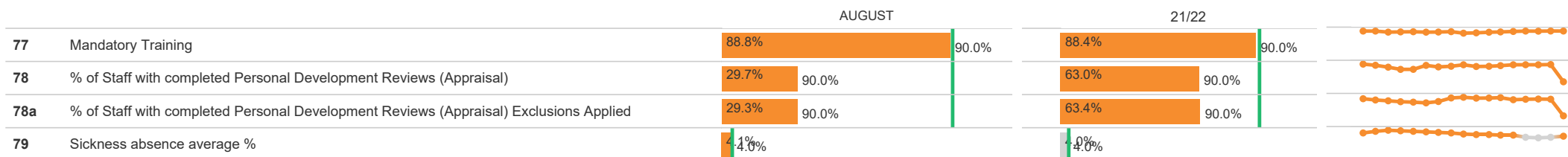
		AUGUST		21/22		
77	Mandatory Training	88.8%	90.0%	88.4%	90.0%	
78	% of Staff with completed Personal Development Reviews (Appraisal)	29.7%	90.0%	63.0%	90.0%	
78a	% of Staff with completed Personal Development Reviews (Appraisal) Exclusions Applied	29.3%	90.0%	63.4%	90.0%	
79	Sickness absence average %	4.1%	4.0%	4.0%	4.0%	

Performance Thresholds not being achieved in Month - *Note all indicators have been in exception previously in the last twelve months.*

77: Mandatory Training [Workforce]
Performance was 88.9% in August, below the target of 90%. This is below the SPC chart lower control limit based on 2018/19 and 2019/20 data. Excluding Bank staff, compliance is at 93% which is above the threshold of 90%.

The work that services/teams have been undertaking to re-instate training compliance levels has shown good improvement over recent months although the Trust's overall training compliance figure has shown a slight dip this month, which is often the case over the summer due to annual leave. However, the overall training compliance figure minus staff bank has remained at 93.4%, above the Trust overall compliance target.

78: % of Staff with completed Personal Development Reviews (Appraisal) [Workforce]
Performance in August was 70.3% compared to a threshold of 90%. This is below SPC chart normal variation based on 2018/19 data. Performance has been at an average of 68.6% in the previous 12 months.

78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only. [Workforce]
Performance in August was 70.7% compared to a target of 90%. There is increasing focus to improve compliance rates across the Trust. Performance is below SPC chart normal variation based on 2018/19 data.

Additional commentary for 78 & 78a
There has been a slight reduction in the % of completed appraisals this month which could be due to a number of factors including annual leave, capacity and not recording on ESR. Reminders are sent out to all managers giving 3 months' notice of when the appraisal for their teams is due and encouraging managers and colleagues to book their meetings. This is to encourage appraisals to be completed and recorded on the Electronic Staff Record (ESR). Managers are regularly reminded of the need to complete appraisals as an important part of being a supportive and inclusive leader in the Trust. In conversation with staff side the Trust are working on slightly revised paperwork to help support effective and meaningful conversations, which will be launched soon.

The new trust leadership programme includes a module entitled Appraisal Conversations. The aim of the programme is to encourage leaders to engage with their staff and this module will assist and provide practical advice and support in doing so, which it is hoped will continue to improve performance for this indicator.

79: Sickness absence average % rolling rate - 12 months
The sickness absence rate for the Trust to the end of August is 4.1% (the Trust target for sickness absence is 4.0%). Performance is below SPC chart normal variation based on 2018/19 data. Sickness absence reporting on the new operational Workforce Tableau report now reflects reporting for the current month only.

The Executive Directorate shows sickness absence at 5.3% for Corporate Governance. Similarly, within the Finance Directorate sickness absence within Estates and Facilities sits at 5.3%.
Nursing, Therapies & Quality have a sickness absence rate of 10.8% within Quality Assurance.

Within the Operations Directorate the sickness absence rate for CYPS is 4.4%, with the CYPS Learning Disabilities team reported at 18.3%. The sickness absence rate for Hospitals is 4.2%. Working Well alongside the HR Managers assigned to the service areas are continuing to support line managers on all aspects of the operation of the Supporting Attendance Policy, helping to maintain consistency in its application. With the new Workforce tableau report this will enable HR Managers to further understand the services with higher sickness absence levels to be able to provide additional support focused in those areas.

Measuring what matters

A performance management plan

2022/23

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

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Introduction

In July 2021, leaders within Gloucestershire Health and Care NHS Foundation Trust (GHC) came together to ask themselves whether the organisation was measuring what matters most to the business. The aim was to inform and develop a high-level, long-term performance plan to further improve care outcomes, experiences, clinical safety and inequalities.

This document summarises the key ideas that came from this Seminar and all the discussions that followed with wider stakeholders. Although there is crossover, the learning is clearly summarised through **ten high level themes** with associated aims and high-level milestones* that can provide a robust performance reporting foundation for the organisation and help to measure progress.

Milestones are currently provisional whilst wider stakeholder engagement on theme structure, detail and dates is underway

Key themes
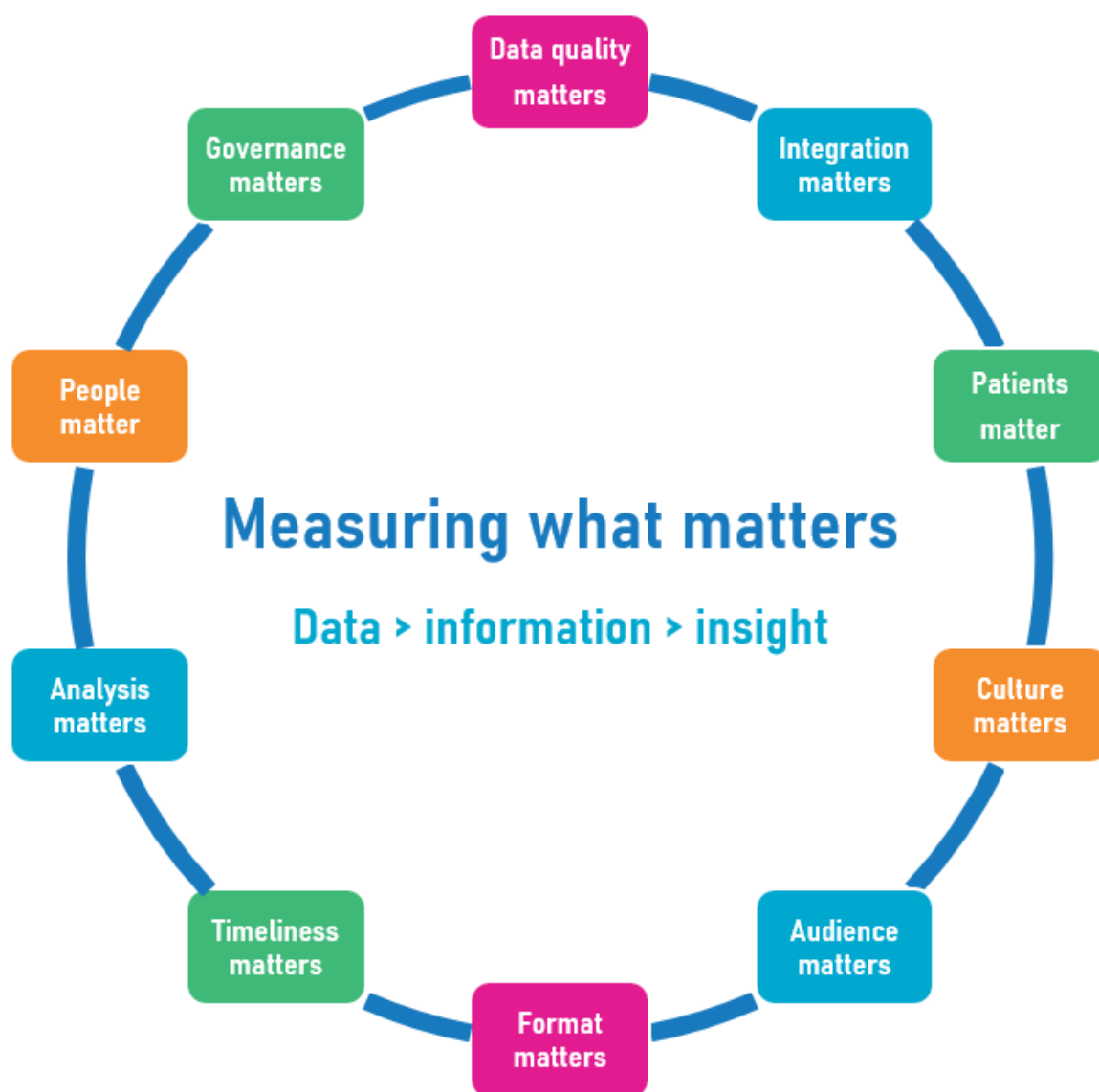
Data quality matters: *The numbers need to make sense*

Business intelligence services, clinical system teams and operational managers work together every day to ensure that clinical and administrative staff have access to informative performance reports that reflect their daily activities. However, difficult, routine challenges can often mean that data quality remains an ever-present, important risk for the organisation.

To achieve the full potential of reporting, there must be robust data recording within all Trust data systems. All systems users have a responsibility in assuring their data capture is timely, accurate and of high quality so that it reflects actual delivery and can be relied upon; for themselves and their colleagues. Additionally, support services, systems managers and processes must work collectively to support system users with the training and time to coordinate a routine cycle of data validation and audit to ensure that it is meaningful and representative.

Aims:
- *Automated, regularly available data quality exception monitoring for all services*
- *Subscription and alert functionality setup to automatically inform staff of key data quality exceptions when they occur*
- *Routine data quality conversations and checks within all staff supervision sessions*
- *Regular data quality audits within services and at a clinical and corporate level*
- *Coproduced schedule for contractual, but clinically relevant and operationally beneficial Data Quality Improvement Plans (DQIPs)*
- *Corporate and operational collaboration to improve training, digitalise processes and upgrade technology and system software to minimises the burden of data collection*

Key Milestones:
- *Tableau subscriptions and alert functionality promoted across services by December 2021*
- *Nursing, Quality and Therapies (NQT) Directorate Data quality audit schedule for 2022/23 to be agreed by Jan 2022 for April 2022 start*
- *SystmOne Simplicity project (to improve accuracy, consistency, and service quality) to be delivered by the end of Q2 2022/23 (by October 2022)*
- *Revised data quality reporting portfolio deployed within Tableau for physical health services through 2022/23 but concluded by October 2022*

Integration matters: *Multiple systems but a single truth*

Where it is available, native system reporting can offer value to an organisation however unconnected access to disparate data can be frustrating and confusing when things don't align with each other or make sense. Although equally relevant to corporate systems, independent clinical system data doesn't deliver GHC's merger ambitions of aligning mental health, learning disabilities and physical health services. Although challenging, triangulating information from multiple sources into unified presentations can aid staff at all levels understand how their services are really performing.

Alongside better system interoperability, GHC is bringing together data from multiple data sources such as workforce, finance, quality and clinical systems into a single data warehouse. This integrated data warehouse unifies multiple data sources across clinical and corporate systems using a common language and organisational hierarchy which is now managed through a strict change control process. Collectively, this will ensure that stakeholders will have a holistic presentation of how they are performing within the organisation; a single version of the truth that resonates with services.

Ultimately, through the single BI visualisation platform 'Tableau' this holistic performance management will aid user understanding, data confidence and engagement. Integrated intelligence will help consumers better understand their services and the wider system it operates within. It will allow them to ask the right questions, better inform their planning and strengthen their decision making.

Aims:
- *Further develop existing clinical and corporate system extracts and dataset reporting capabilities such as appraisals (within ESR) and improve (near) real-time data feeds*
- *Plan for the ongoing data integration of additional clinical and corporate systems where feasible and valuable such as Datix, Totara (Care to Learn Training) and Allocate (Rostering)*
- *Consider and plan for wider complimentary data systems data warehouse inclusion such as Mitel (telephony), Sustainability (carbon outputs) sources, Security and Estates*

Key Milestones:
- *Server migration to allow for reconfiguration and resolve licensing concerns by November 2021*
- *Develop additional Board performance dashboard workforce indicators to include:*
    - *Deployment of monthly Vacancy Rate by Sept 2021*
    - *Development of monthly (Cumulative) Annual Leave Consumption by Oct 2021*
    - *Development of monthly Turnover/ Stability Rate by Nov 2021*
- *Deploy first Datix Reports by April 2022*
- *Deliver Totara (Care to Learn) extraction by April 2022 and first report deployment by Oct 2022*
- *Deliver Allocate (e-Rostering) extraction by April 2022 and first report deployment by Oct 2022*

Patients matter: *Clinical outcomes drive the business*

Although performance monitoring tools for wait times and patient experience feedback provides an outline; for the organisation to be able to effectively monitor whether it is fulfilling its strategic goals the organisation should move towards value-based healthcare. This meaningful approach should optimise interventions, be personally focused and clinically valid to deliver the best patient outcome. These measures can be Clinically Reported Outcome Measures (CROMs), Patient Reported Outcome Measures (PROMs) or Patient Reported Experience Measures (PREMs). This approach should consider whole clinical pathways from prevention, early intervention, early accurate diagnosis, treatment and discharge and be led by clinical experts in the field. Wherever possible, transferable global measures can also help inform wider performance evaluation and benchmarking.

In addition, GHC needs to continue to work closely with system partners to tackle health and inequalities across Gloucestershire and improve health and care for its citizens.

Aims:
- *Through co-production, more time should be invested on understanding patient needs and what matters most to them.*
- *Use clinical leadership across the Integrated Care System (ICS) to review national guidance and regional best practice to inform strategic approaches to value-based healthcare within services and identify what outcome measures are available to service areas*

- *Engage with system owners, users, Commissioners and patients to understand what value measures should be adopted to ensure that they are meaningful to services and patients*
- *Work with system partners to invest more capacity to understand inequalities across provision, particular to improve accessibility of groups underserved within the population or whom aren't accessing GHC services*

Key Milestones:
- *Heads of Profession to liaise with Service leaders and wider stakeholders to develop the organisation's first plan for Value Based Healthcare in 2022/23*
- *Deploy trial of first tranche of new outcome measures by March 2023*

Culture matters: *Organisational values inform behaviour*

The Digital Strategy prioritises programmes which digitally progress the organisation and specifically outlines a priority for Information Management, namely to: Empower people; Empower clinicians; Integrate systems; Revolutionise information and Build the future. In turn, GHC's aims, values and culture need to embrace the potential of data, information and insight across all roles if the Trust is to embed business intelligence as a primary source for decision making. This includes incorporating performance management concepts across its governance processes, operational practices and documentation in an effort to underpin how the Trust expects its staff to operate.

To achieve these performance ambitions, there needs to be strong information leadership across the Integrated Care System (ICS) and within the Trust. Supported by documentation, GHC leaders need to promote the benefits of a strong data culture at all levels which allows others the time to engage, contribute and collaborate.

Aims:
- *Ensure digital technology and infrastructure is in place to enable reliable data extraction, organisation, and presentation*
- *Roll out of (near) real time, point of contact performance and activity monitoring reports and dashboards*
- *Colleagues and system partners have access to reliable, robust data and information*
- *Ensure reliable and simple information interpretation to all staff through a single visual analytics tool*
- *People can be assured that all data sharing and any increase in data use consistently aligns to legal and regulatory compliance with cyber security and information management standards*
- *Increase professionalised informatics accreditation and achievement of professional analyst standards*

Key Milestones:
- *Decommissioning of final ad-hoc Excel physical health reporting by July 2022*

Audience matters: *all perspectives are different*

Performance reporting means different things to different people. To some audiences it can provide assurance that they are moving in the right direction, that they are progressing their strategic aims or can acknowledge strong performance. To others it can be about benchmarking against peers, or it could be about highlighting issues or forewarning risk. More so, people often only really engage with

information if it is provided to them in a format that is easy to use, interpret and it is meaningful to their role. Given every audience member is different there will never be a single format that is right of all stakeholders.

Regardless of the consumer, simplicity is often a common BI requirement as providing clear, headlines from information allows a consumer the time for their own thoughtful consideration, wider debate and further bespoke questioning. Ironically, there can sometimes be conflict with this approach as it can come at the expense of the granular detail which many desire, if not need. Market leading BI tools can offer flexibility to dynamically respond to multiple audience lenses. This approach can often provide reassurance that their interpretation is accurate, but also to allow for tailored interrogation to inform users to ask better questions.

Aims:
- *All colleagues across the Trust, including Board members feel confident to use powerful data interrogation self-service tools and value compelling dashboards to effectively support their own decision making, identify questions, drive improvement and target resources*

Key Milestones:
- Review Key Performance Indicator portfolio by Jan 2022 to inform 2022/23 contract schedule and operational/ strategic needs
- *Publish proposal to restructure the current performance dashboard to support various audience level perspectives by April 2022*

Format matters: *Easily understood data*

Staff are now working across multiple sites at differing times of the day through a variety of devices. Although consumers have different information needs, they also require autonomy and responsiveness to inform the direction of their services. As such it is no longer sufficient for fixed data reports or reminders to be sent to stakeholders intermittently or made periodically available in a single location within a Trust's server at a certain time of day. Data consumers need to be able to pull the data they need whenever they want it.

Good business Intelligence needs to support constant scheduling of information, automating the regular delivery of relevant, user informed reports which will allow stakeholders to access and interact with consolidated information from multiple sources across multiple devices using web browsers wherever they need it. Modern-day business Intelligence must offer flexibility, allowing data to be visualised in a number of different ways; placing the power literally at the fingertips of the individual user so that they can effectively apply their knowledge to add context and answer the question posed. Furthermore, 'seeing is understanding', meaning visual leverage (as opposed to tabular data) can aid consumers to confirm or conflict their assumptions and should be the new normal.

Finally, efficient, user friendly and intuitive data visualisations will improve autonomous usability and release analytical capacity to better support information consumers with education and operational analysis.

Aims:
- *Rationalisation of the current information systems and reports, dynamically automating reporting and linking them to automatically updating datasets wherever possible*
- *Improved visibility and promotion of information leading to higher consumer motivation*

- *The information output from our performance systems is clear, understood and used to actively monitor the status of individual, team, service and Trust performance*
- *Engaged business partnering across all corporate support functions to discuss evidence-based performance and meaning*
- *Expand implementation and scope of BI Analytics tool enabling reports, dashboards, and alerts to be viewable on all devices.*

Key Milestones:
- *Deliver real-time performance dashboard interrogation pilot for Resources Committee members by Sept 2022*

Timeliness matters: *Data when it is needed*

As data appetites increase, the Trust must ensure information is available to stakeholders when they need it, and it needs to be as up to date as possible. It also needs to have the ability to draw out the insight as they require it, probing patient and itemised level data where available. System users also want to see the impact that their interactions can make on data quality through immediate response.

Readily accessible business Intelligence reduces the burden on an overcrowded BI development portfolio and can supply users with dynamic, (almost) real-time information that could be manipulated by the user. This will transform the user engagement within the Trust, free up finite development time which in turn offers capacity to better analyse the data they are supplied.

Aims:
- *Automated reporting direct from system sources using direct and full dataset extracts, updated at least daily wherever possible*
- *Leveraging system suppliers to provide real time, or near real time data extraction, building it into contractual negotiations where appropriate*

Key Milestones:
- *Evaluate (almost) real-time transactional log shipping processing within all new system procurements and extensions, particularly for April 2023 when RiO and SystmOne contracts are due for renewal*

Analysis matters: *take time to ask "so what"*

With aggregated data there is always a risk of overlooking insights only recognised within the detail. Unfortunately, although often desired, busy agendas rarely allow the time to present or analyse the detail that many would like.

However, modern business intelligence tools can now provide the dual benefit of dynamic multi-level interrogation which can be investigated on demand, often by users. In other words, headlines can be presented, but the detail made available. Members, be them clinicians, administrators, managers and analytical business partners can collaborate to ask "*why*" or "*so what*" quickly and repeatedly. This allows for trends and answers to be spotted quickly so that insights can be acted upon. Not that users should be left to find the answers alone. Cohesive business partnering should be established across corporate services to support operational staff. These skilled area experts can help users define their problems, identify who is affected, what is the problem, where it happens

and why it matters. In collaboration they can collectively use empathy to experience the patient pathway and gain the most from the data.

Within GHC, progressive Business Intelligence tools such as Tableau allows users to visualise and analyse their data and iterate it to answer their questions and find the compelling story threads within their arguments, or challenge long held assumptions. Automation also reduces the administrative burden of traditional ad-hoc reporting allowing for more proactive analysis to be undertaken such as trend prediction and forecasts.

Aims:

- *An integrated portfolio of service reports that presents historical trends, indicates predicted performance and demand and capacity forecasting*
- *Managers changing the way they distribute resources, design service pathways and seek development investment based on accurate forecasting models*
- *Health population analysis and benchmarking to inform whole system strategy*

Key Milestones:
- *Realising holistic business partnering across all corporate partners by January 2022*

People matter: *Digital learning and development*

Digital skills are a competitive advantage, but they are often overlooked in a crowded workload of competing activities. They can arm colleagues with the skills to work optimally with data and technology which are now essential for key decision making. Unfortunately, although we all have the potential for further learning, for various reasons there is currently inconsistent digital literacy, confidence, and competence across most large organisations. Some colleagues use information every day to inform their actions and service delivery, whilst others have never realised its benefit and rarely interact with data.

By supporting staff with the time to learn the appropriate skills necessary to improve their digital literacy, colleagues can perform more efficiently in their roles. By delivering the Trust's Digital Strategy and investing in the universal language of data, GHC can improve data fluency across all roles to the benefit of the business.

Empowering all patients, carers and citizens within the County can also progress the organisation. Health literacy and behaviours will help patients and families inform and make good health and lifestyle choices. Recognising early signs of illness will give them the confidence to seek help and can co-create their healthcare decisions, importantly supporting clinicians in their complex roles.

Aims:

- *Self-evaluation of digital skills and knowledge levels determined through audits and surveys*
- *Digital needs assessed for new staff at recruitment and induction*
- *Evaluation of adequate digital skills and knowledge within three months of starting the post*
- *Identify development and ongoing needs in supervisions and appraisals*
- *Robust business partnering between system specialists, analysts and consumers to inform practice and support staff with their decision making*

Governance matters: *principles for a high performing organisation*

GHC needs to successfully deliver national performance standards alongside the contractual thresholds expected by its Commissioners. In addition, it needs to maintain oversight on strategically and operationally important, internally agreed context indicators. These priorities need to be balanced within a safe governance structure which protects its activities, its workforce and its patients.

Alongside existing documentation and governance structures, the Trust seeks to implement a clear, supportive and transparent Performance Management Framework which sets out the overarching principles and approach to delivering a high performing organisation. The primary purpose of a Performance Management Framework is to provide guidance, support, tools and intervention for systematic, continuous improvement and a mechanism for monitoring, managing and escalating service level performance across the organisation. Areas within scope of the Project Management Framework are Key Performance Indicators (KPIs), management by exception, Statistical Process Control (SPC), audience lenses, benchmarking, data quality, performance assurance and operational Performance Exception Action Plans (PEAP). The framework is also a key engagement tool to demonstrate ownership and accountability of performance at every level of the organisation.

In addition, GHC is increasingly recognising the value that effective information sharing can bring across partners within an Integrated Care System. GHC needs to understand where the CCG and other stakeholder programmes are on long term data sharing for both direct and indirect patient care so it can play a full and active part in its development and implementation.

Aims:
- *Performance Management Framework to be agreed and published*
- *Review all contractual and internal service KPIs*
- *A fully supported mechanism of data sharing strategy to be developed across the local health economy*

Key Milestones:

- *Cleanse proxy indicators from Q3; October Data (for Nov 2021 reporting)*
- *Publish Performance Management Framework in Dec 2021*
- *Remove superseded National and Local Performance Indicators by April 2022*
- *Introduce ranked waiting times (over 52weeks) summary into the performance dashboard report – provisional outline for March 2022 for April 2022 Resources Committee*
- *Introducing new internal performance indicators into performance dashboard by July 2022*

Summary

Data isn't an end within itself, but it can help the organisation move to where it needs to be. Through engagement and shared system learning, GHC believes that data can become informative to help our colleagues better understand what has happened, why it happened and how it happened. Furthermore, through balanced co-production, an understanding of our information can provide evidence-based insight to legitimise opinions or inform its future decisions, mitigate risk or allow repeated success.

Measuring what matters

Data › information › insight

By working together through a cycle of continuous improvement, GHC can establish the best digital and intelligence capabilities to provide outstanding care which makes a difference and enables people to live the best lives they can.

A high-level timetable to monitor progress against this plan and the milestones listed within this paper (as presented on the next page) will be provided regularly within the monthly Performance Dashboard from October 2021 (Q3).

Measuring what matters

A performance management plan

2022/23

Theme	(Provisional) Milestone	Target date	Progress
Data Quality matters	*Tableau subscriptions and alert functionality promoted across services*	*Dec 2021*	
	NQT Data quality audit schedule for 2022/23 to be agreed	*Jan 2022 for Apr '22 start*	
	SystmOne Simplicity project (to improve accuracy, consistency, and service quality) to be delivered	*by Oct 2022*	
	Revised data quality reporting portfolio deployed within Tableau servers for physical health services	*by Oct 2022*	
Integration matters	*Server migration to allow for reconfiguration and resolve licensing concerns*	*by Oct 2021*	

	Develop additional Board performance dashboard workforce indicators to include:
	  o *Deployment of monthly Vacancy Rate*
	  o *Development of monthly (Cumulative) Annual Leave Consumption*
	  o *Development of monthly Turnover/ Stability Rate*
		by Sept 2021
		by Oct 2021
		by Nov 2021	

	Deploy first Datix Reports by April 2022	*by April 2022*	
	Deliver Totara (Care to Learn) extraction by April 2022 & first report deployment	*by Oct 2022*	
	Deliver Allocate (e-Rostering) extraction by April 2022 & first report deployment	*by Oct 2022*	

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Patients matter	Heads of Profession to liaise with Service leaders and wider stakeholders to develop the organisation's first plan for Value Based Healthcare in 2022/23	By Dec 2022	
	Deploy trial of first tranche of new outcome measures	by April 2023	
Culture matters	Through business partnering, Tableau user training and support will be offered from November 2021 to users from the BI service ahead of utilising the system and then ongoing whilst using it within their day-to-day business processes	by April 2022	
	BI support guidance will be made available through the intranet to support users	by Oct 2021	
	Learning & Development Service to inform a Digital Competency timetable for 22/23	by April 2022	
Audience matters	Review Key Performance Indicator portfolio to inform 2022/23 contract schedule and operational/ strategic needs	by Jan 2022	
	Publish proposal to restructure the current performance dashboard to support various audience level perspectives	by April 2022	
Format matters	Deliver real-time performance dashboard interrogation pilot for Resources Committee members	by Sept 2022	
Timeliness matters	Evaluate (almost) real-time transactional log shipping processing within all new system procurements and extensions, particularly when RiO and SystmOne contracts	by April 2023	
Analysis matters	Realising holistic business partnering across all corporate partners by January 2022	by Jan 2022	
People matter	Through business partnering, Tableau user training and support will be offered from November 2021 to users from the BI service ahead of utilising the system and then ongoing whilst using it within their day-to-day business processes	from Nov 2021	
	BI support guidance will be made available through the intranet to support users	from Oct 2021	

	Learning & Development Service to inform Digital Competency timetable for 22/23	*by April 2022*	
Governance matters	*Cleanse proxy indicators*	*Oct Data (for Nov 2021 reporting)*	
	Publish Performance Management Framework	*in Dec 2021*	
	Removing superseded National and Local Performance Indicators	*by April 2022*	
	Introduce ranked waiting times (over 52weeks) summary into the performance dashboard report – provisional outline	*for March 2022 for April 2022 Resources Committee*	
	Introducing new internal performance indicators into performance dashboard	*by July 2022*	
	Deliver real-time interrogation pilot for Resources Committee	*by Sept 2022*	

REPORT TO:	**Trust Board – 30th September 2021**
PRESENTED BY:	Sandra Betney, Director of Finance
AUTHOR:	Stephen Andrews, Deputy Director of Finance
SUBJECT:	**FINANCE REPORT FOR PERIOD ENDING 31st August 2021**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☐   Endorsement ☐   Assurance ☑   Information ☐

The purpose of this report is to
Provide an update of the financial position of the Trust.

Recommendations and decisions required

- The Board to note the month 5 position

Executive summary
- The Trust has a H1 plan of break even
- The Trust's position at month 5 is a surplus of £34k
- The Trust is forecasting a H1 position of break even
- The cash balance at month 5 is £58.8m
- Capital expenditure is £1.651m at month 5
- The Trust has spent £0.825m on Covid related revenue costs between April and August
- Guidance on financial framework H2 (October 21 to March 22) is not expected until the end of September

Risks associated with meeting the Trust's values

Risks identified within the paper.

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Corporate considerations	
Quality Implications	
Resource Implications	
Equality Implications	

Where has this issue been discussed before?

Appendices:	*Finance Report*

Report authorised by: Sandra Betney	**Title:** Director of Finance

Overview

- Gloucestershire ICS has been given an overall funding envelope that it collectively has to manage for the first six months of 21/22, known as H1

- The Trust has a H1 financial plan of break even following allocation of the system envelope

- At month 5 the Trust has a small surplus of £34k and a six month forecast position of break even in line with the plan

- The Trust has recorded Covid related expenditure of £0.825m for April to August

- The Trust has revised its five year capital programme. In 21/22 the plan remains at £15.993m but a number of adjustments to scheme costs and priorities have been agreed.

- 21/22 Capital plan is £15.993m and spend to month 5 is £1.651m which is £2.7m less than the year to date plan to NHSI. Backlog maintenance schemes are being brought forward to replace schemes that have slipped.

- Cash at the end of month 5 is £58.8m, a increase of £1m on last month

- Guidance on the financial framework H2 (Oct 21 – March 22) has been delayed by 5 weeks and is not expected until the end of September. This is expected to advise;

    - Efficiency Averages to 2% (no system exceeds 3%) which is reflected in the Risk slide

    - Covid funding will be reduced by 5% compared to H1

    - Pay award will be funded

GHC Income and Expenditure

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Statement of comprehensive income £000	2021/22 Original Plan	2021/22 NHSI H1 plan	2021/22 NHSI H1 plan ytd	2021/22 Actual ytd	Variance	2021/22 H1 Forecast	2021/22 Full Year Forecast
Operating income from patient care activities	220,598	112,680	93,900	95,197	1,297	114,220	228,751
Other operating income	6,700	5,634	4,695	3,475	(1,220)	4,086	9,663
Employee expenses	(170,274)	(84,531)	(70,443)	(73,223)	(2,781)	(87,326)	(175,894)
Operating expenses excluding employee expenses	(53,533)	(32,454)	(27,045)	(24,388)	2,657	(29,751)	(60,048)
PDC dividends payable/refundable	(2,701)	(1,353)	(1,128)	(1,079)	49	(1,295)	(2,612)
Other gains / losses	0	0		6	6	8	20
Surplus/(deficit) before impairments & transfers	**790**	**(24)**	**(20)**	**(12)**	**8**	**(58)**	**(120)**
Remove capital donations/grants I&E impact	100	24	20	46	26	60	120
Surplus/(deficit)	**890**	**0**	**0**	**34**	**34**	**2**	**0**
Adjust (gains)/losses on transfers by absorption/impairments	0	0	0	**0**	0		0
Revised Surplus/(deficit)	**890**	**0**	**0**	**34**	**34**	**2**	**0**

Note. The variance compare NHSI H1 plan ytd against Actual

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GHC Balance Sheet

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STATEMENT OF FINANCIAL POSITION (all figures £000)		2020/21	2021/22	2021/22	2021/22			2021/22
		Actual	Original Plan	NHSI H1 plan	NHSI H1 plan ytd	Actual	Variance	Full Year Forecast
Non-current assets	Intangible assets	488	488	488	488	289	(199)	200
	Property, plant and equipment: other	109,796	119,881	115,135	113,552	108,662	(4,890)	118,892
	NHS receivables	276	0	0	0	0	0	0
	Non-NHS receivables	316	0	0	0	248	248	252
	Total non-current assets	**110,876**	**120,369**	**115,623**	**114,040**	**109,199**	**(4,841)**	**119,344**
Current assets	Inventories	718	418	568	618	718	100	418
	NHS receivables	6,077	5,877	5,977	6,010	6,968	958	5,512
	Non-NHS receivables	5,928	5,928	5,928	5,928	3,475	(2,453)	4,698
	Cash and cash equivalents:	52,333	38,340	44,547	46,878	58,880	12,002	47,288
	Property held for sale	0	0	0	0	0	0	0
	Total current assets	**65,056**	**50,563**	**57,020**	**59,434**	**70,041**	**10,607**	**57,916**
Current liabilities	Trade and other payables: capital	(5,108)	(3,108)	(4,108)	(4,441)	(2,671)	1,770	(5,345)
	Trade and other payables: non-capital	(23,762)	(20,262)	(22,012)	(22,595)	(29,963)	(7,368)	(24,493)
	Borrowings	(107)	(107)	(107)	(107)	(108)	(1)	(108)
	Provisions	(3,526)	(1,526)	(2,526)	(2,859)	(2,603)	256	(2,933)
	Other liabilities: deferred income including contract liabilities	(2,273)	(773)	(1,523)	(1,773)	(2,785)	(1,012)	(3,144)
	Total current liabilities	**(34,776)**	**(25,776)**	**(30,276)**	**(31,775)**	**(38,130)**	**(6,355)**	**(36,022)**
Non-current liabilities	Borrowings	(1,363)	(1,363)	(1,363)	(1,363)	(1,331)	32	(1,246)
	Provisions	(1,423)	(1,423)	(1,423)	(1,423)	(1,423)	0	(1,423)
	Total net assets employed	**138,370**	**142,370**	**139,580**	**138,913**	**138,356**	**(557)**	**138,569**
Taxpayers Equity	Public dividend capital	126,578	126,578	126,578	126,578	126,578	0	126,576
	Revaluation reserve	6,826	6,826	6,826	6,826	6,826	0	6,828
	Other reserves	(1,241)	(1,241)	(1,241)	(1,241)	(1,241)	0	(1,241)
	Income and expenditure reserve	6,207	10,207	7,417	6,750	6,193	(557)	6,406
	Total taxpayers' and others' equity	**138,370**	**142,370**	**139,580**	**138,913**	**138,356**	**(557)**	**138,569**

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Cash Flow Summary

Gloucestershire Health and Care
NHS Foundation Trust

Statement of Cash Flow £000	YEAR END 20/21		ORIGINAL PLAN 21/22		ACTUAL YTD 21/22		YEAR END FORECAST 21/22	
Cash and cash equivalents at start of period		37,720		52,333		52,333		52,333
Cash flows from operating activities								
Operating surplus/(deficit)	(203)		**2,800**		1,060		2,574	
Add back: Depreciation on donated assets	127		0		55		147	
Adjusted Operating surplus/(deficit) per I&E	**(76)**		**2,800**		**1,115**		**2,721**	
Add back: Depreciation on owned assets	8,734		6,500		3,259		7,238	
Add back: Impairment	5,006		0					
(Increase)/Decrease in inventories	0		300		(0)		300	
(Increase)/Decrease in trade & other receivables	5,722		200		1,907		1,795	
Increase/(Decrease) in provisions	492		(1,500)		(923)		(593)	
Increase/(Decrease) in trade and other payables	7,758		(1,500)		2,322		(3,346)	
Increase/(Decrease) in other liabilities	(1,409)		0		512		871	
Net cash generated from / (used in) operations		26,227		6,800		8,192		8,985
Cash flows from investing activities								
Interest received	9		0		7		15	
Purchase of property, plant and equipment	(10,769)		(17,993)		(1,621)		(11,965)	
Sale of Property	0		0					
Net cash generated used in investing activities		(10,760)		(17,993)		(1,614)		(11,950)
Cash flows from financing activities								
PDC Dividend Received	679		0		0			
PDC Dividend (Paid)	(1,170)		(2,800)		0		(1,959)	
Finance Lease Rental Payments	(363)		0		(31)		(121)	
		(854)		(2,800)		(31)		(2,080)
Cash and cash equivalents at end of period		52,333		38,340		58,880		47,288

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Covid 1

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- The Trust has spent £825.0k up to 31st August 2021
- The Trust has received system COVID funding for the In Envelope expenditure
- Out of envelope income has been included at £80.7k

For periods up to and including 31/08/2021 (M5)	Plan 21/22 £	Plan ytd £	Income ytd £	Expenditure ytd £	Full Year Net Forecast £
Expand NHS Workforce - Medical / Nursing / AHPs / H	507,832	211,597		189,637	346,643
Remote management of patients	186,000	77,500		77,500	186,000
Existing workforce additional shifts	223,440	93,100		25,520	72,090
Decontamination	82,510	34,379		20,788	37,156
Backfill for higher sickness absence	223,440	93,100		76,399	92,832
Remote working for non patient activites	186,000	77,500		77,500	186,000
National procurement areas	72,000	30,000		0	0
Other	174,000	72,500		0	0
COVID-19 virus testing (NHS laboratories)			(276,934)	276,934	0
TOTAL IN ENVELOPE	1,655,222	689,676	(276,934)	744,278	920,721
Vaccine Program - Local Vaccination Service	0	0	(51,544)	51,544	0
Vaccine Program - Lead Employer	0	0	(29,226)	29,226	0
TOTAL OUT OF ENVELOPE	0	0	(80,770)	80,770	0
TOTAL	1,655,222	689,676	(357,704)	825,048	920,721

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Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

Capital 5 year Plan	Revised Plan	Plan to Date	Actuals to date	Forecast Outturn	Plan	Plan	Plan	Plan	
£000s	2021/22	2021/22	2021/22	2021/22	2022/23	2023/24	2024/25	2025/26	Total
Land and Buildings									
Buildings	4,737	2,181	721	4,737	1,500	2,500	1,000	1,000	10,737
Backlog Maintenance	3,831	700	505	3,831	0	2,876	1,250	1,393	9,350
Urgent Care	750	188	34	750	0	0	0	0	750
Buildings - Finance Leases							1,500		1,500
LD Assessment & Treatment Unit						2,000			2,000
Cirencester Scheme						5,000			5,000
Medical Equipment	2,221	643	57	2,221	0	130	1,030	1,030	4,411
IT									
IT Device and software upgrade	200	0	0	200	600	600	600	600	2,600
IT Infrastructure	1,086	455	256	1,086	996	1,300	1,300	1,300	5,982
Clinical Systems	0		0	0	1,000	0	0	0	1,000
Unallocated	168		0	168	0	0	2,300	2,300	4,768
Sub Total	**12,993**	**4,167**	**1,573**	**12,993**	**4,096**	**14,406**	**8,980**	**7,623**	**48,098**
Forest of Dean	3,000	230	78	3,000	16,000	3,500	0	0	22,500
Total of Original Programme	**15,993**	**4,397**	**1,651**	**15,993**	**20,096**	**17,906**	**8,980**	**7,623**	**70,598**
Disposals					(1,349)	(2,454)	(2,000)	0	(5,803)
Donation - Cirencester Scheme					0	(5,000)	0	**0**	(5,000)
	15,993	**4,397**	**1,651**	**15,993**	**18,747**	**10,452**	**6,980**	**7,623**	**59,795**

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Forest of Dean scheme includes prior year spend of £1.4m giving total scheme cost of £23.9m

Projects involving building works are experiencing the highest slippage due to national shortages in building materials.

A review of the capital schemes that might be delayed has been carried out and it has been determined that there are none that are potentially delayed that will have an impact on patient safety, effectiveness or experience.   The schemes that would impact on this are replacement windows and ligatures but these are due to continue.

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Risks

Risks to delivery of the Trust's financial position are as set out below:

Risks 21/22	21/22 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
Delivering Differential CIP schemes	363	363	0	3	2	6
Delivering Value Scheme CIPs	900	900	0	5	3	15
Delivering non recurring savings	450	0	450	1	2	2
Efficiencies need to be higher than assumed	950	950	0	4	3	12
Risks 22/23	22/23 Risks	Made up of: Recurring	Made up of: Non Recurring	Likelihood	Impact	RISK SCORE
IFRS 16 revenue impact not fully funded	1,300	1,300	0	2	3	6
If 21/22 CIP made non recurrent, then delivery needs to be made rec	900	900	0	3	3	9
Total of all risks	4,863	4,413	450			

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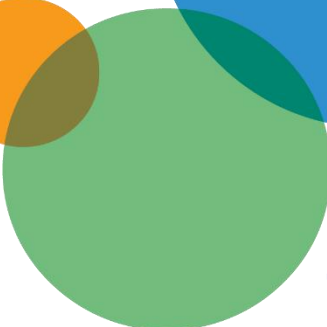
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REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Dr Amjad Uppal, Medical Director

AUTHOR: Dr Emma Abbey, Medical Appraisal Committee Chair
         Dr Raeema Patel, Member of Medical Appraisal Committee

SUBJECT: **MEDICAL APPRAISAL & REVALIDATION ANNUAL REPORT 20/21**

If this report cannot be discussed at a public Board meeting, please explain why.	

This report is provided for:
Decision ☐   Endorsement ☑   Assurance ☑   Information ☑

The purpose of this report is to:

1.1 The Medical Appraisal and Revalidation Report provides a summary of the work that has been undertaken within the Trust to support the safe provision of clinical services through the medical practitioners working to this Designated Body aligned with national policy.

1.2 It provides assurance as to the application of national policy with regard to the regulation and Revalidation of Medical Practitioners and insight into the processes and resources that are required to undertake this work.

Recommendations and decisions required

1) That the Trust Board **accepts** and **endorse** the Medical Appraisal Annual Report and:

- **Recognise** that levels have been maintained in the application of appraisal, recording and quality assuring is recognised and that this has occurred without significant additional funding.
- **Recognise** that the figures for engagement in appraisal reflect a snap shot at one point in the year and that the Trust will continue to achieve appraisal consistent with the provision of safe medical services on an annual basis supported by the Revalidation statistics provided.
- **Recognise** that there are a number of exceptions / reasons for non-compliance that contribute to a compliance point of less than 100%.

Gloucestershire Health and Care NHS Foundation Trust – **TRUST BOARD PUBLIC SESSION – 30 Sept 2021**
AGENDA ITEM: 12 MEDICAL REVALIDATION ANNUAL REPORT – COVER REPORT   Page 1
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- **Recognise** that effective appraisal has supported timely and appropriate Revalidation for all Doctors to date.
- **Recognise** that the good employment practice with regard to recruitment is supporting safe practice.
- That locum use remains necessary for the safe provision of clinical services but that this is monitored appropriately.
- **To note** in particular the assurance for NHS England in section 13 that the Trust meets requirements.

2) That the Board **agrees** the content and submission of the Statement of Compliance to NHS England and that this signed by the Chair on behalf of the Trust (section 13 page 11-16).

Executive summary

- Medical Appraisal has continued to be instituted within Gloucestershire Health and Care NHSFT aligned with national policy.
- The Medical Appraisal Committee has instituted a work plan that will further deliver assurance annually and sustain quality.
- Headline figures at the end of March 2021 demonstrate that at that time 83% of Doctors had a currently valid appraisal. Of the 17% non-compliant, 12.5% are explained by exclusion criteria such as being a new starter or long-term sick leave. The 4 (4.5%) without a reason were overdue by two months or less.
- Doctors revalidation was effectively managed with no non-engagement referrals.
- Recruitment processes provide appropriate safety and quality checks aligned with national policy and best practice.
- Use of locum practitioners is being monitored and used to sustain service commitments and activity appropriately.
- The MAC membership includes a range of subspecialties, including non-psychiatry, and both consultant and SAS level doctors. Ivars Reynolds, a long established MH Act Manager, was welcomed to the Committee in 2019 in order to provide Lay oversight for the work of the Committee and input into medical appraisal.

Risks associated with meeting the Trust's values

There are no identified risks associated with the Trust's values.

Corporate considerations	
Quality Implications	Required and monitored by NHSE.
Resource Implications	Time commitment from clinical and administrative staff
Equality Implications	None

Where has this issue been discussed before?
Medical Appraisal Committee – July 2021 Quality Committee – Sept 2021

Appendices:	Annual Report

Report authorised by: Dr Amjad Uppal	**Title:** Medical Director

Annual Medical Appraisal Board Report

Appraisal year:	**1st April 2020 – 31st March 2021**
Author:	**Dr Raeema Patel** ***On behalf of Medical Appraisal Committee***
Prepared for:	**Trust Board via Trust Quality Committee**

1. Executive summary

Of the 88 doctors requiring appraisal during the 2020-21 appraisal year, 73 (83 %) were compliant as at 1st April 2021; this is slightly down on the previous year (87.6% at end of 2020); and represents a sustained improvement (75% end of 2014).

When the Medical Appraisal Committee (MAC) was set up in 2013 the focus was on developing and implementing the basics required to ensure doctors engaged in and completed a standardised medical appraisal. Since then the MAC have focussed on improving the quality of medical appraisals undertaken in the organisation.

Each year a quality assurance audit of appraisal outputs is conducted; to date this has demonstrated sustained improvement in quality, providing significant validation and assurance to Governance Committee and Board that the organisation is fulfilling its statutory obligations. The most recent verification visit by NHS England was in June 2019, with future visits expected on a 5-year cycle.

2. Purpose of the Paper

The purpose of this paper is to report on the state of medical appraisal and revalidation to the Trust Board over the preceding appraisal year. It is also to report on progress made towards further developing and refining systems and procedures to support medical appraisal and to improve the quality of medical appraisals taking place in the organisation. In addressing these two issues the paper provides assurance to the Trust regarding both the quality of the medical workforce and its sustainability.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. The strengthened annual appraisal process is the primary supporting mechanism by which

revalidation recommendations are made to the General Medical Council (GMC) for the re-licensing of doctors.

All non-training grade doctors in an organisation relate to a senior doctor, the Responsible Officer (usually the Medical Director). Completion of satisfactory annual appraisals over a five-year period is a crucial factor in enabling the Responsible Officer (RO) to make a positive affirmation of fitness to practice to the GMC.

4. Governance Arrangements

The Trust Medical Appraisal Committee (MAC) was set up in 2013. The aim and objectives of the committee are; to oversee the process of appraisal of all licensed doctors employed within the trust; to maintain robust systems for the recruitment, training, support and performance review of all medical appraisers within the organisation; and to review and quality assure the standard of appraisals conducted within the trust.

The MAC comprises of the Medical Director/Responsible Officer, Revalidation Officer, a separate chair, the director of medical education, at least 2 consultant representatives/lead appraisers (selected to represent the geographical & sub-specialty spread of consultants within the Trust) and at least 1 SAS doctor representative (currently 2).

The MAC convenes quarterly; this includes a year-end away half-day to review the results of the quality assurance audit and to scrutinise the end of year appraisal compliance figures. The committee review the annual work plan and the progress made against the Terms of Reference developed at inception of the committee.

Key outputs from the MAC during the last year include:

- Review of the medical appraisal policy
- Review of the appraisal systems for doctors joining the trust following the merger process, and how these will be included into the current systems.
- Further refinement of the user-friendly guide for completion of appraisal portfolios (including how to obtain data, and what supporting information to include)
- Further refinement / development of 6-monthly medical appraiser support forums
- Review of the membership of the MAC (including proactive turnover of members) to ensure compliance with the aim of 3-year terms
- Completion of the annual quality assurance audit and further improvement in systems for disseminating learning from this. The March 2021 audit covered all appraisals completed from 1st April 2019 to 31st March 2021.
- Continued review of the currently active appraiser list
- Performance review of newly qualified medical appraisers
- Ensuring the continuation of high-quality appraisal during the global pandemic, which adhering to the principles of a light touch appraisal, as proposed by NHS England.

Alongside these new and ongoing developments, the MAC continues to regularly monitor appraisal compliance rates and engagement in the process; provide approved baseline and refresher training for medical appraisers (provision is determined by current need); monitor training compliance and output of approved appraisers; enforce required minimum and maximum numbers of completed appraisals conducted by each approved

appraiser within a 2 year cycle (this is currently under review); and regularly review appraisee feedback.

The Strengthened Appraisal and Revalidation Database (SARD JV) was introduced in 2013 and training made available for all users. All appraisals and job plans are completed and documented in this software package. Use of SARD JV contributes significantly to the ease and transparency of compliance monitoring, and hence maintaining the overall high compliance rates seen since its introduction.

Administrative support for the MAC, and for the use of SARD JV, is provided by the Medical Director's office. Additional technical support is also provided by SARD JV staff. All doctors requiring appraisal are sent email reminders 3 months and 6 weeks before their appraisal due dates. Weekly emails and correspondence are then undertaken from the due date onwards. If a doctor becomes non-compliant the Medical Director sends an assertive reminder. If the doctor remains non-compliant after 1 month and no appraisal meeting date has been set, a face to face meeting with the Medical Director is arranged. A process for escalation to the GMC if non-engagement continues is also in place.

Priorities for the MAC for the next year include further consideration of ways to improve patient and public involvement in appraisal and revalidation processes (held back by continuing difficulty in identifying a fit-for-purpose process); further refinement of the number and nature of active qualified medical appraisers within the organisation; and focus on moving beyond compliance towards further quality improvement. The committee are in the process of sourcing an easy read patient feedback form for 360-degree feedback, acknowledging that clinicians from certain sub-specialities have identified this as being a barrier to collecting patient feedback.

5. Medical Appraisal

5.1. Appraisal and Revalidation Performance Data

Of the 88 doctors requiring appraisal during the 2020-21 appraisal year 73 (83 %) were compliant as at 1st April 2021; this is slightly lower than the previous year (87.6% at end of 2020); and represents a sustained improvement (75% end of 2014). Of particular note is the reduction in non-compliant without a reason (see chart below).

In 2018-19 the "appraisal year" was introduced (1 April to 31 March). This aims to prevent slippage of appraisal date, and expects that each appraisee will have one completed appraisal per appraisal year unless authorised by the RO.

Compliance with annual appraisal
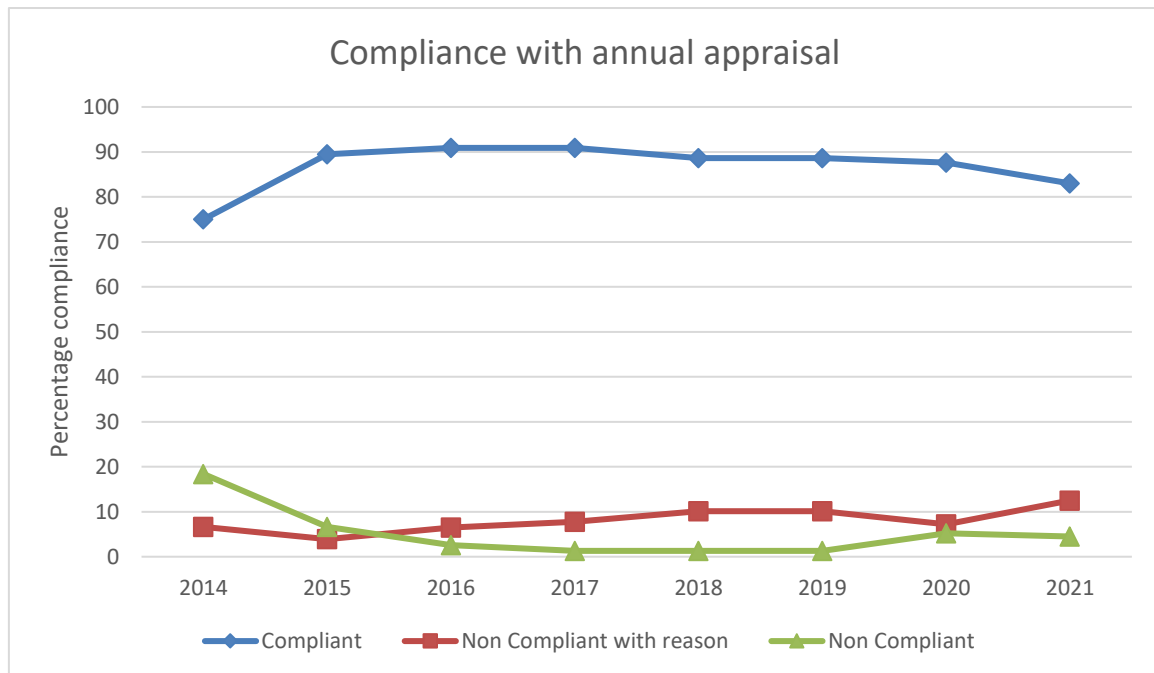
Sub-group numbers were insufficient to conduct any meaningful statistical analyses; however general trends in the data reviewed suggest that there were no significant differences in compliance rates between different grades of doctor, or locality or specialty worked. Notably compliance remains reasonable within trust locums (currently 50%; and of those non-compliant all had an acceptable reason); typically a group in which engagement and compliance is hard to establish and maintain.

Of the 15 doctors who were non-compliant; 11 (12.5%) had acceptable reasons (8 being new starters; 2 on or returning from long term sickness; and 1 having an agreed extension due emergency leave. The 4 (4.5%) without a reason were overdue by two months or less.

The system for monitoring compliance (SARD JV) does not allow for any flexibility around the appraisal due date. Once the due date has passed (even by a day) the appraisee is deemed non-compliant. This is at odds with the Trust policy which allows for one month before or after the due date for completion of appraisal. Compliance rates are therefore unlikely to regularly reach 100% and will fluctuate monthly throughout the appraisal year.

To account for this, and given that at any time there will be a small number of doctors currently non-compliant with a reason, the MAC agreed in 2018 that overall compliance rates maintained above 75% should provide adequate assurance of engagement in the process and completion of medical appraisals within the medical workforce.

For further details see appendix A.

5.2. Appraisers

There are currently 19 trained medical appraisers within the establishment of non-training grade doctors. All consultants and SAS doctors continue to be offered access to training in order to both provide a cohort of appraisers and increase awareness and knowledge of appraisal for appraisers and appraisees alike.

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The merger with GCS has brought 12 doctors into the Trust workforce. These doctors received appraisal via an external source. Over the past 2 years the majority of these doctors have transitioned over to the SARD appraisal system with a GHC appraiser. We have noted an increase in appraisers running at full capacity in consequence and will be monitoring this over the coming year.

The MAC have set minimum numbers of completed appraisals required in a 2-year period by an appraiser. These standards were introduced in 2014 and enforced in 2016; 8 appraisers were then removed from the active list, and this review of activity has continued annually. Appraisers who consistently do small numbers are asked whether they wish to continue in this role.

The MAC have developed a formal recruitment process and set minimum baseline and refresher training requirements. The MAC continue to encourage SAS doctors to become trained and practising appraisers.

Not all appraisals undertaken by appraisers are captured by SARD JV or relate to doctors with whom GHC has a prescribed connection. Some appraisals are undertaken for colleagues working outside GHC, in retirement or within other roles such as the Deanery.

5.3. Quality Assurance

In July 2015 the Trust was visited and scrutinised by the NHS England Independent Verification Review Team; whose purpose is to assess and validate the status of appraisal and revalidation systems within all designated bodies. The process is designed to provide independent assurance to trust boards that the organisation is fulfilling its statutory obligations in respect of the RO's statutory responsibilities. A comparator report is received each year from NHS England, which allows the Trust to benchmark itself against other Trusts. As GHCNHSFT is comparatively small compared to other Trusts, a small number of doctors can make a significant difference to percentages quoted.

Overall the trust was highly commended and scored at least 5 out of 6 (equating to 'Excellence') in all core standards; scoring highest for 'Engagement & Enthusiasm'. No required actions were recommended by the scrutiny panel, and few suggestions made for improvement, mainly concerning HR procedures (since enacted). Many areas of good practice were noted including the overriding focus on quality of medical appraisals, use of SARD JV as a tool to support quality and compliance, automatic inclusion of complaints and serious incidents within individual appraisal portfolios, and the processes to support learning and quality improvement from the annual quality assurance audits. An Independent Verification Visit by NHS England took place in June 2019 and found no further actions required.

As RO/Deputy RO the Medical Director and/or Deputy Medical Director is required to individually review all completed appraisals for both completion and quality. The MAC has developed additional assurance processes to support this, as below:

5.3.1. Support for appraisers

Alongside ensuring robust recruitment and training processes for medical appraisers, regular support and review of the role takes place within 6 monthly appraiser support

forums, existing consultant CPD peer groups, as part of appraisers' own appraisals and via informal support offered by members of the MAC itself.

5.3.2. Feedback from appraisees

Appraisee feedback forms are automatically generated by SARD-JV and sent to appraisees after all completed appraisals. Return rates are high. Completed returns are screened by the medical director's office and reviewed quarterly by the MAC. Any concerning feedback is followed up individually by the MAC chair in order to address potential problems in a timely manner. Collated (anonymised) feedback covering the entire appraisal year is circulated to all appraisers, and individualised (anonymised) feedback to appraisers. Summarised feedback has previously been benchmarked against feedback collated from other similar organisations (and considered comparable).

5.3.3. Automatic uploading of complaints and anonymised SI reports

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will then be referred to and reflected on as part of appraisal.

5.3.4. Annual Quality Assurance audit

The annual medical appraisal quality assurance re-audit was conducted in April 2021 by all members of the MAC, using a nationally recognised medical appraisal QA tool. New appraisers were audited at the time of completion to avoid delay in scrutiny. Due to Covid, this audit covered years 19-20 and 20-21.

8 (11% of all) completed appraisal summaries were randomly selected for both years (16 in total) for audit for completeness and quality; 5 additional appraisals done by new appraisers this year were also audited. Consent was sought from individual appraisees. Results were reviewed at an away day and an action plan subsequently developed, including:

- Preparation of a comprehensive audit report,
- dissemination of key learning points to all appraisers and appraisees and
- individualised feedback provided to appraisers in relation to the specific cases audited.

The results demonstrated maintenance of quality of appraisal outputs. This year the average score from the Excellence Tool stayed the same but the score range was very tight, indicating a more uniform high standard of appraisal documentation.

SARD JV has informed the MAC of its intention to develop its own audit tool, based on the ASPAT, which will be able to automate a lot of the data gathering currently done by this audit. The committee will consider this once it is available, as previous trial of the ASPAT tool in 2019 found that the Excellence tool still provided better scrutiny of appraisal than ASPAT.

The audit will be repeated annually.

Please refer to appendix B.

5.4. Access, security and confidentiality

Appraisees are advised to only upload anonymised documents to their appraisal portfolios so that no patient identifiable information is included. The Medical Director's office has administrative access to SARD portfolios in order to support appraisees and upload information with the agreement and knowledge of appraisees.

5.5. Lay Participation in medical appraisal

Ivars Reynolds, a long-established member of the Mental Health Managers Review panels remains a member of the MAC. His background is in social work and performance management.

5.6. Clinical Governance

The Medical Director's office automatically populates individual doctor's SARD JV portfolios with anonymised complaints and anonymised serious incident reports. The expectation is that these will be readily available to both appraiser and appraisee so that they can be discussed and reflected on in the course of the pre-appraisal preparation and appraisal meeting.

The MAC has set an expectation of 2 completed multi-source feedback (MSF) exercises within each 5-year revalidation cycle. This is greater than the national minimum standard (one completed cycle per 5 years) but provides opportunity to gain more frequent and appropriate feedback allowing the identification, addressing and review of any issues highlighted. Provided the national standard is achieved and there is appropriate consideration in appraisal of one MSF this does not prevent recommendation for revalidation being made. NHS England has a position statement on when to repeat MSF exercises following a change of role which the trust adheres to.

6. Revalidation Recommendations

During the last year 6 revalidation recommendations were due; positive recommendations were made for all of these (100%). All doctors due for a recommendation in the period March to September 2020 were automatically deferred for a period of one year by the GMC due to the Covid pandemic. The GMC are clear that deferral should not be considered as a negative outcome; rather acknowledgement that doctors require more time (for a variety of valid reasons) to gather sufficient evidence for appraisal to take place and revalidation recommendations to be made.

Deferrals are typically recommended either due to long term sickness or to provide additional time in order to gather further evidence required; such as Statutory and Mandatory training compliance or completion of a multi-source feedback exercise.

See appendix C for further details.

7. Recruitment and engagement background checks

Recruitment and engagement checks are completed when doctors are first employed at Gloucestershire Health and Care NHS Foundation Trust; they are in line with the Trust's

Pre-Employment Checks Policy. All pre-employment checks for substantive doctors are completed before employment is started. These checks include:

- Occupational Health Clearance, including any night working
- Identity Verification
- Qualifications
- Right to Work
- DBS - Disclosure and Barring Service - Enhanced Level checks
- References from two line-managers over the last two years
- Medical Practice Transfer Form - information from previous medical director

Please see Appendix E.

8. Monitoring Performance

The performance of Doctors is monitored through the combination of perspectives provided by the following source materials and processes: -

- ❖ Initial design of Job Description and Person Specification
- ❖ Effective recruitment and selection processes
- ❖ Job planning
- ❖ Peer Group membership and attendance
- ❖ Appraisal
- ❖ Monitoring of Serious Incidents, Complaints and Compliments
- ❖ Participation in Supervision
- ❖ Activity data
- ❖ Participation in Continuing Professional Development
- ❖ Completion of Statutory and Mandatory Training
- ❖ Diary Monitoring Exercises
- ❖ Attendance / sickness absence

These perspectives are available through a combination of routine reports and intermittent reviews reporting to the RO, Clinical Directors, Clinicians and Managers. Most also constitute areas that are considered as part of the Appraisal process.

Please refer to appendix D.

9. Responding to Concerns and Remediation

The Policy on the Management and Remediation for Concerns about the Professional Conduct and Clinical Performance of Medical Practitioners provides a framework that interprets national policy and best practice for local delivery.

No doctors are currently in receipt of input within the framework provided by this policy.

Please refer to appendix D.

10. Risk and Issues

Overall engagement in and compliance with appraisal has remained high throughout the last appraisal year despite the challenges presented by the pandemic. This is largely due to the improved engagement of doctors achieved over recent years and also to the

ongoing work of the Medical Director's team in monitoring compliance and providing prompting and support. This has been possible due to the universal use of the SARD-JV software.

However, the sensitivity of the monitoring system, which allows no latitude in completion date before a doctor is flagged as non-compliant, combined with the limited range of exceptions, mean that rolling compliance rates vary from month to month without appraisal uptake having altered markedly. Exceptions this year are again accounted for mostly by new starters.

There is a significant time and therefore cost associated with both completion of appraisals as an appraisee (estimate 16-36 data collection hours per annum) and appraiser (4-6 hours per appraisal). This does not take account of the activity associated with populating appraisal documentation or undertaking multi-source feedback, audits, peer groups, supervision and training. This impacts on the availability of retired doctors to undertake locum and part time work and will create a particular pressure in Mental Health service provision in the future.

Recruits from outside the UK have not taken part in this process and thus for the first year of any practice have not undertaken appraisal whilst they are collecting data. This is a nationally recognised issue and one further expanded on in the Pearson review.

The scope of work that a doctor can undertake is determined by and determines their CPD and CME requirements. There is a raised expectation that any activities have an associated CME/CPD function. This does limit practitioner flexibility and cover to specialist areas, a particular issue in relation to on-call rotas and 7 day working.

11. Corrective Actions, Improvement Plan and Next Steps

The MAC will continue to review its work plan against the terms of reference annually. The Trust medical appraisal policy was reviewed in November 2020. Priorities for the MAC for the next year include ongoing consideration of ways to improve patient and public involvement in appraisal and revalidation processes; further refinement of the number and nature of active qualified medical appraisers within the organisation; and continuing focus on moving beyond compliance towards further quality improvement.

The MAC will investigate individual cases where appraisal is not completed (without reason) within a reasonable time frame. Subsequent investigation reports will be submitted to the Medical Director/Responsible Officer who will decide on further action. Doctors who have not completed annual appraisal are not eligible for routine pay progression or local clinical excellence awards; Gloucestershire Health and Care NHS Foundation Trust has the right to terminate the contract of a doctor if they do not undergo annual appraisal without having good reason.

Workforce planning will need to take account of the possible limitations to the scope of practice and perhaps the limited workforce that may be available due to retirement.

12. Recommendations

The Board is asked to accept the Annual Report on Medical Revalidation and Appraisal and:

❖ Recognise the support provided to Appraisal and Revalidation within GHC NHSFT through the use of SARD JV and the engagement of clinicians in this.

❖ Recognise the work undertaken and planned by the Medical Appraisal Committee to support the work of the Medical Secretariat and Responsible Officer in providing, maintaining and developing sustainable recording, reporting and assurance systems.

❖ Recognise that snapshot compliance figures do not reflect annual uptake of appraisal but are primarily a function of the way data is collected. In any year the expected outturn is for 100% of doctors with a prescribed connection to this Designated Body to be appraised; however, there will be exceptions which will reduce the overall figure.

❖ Appropriate processes are in place for the review of Appraisals, Appraiser performance, maintenance of Appraisal capacity and the quality of appraisals.

❖ Employment checks are undertaken consistent with national standards and best practice.

❖ Locum use, whilst significant, is reviewed and regulated, aimed at maintaining clinical provision to cover mostly medium to long term absence including long term sickness and recruitment.

❖ To note in particular the assurance in section 13 and for the Chair of the Trust to complete the Statement of Compliance on behalf of the Trust.

13. NHSE Statement of Compliance

Section 1 – General

The board / executive management team – of Gloucestershire Health and Care NHS Foundation Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

> Action from last year: None
>
> Comments: Dr Uppal has already been appointed at Responsible Officer for the new merged organisation. Dr Haynes is Deputy Responsible Officer.
>
> Action for next year: None

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

> Yes/No [delete as applicable] Yes
>
> Action from last year: None
>
> Comments:
>
> Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

> Action from last year: Yes
>
> Comments: Maintained by Medical Director's office.
>
> Action for next year: None

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

> Action from last year: None
>
> Comments:
>
> Action for next year: Policies will need to be reviewed and aligned for new merged organisation.

5. A peer review has been undertaken of this organisation's appraisal and revalidation processes.

> Action from last year: None
>
> Comments: Undertaken in April 2021 on 19/20 and 20/21 by the Medical Appraisal Committee.
>
> Action for next year: Repeated annually at the MAC away half day.

7. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

> Action from last year: None
>
> Comments: Process is in place and actively monitored by the Medical Secretariat
>
> Action for next year: Continue with current provision.

Section 2 – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.

> Action from last year: None

Comments: Except those where there is an accepted reason agreed by the Responsible Officer.

Action for next year: Continue with current practice.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: None

Comments: Yes a full record of non-compliance and reasons for exemption is maintained by the Medical Secretariat.

Action for next year: Continue with current practice. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: None

Comments: Submitted to the board annually.

Action for next year: Continue with current practice.

3. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: None

Comments: Appraiser numbers are regularly monitored by the MAC, and a minimum and maximum number of appraisals per year stipulated for appraisers.

Action for next year: Continue with current practice.

4. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: None

Comments: 10% appraisals audited annually for quality control. Appraisers are monitored for attendance at update training. Feedback is sought from appraisees and followed up by the MAC chair.

Action for next year: Continue with current practice.

5. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

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[1] http://www.england.nhs.uk/revalidation/ro/app-syst/
[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Action from last year: None

Comments: Annual audit of 10% appraisals, and the first 3 appraisals done by each new appraiser. This considers whether the appraisal has covered (at appropriate depth) scope of work, progress towards previous year's PDP, and a SMART PDP for next year which reflects the trust's aims and objectives. It considers whether appropriate challenge and support has been present, and whether the doctor is on course for successful revalidation.

Action for next year: Continue with current practice.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

    Action from last year: None

    Comments: A thorough system is in place with the Medical Secretariat.

    Action for next year: Continue with current practice.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

    Action from last year: None

    Comments: Doctors are informed at regular intervals of the status of their revalidation and what recommendation will be made. If a recommendation other than positive is made the doctor would be fully informed as to the reasons for this.

    Action for next year: Continue with current practice.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

    Action from last year: None

    Comments: The appraisal system combined with job planning is an effective means of delivering effective clinical governance for doctors.

    Action for next year: Continue with current practice.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: None

Comments: A thorough system is in place with the Medical Secretariat.

Action for next year: Continue with current practice.

3. There is a process established for responding to concerns about any licensed medical practitioner's fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: None

Comments: A thorough system is in place with the Medical Secretariat and supported by a current responding to concerns policy.

Action for next year: Continue with current practice.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors[2].

Action from last year: None

Comments: An annual report to the board provides quality assurance on concerns.

Action for next year: Continue with current practice.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation[3].

Action from last year: None

Comments: Yes

Action for next year: Continue with current practice.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

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[4]This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: None

Comments: Yes

Action for next year: Continue with current practice.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

    Action from last year: None

    Comments: A thorough process is in place within Medical Staffing and HR.

    Action for next year: Continue with current practice.

Section 6 – Summary of comments, and overall conclusion

The Medical Appraisal Committee supports the RO and his office by ensuring high quality appraisals for all doctors within the trust. These systems are now established and repeated annually; they ensure medical governance. Data collection is possible via the SARD JV software, with all doctors using this for appraisal to ensure immediate knowledge of poor compliance.

There are no actions outstanding for this report, as the annual reviews will continue to ensure the provision of high quality appraisals for trust doctors. Policies have been reviewed and aligned for the new merged organisation.

Section 7 – Statement of Compliance:

The Board of Gloucestershire Health and Care NHS Foundation Trust has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Gloucestershire NHS Foundation Trust

Name: Ingrid Barker   Signed: _ _ _ _ _ _ _ _ _ _

Role: Chair   Date: _ _ _ _ _ _ _ _ _ _

Audit of all missed or incomplete appraisals (as of 1ˢᵗ April 2021)

Doctor factors (total)	
Maternity leave during the majority of the 'appraisal due window'	
Sickness absence during the majority of the 'appraisal due window'	2
Prolonged leave during the majority of the 'appraisal due window'	1
Suspension during the majority of the 'appraisal due window'	
New starter within 3 month of appraisal due date	5
New starter more than 3 months from appraisal due date	3
Postponed due to incomplete portfolio/insufficient supporting information	
Appraisal outputs not signed off by doctor within 28 days	4
Lack of time of doctor	
Lack of engagement of doctor	
Other doctor factors	
Appraiser factors	
Unplanned absence of appraiser	
Appraisal outputs not signed off by appraiser within 28 days	
Lack of time of appraiser	
Other appraiser factors (not known)	
Organisational factors	
Administration or management factors	
Failure of electronic information systems	
Insufficient numbers of trained appraisers	
Other organisational factors (describe)	
Total	15

Quality assurance audit of appraisal inputs & outputs using the Excellence audit tool

Number	Criterion (following scrutiny of the appraisal summary, score 0-2 for each criteria)	Frequency (% in brackets)		
		absent	room for improvement	well done
1	Includes whole scope of work?	1 (5%)	8 (38%)	12 (57%)
2	Free from bias?	0	0	21 (100%)
3	Challenging & supportive?	0	4 (19%)	17 (81%)
4	Exceptions explained?	0	0	21 (100%)
5	Reviews & reflects?	0	5 (24%)	16 (76%)
6	Review of previous PDP?	0	2 (10%)	19 (90%)
7	Encourages excellence?	0	3 (14%)	18 (86%)
8	Gaps identified?	2 (10%)	4 (19%)	15 (71%)
9	SMART PDP?	0	2 (10%)	19 (90%)
10	Relevant PDP?	0	2 (10%)	19 (90%)

Quality assurance audit scores
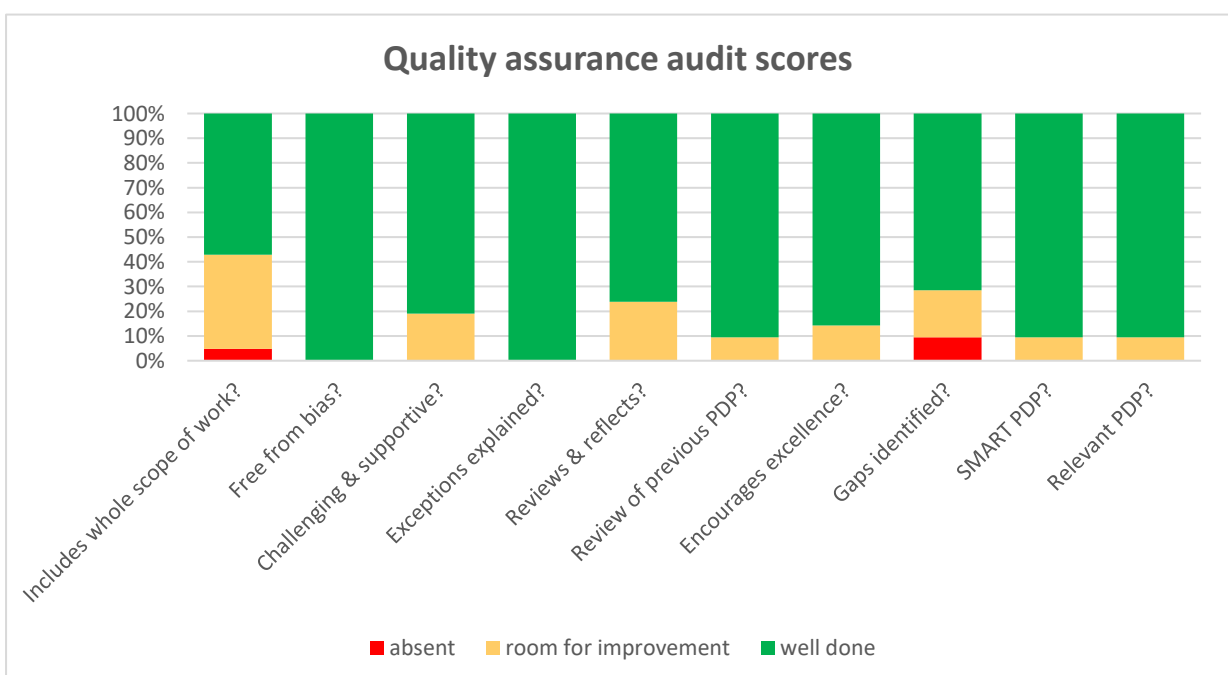
Audit of revalidation recommendations

Note: The GMC automatically deferred doctors' revalidation for one year due to Covid-19.

Revalidation recommendations between 1st April 2020 to 31st March 2021	
Recommendations completed on time (within the GMC recommendation window)	6 (Positive) 0 (Deferral)
Late recommendations (completed, but after the GMC recommendation window closed)	0
Missed recommendations (not completed)	0
TOTAL	6 (Positive) 0 (Deferral)
Primary reason for all late/missed recommendations For any late or missed recommendations only one primary reason must be identified	
No responsible officer in post	0
New starter/new prescribed connection established within 2 weeks of revalidation due date	0
New starter/new prescribed connection established more than 2 weeks from revalidation due date	0
Unaware the doctor had a prescribed connection	0
Unaware of the doctor's revalidation due date	0
Administrative error	0
Responsible officer error	0
Inadequate resources or support for the responsible officer role	0
Other	0
Describe other – Trust was in negotiations with Doctor and GMC	0
TOTAL [sum of (late) + (missed)]	0

Audit of concerns about a doctor's practice (1st April 20 to 31st March 21)

Please note this does not include information about dentists. This will be incorporated next year.

Concerns about a doctor's practice	High level[4]	Medium level[2]	Low level[2]	Total
Number of doctors with concerns about their practice in the last 12 months Explanatory note: Enter the total number of doctors with concerns in the last 12 months. It is recognised that there may be several types of concern but please record the primary concern	1		2	3
Capability concerns (as the primary category) in the last 12 months	1 - Concerns cover all areas			
Conduct concerns (as the primary category) in the last 12 months				
Health concerns (as the primary category) in the last 12 months			2	3
Remediation/Reskilling/Retraining/Rehabilitation				
Numbers of doctors with whom the designated body has a prescribed connection as at 31 March 2021 who have undergone formal remediation between 1 April 2020 and 31 March 2021 *Formal remediation is a planned and managed programme of interventions or a single intervention e.g. coaching, retraining which is implemented as a consequence of a concern about a doctor's practice* *A doctor should be included here if they were undergoing remediation at any point during the year*				0
Consultants (permanent employed staff including honorary contract holders, NHS and other government /public body staff)				0
Staff grade, associate specialist, specialty doctor (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS and other government /public body staff)				0
General practitioner (for NHS England area teams only; doctors on a medical performers list, Armed Forces)				0
Trainee: doctor on national postgraduate training scheme (for local education and training boards only; doctors on national training programmes)				0
Doctors with practising privileges (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade)				0

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[4] http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/03/rst_gauging_concern_level_2013.pdf

Concerns about a doctor's practice	High level[4]	Medium level[2]	Low level[2]	Total
Temporary or short-term contract holders (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc) All Designated Bodies				0
Other (including all responsible officers, and doctors registered with a locum agency, members of faculties/professional bodies, some management/leadership roles, research, civil service, other employed or contracted doctors, doctors in wholly independent practice, etc) All Designated Bodies				0
TOTALS				0
Other Actions/Interventions				
Local Actions:				
Number of doctors who were suspended/excluded from practice between 1 April and 31 March: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included				0
Duration of suspension: Explanatory note: All suspensions which have been commenced or completed between 1 April and 31 March should be included Less than 1 week 1 week to 1 month 1 – 3 months 3 - 6 months 6 - 12 months				
Number of doctors who have had local restrictions placed on their practice in the last 12 months?				0
GMC Actions: Number of doctors who:				
Were referred by the designated body to the GMC between 1 April and 31 March				0
Underwent or are currently undergoing GMC Fitness to Practice procedures between 1 April and 31 March				0
Had conditions placed on their practice by the GMC or undertakings agreed with the GMC between 1 April and 31 March				1 (c/f from 17/18)
Had their registration/licence suspended by the GMC between 1 April and 31 March				0
Were erased from the GMC register between 1 April and 31 March				0
National Clinical Assessment Service actions:				
Number of doctors about whom the NHS Resolution (previously NCAS) has been contacted between 1 April and 31 March for advice or for assessment				2
Number of NHS Resolution assessments performed				0

Audit of recruitment and engagement background checks

Number of new doctors (including all new prescribed connections) who have commenced in last 12 months (including where appropriate locum doctors)	
Permanent employed doctors	5
Temporary employed doctors	9
Temporary employed doctors who became substantive	5
Locums brought in to the designated body through a locum agency	16
Locums brought in to the designated body through 'Staff Bank' arrangements	9
Doctors on Performers Lists	0
Other Explanatory note: This includes independent contractors, doctors with practising privileges, etc. For membership organisations this includes new members, for locum agencies this includes doctors who have registered with the agency, etc	0
TOTAL	**44**

For how many of these doctors was the following information available within 1 month of the doctor's starting date (numbers)?

	Total	Identity check	Past GMC issues	GMC conditions or undertakings	On-going GMC/NCAS	Disclosure and Barring Service	2 recent references	Name of last responsible officer	Reference from last responsible	Language competency	Local conditions or undertakings	Qualification check	Revalidation due date	Appraisal due date	Appraisal outputs	Unresolved performance
Permanent employed doctors	5	5	5	5	5	5	5	5	0	5	0	5	5	0	0	5
Temporary employed doctors	9	9	9	9	9	9	9	9	0	9	0	9	9	0	0	9
Temporary employed doctors who became substantive	5	5	5	5	5	5	5	5	n/a	5	n/a	5	5	n/a	n/a	n/a
Locums brought in to the designated body through a locum agency	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Locums brought in to the designated body through 'Staff Bank' arrangements	8	8	8	8	8	8	8	8	0	8	0	8	8	0	0	0
Doctors on Performers Lists	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other (independent contractors, practising privileges, members, registrants, etc)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	44	44	44	44	44	44	44	44	16	44	16	44	44	16	16	16

NB. MPIT forms from previous Designated Body

These forms provide information from previous Responsible Officer. We have experienced huge difficulty getting responses to these requests for MPIT forms especially within 1 month of starting; the GMC have been made aware. Plus, this form is not required for all new doctors employed, i.e. Covid FTC exempt, trainees who are then appointed etc.

For Providers of healthcare i.e. hospital trusts – use of locum doctors:

Explanatory note: Number of locum sessions used (days) as a proportion of total medical establishment (days)

The total WTE headcount is included to show the proportion of the posts in each specialty that are covered by locum doctors

Locum use by specialty:	Total establishment in specialty (current approved WTE headcount)	Consultant: Overall number of locum days used	SAS doctors: Overall number of locum days used	Trainees (all grades): Overall number of locum days used	Total Overall number of locum days used
Surgery	0	0	0	0	0
Medicine	0	0	0	0	0
Psychiatry	104.62(Total WTE)	3 WTE	4 WTE	0	7 WTE
Obstetrics/Gynaecology	0	0	0	0	0
Accident and Emergency	0	0	0	0	0
Anaesthetics	0	0	0	0	0
Radiology	0	0	0	0	0
Pathology	0	0	0	0	0
Other – Occ Health	0	0	0	0	0

Total in designated body (Includes all doctors, not just those with a prescribed connection)					
Number of individual locum attachments by duration of attachment (each contract is a separate 'attachment' even if the same doctor fills more than one contract)	Total	Pre-employment checks completed (number)	Induction or orientation completed (number)	Exit reports completed (number)	Concerns reported to agency or responsible officer (number)
2 days or less	0	0	0	0	0
3 days to one week	0	0	0	0	0
1 week to 1 month	4	4	4	0	0
1-3 months	3	3	3	0	0
3-6 months	5	5	5	0	0
6-12 months	2	2	2	0	0
More than 12 months	2	2	2	0	0
Total	16	2	2	0	0

Gloucestershire Health and Care
NHS Foundation Trust

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 SEPTEMBER 2021**

PRESENTED BY: Ingrid Barker, Chair

AUTHOR: Ingrid Barker, Chair

SUBJECT: **REPORT FROM THE CHAIR**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐   Endorsement ☐   Assurance ☑   Information ☑

The purpose of this report is to
To update the Board and members of the public on my activities and those of the Non-Executive Directors to demonstrate the processes we have in place to inform our scrutiny and challenge of the Executive and support effective Board working.

Recommendations and decisions required

The Board is asked to:
- **Note** the report and the assurance provided.
- **Note** the changes within the Non-Executive Directors and subsequent Portfolio amendments

Executive summary

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board developments – including updates on Non-Executive Directors
- Governor activities – including updates on Governors
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

Risks associated with meeting the Trust's values
None.

Corporate considerations	
Quality Implications	None identified
Resource Implications	None identified
Equality Implications	None identified

Where has this issue been discussed before?
This is a regular update report for the Trust Board.

Appendices:	**Appendix 1** – Non-Executive Director Portfolios from 1ˢᵗ October 2021 **Appendix 2** - Non-Executive Director – Summary of Activity – July and August 2021

Report authorised by: Ingrid Barker	Title: Chair

Gloucestershire Health and Care NHS Foundation Trust – **TRUST BOARD PUBLIC SESSION – 30ᵗʰ Sept 2021**
AGENDA ITEM: 13 – REPORT FROM THE CHAIR   Page 2

working together | always improving | respectful and kind | making a difference

with you, for you

REPORT FROM THE CHAIR

1. INTRODUCTION AND PURPOSE

This report seeks to provide an update to the Board on the Chair and Non-Executive Directors activities in the following areas:

- Board developments
- Governor activities
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

2. BOARD

Bereavements

It is my sad duty to report that the Trust has lost two senior colleagues over the past few weeks.

Alison Willmott-Miller who passed away in August after a long battle with illness. Alison had been the Deputy Director of Human Resources for GHC until she took ill health retirement a couple of months ago. She joined the former 2gether NHS Foundation Trust in 2014 as Assistant HR Director. Prior to this, having first started working in the NHS in catering, Alison worked from 1997 in various Medical Staffing and HR roles in the Royal Orthopaedic Hospital NHS Foundation Trust, Worcestershire Health and Care and Worcestershire Community and Mental Health NHS Trust. Alison was a respected, dedicated and hardworking colleague who will be deeply missed by those who worked with her over the years. Trust colleagues are being invited to contribute to a fundraising collection for St. Richard's Hospice, who cared for Alison in her final stages of illness, through their @JustGiving page.

Dr. Mike Roberts who passed away on 14th August after a period of illness. Mike was the Medical Director for Gloucestershire Care Services NHS Trust from May 2015 until January 2019 when he stepped down to focus on his role as a GP at Rosebank Surgery in Gloucester. Mike had previously served as Professional Executive Chair for West Gloucestershire Primary Care Trust, Medical Professional Lead (and responsible officer) for Gloucestershire PCT and as a member of the Gloucestershire Local Medical Committee. He also had a particular interest in clinical governance and was a member of the Performance Advisory Group of NHS England, which dealt with complaints about concerns about GP performance. Mike's warmth and humour, as well as his deep commitment to the community he served in inner city Gloucester, were his hallmarks. He will be greatly missed by many. A collection from Board colleagues was made and a donation was sent to the family's chosen charity, Amnesty International.

The Trust was represented by friends and colleagues at both funerals and our thoughts are with Alison and Mike's families at this very sad time.

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2.1 Non-Executive Director (NED) Update

- Today's meeting will be Maria Bond's last meeting with the Trust Board. I recognised Maria's significant contribution to 2gether and GHC in my July Report, so here I would just like to record my personal thanks to Maria for being such a key member of the Non-Executive Team during the pandemic and for the support, advice and assistance she has given to me and the rest of the Board during her time with us. I know she will continue to be a strong advocate for the Trust and the NHS as a whole. We wish her well as she embarks on her new role as a NED with Gloucester City Homes

- With the departure of Maria Bond on 30th September and the arrival of new Non-Executive Director Clive Chadhani on 1st October, we have taken the opportunity to review the Non-Executive **Portfolios**, a copy of which is appended to this report (Appendix 1).

- The Non-Executive Directors and I continue to hold our **monthly meetings** and meetings were held on 24th August and 21st September. NED meetings have been helpful check in sessions as well as enabling us to consider future plans and reflect on any changes we need to put in place to support the Executive at this difficult time and to continuously improve the way we operate.

- I continue to have regular meetings with the **Vice-Chair and Senior Independent Director**, along with individual 1:1s with all Non-Executive Directors.

2.2 Board Updates:

An **Extra-ordinary meeting of Private Board** was held on 18th August to consider our Trust response to proposals for the development of the ICS.

Board Development:
We continue to devote significant time to considering our Board ways of working and how we ensure that transformation remains central to the way we work, whilst the necessary focus is maintained on ensuring high quality care and colleagues' wellbeing. The following sessions have taken place:

Board Seminar – 18th August – Research and Innovation (more detail within the CEO's Report)

Board Training – 18th August – Oliver McGowan (more detail within the CEO's Report)

3. GOVERNOR UPDATES

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 25th August, along with Trust Secretary / Head of Corporate Governance Lavinia Rowsell, and Assistant Trust Secretary, Anna Hilditch, to discuss agenda planning for the Council meeting on 8th September, and I had a

one-to-one meeting on 2ⁿᵈ September. These sessions are helpful as we work together to further develop the Council of Governors.

- A meeting of the **Council of Governors** was held on 8ᵗʰ September where matters covered included an update on the development of the Governor Dashboard and a Holding to Account presentation in relation to the Audit and Assurance Committee. Both of these developments help to ensure the Council of Governors knows what is happening at the Trust and can challenge and ask informed questions of the Non-Executive Directors to support the effective working of the Trust.

- I had an introductory meeting with **Councillor Rebecca Fairfax**, the County Council's nominated Governor on 16ᵗʰ September.

- **Governor changes**:
  June Hennell, Public Governor for Stroud, has recently stood down as a Governor with immediate effect. June is unwell at the moment and we all send her our very best wishes for a speedy recovery. June's experience and passion will be greatly missed on the Council. Arrangements are being put in train to hold an election for this public governor vacancy in Stroud.

4. **NATIONAL AND REGIONAL MEETINGS**

Since the last meeting of the Trust Board in July, I have attended a breadth of national
meetings:

- **South West Provider NHS Chairs** – 6ᵗʰ September – where we heard from the Director of Primary Care and Population Health for the South West talk about the challenges and plans for primary care in the region.

- **NHS Providers Chairs and Chief Executives Network** – 14ᵗʰ September – where we received a strategic policy update from the Deputy CEO for NHS Providers and an update on Integrated Care Systems

- **National Chair's Advisory Group** on 20ᵗʰ September.

- **NHS Confederation NHS Reset Webinars** continue to take place on a regular basis and attended by some of the Non-Executive Directors. These recognise the continuing challenges faced by the NHS and the need to move effectively to a new normal taking with us the learnings from the past months.

- **NHS Confederation Mental Health Network** – meetings take place weekly and I attend when my diary permits.

- **South West/South East Regional Roadshow with Amanda Pritchard (CEO) and Mark Cubbon (Interim COO), NHS England – 17ᵗʰ September** – this was an opportunity for Chairs and CEOs to discuss top priorities with the NHS Leadership Team.

5. WORKING WITH OUR PARTNERS

I have continued my regular virtual meetings with key stakeholders and partners where views on the working of the health and care system and the way we can mutually support each other are key issues for consideration. Highlights are as follows:

- The Chief Executive and I had an introductory meeting with the newly appointed **Police and Crime Commissioner, Chris Nelson**, and his **Deputy, Nick Evans**, on 25th August where we discussed matters of joint interest and concern. A follow up meeting is being scheduled for the Autumn and we look forward to working with them going forward.

- The **County's ICS Health Chairs** continue to meet virtually and we held a meeting on 14th September.

- The **Chair of Gloucestershire Hospitals NHSFT**, Peter Lachecki, and I continue to meet virtually on a regular basis to discuss matters of mutual interest.

- I also continue to have regular meetings with the **Independent Chair of the ICS Board, Dame Gill Morgan.**

- **ICS Boards** were held on 19th August and 16th September. A number of important operational and strategic issues were discussed. Partnership work is a key aspect of the County's response during the pandemic and this group helps ensure effective working is supported. Discussions also took place regarding the development plans for the ICS over the coming year.

- A **joint meeting of Gloucestershire County Council's Health and Wellbeing Board and the ICS Board** was held on 21st September where the Boards considered future working arrangements as part of the new ICS developments.

- As part of the Trust's continuing partnership working with the **University of Gloucestershire**, I attended a **multi-disciplinary/agency workshop** on 13th September where we discussed broader partnership ambitions and potential areas for development.

- **Children and Young People's Mental Health Summit – 7th October 2021**
  One in eight children and young people already have a diagnosable mental health condition, and research suggests that the pressures created by the Covid-19 pandemic are exacerbating their needs. We know that children and young people from certain demographics are already disproportionately affected by mental health issues, with the pandemic widening these inequalities as well as increasing the overall prevalence. While our children's mental health support services in Gloucestershire deserve enormous credit for responding to the challenges of the pandemic so far, we are unfortunately already seeing an unprecedented and sustained surge in need across the county. There has also been ongoing work to make improvements to support across the county including

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on line options, support in schools and creative health, as well as further recruitment of staff to services. With demand likely to continue, we cannot afford to lose momentum. I have been asked to Chair a Summit taking place on Thursday 7th October and which is being organised by Gloucestershire Clinical Commissioning Group, to further develop our county-wide commitments to better support our young people's mental health

6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

The Trust was pleased to welcome several high-level visitors throughout August, as follows:

- **11th August – Sir Kier Starmer, Leader of the Labour Party**, visited Stroud Hospital as part of a 'summer tour'. He was welcomed by Trust colleagues including Senior Independent Director, Marcia Gallagher, who kindly attended on my behalf (I was on annual leave). Sir Kier spent time talking to colleagues about a range of issues, including how the pandemic had impacted on the Trust's teams and services. Stroud Hospital Matron, Liz Lovatt, gave him a guided tour of the hospital, which included introducing Sir Kier to teams. He then spent time in the garden answering questions and asking staff about the issues that matter to them.

- **12th August – Richard Graham, MP for Gloucester**, accompanied by Deputy Chief Operating Officer, Sarah Birmingham, spent time with colleagues at mental health inpatient units at Wotton Lawn Hospital, CAMHS and CYPS at Acorn House, the Integrated Care Team at Collingwood House and Adult Community Mental Health colleagues at Pullman Place in Gloucester.

- **25th August – County Councillor David Drew,** newly appointed Member and Vice Chair of Gloucestershire County Council's Health Overview and Scrutiny Committee, visited the Vale Hospital in Dursley. The Trust's Director of Nursing, Quality and Therapies, John Trevains, and I welcomed him to the hospital. We received a presentation on sites and services in the Stroud and Berkeley Vale communities. We were then joined by Angela Dodd, Head of Therapies, who led a tour of the hospital noting the full reopening of the Minor Injuries and Illness unit, the rehab garden and allotment. My thanks to John Trevains, Angela Dodd and colleagues for sparing time in their busy schedules.

- **31st August – County Councillor Stephen Davies, Gloucestershire County Council's Cabinet Member for Children's Safeguarding and Early Years -** I was delighted to host this visit to Evergreen House at Charlton Lane, where Cllr Davies received presentations from colleagues who work within the Trust's Children's Services area, including CYPS Physiotherapy Service, Children's Learning Disabilities Service, Health Visiting overview, Immunisation Team, Vulnerable Children's Service and Young Minds Matter.

- On 7th September, Justine Hill (Deputy Service Director, Mental Health Specialist Services) and I met with **John Nolan, Chief Executive of the Nelson Trust**, at their Women's Centre in Gloucester, to discuss matters of mutual interest.

- I chaired a quarterly meeting of the **County's Leagues of Friends Chairs** meeting on 9th September.   Angela Potter, the Trust's Director of Strategy and Partnerships, was also in attendance and gave updates on the Trust's response to COVID-19; the Integrated Care System; Fit for the Future; Forest of Dean Hospital; Minor Injury and Illness Units; Stroke Unit. It was interesting to receive updates from the Chairs on activities which have taken place within their areas.

- I met with the Chief Executive of the **Barnwood Trust,** Sally Byng, for a discussion on matters of mutual interest on 15th September.

7.   ENGAGING WITH OUR TRUST COLLEAGUES

- **Appointment and Terms of Service Committees (ATOS**) were held on 25th August and 1st September.

- Formal **quality visits** by myself and the Non-Executive Directors have now resumed to services across the Trust. I visited **Colliers Court in Cinderford** on Tuesday 24th August. My thanks to Jonathan Thomas, Community Services Manager, for sparing time in his busy schedule to introduce me to the various teams based at Colliers Court, which is a base for several mental health and learning disability teams as well as the complex care at home team.

- Following a comprehensive national recruitment process supported by NHS Executive Search, I am delighted to confirm that David Noyes will be joining the Trust as **Chief Operating Officer (COO).** David is currently the COO at Solent NHS Trust; prior to that he was Director of Planning, Performance and Corporate Services at Wiltshire CCG, and previously David was a Naval officer for 28 years, specialising principally in logistics, including a deployment as Chief Operating Officer for logistics with the Army's Logistics Brigade in Afghanistan. David's start date with the Trust will be confirmed as soon as possible.

- I carried out an informal visit to the **Mental Health Liaison Team** based at Gloucestershire Royal Hospital on 1st September, where I was met by Gill Hughes, Deputy Lead Nurse. My thanks to Gill and the team for sparing time in their very busy schedules.

- I attended a meeting of the Trust's **Women's Leadership Forum** on 6th September where we heard a fascinating presentation from Superintendent Jane Probert from Gloucestershire Constabulary.

- The **Trust's AGM** took place on 22nd September. This was again a virtual event which provided the latest updates about the Trust including our response to the pandemic and our financial position. There was an opportunity to ask questions of the Council of Governors and the Board.

- I attended a **Reciprocal Mentoring Development Workshop** on 23rd September which reinforced the benefits to both parties in these partnerships.

- I attended a meeting of the **Senior Leaders Network** on 28th September.

- As part of my regular activities, I continue to have a range of virtual **1:1 meetings with Executive colleagues**, including a weekly meeting when possible with the Chief Executive and the Trust Secretary/Head of Corporate Governance.

Whilst drop in chats with services and colleagues continue to be mainly virtual I continue to try to make myself available to support colleagues and recognise their endeavours. I have an active presence on social media to fly the GHC flag and highlight great work across the county.

8. NED ACTIVITY

The Non-Executive Directors continue to be very active, attending virtual meetings across the Trust and where possible visiting services.

See **Appendix 2** for the summary of the Non-Executive Directors activity for July and August 2021.

9. CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided.

			APPENDIX 1 - NON-EXECUTIVE DIRECTOR – PORTFOLIOS – FROM 1ST OCTOBER 2021							
NON-EXECUTIVE DIRECTOR	**LOCALITY**	**CHAMPION**	AUDIT *	RESOURCES	QUALITY	MHLS	REAT PLACE TO WORK	CHARITABLE FUNDS	ATOS	FOREST ASSURANCE
Graham Russell (Vice-Chair) Graham.russell@ghc.nhs.uk	Stroud		X		X		C		X	VC
Marcia Gallagher (Senior Independent Director – SID) Marcia.gallagher@ghc.nhs.uk	Forest	• Counter-fraud, Security and Procurement • Health & Safety	C		X			VC	X	
Dr Stephen Alvis Steve.alvis@ghc.nhs.uk	Cotswolds	• Primary Care Networking countywide • Learning from Death		X	VC	VC (C MHAMF)			X	X
Steve Brittan Steve.brittan@ghc.nhs.uk	Tewkesbury	• Technology and Innovation	X	C			X		X	C
Sumita Hutchison Sumita.hutchison@ghc.nhs.uk	Gloucester	• Equality and Diversity • Climate Protection • Wellbeing Guardian				C	VC	C	X	
Jan Marriott Jan.marriott@ghc.nhs.uk	Cheltenham	• FTSU • Learning Disabilities		VC	C				X	

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Clive Chadhani clive.chadhani@ghc.nhs.uk	Greater England & Wales	• TBC	VC	X				X	X	

All NEDs are members but 4 are nominated as regular attendees

Quality/Resources link – Jan Marriott

Quality/Great Place to Work link – Graham Russell

Resources/Great Place to Work link – Steve Brittan

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NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
Dr. Stephen Alvis	Nosocomial Transmission Panel Meeting with Governor NHS Reset Chairs meeting Team Talk Chief Operating Officer Recruitment – discussion group Senior Leadership Network	GGI meetings (3) Planning meeting for GGI meeting	Quality Committee MHAM Forum Council of Governors Extraordinary Trust Board MHLSC Trust Board (Public and Private) NEDs meetings (2) Board Seminar Board Training Extraordinary Private Board
Maria Bond	Meeting with Trust Chair Senior Leadership Network Meeting with Joint Director of Locality Development and Primary Care Serious Investigation Review meeting Chief Operating Officer Recruitment – discussion group Chief Operating Officer feedback meeting	NHS Reset Chairs meetings	Quality Committee Council of Governors Extraordinary Trust Board NEDs meetings (2) Trust Board (Public and Private) Audit and Assurance Committee Board Seminar Board Training Extraordinary Private Board Appointment and Terms of Service Committee
Steve Brittan	Quality Visit – Tewkesbury Hospital Meeting with Director of HR	NHS Reset Chairs meeting	Council of Governors Extraordinary Trust Board

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NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Meeting with Director of Strategy and Partnerships Meetings with NEDs (3) Meetings with Director of Finance (3) Meeting with Sustainability Manager Governor Chief Operating Officer recruitment discussion group		Trust Board (Public and Private) Forest of Dean Programme Board Audit & Assurance Committee Board Seminar Board Training Extraordinary Private Board NEDs meetings (2) Appointment and Terms of Service Committee Resources Committee
Marcia Gallagher	Meeting with ICS Chair Meeting with Trust Chair (2) Meetings with Chief Executive (2) Senior Leaders Network GHFT Audit Committee Mentoring meetings with new NED	Good Governance Institute (3) Meeting with Sir Keir Starmer at Stroud Hospital NHS Reset – Digital Visit to Friendship Café and Gloucester City Farm	Extraordinary Trust Board Trust Board (Public and Private) NEDs meetings (2) MHAM Forum Council of Governors Development session Forest of Dean Programme Board Audit and Assurance Committee Board Seminar Board Training Appointment and Terms of Service Committee Resources Committee
Sumita Hutchison	NED recruitment – panel interviews Meeting with SW HWB Guardian Meeting		Quality Committee Extraordinary Trust Board NEDs meetings (2)

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NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Meeting with Trust Chair Meeting with HR and OD Manager Summer Diversity Event Meeting with NED Meeting with Governor Meeting with Sustainability manager Meeting with Director of Nursing		MHLSC Trust Board (Public and Private)
Jan Marriott	Dragon's Den Style assessment for MSC ANP Project with University of Gloucestershire Meetings with Trust Chair (2) Meeting with Trust Chair and ICS Chair Meeting with Medical Director Meeting with Director of Strategy and Partnerships Meeting with NED Meeting with FTSU Guardian Meeting with Patient and Carer Experience Manager Learning Disabilities Services away-day Summer Diversity Celebration Meeting with Vice-Chair and Operational colleagues Meeting with Chief Executive	Mental Health Operational Group	Extraordinary Trust Board MHLSC Trust Board (Public and Private) NED meetings Council of Governors Board Seminar Board Training Extraordinary Trust Board (Private)
Graham Russell	Meetings with Director of Finance (2) Meetings with Trust Chair (2)	Pre-meet for meeting with MPs	Council of Governors (2) ICS Board (2)

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NED Name	Meetings with Executives, Colleagues, External Partners	Other Meetings	GHC Board / Committee meetings
	Meeting with Senior Independent Director ICS Board pre-meet Resources Committee pre-meet Chaired Mental Health focused meeting with Gloucestershire MPs Mental Health and Wellbeing Partnership Board (CCG) Meeting with NED Mental Health accommodation discussion Chief Operating Officer shortlisting and interview panel		Extraordinary Trust Board Trust Board (Public and Private) NED meetings (2) Forest of Dean Programme Board Board Seminar Board Training Extraordinary Private Board Appointment and Terms of Service Committee Resources Committee

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Gloucestershire Health and Care
NHS Foundation Trust

REPORT TO:	**TRUST BOARD PUBLIC SESSION – 30 September 2021**
PRESENTED BY:	Chief Executive Officer and Executive Team
AUTHOR:	Paul Roberts, Chief Executive Officer
SUBJECT:	**REPORT FROM THE CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:

Decision ☐   Endorsement ☐   Assurance ☒   Information ☒

The purpose of this report is to

Update the Board on significant Trust issues not covered elsewhere and on my activities and those of the Executive Team.

Recommendations and decisions required

The Board is asked to note the report.

Executive Summary

The Executive team and I remain working proactively and adaptably as we continue to respond to the ever-changing situation presented by the ongoing pandemic, recovery, and service pressures. We continue to work on ensuring our response to the pandemic follows government guidance and works to meet the needs of our service users and on achieving the aims set out in the Trust Strategy.

As we near the end of the summer we have been working on establishing an effective plan for the winter months with a strong consideration for current and predicted system pressures.

We are working in partnership across the region to ensure effective collaboration and system working so we can create the best possible care for our patients and a great place to work for our colleagues.

The efforts put in by all colleagues to continue to move services and projects forward, while responding to the pandemic continues to be extraordinary. I am proud and grateful

for the hard work, determination, and motivation of all those working within the Trust as we continue to work towards achieving our goals.

The Report demonstrates the Trust's ongoing commitment and focus on inclusion, diversity and equality which continues to receive significant focus despite the operational pressures.

As well as updates on the activity and focus of the CEO, this report provides updates on Bereavements, Awards, the Chief Operating Officer Appointment, and People & Workforce.

Risks associated with meeting the Trust's values

None identified

Corporate considerations	
Quality Implications	Any implications are referenced in the report
Resource Implications	Any implications are referenced in the report
Equality Implications	None identified

Where has this issue been discussed before?

N/A

Appendices:	Report attached.

Report authorised by: Paul Roberts	**Title:** Chief Executive Officer

CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

1.0   CHIEF EXECUTIVE CONTEXT AND ENGAGEMENT

1.1   Covid-19 and service pressures

Gloucestershire numbers at the time of writing this report are lower than other areas across England with 109 cases per 100,000 in the last 7 days. The current expected trajectory is that these numbers will flatten at this level and then are likely to rise in the coming weeks. At time of writing we have no current positive cases within our services. Colleagues are working hard to continue to plan and implement vaccine delivery, including booster vaccines, school immunisation programmes, and winter flu vaccines. Additionally, health and safety training and policies are being put in place to deliver this new programme for colleagues and patients, for example dry ice handling courses are taking place (supported by estates) to manage the cold chain for vaccines. Risks are being assessed on a regular basis including vaccine supply, workforce availability and meeting additional demands. While there is a great deal to deliver, colleagues feel confident that we will be able to meet these expectations.

The pressures faced by all our patient services remain extremely high. A great deal of work has been undertaken to ensure that patients who need to move from acute care to community-based care can do so as quickly and efficiently as possible. Achieving this is clearly better for patients but it also relieves pressure on our acute Trust partner too. The numbers and complexity of patients remains very high indeed and therefore all parts of the health and social care system are working unrelentingly to deliver these services together.

Bed availability continue to be a critical concern. Due to unprecedented pressures on beds in our Gloucestershire Health and Social care system we took a risk assessed operational decision to reopen 8 beds, closed for social distancing requirements, across our community hospitals. This decision was taken due to higher risks to our patients in Gloucestershire. The reopening of these beds is being done in the safest manner with consideration for staff and patient safety. Our enhanced pre-admission screening procedures and our inpatient swabbing schedules alongside our diligence with staff PPE, regular LFD testing and our enhanced cleaning measures, establish that our protective controls can be considered strong. We will also only be admitting double vaccinated patients to these areas with a recorded antibody response within agreed parameters. This is a necessary step needed to be able to offer the best care to our service users within the Trust and our health and care system. John Trevains, the Director of Nursing, Therapies & Quality and Infection Prevention & Control has assured me he feels confident that this is the safest course of action in the circumstances faced by patients and our wider system.

Mental health services for children, young people and adults also continue to have significant pressure. Demand has increased as has complexity and there continues to be significant issues with securing sufficient workforce. Colleagues

in these services have worked under considerable pressure to maintain and recover services and review patient pathways in order to respond to demand.

Board members will also have read in the national press that during August and September there has been a significant shortage of **blood tubes**, which will be pressing over the coming weeks before supplies start to improve. As recommended in the letter issued by our national medical leads setting out expectations for the NHS in England, we are preserving supplies for the most-pressing needs. Supplies are expected before the end of September.

1.2   Internal engagement and developments

The Trust has continued to hold its **Covid-19 briefing calls** for senior and on call managers. The frequency of these meetings is dictated by the level of activity in the Trust and system and are currently being held twice weekly. These calls provide daily national, regional and local updates and data on the number of Covid-19 positive patients in Gloucestershire hospitals. They also provide an update on the GHC testing team, number of staff isolating and any PPE stock updates. These calls ensure we can respond quickly to changes, and are able to assess resilience in these key areas on a regular basis and put in place any actions required.

Virtual **Senior Leadership Network** (SLN) meetings were held on 24th August and 28th September. These provide an excellent opportunity to update participants on Trust and national developments. The August session featured a presentation on *Civility Saves Lives* by Dr Chris Turner. This session discussed how our behaviour towards each other impacts team performance including: the impact rudeness has in the workplace, ways of getting the best out of each other, and finding the value of explicitly respecting each other. A great deal of positive feedback was received following this session – and this campaigning approach is a component part of the Trust quality strategy approved at the last Board meeting.

Monthly **Team Talk** sessions continue to be held as digital events and are led by an Executive or a Deputy. They are open for all Trust employees to attend and provide an opportunity for the Executive Team to share the latest Trust news and for staff to share their thoughts, feelings and concerns. The sessions typically cover an update on the latest Covid-19 and workforce news, amongst other recent items of interest, such as: Clinical System Review updates, Stroud Hospital refurbishment, the approved Quality Strategy, the implementation of Electronic Document Management System, the accreditation of Endoscopy units, the creation of 'Flourish', Immunisation updates, and an update on the 'Be-Kind to You' month. The Team Talk sessions help to ensure effective communication across the Trust and provides an opportunity for the staff voice to be heard directly by the Executive Team.

Due to the rise in demand, **Corporate Induction** for the month of September reverted back to being held weekly as opposed to the previous shift to fortnightly sessions. Corporate Inductions continue to provide an excellent

opportunity for myself and/or the Executive Team to welcome new colleagues into the Trust, introduce our core values, and ensure that everyone feels included.

On 18th August a **Board Seminar** session was held. During the morning session, Dr Amjad Uppal, Medical Director, facilitated a session on Research and Innovation. Presentations were given by senior colleagues followed by collaborative breakout sessions that explored the Trust's values within Research and Innovation initiatives. The morning's session was closed off with a presentation of good news stories on grants, sexual health, and our own account of research within the Trust.

Following the morning session **all seminar participants took place in the Oliver McGowan training**. This Learning Disability and Autism training was provided by Inclusion Gloucestershire. This training is provided across the Trust for Tier 1 (all staff working in any sector who may occasionally interact with people with a learning disability and/or autistic people, but who do not have responsibility for providing direct care or making decisions about care or support) and Tier 2 (Health and social care staff and others with responsibility for providing care and support for an autistic person or people with a learning disability, but who would seek support from others for complex management or complex decision-making) staff. The training was developed following joint working with Oliver McGowan's mother, after Oliver's tragic death. She introduces the training, and vividly recreates Oliver the individual, to help ensure that, as with any service user, we listen and respond to the story and views of individuals with learning difficulties and autism.

On 24th August and 21st September I attended the **NED's meeting** to provide the Chief Executive's update.

I attended the **Appointment and Terms of Service Committee** meeting on 25th August for the annual review of Executive Directors performance and remuneration. It is the responsibility of the Chief Executive to complete the annual appraisals and reports to the Appointment and Terms of Service Committee. I also provided an update on the COO Recruitment (more details outlined in section 4.0).

Weekly **Executive Director Meetings** continue, where collectively the executive team oversee the day to day, and longer term executive management of the Trust. Key agenda items over the past two months have included: clinical service pressures, support for the health and wellbeing of staff, ICS development and transition, recruitment and retention, winter planning and prioritisation, as well as specific operational and workforce pressures in Wotton Lawn Hospital.

I chair the **Trust Senior Team Meetings** bi-monthly which were launched in June. The Trust Senior Team is a forum to bring together senior management and clinical leaders to provide advice to the Executive on the direction and operational management of the Trust. The meeting held on 17th August

included an informative presentation and discussion from Rosemary Neale, Service Director, on Adult Mental Health and the Learning Disability (LD) community, as well as a useful presentation from the Quality Improvement (QI) team on Quality Improvement within a system context and a deeper look into the Quality Strategy. There were also updates provided on the Diversity Networks within the Trust. The Senior Team meetings support the Executive in the delivery of the Trust's strategic aims and objectives through a focus on performance, delivery and leadership development.

The **Trust Annual General Meeting (AGM)** was held on 22nd September where the Chair and I facilitated the latest Trust updates including the Trust's response to the ongoing Covid-19 pandemic, our financial position, as well as a question and answer session with our Council of Governors and Board.

1.3 Mental Health Focus

My own focus on mental health is local, regional and national to progress the mental health agenda as the wider impacts of the pandemic manifest themselves and as services consider how mental health services can continue through the service recovery process. Throughout these conversations and meetings, it is evident that all colleagues and partners believe in the importance of Mental Health Services and are working tirelessly to ensure the best possible service is given across the Trust. As well as the implications for individual citizens these pressures have an impact on all public services. The aim at the establishment of the Trust to provide joined up services, which consider a service users physical and mental health concerns, continue to be an important strand of this work.

I chair the monthly **South West (Regional) Mental Health CEO's** meeting, which acts as the overarching governance summit for the regional South West NHS Provider Collaborative.

On 2nd September I attended the **SW Regional & National Mental Health and Learning Disability and Autism "Deep Dive" meeting**. This meeting, led by national director Claire Murdoch, was broken up into two sessions. The first focused on mental health with an overview of performance, finance, and workforce. The second session centred on learning disabilities and autism looking at a performance review of 2020-2021 and then discussed quality improvement across the regions.

I attended the **extended SW Regional Mental Health** meeting 27th September.

The bi-monthly national NHS England **Mental Health Trusts CEO meeting**, chaired by Claire Murdoch continues to take place. Over the last two months these useful sessions provided updates on mental health, learning disabilities and autism and featured presentations on mental health services data sets, as well as the EPR usability survey, and the IPS resource pack.

I chaired the **South West Mental Health Programme Board** on 26ᵗʰ August. The Mental Health Programme Board looks to develop, implement and support the long-term plan, ambitions, and South West-wide Mental Health priorities. The August meeting discussed the quality and alignment project for mental health data, included mental health performance narratives provided by each system, a discussion on mental health finance, as well as CYP (Children and Young People) benchmarking update and next steps.

I had many informative meetings to discuss Mental Health initiatives across the South West including monthly meetings with Regional Director of Commissioning, Rachel Pearce, and a meeting with Programme Director for New Care Models, Anne Forbes.

Ensuring these initiatives are joined up and learn from best practice is central to the Trust's work in these areas and my wider input into the regional mental health strategy is useful to our local focus as it enables me to be aware of and influence developments across the region.

In Gloucestershire, I now chair the **Community Mental Health Transformation Programme Board**. The CMHT meeting held virtually on 20ᵗʰ September discussed updates on the CMHT People Participation Board (facilitated by Inclusion Gloucestershire), VCSE, as well as NHSE feedback and reporting. We also discussed the programme board's structure with the aim to agree purpose, participation, responsibilities, workstreams and interdependencies.

On the 25ᵗʰ October, the Chair and I had an introductory meeting with the **Police & Crime Commissioner, Chris Nelson** along with his Deputy Nick Evans. During this meeting we discussed **Mental Health** services at length and agreed to progress the conversation further in the coming months.

Following the **Mental Health Liaison Services** meeting on the 5ᵗʰ July the Executive team and I have been working collaboratively to see how we can support the team's concerns pertaining to CYPS and consultant support. Execs have met with the team to discuss implementing actions to address these highlighted areas.

1.4 Tackling Inequalities

I have continued to develop my work as **lead CEO for tackling inequality,** for the Gloucestershire ICS (Integrated Care System). I regularly convene and attend meetings that seek to respond to and in the longer term prevent the systematic inequalities brought to light by the pandemic, as well as the long-standing inequalities which were already recognised. As part of this work, Gloucestershire County Council and the ICS have established an "**inequalities panel**", which I have joined. This is designed to provide oversight of the wider inequality agenda and in particular to provide co-ordination of the Health and Wellbeing Programme and the ICS Programme. The second meeting of this panel, which took place on 12ᵗʰ August, discussed allocation of responsibilities,

health inequalities posts, initial priorities, and included an update on anchor institutions.

I am a member of the **South West Inequalities Leadership Forum** which is designed to share good practice and monitor progress across the South West NHS Region. The most recent meeting took place on 20th September.

I chair the monthly **Gloucestershire Covid-19 Vaccination Equity Group.** The most recent meeting took place on 21st September. The group discussed the latest data report, activities and interventions by the Communications, Operations, and Community Engagement teams, an update on the Better Conversations training, as well as a plan for future meetings. Katie Hopgood, Consultant in Public Health, kindly chaired this meeting on my behalf while I attended the Joint HWB and ICS Board session.

I am a member of the **SW Equality Diversity and Inclusion Board** and attend monthly meetings that discuss various initiatives focusing on improving the experience of NHS colleagues. The meeting held on 23rd September included presentations on talent management and equality, health inequalities, an update on the leading for inclusion programme (for which we are the sponsors for), and an update on the NHS Race Ahead – Big Conversation on Race.

Following the launch of the **Leading for Inclusion Programme** presented at the **SW Regional Chief Executives** meeting on 8th July, the programme has now launched its first workshop which was held on 8th September. This session started the conversation about the role we can play as leaders and how we can affect the cultural change we need to see so that all of our NHS workforce have a positive experience. While I was unable to attend this session due to annual leave, I fully support the initiative and look forward to progressing these values throughout the Trust.

I have attended recent meetings for the **Walk In My Shoes (WIMS)** community reverse mentoring programme at which we have been discussing the approach to putting this programme on a more sustainable longer term basis.

The **Reciprocal Mentoring for Inclusion in GHC Workshop** took place on 23rd September. This full day workshop was well received by all having featured important discussions on building the success of this programme, removing/reducing obstacles, social identities, sharing lifelines, and what needs to happen next.

I continue to meet with new **International Nurses** who join the Trust each month. Recently I have had the pleasure of welcoming Haila Forbes, Archana Achtuthan, Divya Davis, Rinmariya Jose and Jancy James. We are very privileged as an organisation to have such a diverse workforce and greatly benefit from the knowledge and experiences that international team members bring to the Trust.

Equality, Diversity and Inclusion continues to be at the core of how we operate as a Trust. I will continue to support and encourage these values across all that we do.

1.5   ICS (Integrated Care System) and System Partners

Our Trust plays an important role in the Gloucestershire system with colleagues working committedly to meet the needs of our community. I have regular meetings with the **CEO of Gloucestershire Hospitals NHS Foundation Trust (GHFT)** – Deborah Lee and the **Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG)** - Mary Hutton to keep abreast of any issues facing our partner organisations.

The **ICS Board**, **ICS Executive** and **ICS CEO Meetings** continue to take place monthly focusing on system-wide planning and resilience, and provide updates on organisational matters and projects. The regular meetings, held with senior colleagues across the health system, help ensure joined up working and provide a forum to discuss items affecting multiple partners. Additionally, fortnightly I have met with Mary Hutton and Deborah Lee to discuss the **ICS Transition.**

On 31st August I attended the **ICS Provider Collaborative Leads Meeting** which discussed workstreams, communications, benefits and concerns as well as patient flow. Good discussions were had to ensure proactive and productive ways of working across the collaborative moving forward.

The **Joint Health and Wellbeing and ICS B**oard meeting took place on 21st September. The purpose of the meeting was to understand the current function and membership of the two boards, to understand the existing governance architecture as it relates to the Boards, to understand the proposed function of the Health and Care Board and to explore options for how the Boards will operate in Gloucestershire in the future. There was a great deal of common ground and both Boards are hoping to agree much closer working arrangements reflecting opportunities in the new ICS legislative framework.

The system Gold Health System Strategic Command CEOs (now called the **Executive Review Group**) has continued to take place weekly as part of the **Gloucestershire ICS Covid-19 Response Programme.** This forum has proved essential in overseeing the system response to the Covid-19 pandemic (and continues to do so as we enter wave 3) and in providing a regular liaison point between senior leaders in the NHS and social care system.

Our work on **Organisational Development** continues in collaboration with the Gloucestershire County Council facilitated by Insightful Exchange. On 2nd September we had a collaborative meeting to assess and plan the next steps of this project moving forward into 2022. At this meeting, all participants reinforced the commitment to this programme around partnership working and building these working relationships between the two organisations.

I am the Executive sponsor for the **Improvement Community Programme** and have had two meetings in the past couple months with Kathryn Hall, Associate Director Service Improvement and Redesign (GCCG) to help progress the programme's agenda. The improvement community is a co-operative network led by our system QI leads, building shared best practice and collaborating on innovative system development initiatives. July to September has been a planning period to mobilise, connect, consult and create the interim plan for current delivery and agree resources and integration. The next 2 quarters will see further development, action and delivery.

I continue to attend the **Gloucestershire MP briefings**, led by CEOs of the Gloucestershire NHS organisations and senior County Council officers and Leaders. The frequency of these meetings has changed as of August from fortnightly to monthly. These meetings provide updates on the Covid-19 situation in Gloucestershire including testing and vaccinations, as well as updates on elective diagnostics recovery, system flow delivery, PPE equipment and supplies, transport and communication.

The Chair and I are in the process of scheduling annual meetings with each of the Gloucestershire MPs in order to give a briefing on Trust activities. These meetings will be taking place over the next 2-3 months with the aim to ensure proactive communication, address any concerns, and encourage working together.

I attend the monthly **Community Chief Executives Network** meetings. The meeting held on 25th August featured informative discussions on shared learning for system support, community restoration and where we are in the SW, pressures on social care, as well as the NSHX survey on ESR usage.

I attended the **Urgent & Emergency Care Extraordinary meeting** on 3rd August.

I attended the meeting pertaining to **Therapy Support for Assessment Beds** on 26th August.

The **Health and Overview Scrutiny Committee** on 14th August was rescheduled and will take place on 12 October 2021.

1.6   Site Visits

We have had a few recent site visits across the Trust. On 11th August Sir Keir Starmer, Leader of the Labour Party, visited **Stroud Hospital** as part of a 'summer tour', I was represented by acting COO Hilary Shand. He spent time speaking to colleagues about a range of issues, including how the pandemic had impacted our teams and services. Matron Liz Lovett gave him a guided tour of the hospital, which included introducing him to teams. He then spent time out in the garden answering questions and asking staff about the issues that matter to them.

12th August Richard Graham visited **Wotton Lawn Hospital** for a presentation by MH inpatient colleagues, Acorn House for CAMHS (Children and Adolescent Mental Health Services) and CYPS (Children and Young Peoples Services) presentations, **Collingwood House** for presentations for the Integrated Community Team and **Pullman Place** for presentations from Adult Community MH colleagues. Deputy COO Sarah Birmingham represented me for this visit.

On the 25th August Cllr David Drew visited the **Vale Hospital**. John Trevains, Director of Nursing Therapies and Quality, and Ingrid Barker, Trust Chair, welcomed him to the hospital where he received a presentation on sites and services in the Stroud and Berkeley Vale communities and included a tour of the hospital.

31st August Cllr Stephen Davies visited **Evergreen House**. This visit featured enlightening presentations on CYPS and CAMHS which were very well received by all participants.

2.0   BEREAVEMENTS

It is with great sadness that I report the Trust has recently lost two senior friends and colleagues: Alison Wilmott-Miller (Deputy Director of Human Resources) and Dr Mike Roberts (previously Medical Director for GCS). Our thoughts are with the families during this very sad time. More details are included in the Chair's report.

3.0   AWARDS

I am delighted to announce that there have been some exciting awards nominations and recognitions for certain individuals and initiatives within the Trust. Firstly, the Trust has been shortlisted as **Employer of the Year in the 2021** GloucestershireLive **Apprenticeship Awards**. In addition, Evie England and Elle Yemm have been shortlisted in the Outstanding Apprentice of the Year (Business, Administrative & Financial Services) category and Zoe Carter has been shortlisted in the Outstanding Apprentice of the Year (Health, Wellbeing, Care & Education) category.

One Gloucestershire ICS has been shortlisted in the prestigious 'Integrated Care System of the Year' category at the HSJ Awards 2021. The Gloucestershire award entry 'Integrated Working During COVID-19' sets out the remarkable contribution and joint working over this period from health and care professionals on the frontline and in support services. It recognises the strength of the One Gloucestershire partnership including the vital role and work of public health, social care, local councils and those in the voluntary and community sector.

The ICS has also been shortlisted in another category – **Provider Collaboration of the Year**. This nomination was for the Gloucestershire dementia 'Co diagnosis' project. Covid had a catastrophic effect on people with dementia – who represented 36% of Covid deaths. During the pandemic our

memory assessment service (MAS) was closed to referrals with staff redeployed, which meant some patients could not be assessed or treated. Virtual multi-disciplinary teams were set up with GPs and GHC nurses to diagnose and start treatment. This led to over 60 patients being diagnosed and greatly decreased waiting times.

Higher Trainee Ross Runciman is celebrating the news that he has been shortlisted in this year's RCPsych Awards. Ross was nominated for the Higher Psychiatric Trainee of the Year category by Dr Joe Stratford, Consultant Psychiatrist and Director of Medical Education. Winners will be announced at the RCPsych Awards virtual ceremony on Thursday 11 November.

The Trust has also been approached as an exemplar Trust for the National NHS Food Review. This offers up an excellent opportunity to lead on innovation and participate in pilot programmes.

Additionally, we have officially launched the first annual **Better Care Together awards**. This event will be held virtually on 01 December 2021 and will celebrate outstanding commitment, dedication, care, compassion and expertise within the Trust. Nominations are open for the eight award categories that fully embrace and celebrate the Trust's core values. A judging panel, chaired by the Trust Chair, will meet to consider the submissions and create a shortlist in October. We look forward to receiving nominations for these categories and thank everyone within the Trust for their outstanding efforts towards creating better care together.

4.0 CHIEF OPERATING OFFICER APPOINTMENT

Following a comprehensive national recruitment process, supported by NHS Executive Search, we are delighted to confirm that **David Noyes** has accepted our offer of the Chief Operating Officer post.

David is currently the Chief Operating Officer (Southampton and County Wide Services) at Solent NHS Trust, where he has been for the past four years. Prior to that, he was Director of Planning, Performance and Corporate Services at Wiltshire CCG - also for four years. Before joining the NHS David was a Naval officer for 28 years specialising principally in logistics, including a deployment as Chief Operating Officer for logistics with the Army's Logistics Brigade in Afghanistan.

David is very much looking forward to joining the Trust during this exciting time and looks forward to working with colleagues both within the Trust and the ICS. David is excited about delivering the best possible outcomes for the people we serve and looks forward to making a difference.

We are immensely grateful to Hilary Shand, our Deputy COO, who has agreed to continue as interim COO until December, a role she has been holding since April 2021 following John Campbell's departure. We look forward to Hilary's

continued support in the interim COO role until December. David's start date will be confirmed in due course.

I would like to thank all colleagues, system partners and experts by experience who supported the recruitment process.

5.0   PEOPLE AND WORKFORCE

Following the launch of the Trust's People Strategy, we are continuing to put our people first and are working on many different projects and programmes to help ensure and where required further develop a great working environment for all colleagues. This includes work on recruitment and retention, the establishment of the People's Participation Board, the creation of a Wotton Lawn Hospital Task and Finish Group (see below), the Future Ways of Working programme, and staff surveys. We encourage colleagues to participate in the staff surveys so we can ensure all team members can contribute their voice to the conversation as we look at making improvements across the Trust.

Additionally, following the announcement that the Government has accepted recommendations of a 3 per cent pay award through the NHS Pay Review Board, we can confirm that the pay award will be made in September's payroll run. This will be backdated to 1 April 2021.

This year has certainly not been without challenges, but I am grateful to say that the Gloucestershire Health and Care team has stepped up to every challenge presented with rigor, dedication, and excellence. I thank colleagues for their exceptional effort and look forward to working with you to find new opportunities and achieve our goals as health care providers within the community of Gloucestershire.

Given the system pressures described earlier in the report the **GHC Recruitment Team** are currently facing an exceptionally high volume of work, with over 160 job advertisements going out in July. **Wotton Lawn** continues to be an area of focus with the sort of higher vacancy rates that are experienced across the sector nationally. A Wotton Lawn Hospital Task and Finish Group has been established to help identify potential recruitment and retention solutions. Although the recruitment pressures are high at the moment, all team members are working to create new innovative solutions to address the areas of concern and progress is being made.

6.0   CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report.

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Angela Potter, Director of Strategy & Partnerships

AUTHOR: Angela Potter, Director of Strategy & Partnerships

SUBJECT: **INTEGRATED CARE SYSTEM UPDATE**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐   Endorsement ☐   Assurance ☐   Information ☑

The purpose of this report is to
This paper provides an update on the activities that are taking place across the Gloucestershire Integrated Care System (ICS).

Recommendations and decisions required
•   Trust Board is asked to note the contents of this report.

Executive Summary
This paper provides an overview of a range of activity taking place across the Integrated Care System. This update includes: • Joint development session between the Health & Wellbeing Board and the Integrated Care Board to consider future structures and working arrangements. • Fit for the Future update • The Build Back Better Fund and grants being made available to local communities • Integrated Locality Partnership updates

Risks associated with meeting the Trust's values
None

Gloucestershire Health and Care NHS Foundation Trust – **TRUST BOARD PUBLIC SESSION – 30 Sept 2021**
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Corporate considerations	
Quality Implications	The Trust will make specific note of any engagement and feedback reports specific to our surveys and include them within future service reviews and developments
Resource Implications	None specific to the Trust
Equality Implications	The Trust is actively engaged in wider inequalities work and will build any findings into the Trust service developments moving forward

Where has this issue been discussed before?
Regular report to Trust Board

Appendices:	ICS Board minutes – 16th August 2021

Report authorised by: Angela Potter	**Title:** Director of Strategy & Partnerships

INTRODUCTION

This paper provides Board Members with an overview and update on the activities that have been taking place across the Gloucestershire Integrated Care System (ICS).

1.0 JOINT HEALTH AND WELLBEING BOARD (HWB) AND ICS BOARD DEVELOPMENT SESSION (21ST SEPTEMBER 2021)

The normal HWB meeting was replaced by a joint development session with members of the ICS Board to consider how the HWB Boards functions under the new ICS structures beyond April 2022. It was recognised that there is a considerable overlap across the roles and functions between the current remit of the HWB and the new Integrated Partnerships Board which is a mandated part of the ICS structures and the group have considered the potential options for this which will continue to evolve over the coming months.

2.0 FIT FOR THE FUTURE UPDATE

A number of service reviews continue as part of the Fit for the Future programme with the lung function and sleep services solutions appraisal workshops taking place on the 26th August 2021 and the public engagement on these services completed on the 6th September and an outcome report will be produced in due course which will help inform the next steps for these services.

3.0 WIDER ICS AND PARTNER UPDATES:

3.1   Support for victims of domestic abuse

Gloucestershire County Council has recently approved the investment of £1m grant funding into supporting the development of services to support people affected by domestic abuse across the county.

A Domestic Abuse Local Partnership Board (LPB) was formed in May this year, and has recommended a number of options where the funding could make the most difference to supporting victims. These include additional support in Places of Safety and Stroud Beresford Refuge, support in new Dispersed Refuge units and providing mobile advocacy. This investment will enhance the current support offer already available in Gloucestershire which includes: core services for victims of domestic abuse; services to address perpetrator behaviour; services for young people (13-19) and support for victims of stalking.

3.2   Build Back Better Fund

Funding has been allocated to help communities recover from the pandemic. This could be into the economy the county's market towns and high streets or

into the electoral divisions whereby each county councillor can support bids in their area to support a range of initiatives such as community health and well-being, digital inclusion, nature and the environment or healthy lifestyles and safer neighbourhoods. Funding can be applied for up to March 2025.

3.3   Appointment of National Director of Learning Disability & Autism

NHS England has appointed Tom Cahill as the national director of Learning Disability & Autism on the 9th September 2021. He will be leading a review, working with commissioners, of every single inpatient with a learning disability, autism or both in a mental health inpatient care setting to ensure that each person has a clear care and treatment plan and discharge date in place. If these are not in place, the review will explore why not.

3.4   100 Days Together - Partnership engagement

Organisations across Gloucestershire have spent all summer celebrating positive work being done in Gloucester City. It aimed to show how people and organisations are working together as the county re-emerges from lockdown and has included input from the health sector along with a wide range of partners such as Gloucestershire Constabulary, The Craven, Gloucester City Homes, and Gloucester City Council.

This has been a great opportunity to highlight our wider partnership working and promote our services whilst simultaneously raising awareness around how to access our services and engage with our partner organisation.

4.0   INTEGRATED LOCALITY PARTNERSHIPS (ILPS) UPDATES

Helen Goodey and colleagues gave an excellent presentation to the ICS Board in September encompassing a range of the projects that system partners are taking forward across a range of the ILP's.

4.1   **Gloucester ILP**

The Trust teams provided partnership presentations at the September meeting with a focus on the community mental health transformation programme and the Individual Placement scheme which focuses on the support into employment that our teams give to people who are under the care of a secondary mental health team.

The health inequalities including the Matson Community Health Equalities Partnership Group continues with some strong links into strengthening local communities and some strengths-based research has been funded with the Black South West research programme into the level of voluntary sector organisations that are black or Asian led.

4.2   **Cheltenham ILP**

Cheltenham ILP met in August 2021. The group reviewed the health inequalities data for the locality recognising that whilst Cheltenham has a

younger population there is a higher than average over 80s population and a correlating higher than average over 65s emergency admission rate. This data will continue to be used to inform priority areas for programmes of work moving forward and link it into the population health management work.

4.3 **Stroud ILP**

The Trust's team along with the CCG provided a partnership presentation on the Community Mental Health Transformation programme and there was a focus on hospice services. Berkeley Vale Primary Care Network (PCN) have appointed a Young Persons Social prescribing link worker who has been receiving a number of queries regarding Eating Disorder problems – two forums were held in September to explore these issues further and feedback will be provided through the PCN moving forward.

4.4 **Cotswolds ILP**

The Cotswolds ILP are next due to meet on the 28th September.

4.5 **Forest ILP**

Members continue to take the opportunity to review and refresh connections and consider what the priority pieces of work need to be across the Forest. The meeting had a focus on children and young people and the links with schools moving forward and also looked at the data regarding pregnancy and flu vaccination and actions to try and improve the uptake moving into this year's vaccination programme.

4.6 **Tewkesbury ILP**

The group are actively taking forward the planning necessary to consider the impact on health and care services from both an increase in the number of Afghanistan refugees to Gloucestershire and also that the Tewkesbury garden town will see 10,000 new homes built between now and 2050.

5.0   FOCUS ON PATIENT, CARER AND STAFF FEEDBACK AND ENGAGEMENT

5.1   Healthwatch Gloucestershire – Discharge experience

Healthwatch Gloucestershire have now completed a report which focused on people's experiences on being discharged from hospital in Spring 2021. The report reflects the in-depth experiences of 11 respondents and found that although people considered services in hospital to be good, improvements were identified in the discharge and transfer processes from and between hospitals, particularly around communication with the patients and their carers. The Trust is keen to utilise this feedback in order to improve people's experiences and it has continued to flag important areas for us to continue to improve the care and support that we provide to our patients and their carers.

5.2 Expert by Experience Programme

The Trust has 7 new Experts registered since the last meeting and recruitment training is being delivered. Additionally, we have a Quality Improvement programme running specifically involving Experts by Experience to look at how they can continue to add value to the Trust's recruitment process.

6.0 ICS ACCOUNTABLE OFFICERS REPORT

Due to meeting timings there is no Accountable Officers report this month. The minutes from the previous ICS Board meeting in August are available in the reading room.

Angela Potter
Director of Strategy & Partnerships

REPORT TO: TRUST BOARD PUBLIC SESSION – 30 September 2021

PRESENTED BY: Sarah Birmingham, Deputy Chief Operating Officer

AUTHOR: Sarah Birmingham, Deputy Chief Operating Officer

SUBJECT: OPERATIONAL RESILIENCE AND CAPACITY PLAN

If this report cannot be discussed at a public Board meeting, please explain why.	*N/A*

This report is provided for:
Decision ☐   Endorsement ☐   Assurance ☒   Information ☐

The purpose of this report is to:

Present to the Board three papers for assurance, that together provide the overall details of operational resilience and sustainability plans and tools implemented through periods of service disruption be that surge, adverse weather conditions, pandemics and any other interruption requiring business continuity, escalation or enhanced preparatory plans to be put in place.

This plan embraces the Trust Operational Winter Planning, Surge management and escalation and Covid-19 arrangements for the Trust.

Recommendations and decisions required

The Board is asked to:
- **Assure** the operational resilience and capacity plans and tools to be implemented through surge and escalation ensuring business continuity.

Executive summary
The Trust is required to have a robust resilience and capacity plan in place with particular emphasis on the winter period (November – March).

Within this presentation there are three papers that complement each other as follows:

- Operational Surge and Resilience document v1.8: outlining the corporate breadth of business continuity and resource
- Surge and Escalation Plan v.1.0: details escalation processes in place from service to system
- Winter Plan (Operations) – A paper outlining approach, staff voice and priorities of schemes

The Gloucestershire A&E Delivery Board is the forum in which capacity planning and operational delivery across the health and social care system is coordinated, and funding available for winter schemes is prioritised across all providers.

In order to take a system-wide approach to managing operational issues the NHS recognises the need to establish sustainable year-round delivery. This will require the Trust's capacity planning to be on-going, robust and aligned with other organisations plans across the Health and Social Care system, with a move towards a proactive system of year-round operational resilience, as response and escalation to surge is the same regardless of the source of the disruption.

The 2021/22, Operational Resilience and Capacity Plans includes additional assurance and planning around prioritisation of the operational (service) winter schemes, escalation, Covid-19 and general incident/surge response.

The operational plan reflects the learning from the experience of the first waves of Covid, and last winter overall and was the basis for this year's planning arrangements, prioritising the operational schemes to be focused on in agreement with partner organisations and identifying new ways of working as we enter the winter period.

Risks associated with meeting the Trust's values
Specific risks are identified within the body of the report

Corporate considerations

Quality Implications	All escalation action cards will be approved through QAG and the EPRR forum
Resource Implications	Resources required to enact the service winter schemes are approved through the A&E Delivery Board.
Equality Implications	None identified

Where has this issue been discussed before?
The Operational Resilience and Capacity Plan has been through a number of consultation processes across the operational directorates within the Trust. Sign off for the Service operational winter schemes were discussed and endorsed at the Executive Committee 10th Aug 2021. All papers where tabled for assurance and endorsement at the Resources Committed on the 26 August 2021.

Appendices:	**Appendix 1 -** Operational Surge and Resilience document v1.8 **Appendix 2 -** GHC Surge and Escalation Plan Surge and Escalation Plan v.1.0 **Appendix 3 -** Winter Plan (Operations) -Paper outlining approach, staff voice and priorities of schemes

Report authorised by: Sarah Birmingham	**Title:** Deputy Chief Operating Officer

with you, for you

NHS

OPERATIONAL RESILIENCE AND CAPACITY PLAN

Policy Number	**ORT 012**
Version:	FINAL
Purpose:	This plan sets out the Trust's approach for maintaining continuity of services during increased demand and/or reduced capacity for service users, partner agencies and the health and social care system of Gloucestershire.
Consultation:	Chief Operating Officer, Pan Directorate Governance Forum, Organisational Resilience Team
Approved by:	EPRR Governance Forum
Date approved:	16th August 2021
Author:	John Hudson – Resilience Manager
Date issued:	
Review date:	July 2022
Audience:	All Staff
Dissemination:	Trust Intranet, On-Call Managers Information Portal
Impact assessments:	

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Version History

The version history should be updated each time the document is revised

Version	Date	Reason for Change
1.1	15/01/2021	Updated OPEL 4 actions to reflect learning from extreme Covid-19, flu outbreak and Winter pressures.
1.2	30/01/2021	Amending OPEL actions / re format
1.3	16/08/2021	Updated 4x4 arrangements Updated IPC arrangements

CONTENTS

1. INTRODUCTION

1.1. Background

Gloucestershire Health and Care NHS Foundation Trust is required to have a robust resilience and capacity plan in place with particular emphasis on the winter period (November – March). From here on this plan will refer to the organisation as "the Trust".

The Gloucestershire A&E Delivery Board is the forum in which capacity planning and operational delivery across the health and social care system is coordinated.

In order to take a system-wide approach to managing operational issues the NHS recognises the need to establish sustainable year-round delivery. This will require the Trust's capacity planning to be on-going, robust and aligned with other organisations plans across the Health and Social Care system, with a move towards a proactive system of year-round operational resilience. For 2020/21, the plan will include additional assurance and planning around Covid-19 and general incident/surge response.

Surge Management - to ensure the learning from the Covid-19 incident was fully captured, there were a series of facilitated sessions to capture, what had worked well, what could be improved and could be done differently in the future. This then fed into a series of surge workshops. These sessions consider a range of scenarios to test our plans. Following these sessions teams have worked with the Trust Business Continuity Planning specialist to update their plans.

1.2. Aim and Objectives

The aim of this plan is to manage the challenges of increased demand and/or reduced capacity and minimise the impact on service users.

The objectives of the plan are to:

- establish a shared understanding of surge and escalation issues across the Trust for the services it provides;
- define a flexible approach for response which can be utilised irrespective of situation, duration, scale and type;
- define procedures and processes with regard to escalation to be utilised in the event of an actual or potential surge and capacity issues or issues;
- set out the principles by which mutual aid is requested locally to support the system; and
- Describe triggers in services that indicate escalation.

2. PROCESS FOR ENSURING OPERATIONAL RESILIENCE AND CAPACITY

2.1. Information

2.1.1. The Trust has used a range of information sources (see figure 1) to compile a situational picture of the likely demand for services over the winter period. This picture considers the risks and challenges in identifying and providing the necessary capacity to meet the demands of its local population

Figure 1: Information sources used to inform situational picture (not an exhaustive list)

The Trust			
Capacity modelling (including Covid-19 restrictive modelling)	GHC Daily SitReps	Gloucester CCG performance data (SHREWD - Escalation)	South West Regional COVID-19 Healthcare Setting Outbreak Framework
Review of previous winter issues	Operational resilience and capacity guidance 2021/22	NHS Operational Pressures Escalation Levels (OPEL) Framework	Gloucestershire CCG Escalation Plan and Framework 2020/21
Local Outbreak Management Plan	Second Wave and Surge Management Scenario planning	Trust and system-wide learning from the Covid-19 pandemic response	Single Point of Clinical Access

2.1.2. Learning from previous experiences the Trust has identified a number of risks, Appendix 4, mitigation of the risks are supported by the Trust response arrangements.

Covid-19 Risk Management
As the Covid-19 incident has continued over many months we have moved from the traditional command and control structure to a programme approach. The programme approach has allowed a wider group of staff to be involved in the decision making and delivery of all the work associated with Covid-19. The Programme team work closely with the incident team. We have been establishing more semi-permanent teams such as testing and PPE/Stock Management. Each project within the programme, submits a fortnightly highlight report and any new risks get added onto the risk log. These are reviewed by a risk group, including IPC, incident team and governance input. This process ensures there is a weekly review of all risks and ensures mitigating actions are progressed. New risks are reviewed by the risk group and a decision is taken whether to escalate to Trust risk register (as it would be more effectively managed at that level) or to manage in a detailed way by the Programme team and Programme Executive.

The risk process is constantly reviewed and updated and regular review of risks ensures mitigation is progressed to lower the risk probability or close the risk.

2.2. System Level Reporting

Demand on services during winter can lead to unexpected pressures, requiring departments, services, directorates and the Trust as a whole having robust systems in place for effectively escalating and deescalating services and resources to meet fluctuations in demand. For the winter period, there will be daily escalation status reporting processes to NHS England and NHS Improvement in place (by exception). The required level of reporting is determined by a number of triggers set by NHS ENGLAND – Improvement. System level reporting is inline Operational Pressures Escalation Level (OPEL) as identified in Figure 2.

Figure 2: Definition of Operational Pressures Escalation Level

OPEL 1	**Patient Flow Management** The local health and social care system capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. The local A&E Delivery Board area will take any relevant actions and ensure appropriate levels of commissioned services are provided.

OPEL 2	**Mitigation of escalation** The local health and social care system is starting to show signs of pressure. The local A&E Delivery Board will be required to take focused actions in organisations showing pressure to mitigate the need for further escalation. Enhanced co-ordination and communication will alert the whole system to take appropriate and timely actions to reduce the level of pressure as quickly as possible.
OPEL 3	**Whole system compromised** The local health and social care system is experiencing major pressures compromising patient flow and continues to increase. Actions taken in Opel 2 have not succeeded. Further urgent actions are now required across the system by all A&E Delivery Board partners and increased external support may be required.
OPEL 4 (Whole System**)**	**Severe pressure and failure of actions** Pressure in the local health and social care system continues to escalate, leaving organisations unable to delivery comprehensive care. There is increased potential for patient care and safety to be compromised. Decisive action must be taken by the local A&E Delivery Board to recover capacity and ensure patient safety. All available local escalation actions have been taken, and external extensive support and intervention may be required.

OPEL 1: No reporting required.

OPEL 2: No local reporting required relating to CCG or NHSE/I.

OPEL 3: NHSE/I trigger/ SitRep and escalation reporting. The reporting process is as follows:

09:00 - escalation status declared OPEL 3 by SHREWD, or declaration of internal incident by partner/s;

09:00 – Demand and Capacity OCT discuss Plans for discharges in next 48 hours;

09:30 - Daily call required, is now with Microsoft Teams with the focus being the content for the exception report, de-escalation and ensuring that the appropriate action cards are being implemented, in hours the Demand and Capacity team attend this call, Out of Hours this is attended by the On-Call Manager. A system wide action plan is circulated with the expectation it is completed and returned to the Clinical Commissioning group;

11:00 (next day) – Submit exception report to NHSE/I.

OPEL 4: The Clinical Commissioning Group Chief Executive must be informed of this decision who will inform NHSE/I of escalation. NHSEI South West On-call - **0303 033 8833**

2.2.1. If the reporting falls on a Friday, Saturday or Sunday, a handover will be required between the reporting leads (5pm on Friday and 9am on Monday), with the relevant reports being submitted by 11am on the Monday. If the reporting falls on a bank holiday, the reporting will need to be handed over to the reporting lead by 9am the next working day.

2.2.2. The Trust has considered the possibility of preventative measures becoming overwhelmed and the requirement to activate and mobilise resources under a command and control framework that ensures disruptions and variability in the standards of service delivery to patients can be managed effectively. Response, adaption and recovery measures to maintain demand and capacity balance activated through robust escalation triggers have been developed as part of the planning process.

2.2.3. <u>External triggers and escalation</u> – Gloucestershire Clinical Commissioning Group through their A&E Delivery Board oversees the development and maintenance of their Escalation Framework. The framework sets out agreed actions (see figure 3 and figure 4 below) to be taken when capacity constraints have the possibility of compromising patient care and to prevent / resolve capacity issues that cause individual providers and/or the wider health system to escalate into an OPEL 3 or 4 status.

2.2.4. <u>Internal triggers and escalation</u> – the whole system escalation is described in Figure 5.

2.2.5. <u>Command, Control and Coordination arrangements</u> – Are based on the Trust's existing management structure. The Trust's Incident Command System Policy (ORT 003), provides a standardised approach to incident command, control and coordination from which managers designated with key functional roles (Coordination, Operations, Planning, Logistics and Finance) are able to effectively and efficiently resolve an incident as quickly as possible, while maintaining core critical services, at any time including the winter period.

2.2.6. Directorate/Service leads will monitor pressures across their areas of responsibility. If circumstances dictate, a decision will be taken to activate more formal command and control arrangements to support the operational response to growing pressures. In the event that pressure continues to increase, putting service quality and/or safety at risk, (requiring the Trust to Escalate to OPEL 3 or OPEL 4, a decision will be taken to extend the Incident Coordination Team provision and/or to review the Incident Coordinator in relation to their decision-making powers in light of the increased pressures. Figure 7 below provides a visual depiction of the teams and resources that may be required, but the roles activated will ultimately depend on the scale and type of pressures being experienced.

2.2.7. No mixed sex wards exist within the Trust and an Executive decision was taken that this will not be breached in a Community Hospital without the Chief Executive Officer agreement.

Escalation and Protocol Flow Chart: Local partners, NHS England and NHSE Improvement
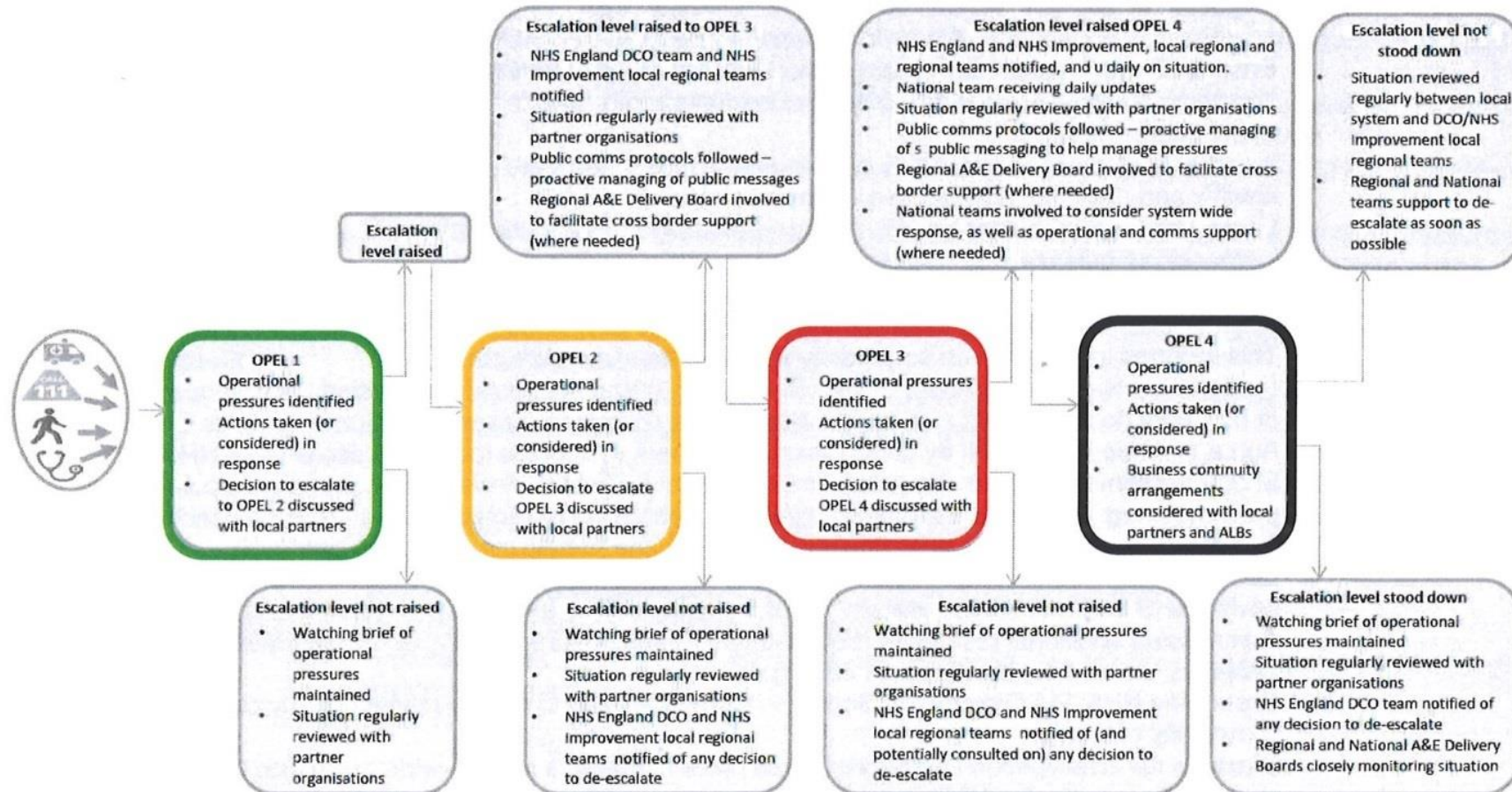
Figure 4: SHREWD Escalation Triggers

PRE-HOSPITAL
IN HOSPITAL
DISCHARGE

WHOLE SYSTEM

DEMAND | **PRE-HOSPITAL** | **IN HOSPITAL** | **DISCHARGE**

Metric	Level 1 - Normal	Level 2	Level 3	Level 4	Level 1 - Normal	Level 2	Level 3	Level 4	Level 1 - Normal	Level 2	Level 3	Level 4
Single Point of Clinical Access call volume per hour Weekday	8	10	13	<=15								
Weekend – not included on SHREWD, these are Single Point of Clinical Access specific Key Performance Indicators	3	5	6	7								
Rapid Response RAG rating (Referral rate in and Nos in service)	1	2	3	4								
Number of patients on Single Point of Clinical Access working list at time of report									<=10	11	12-14	>=15
Number of Single Point of Clinical Access patients with no plan									0	1-5	6-11	>=12

	CAPACITY												

PRE-HOSPITAL   **IN HOSPITAL**   **DISCHARGE**

Metric	Level 1 - Normal	Level 2	Level 3	Level 4	Level 1 - Normal	Level 2	Level 3	Level 4	Level 1 - Normal	Level 2	Level 3	Level 4
Single Point of Clinical Access Abandoned call rate	<5%	<8%	<12%	12%>								
MIiU longest wait	<3 hrs	3-4	4+ in 1 unit	4+ in 1+ units								
Total number of Community Hospital beds available weekdays / Saturdays / Sundays					>=10 / >=5 / 3	6-9 / 3-4 / 2	0-5 / 1-2 / 1	0 / 0 / 0				
Total Number of Reablement Beds available Weekdays / Saturdays / Sundays					>=6 / >=5 / >=3	3-5 / 3-4 / 2	1-2 / 1-2 / 1	0 / 0 / 0				
Beds closed due to Infection Control					0	1 ward /area	2-3 wards / areas	>4 wards/ areas				
No of Unfilled shifts (agency & Bank) - Community Services									1	2	3	4
No of Unfilled shifts (agency & Bank) - Community Hospitals					1	2	3	4				
% MIiU patients seen within 4 hours	100%	98%	85%	75%								

The table below identifies Trust wide escalation and the key roles and responsibilities that will be required to ensure resources are used effectively to manage the possible challenges and risks that the Trust may experience. Should this be a specific Covid-19 related escalation the Trust would follow the system wide Local Outbreak Management Plan

Figure 5 - Trust Escalation and Actions

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
Trust services functioning as normal and able to manage any fluctuation in services without consequence Sickness absence within normal limits for time period Demand and Capacity Team will participate in the daily whole system conference call to review activity and demand and pre-empt surges and take mitigating actions Influencing factors: • Premises • Workforce • IT • Resources, assets, utilities and supplies • Surge in demand • Queuing ambulances		**Demand and Capacity Lead** • Review GHC Kit bag • Complete actions • Contribute to whole system solutions • Take internal and external actions • Escalate issue to Deputy Chief Operating Officer • Initiate communication strategy Trust surveillance systems in place to monitor for increased D & V or Flu or Covid-19 activity or rising staff absence.	*Pre-surge periods: circulation of plans and procedures to partner organisations.* **Communications (internal)** Comms Team to rest of Trust (various times): Various campaigns e.g. vaccination, winter preparedness. **Communications (external)** Designated Locality Lead to contribute to Teleconferences as required.	**Command and Control in place:** Maintain normal Trust structures and operational management hierarches (includes On-Call arrangements). **Responsible for activation:** N/A **When and where will it be triggered:** In hours: N/A Out of hours: N/A **Communication requirements;** Internal: N/A External: N/A	No impact at present – Trust services operating within normal tolerances	No implications for other organisations at this stage.
• Community Services experiencing sustained rise in activity • Minimal bed capacity at inpatient sites impacting patient flow. • No Psychiatric Intensive Care Unit beds in County • Significant disruption to travel • Cancelled Patient Transport Service provision • Covid-19 staff testing capacity limited, delaying return to work • Weather conditions impacting on service continuity in 1 locality • Staff absence has risen 4% on seasonal average in anticipated surge areas or 10% across Trust • Multiple infection outbreaks (e.g. D&V) • Localised Covid-19 outbreak/lockdown affecting single locality or Service		OPEL 1 action plus the following: Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. Maximise use of reablement/intermediate care beds All services to identify blockages to discharge and escalate to relevant Head of Service SPCA lead to call IDT to prioritise working list Community hospitals to bring forward discharges to allow transfers in as appropriate. Community hospitals to liaise with Social and Healthcare providers to expedite discharge Additional ward rounds to take place within community providers to expedite discharge and create capacity Community providers to lower admission/treatment thresholds wherever possible through implementation of previously agreed flexible working arrangements to alleviate pressure Apply flexibility regarding beds and staffing to increase capacity where possible Expedite rapid assessment by multidisciplinary team (MDT) including Social Care assessment	**Communications (internal)** In addition to the above; Any specific directorate/service pressures likely to have an impact on other services. **Communications (external)** In addition to the above; Lead Locality Directors to; Clinical Commissioning Group/ NHS England to participate in any addition telephone conferences	In addition to the above; **Command and Control in place:** Consider requirement for additional internal telephone conferences. **Responsible for activation:** Winter Director in consultation with winter Locality Directors. **When and where will it be triggered:** In hours: As required | virtual via telephone conference Out of hours: As required | virtual via telephone conference **Communication requirements;** Internal: Community Service Manager/ Matrons and Executive Management Team, On-Call Team (as required) External: N/A	Maintain communication flows between operational leads and overall coordinator. Add additional control if required by pressures and circumstances. Minimise disruption to services upstream and downstream of potential issues. Ensures a shared situational picture of current pressures and mitigation.	Mental Health Liaison Team/Crisis Teams/ Rapid Response – additional support to facilitate admission avoidance and discharge planning processes. Community teams/ CYPS – additional resource may be required to support admission avoidance and early transfer/ discharge Clinical Commissioning Group/NHS England – requirement for additional telephone conferences.

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
• Intermittent corporate systems issue e.g. intranet or Electronic Staff Records • Clinical systems outage for < 2hours • Intermittent IT infrastructure e.g. telephony & network • Escalation Level in the County at 2 (Pressure) or 3 (Severe Pressure) – requirement to support mutual aide		Ensure all staff in MHLT are aware of escalation level and to reflect this within their working day and prioritisation of system. MHLT to ensure pathways are being used appropriately, confirm that guidance is accessible and communicate when information cannot be found Where possible, community-based services to increase support and/or communication to patients at home to prevent admissions. Expedite rapid assessment for patients waiting within another service e.g. ED For inpatients in acute hospitals prioritise MH assessments where delays are impacting on quality/capacity of service provision MHLT to ensure all referrals are verbally responded to within 2-hour target and subsequent response is in keeping with level of risk identified using risk matrix MHLT Manager to ensure that all patients awaiting review before discharge are to be prioritised so that they are seen within 4 hours where staffing capacity permits				
• *Inpatient bed occupancy is reached* • 136 suite unavailable • *Sustained, very significant increase in activity with demand outstripping supply for critical services* • Significant Planned activity unable to be delivered • Severe weather conditions impacting on service continuity in > 1 locality • Covid-19 outbreak/lockdown in > 1 localities or teams • Sustained (> 2 hours) corporate systems issues e.g. intranet or ESR • Sustained Clinical systems outage (> 2 hours) • Sustained IT infrastructure outage e.g. telephony & network • infection control outbreak, impacting on > 1 clinical area		All actions from OPEL 1 & 2 plus below: Senior Nurses to review patients that could be moved with ongoing support requirements in order to realise capacity Mix sex breach requests to be sent to CEO for review and decision - CEO agreement only. Head of Services to escalate blockages to Deputy COO/COO SPCA - Prioritise discharge from relevant GHT site As able, Rapid Response to send staff into ED MIIU social media push to advise capacity Capacity Manager / Deputy Director to monitor escalation status, taking part in teleconferences as required. SPCA - call in bank staff to handle call volumes Assess and reprioritise any non- housebound DN visits Review all daily visit patterns to identify bi-daily options Review all non-urgent visits All community care teams to review all patients awaiting assessments (with single point of access) in order to expedite discharge or transfer	**Communications (internal)** In addition to the above; Incident Coordinator (IC) (ED/DD) – Establish the Integrated Care System Planning Section to facilitate robust communication to all relevant stakeholders. Comms/ Media representatives to support, advise Incident Coordinator and to facilitate core messages (in conjunction with partners) **Communications (external)** In addition to the above; Incident Coordinator to work within NHS formal/informal response structures. Manage any media interest (in conjunction with partners) Prepare responses to any additional SitRep report requirements, including but not limited to; o Service pressures & disruption	In addition to the above; **Command and Control in place:** Additional daily Microsoft Teams/Tele conferences. Decide if Incident Coordination Centre should be activated, and if so if in part or full Pre-allocation of Incident Coordination Centre roles in the event that a more formal structure is activated. **Responsible for activation:** Winter Executive in consultation with Lead Winter Locality Directors. **When and where will it be triggered:** In hours: As required	virtual via Microsoft Teams/Telephone conference or Incident Coordination Centre Out of hours: As required	virtual via Microsoft Teams/Telephone conference or Incident	Improved communication flows and situational awareness. Clear lines of authority, accountability. Clear decision-making forum Centralised decision making on resource allocation. Centralised decision making of service prioritisation and service reductions/closures. Ensures a shared situational picture of current pressures and mitigation. Central point for all external stakeholders to communicate through.	In addition to the above; Patients/ Relatives - Possible reduced standards of care. No mutual aid likely Psychiatric Intensive Care Unit – No beds Department of Health – Performance targets not being achieved. Clinical Commissioning Group – Not fulfilling all contractual obligations

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
• Gloucestershire Clinical Commissioning Group Escalation Plan at Level 3 (Red) **Patient safety at risk due to demand on services**		where possible – this to include In-reach teams and community hospitals Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible Community providers to expand capacity wherever possible through additional staffing and services, including primary care Community providers to consider the use of wider group of agencies (e.g. higher cost agencies) to increase staffing capacity Patients waiting at home for admission to be referred to Community Teams (by In-reach nurses) and/or single point of access and Emergency Medical Unit (EMU) Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible. Review all discharges currently referred and assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities, where possible. Community based teams to increase support to service users at home to prevent admission. Escalation to relevant on call manager Liaison with Social Care if delays relate to arranging MH Act Assessment Liaison/joint working with Social Care and Housing to identify appropriate accommodation/care packages Regardless of level of risk and within resource available will prioritise ED referrals MHLT manager to prioritise ED referrals and recruit additional resources from off duty staff and staff bank MHLT manager to recruit additional resources from off duty staff and staff bank. MHLT Manager to prioritise assessments in ED from 2 hours to 1 hour where staff capacity permits Close smaller MIIUs and reallocate staff to strategic MIIUs (Stroud, Cirencester, North Cotswolds & Lydney) Provide senior clinical support for weekends across Community Services and Community Hospitals	○ Staffing issues ○ Capacity issues ○ Planned reductions/ closure of services. ○ Mutual aid support	Coordination Centre **Communication requirements;** Internal: Executive Management Team/ Community Service Manager Teams/ Matrons/ Comms/ others as required. External: Gloucestershire Clinical Commissioning Group, Gloucester Hospital Trust, South Western Ambulance Service, NHS England, Commissioning Support Unit, Gloucester Council.		

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
		Professional Leadership (Clinical) rota - with time off in lieu and payment for hours worked Provision of clinical leadership for all out of hours service provision Dial into escalation calls, link with shift/ward leads and available for clinical queries advice and guidance, based on site with a clinical team Inpatients ICT Home First DN Rapid Response SPCA Implement GHC Operational Flow Hub to run alongside ICC. Implement additional afternoon (and evening if required) GHC Operational Flow meeting. Review staffing levels and manage Staff shortages with flexible use of the incentive policy for the following staff groups: - RN - HCA - All Bank Staff MIiU offering ED Streaming of 15 appointments for the Streaming Nurse in ED to use per day in MIIUs across working closely with system partners with implementation planned for 2 weeks' time MIiU's supporting the supply of grab bags/ oximeters for Covid-19 Virtual Ward with the aim of less Covid-19 admissions and preventing undiagnosed deterioration. Post discharge Covid-19 Virtual ward, managing respiratory and non-respiratory patients. CHST continue to offer seasonal Covid-19/ Flu vaccination as part of mass vaccine programme Hold internal meetings - 09:00 Flow meeting - 12:30 Flow meeting - 16:00 GHC Covid-19 briefing, Monday and Friday - 16:30 Daily Oversight Call, Monday and Thursday Ensure Medical resilience in Hospitals particularly at weekends Ensure estates/facilities teams have resources				

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
• Sustained, extreme activity experienced having a detrimental impact on services • Significant impact on several community services that are a high clinical risk • Unable to continue some/all business-critical services • Critical Community/Children & Young Persons Services struggling or unable to cope • Severe weather conditions impacting on service continuity in all localities • Covid-19 outbreak/lockdown countywide/nationally • Prolonged (> 24 hours) corporate systems issues e.g. intranet or ESR • Prolonged Clinical systems outage (> 24 hours) • Prolonged (>24 hours) IT infrastructure outage e.g. telephony & network • Services struggling to provide priority care • Unable to continue some/ all business-critical services • Gloucestershire Escalation Plan at Level 4 (Black) **Patient safety risks due to demand on services**		All actions from OPEL 1, 2 & 3 plus below: Hold daily virtual board rounds 3 times a week for Community Hospitals led by Hospitals Directorate with inclusion of the Demand and Capacity team and Adult Social Care colleagues Continue to flex criteria for admission to a Community Hospital. Further caseload review and reprioritisation of therapy in community services. Divert therapists to support Home First. Weekend on call rota all Service Directors and Deputies with time off in lieu and payment for hours worked MH and PH Services On-Call Manager, have a second person on call rota in place with time off in lieu and payment for hours worked Enhance the ICC cover with second person on call, with time off in lieu and payment for hours worked Review lowering levels of care Rapid Response to become a Receiver as well as a User on Cinapsis providing easy access to RR for SWAST to prevent admissions. Review opening hours of SPCA at weekends Explore options of opening additional inpatient bed capacity across our estate, with mutual aid as required if demand increases during the preceding week. Gain agreement from the system to cease elective activity within and outpatients and redeploy staff to inpatient wards. Gain agreement from the system to cease elective activity including theatre, endoscopy and redeploy staff to inpatient wards. Increase non-clinical support on inpatient wards Complex care at home to support with Adult PH Community Health Teams under the Directions of the Service Director Further caseload review and reprioritisation of therapy. Divert therapists to support Home First model Response team and colleague redeployment to add capacity into Home First and reablement pathways Ensure IPC cover on site with time off in lieu and payment for hours worked	As above	As above	As above	In addition to the above; Patients/ Relatives - Possible reduced standards of care. No mutual aid likely Psychiatric Intensive Care Unit – No beds Department of Health – Performance targets not being achieved. Clinical Commissioning Group – Not fulfilling all contractual obligations

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
• What needs to happen (actual), or be about to happen (prospective trigger)? • Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		• What will be done to mitigate the raised level of pressure as a result of moving to this level? • Who by? When? Where?	• What will be communicated intra and/ or inter Trust? • Who by? When?	• What Incident Command System arrangements will be in place? • Who has the authority and responsibility to trigger? • Arrangements in hours & Out of Hours?	• Expected impact of these actions	• Any implications of these actions on other organisations
		Redeploy colleagues from NQT to provide additional clinical rota to support colleagues Targeted short-term redeployment colleagues from NQT, finance and strategy and partnership's into HCA, admin and support worker rolls. Review of all current placement of RN and AHP colleagues across GHC and ensure colleagues are deployed as per priority.				

Trigger	OPEL Level	Action	Communication	Command and control	Impact	Implications?
•What needs to happen (actual), or be about to happen (prospective trigger)? •Are these internal Trust triggers or external ones i.e. Clinical Commissioning Group or NHS E?		•What will be done to mitigate the raised level of pressure as a result of moving to this level? •Who by? When? Where?	•What will be communicated intra and/ or inter Trust? •Who by? When?	•What Incident Command System arrangements will be in place? •Who has the authority and responsibility to trigger? •Arrangements in hours & Out of Hours?	•Expected impact of these actions	•Any implications of these actions on other organisations

2.2.8. Critical Services Categorisation – We recognise service prioritisation is a dynamic assessment and dependant on the nature and duration of the incident our priority ratings may change.

The current service prioritisation status is illustrated below in figure 7.

Figure 7 - **Operational Services Impact Assessment (Covid-19)**

Service areas	Specialism	Service	Priority Rating
Hospitals	Physical Health	Inpatients (+ supporting functions)	1
Hospitals	Physical Health	*Out-patients*	*2*
Hospitals	Physical Health	*Theatre*	*2*
Hospitals	Physical Health	*Endo*	*2*
Hospitals	Learning Disabilities & Mental Health	Inpatients (plus supporting functions)	1
Hospitals	Learning Disabilities	LDISS	1
Hospitals	Learning Disabilities	IHOT	2
Urgent Care	Physical Health	Rapid Response	1
Urgent Care	Physical Health	Integrated Assess Team	1
Urgent Care	Physical Health	Minor Injury and Illness Units	1
Urgent Care	Physical Health	Single Point of Clinical Access	1
Urgent Care	Physical Health	IV Therapy	1
Urgent Care	Physical Health	Evening and Overnight District Nursing	1
Urgent Care	Mental Health	Contact Centre	1
Urgent Care	Mental Health	Crisis incl. Street Triage	1
Urgent Care	Mental Health	AMHP	1
Urgent Care	Mental Health	Psychiatric Liaison	1
LTC	Physical Health	Care Home Support Team	2
LTC	Physical Health	Respiratory - Home Oxygen Service	1
LTC	Physical Health	Respiratory - Core	2
LTC	Physical Health	Pulmonary Rehab	2
LTC	Physical Health	Diabetes	2
LTC	Physical Health	Homeless Healthcare	1
LTC	Physical Health	Heart Failure	2
LTC	Physical Health	Cardiac Rehab	2
LTC	Physical Health	Bone Health	2
LTC	Physical Health	McMillan	2
Sexual health	Physical Health	Sexual Assault Referral Centre	1
Sexual health	Physical Health	Pregnancy Advisory Service	1
Sexual health	Physical Health	Sexual health - GUM/HIV	1

Service areas	Specialism	Service	Priority Rating
Dental	Physical Health	Dental - Springbank	2
Dental	Physical Health	Dental OOHs/Urgent	1
Therapy & Equip	Physical Health	Podiatry - Inpatients	1
Therapy & Equip	Physical Health	Podiatry - Core	2
Therapy & Equip	Physical Health	Adult MSK	2
Therapy & Equip	Physical Health	Adult MSKAPS	2
Therapy & Equip	Physical Health	SALT - IP services	1
Therapy & Equip	Physical Health	SALT - community	2
Therapy & Equip	Physical Health	Wheelchair Assessment service	2
Therapy & Equip	Physical Health	Integrated Community Equipment Service	1
Therapy & Equip	Physical Health	Telecare	1
Specialist	Mental Health	IAPT	2
Specialist	Mental Health	MHICT	2
Specialist	Mental Health	Eating Disorders	2
Specialist	Mental Health	ASC/ADHD	2
Specialist	Mental Health	Perinatal Team	2
Specialist	Mental Health	Criminal Justice Liaison Team	2
Specialist	Mental Health	GRiP	2
Specialist	Mental Health	MHICMAS	2
Specialist	Mental Health	Accommodation Team	2
Adult Community	Physical Health	Referral centre	1
Adult Community	Physical Health	Reablement	1
Adult Community	Physical Health	District Nurses	1
Adult Community	Physical Health	OT - core	2
Adult Community	Physical Health	Physio - Core	2
Adult Community	Physical Health	Complex leg wound/lower limb	1/2
Adult Community	Physical Health	Lymphoedema service	1/2
Adult Community	Physical Health	Complex care at home	1/2
Adult Community	Physical Health	Tissue Viability Service	2
Adult Community	Mental Health	AOT	2
Adult Community	Mental Health	Recovery	2
Adult Community	Mental Health	OP CMHT	2
Adult Community	Mental Health	Dementia Education	2
Adult Community	Mental Health	MAS	2
Adult Community	Learning Disabilities	CLDT	2
Adult Community	Mental Health	CPI	2
Adult Community	Mental Health	Back 2 Work	2
Adult Community	Mental Health	Homeless MH	2
CYPs	Physical Health	Children's Community Nursing Team	1
CYPs	Physical Health	Children's' Complex Care Service	1

Service areas	Specialism	Service	Priority Rating
CYPs	Physical Health	Physiotherapy - IP only	1
CYPs	Physical Health	Occupational Therapy - IP only	1
CYPs	Physical Health	SALT - IP only	1
CYPs	Physical Health	Physio - Core	2
CYPs	Physical Health	OT - core	2
CYPs	Physical Health	SALT - core	2
CYPs	Physical Health	Immunisation Service	2
CYPs	Physical Health	IMMS - BCG	1
CYPs	Physical Health	School Nursing	2
CYPs	Physical Health	Children in Care	1
CYPs	Physical Health	HV	2
CYPs	Mental Health & Learning Disabilities	CAMHS VCS	1
CYPs	Mental Health & Learning Disabilities	CORE CAMHS LEVEL 2/3	1
CYPs	Mental Health & Learning Disabilities	CAMHS Level 2 Parenting	2
CYPs	Mental Health & Learning Disabilities	CAMHS Interagency Teams (GMAT)	2
CYPS	Mental Health & Learning Disabilities	TACS (Turnaround for children)	1
CYPs	Mental Health & Learning Disabilities	Functional Family Therapy	2
CYPs	Mental Health & Learning Disabilities	CAMHS LD	1
CYPs	Mental Health & Learning Disabilities	CAMHS MHST	2
Covid	Covid	Stock Team	1
Covid	Covid	Testing Team	1
Medical	Medical	Medical staffing MH / LD	1
Medical	Medical	Medical staffing PH	1
Facilities	Facilities	Facilities PH, MH / LD	1

N.B. A separate service impact assessment was carried out in March 2020 for Corporate Services and is available on request.

3. OUT OF HOURS ARRANGEMENTS

3.1.   The On-call Management Team arrangements are as follows:

   Executive On-Call;

   Mental Health Services Manager On-Call;

   Physical Health Services Manager On-Call;

   The rotas for the three On-Call groups are managed by the Organisational Resilience Team, details of roles and responsibilities are identified in Appendix 3.

3.2.   **Directorate/Locality escalation plans –**

Each Locality has operational management protocols/principles in place to manage increases in demand. These principles are used to support the Trust wide Escalation Plan and the Public Health England Local Outbreak Management Plan.

3.3.   **Mutual Aid**

The Trust Escalation Procedures support operational capacity and demand across the health economy, however, the organisation works closely with partner organisations and key stakeholders. Whilst the actions that the organisation take is crucial it recognises the vital role of mutual aid and support in ensuring that the whole system stays safe during times of pressure. Should there be a requirement or request for mutual aid the Trust will follow the Local Health Resilience Partnership Mutual Aid policy. There may also be a requirement or need to work with other non-health related interested parties therefore the Local Resilience Partnership Mutual Aid policy will be followed.

4. ON-GOING MANAGEMENT, MAINTENANCE AND MONITORING

4.1.   **Capability Maintenance**

Plans, procedures, training, equipment, escalation processes and response systems are constantly reviewed and amended as we learn from events, new National guidance and identified best practice, to ensure the most up to date information is contained within documents. The Organisational Resilience Team works in collaboration with ward/department/directorate and site leads to ensure response capabilities are monitored and maintained.

4.2.   This document will be reviewed by winter planning leads and the Organisational Resilience Team annually or earlier if changes are required. Any changes will be viewed and agreed by the Trusts respective assurance processes and Executive committee.

4.3.   **Document availability**
A full and up-to-date copy of this document will be available electronically via the Trust Intranet Page.

4.4.   It is the responsibility of all staff to ensure they are reading the most up-to-date version of this document (verification can be sought from either the Organisational Resilience Intranet page or the Organisational Resilience Team).

5. SOURCES OF ADDITIONAL INFORMATION
   - Incident Management and Coordination Policy
   - Incident Command System Policy
   - Site/Team Emergency Response Guides/Business Continuity plans
   - GHC Internal Escalation Action Cards

- Operational Pressures Escalation Levels (OPEL) NHS Standard Contract
- NHS Commissioning Board Command and Control Framework
- Everyone counts: Planning for Patients 2013/14
- Flu Plan - Winter 2020/21
- Attendance in Adverse Weather or Emergency Event Policy
- On-Call Manual
- Communications Plan
- Seasonal Flu and Testing Plan
- Covid-19 Service Plan
- Demand and Capacity Modelling
- Scenario Planning
- Response and Second Wave position

Appendix 1 – Staff Seasonal Flu Vaccination Action Plan 2021/22

A	Committed leadership	Trust self- assessment
A1	Board record commitment to achieving the ambition of vaccinating all frontline healthcare workers	Target is 100%
A2	Trust has ordered and provided a quadrivalent (QIV) flu vaccine for healthcare workers	Working Well ordered 6,000 vaccines for GHC Staff in April 2021
A3	Board receive an evaluation of the flu programme 2021/22, including data, successes, challenges and lessons learnt	The Trust achieved 86% uptake
A4	Agree on a board champion for flu campaign	Director of HR & OD Director of Nursing, Therapies & Quality Director of Infection Prevention & Control
A5	All board members receive flu vaccination and publicise this	Need to organise with Comms
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Flu Team members – Working Well Head of Nursing & Quality Chief Pharmacist Lead Nurse for Infection Control for Mental Health and Learning Disability Lead Nurse for Nursing Projects PA to Head of Nursing & Quality Admin Support, Flu Co-ordinator Communications Team Complex Case Clinical Lead for Demand and Capacity
A7	Flu team to meet regularly from September 2021	Meetings commenced in June 2021
B	Communications plan	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	To be done
B2	Drop in clinics and mobile vaccination schedule to be published electronically, on social media and on paper	Elaine Tingle is working on the clinic plan
B3	Board and senior managers having their vaccinations to be publicised	To be done
B4	Flu vaccination programme and access to vaccination on induction programmes	Being co-ordinated by Elaine
B5	Programme to be publicised on screensavers, posters and social media	To be organised by Comms

B6	Weekly feedback on percentage uptake for directorates, teams and professional groups	To be organised by Comms, with data being provided by Elaine
C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate and empowered	Peer Vaccinators being sought and training being organised by Chief Pharmacist and Health and Wellbeing
C2	Schedule for easy access drop in clinics agreed	Being prepared (to include potential home visits for staff who may continue to be shielding)
C3	Schedule for 24-hour mobile vaccinations to be agreed	To be discussed

Appendix 2 - Flu Vaccination 2021/22

Communications Plan– 2021/22

1. Background

Each year we promote our flu vaccine programme to Trust colleagues, with the aim of increasing uptake of the vaccine by frontline colleagues and ensuring clinics are as accessible as possible across our sites.

This year, with circulation of Covid-19 the flu vaccination is more important than ever and we will need to look at innovative ways to reach colleagues including those shielding and working from home. We will also need to look at how we can deliver clinics both safely and efficiently within available settings and ensure they are communicated in the most effective way.

This year's campaign will be launching in October 2021.

2. Lessons learnt from last year's campaign /areas to focus on

- Regular communications to staff to say when clinics are being held
- Planned clinics with posters
- Incentives including sweets, badges
- Make it easy for staff to tell us if they have had the jab elsewhere (using Smart Survey)
- Communications to keep workforce informed of flu outbreaks
- Flu stories – service users and staff

3. GHC key communications

- Clinic times/ locations
- Online booking system
- Myth busting
- Uptake encouragement /incentives

4. Key messages for this year's campaign

We have agreed key messages, which we will seek to promote at every opportunity through our engagement and communication.

- It's important to take up the offer of a vaccine to reduce your risk of becoming unwell with flu at a time when Covid-19 could still be circulating
- You can have no symptoms of flu but spread it to your friends and family
- The NHS is well prepared and can safely vaccinate you and your loved ones against flu this year

PHE key messages for this year's campaign
- Every year flu hospitalises and kills thousands, and this is anything but an average year
- The flu virus spreads from person to person, even amongst those not showing any symptoms
- It can cause severe complications, particularly for high risk groups
- Keep your guard up against the flu virus. Get the flu jab
- Whilst the threat may be invisible, the protection against it is clear.
- Protect yourself and others with the flu vaccination (for those eligible)
- Flu can be serious and is different from the common cold. Symptoms include a high temperature, body aches and fatigue
- Aside from having your flu vaccine, the best way to prevent the spread of flu is to practice good hand/respiratory hygiene. Catch coughs and sneezes in a tissue, throw the tissue away and wash your hands.

5. Ongoing Evaluation

We will evaluate the effectiveness of our Communications Plan by:

- Monitoring vaccination and booking system data and focusing our communications on areas/teams with low uptake
- Introducing flu champions to encourage uptake
- Ensuring clinics are accessible across the Trust, including those working from home and/or shielding
- Capturing those colleagues who have had the jab elsewhere e.g. GP Surgeries
- Providing ongoing clear and informed myth busting messages

Appendix 3 - On-Call Roles and Responsibilities

Executive On-Call
The Executive On- Call is a 24-hour function.

Role purpose to –
- ➢ Provide overarching strategic support and management to the On-Call managers and any incidents

Key responsibilities to -
- ➢ The Executive On-Call is primarily responsible for but not limited to:
  - o Staff and patient welfare
  - o Reputational damage
  - o Media Management
  - o Exceptional Financial Spend
  - o Escalation and capacity support when required
  - o Advising/supporting On-Call managers
  - o Major Incidents (decision to open the incident Co-ordination Centre)

- ➢ ***Within the Trust, the Executive On-Call will only be contacted through either of the On-Call Services Managers, should the issue be deemed serious enough.***

- ➢ The Mental Health Services Manager On-Call or Physical Health Services Manager On-Call will contact the Executive On-Call in the following circumstances:
  - o The event is of wider public interest and it requires a timely response;
  - o It requires resources beyond those at the disposal of the Services On-Call managers;
  - o It extends beyond the Services On-Call manager's area of responsibility and/or expertise

- ➢ The Physical Health Services Manager On-Call along with the Patient Flow lead will act as the Trust representatives on the System escalation calls, however the Executive On-Call attendance will be required to support if:
  - o The system is at OPEL level 4/Black
  - o Director level attendance is requested by the CCG
  - o If the health system has been level 3/Red for three consecutive days

- ➢ The Executive will act as the press officer for the Trust and deal with enquiries from the press or the public should any untoward incident or serious emergency arise.

- ➢ The Executive will act as the Strategic (Gold) Lead for Out of Hours GHC internal incidents.

- ➢ The Executive On-Call will be the first point of contact for external agencies alerting that an Incident has been declared through the Local Resilience Forum Operation Link protocols. They will act as the Trust's Strategic (Gold) Lead and may be required to liaise with multi-agency partners at a Strategic level, participating in any relevant calls and meetings.

- ➢ For both internal and external incidents, the Executive On-Call, in discussion with the On-Call managers, will decide whether there is a need to open the Incident Coordination Centre.

- ➢ The Executive On-Call will keep the Chief Executive and the Chair briefed regarding any incidents which occur and update them on developments. The seriousness of the incident will be determined by the On-Call Exec and reported to the CCG on call manager if

required.

➢ The Executive On-Call should contact the Chief Executive if an event is likely to enter the political domain or if the consequences of an event pose a dramatic risk. The Chief Executive will decide whether or not to alert the Chair.

➢ A serious event is defined as an incident that may be of concern to the general public and may attract the attention of the media. It may involve patients, staff or buildings in the Trust, e.g.,
   o an unexpected/unexplained deaths or major injury where foul play within the service is suspected;
   o the suicide of any person under NHS care or detained under the Mental Health Act;
   o accidental death and/or serious injury to any individual (patient, staff or visitor) on NHS premises where this might be due to negligence;
   o any incident involving serious outbreak of an infectious disease;
   o serious damage to NHS property including by fire;
   o security risks
   o any other incident likely to give rise to national media interest involving the Trust.

➢ Operational issues will continue to be dealt with by the Services Manager On-Call.

Mental Health Services Manager On-Call

Role purpose -
➢ To provide clinical leadership, support and advice out of hours to the Trust Mental Health Services.

Key responsibilities to -
➢ maintain a *default telephone/ pager-based* advice and support function;

➢ provide clinical leadership / advice / support to Trust services out of hours;

➢ facilitate complex clinical decisions and support liaison with partners and other providers as required;

➢ respond to mental health bed management situations liaise with the Trusts single point of access to facilitate these requests;

➢ support with staffing issues and provide authorisation of agency staff as appropriate

➢ in liaison with Flow Team facilitate a request for an out of area/ Tier 4 placement for a Trust patient;

➢ support with estates concerns where, on occupied sites there is a perceived significant impact on the safety and wellbeing of service users/ visitors and staff;

➢ provide support and leadership for any serious incidents acting as the Trust's tactical (silver) lead for any out of hours internal or external wider issues

➢ attend a site if a serious incident occurs resulting in serious injury or death of a patient, or to support the Physical Health Services Manager On-Call in such a scenario;

➢ provide a written initial report as outlined in the Policy for Reporting Incidents for any

serious incident;

➢ liaise directly with the Physical Health Services Manager On-Call to:
  ○ Resolve issues requiring operational and clinical resolution;
  ○ Manage Serious Incidents requiring an operational and clinical response;

➢ escalate the following to Executive On-Call;
  ○ Serious injury or harm to a patient or staff member;
  ○ Substantial or significant estates concerns;
  ○ Media contact;
  ○ Significant or adverse event requiring service continuity escalation

➢ record all contacts out of hours within the On-Call log and follow up necessary 'in hours' actions;

➢ hand over all issues to the relevant locality managers on the next working day;

➢ the Mental Health Services Manager On-Call may be contacted for variety of issues, as this is not an exhaustive list.

➢ In extreme situations or major incident declaration the On-Call team, in discussion with the Executive On-Call, may be required to open or attend the Incident Coordination Centre, Malvern Room at Edward Jenner Court.

Physical Health Services Manager On-Call

Role purpose to -
➢ provide operational leadership, support and advice to Physical Health Trust services out of hours

Key responsibilities -
➢ maintain a *default telephone/ pager-based* advice and support function;

➢ support continued service provision/capacity issues

➢ represent the Trust on system escalation calls, supporting the Patient Flow Lead, and support with any follow up actions or requests liaising with Single Point of Clinical Access (SPCA) and other relevant services e.g. Rapid Response;

➢ assess the initial information received in respect of a potential or actual disruption to services, advising and facilitating the management of the situation and escalating when appropriate;

➢ provide support and leadership for any serious incidents acting as the Trust's tactical (silver) lead for any out of hours internal or external wider issues

➢ when required, contact a relevant staff member via the Executive On-Call for additional support with an issue e.g. IT, legal, Comms, security

➢ attend a site/ service if a Serious Incident occurs requiring immediate senior operational support;

➢ support estates concerns, where on occupied sites there is a perceived significant impact on the safety and wellbeing of service users/ visitors and staff;

- support with potential or actual disruptions to operational service delivery, e.g. capacity/case load issues and advise and facilitate the management of the situation;

- when required, have discussions with Minor Injury and Illness Units who are wishing to close the unit and to also ensure to inform the Executive On-Call when there are closures;

- provide support to staff when IT or Clinical Systems issues are escalated. This includes ability to unlock offline working for RIO and access to Community Hospital SystmOne drug charts

- ability to utilise an ESR application to search for members of staff who may be reported uncontactable/missing due to lone working

- escalate the following to Executive on call;
    o Serious injury or harm to staff member;
    o Substantial or significant estates concerns;
    o Media contact;
    o Significant or adverse event requiring service continuity escalation;

- record all contacts out of hours within the On-Call log and follow up necessary 'in hours' actions;

- hand over any ongoing issues to the next On-Call Manager or to the relevant leads/ managers on the next working day where required

- On-Call manager may be contacted for a variety of issues, as this is not an exhaustive list.

- In extreme situations or major incident declaration the On-Call team, in discussion with the Executive On-Call, may be required to open or attend the Incident Coordination Centre, Malvern Room at Edward Jenner Court.

Appendix 4 – 4x4 capabilities

To ensure service continuity during periods of adverse weather the Trust has a number of different options available for implementation:

- Localised Emergency Response Guides
- Business Continuity Planning
- Attendance at Work Policy

The use of 4x4 support is only considered when all other options have been exhausted and:
- there is a need to get staff to patients;
- there is a need to get staff to inpatient facilities.

This would be in an extremist situation and require coordinating as most of the health care providers will draw from the same limited providers and organisations. If the situation is critical or major incident the Local Resilience Forum will coordinate all 4x4 requirements.

To support the Trust requirements, there is a number of vehicles, identified below, within the fleet. Additional internal arrangements are vehicles hired in for a defined period of time. Should the 4x4 element of the plan be required this will mean the Incident Coordination Centre (ICC) is activated and all 4x4 requests coordinated via this function.

The Organisational Resilience Team will coordinate the 4x4 requirement through the ICC arrangements during business hours, and then the ICC On Call manager will assist out of hours.

Trust vehicles are in constant use and if required for other duties this will be on an ad hoc basis. Staff volunteers are trained to drive the hired vehicles, the Organisational Resilience Team hold a list of staff who have volunteered to support the Trust 4x4 capability. Their availability will need to be confirmed at the time of their request for support, noting that this will be an advance identification of risk and all arrangements will be in place prior to the event.

Additional vehicles will be available via the voluntary sector, Gloucester Worcester 4x4, as detailed below.

The following governance arrangements are in place to support the volunteer arrangements.

Insurance: Our insurance covers all staff and volunteers of GHC for personal injury and accidental damage whilst driving any vehicle which has been hired, leased or purchased by GHC. A copy of the insurance certificate will be provided to be kept in each hired vehicle.
Human Resources: We would need to check that Staff Volunteer Drivers, if using their own vehicles had completed their annual appraisal declaration within the past 12 months, which includes the line manager and employee signing off the following declaration:
"I have a valid driving licence, business insurance (appropriate for your role within the Trust) and if appropriate a valid MOT certificate."
IPC: Will depend - if staff collecting have had Covid and recovered then can share the vehicle with probably 3 other staff, (also recovered) should still wear type 11R facemasks but will be reduced risk. If staff have not had Covid then It would be sensible to have 1 driver (wearing a mask) and 1 passenger (also wearing a mask), a lot would depend on the duration of the journey etc, would also need to try to keep the windows open to allow for

ventilation.

Remuneration: It has been agreed that TOIL can be taken, this needs to be agreed with the individual line Manager.

The following table identifies the 4x4 resources available to support the Trust arrangements.

Trust Resources Location	Car Make	Car Model	Licence Plate
Lexham Lodge Crisis Team	DACIA	DUSTER 5DR 4X4 1.6 ESSENTIAL	LJ68 BKA
WEAVERS Croft Crisis Team	DACIA	DUSTER 5DR 4X4 1.6 ESSENTIAL	LJ68 BKD
PULLMAN PLACE CRISIS Team	DACIA	DUSTER 5DR 4X4 1.6 ESSENTIAL	LJ68 BKE
CHARLTON LANE	DACIA	DUSTER 4X4 1.5BD COMFORT	LK69 EYT
Cirencester	DACIA	DUSTER 4X4 1.5BD COMFORT	LK69 EYU
Tewkesbury Hospital	DACIA	DUSTER 4X4 1.5BD COMFORT	LK69 EYV
COLLIERS COURT	DACIA	DUSTER 4X4 1.6 ESSENTIAL	MB19 FBJ
Dilke/ Lydney	SKODA	YETI 4 x 4	VO13 VXV
Rapid Response EJC	SKODA	YETI 4 x 4	VO13 VXX
Stroud	SKODA	YETI 4 x 4	VO13 VYW
North Cots Hospital	SKODA	YETI 4 x 4	VO13VXY

TRUST CONTRACTED SUPPLIER OF 4x4 TRANSPORT (EXTERNAL)			
Supplier	**Contact No.**	**Email**	**Additional information**
A&D 4x4	0193 484 2212	aandd4x4@gmail.com	
GLOUCESTERSHIRE 4X4 VOLUNTEERS (EXTERNAL)			
Name	**Contact No.**	**Email**	**Additional information**
GLOS CCG (OOH)	07623 514563	-	
Gloucestershire and Worcestershire 4x4 Coordinator	Tel: 0330 818 2477	CONTROL@GW4X4R.CO.UK	New telephone number is automatically redirected to the controller on call, telephone is the best form of contact to access support.

Appendix 4 – IPC

INTRODUCTION

The Infection Prevention and Control (IPC) Team provides Consultant led specialist infection prevention and control expertise, training, education and support for all staff and sites across Gloucestershire Health and Care NHSFT (GHC). This service is provided 08:30 to 16.30, Monday to Friday.

Outside of these hours, including weekends, Bank Holidays and overnight, GHC has a contract with Gloucestershire Hospitals NHSFT (GHT) to provide urgent IPC advice and support via the GHC On-Call process (GHC On-Call Manager contacts On-Duty Microbiologist). See below for an example of a Standard Operating Procedure for On-Call Managers, where patients develop symptoms of Covid-19:

SOP for on-call
managers for 7b 25.0

The team also has Service Level Agreements (SLA) in place to provide IPC advice and support to Tetbury Hospital as well as Leckhampton Court Hospice (Sue Ryder), Great Oaks and Longfield hospices.

This Winter Surge Plan (WSP) describes the actions which will be taken in order to ensure priority IPC services provided to the Trust can continue in the event of a surge in demand due to a serious outbreak of infectious disease (e.g. Norovirus, C-diff, RSV, influenza, Covid-19 etc.).

IPC TEAM

Name	Title	Substantive WTE	July 2021 WTE
Philippa Moore	Infection Control Doctor (ICD)	4 PA (16 hours per week)	4 PA (16 hours per week)
Sam Lonnen	Infection Control Lead Nurse	0.6	0.6
Marion Johnson	Infection Control Lead Nurse	0.5	0.7
Natalie Matthews	Senior Infection Control Nurse	0.68	0.68
Lisa McLean	Senior Infection Control Nurse	1.0	1.0
Amy Barnes	Infection Control Nurse	1.0	1.0
Louise Forrester	Lead Nurse for Infection Control for MH and LD	0.4	0.4
Emma Bray	Team PA	0.8	0.8

Responsibilities of Infection Control Lead Nurse(s):

- Ensure they have up to date contact details for each member of the team
- Ensure each member of the team has signed the Working at Home agreement in line with Trust Policy
- Ensure each member of the team is set up to work from home, or remotely at other Trust sites, in a way that does not put their health at risk if the need arises
- Ensure a plan is in place for a timely cascade to staff of guidance/instructions when a Winter Surge Event occurs, so that staff are kept informed
- Risk Assessments to be reviewed as appropriate depending on staff circumstances, e.g. Lone Working, Occupational Health Covid-19 Risk Assessments etc.

- Ensure SLA providers are contacted immediately, advised of situation, know how to contact the team and receive regular updates
- Review the position with DIPC/Deputy DIPC daily/weekly as required

Responsibilities of the IPC team staff member:

- Ensure they have the Infection Control Lead Nurse(s) mobile number
- Ensure their contact details are up to date
- Make every effort to get to work, or work from alternative Trust sites, providing there is no risk to self or others (e.g. severe weather)

WINTER SURGE EVENT (SERIOUS OUTBREAK):

The Trust and IPC team's response to an outbreak depends on the severity and nature of the outbreak. The varying levels of response are outlined in the Trusts IPC Outbreak of Serious Infection Policy CLP133. Severe outbreaks may involve local Public Health or Public Health England involvement.

During times of surge, including winter surge and Bank Holidays, if the IPC team are required to work across 7 days this would be built into existing GHC On-Call process, i.e.:

- 7 day working would be agreed with HR/IPC team
- Names/contact details and rotas would be developed
- Names/contact details would be sent to the Incident Co-ordination Centre for inclusion in the On-Call Managers pack and circulated

Actions to be Taken to Increase IPC Team Capacity During Surge

To ensure a serious outbreak is managed effectively, various actions will be considered in order to increase the capacity of the GHC IPC team. These actions would include:

- Lower priority activities would be temporarily paused. The situation would be reviewed with the Deputy DIPC on a daily/weekly basis as required. Appendix 1 gives an indication of the activities that can be safely temporarily paused
- IPC team would be asked if they wish to increase their hours
- Deputy DIPC would engage with HR/IPC if 7-day working is required
- Re-deployment of staff to support the IPC team, for example:
    - 1 member of staff is qualified as an IPC nurse and could be deployed into the team to provide specialist IPC advice and support
    - Staff could be re-deployed to other roles to support outbreak management, e.g. PPE Safety Champions role during Covid-19

Annex – IPC Team Activity with Priorities

Activity	Activity Priority	Can it be Paused?	Comment
Outbreak Management	1	No	Key activity
Outbreak Reporting to PHE	1	No	Mandatory requirement
Daily Results and Surveillance	1	No	Key Activity
IPC Advice and Support (including for new builds, new equipment etc.)	1	Partly	Advice and support prioritised to manage outbreak(s), other non-priority advice and support to be paused
SLA Advice, Support and Audit	1	No	Contractual obligations need to be delivered
Clinical Visits	1	No	Prioritise visits to areas with outbreak(s)
Monthly audits - monitor and follow-up	1	No	Monitor for assurance, prioritise where compliance poor
System Crisis Management Meetings (Bronze, Silver, Gold)	1	No	IPC attendance required
Matron's Walkabouts	2	Yes	Not a priority
Education and Training	2	Yes	Training transferred to e-learning (Level 1 and Level 2)
Policy Reviews	2	Yes	Policies can be extended and reviewed when outbreak over
Annual IPC Audit	2	Partly	Seek alternatives if Annual Audit can't be undertaken (e.g. Covid-19 Assurance Framework) Monitoring of Hospital Audits for assurance
Meetings and other activity	3	Yes	Non-IPC Assurance activity and non-essential meetings can be deferred

Appendix 5 – Staff Health & Wellbeing

The health and wellbeing of every colleague is important at all times.

- ✓ Health and wellbeing is everyone's responsibility
- ✓ Leaders and managers are required to ensure they are setting the tone for their team
  - o Set an example and make sure you are supporting your own wellbeing.
- ✓ It is ok to say you are not ok
  - o Seek help and support, whether that be taking a break; talking to a colleague; or talking to your manager, accessing resources

There are a range of formal resources available access on the health and wellbeing intranet pages

Team time
Colleagues are encouraged to do simple as a 15-minute check-in, ensuring we know how people are feeling, what they worked on yesterday and what they are doing today and do they need any support. Helpful tools are available on the intranet to help.

Rest and Relaxation
Colleagues are reminded to ensure they take care of themselves and take regular breaks, it can be as simple as a quick walk around or stepping away from your immediate environment. Leaders and managers are encouraged to role model and encourage their team to do the same.
Colleagues are reminded that it is important to look after the basics, eating well, exercise, sleep, rest and relaxation.

Formal Resources
All the resources can be found on the intranet

Working Well
Our occupational health service provides advice on how to support colleagues with a physical or mental health issues. They also provide direct support for colleagues, including confidential advice including counselling and other health and wellbeing support. If colleagues need to access a trained counsellor about any issue, financial, home, work etc, they can email workingwell@ghc.nhs.uk to arrange, putting 'Counselling request' in the subject heading. This is available 24 hours per day.

Let's Talk
Provides support for people with anxiety and depression, using a range of therapies, to support colleagues in managing their emotional wellbeing. This is a confidential service which is available on: 0800 0073 2200

Psychology
Our psychologists support individuals or teams, this can be accessed directly the Head of Psychological Services.

Vivup
Is our Employee Assistance Programme (EAP) with advice, counselling and support, for more information click here

Speaking Up
As an organisation we seek to create an environment where people have the confidence to raise questions and concerns. We aim to actively listen to feedback, reflect and learn. Creating a culture of continuous learning. Colleagues can raise a concern directly to our freedom to speak up guardian.

Online resources
There are also a range of free apps available to colleagues, the passwords can be found on the GHC intranet mental health pages.

Digital Wellbeing
It's important that we ensure we take regular breaks as being on digital meetings can be very tiring. We suggest that people start meetings on the hour but finish meetings 10 minutes before t

Appendix 6 – Trust Risk Summary

The risk process is constantly reviewed and updated and regular review of risks ensures mitigation is progressed to lower the risk probability or close the risk.

Ref	Risk Theme	Description of the risk	The Trust Risk Assessment without controls			Existing Controls/ Capabilities	Additional Risk Treatment required	Residual Risk rating		
			L	C	Risk Rating			L	C	Risk Rating
1	Severe weather	Prolonged heavy snowfall causing travel disruption and difficulty in community staff reaching service users.	2	3	Moderate	Service Continuity Plans Service. Director/Community Service manager – prioritisation of staffing and services. Prioritised patient severity list. Policy relating to Staff attending work during severe weather. 4x4 vehicle support arrangements including Staff volunteers, Contracted Transport and LRF 4x4 Protocol.	N/A	2	2	Moderate
2	Staff absence (Severe Weather – Snow and low temps)	Increase in staff absences (above average levels) due to difficulty in getting to work that may have an impact on service quality and patient safety.	2	3	Moderate	1. Service Director/Matron – prioritisation of staffing and services 2. Directorate and Locality contingency arrangements 3. Support from Temporary Staffing Team with providing Bank Staff	1. Severe Weather Procedure (includes 4x4 protocols). 2. Estates grounds and maintenance contracts	2	3	Moderate
3	Staff absence (sickness)	Increase in staff absences (above average levels) due to circulating seasonal viruses.	3	4	High	1. Hand Hygiene Policy 2. Flu Vaccination 3. Combined occupational health and communications team awareness campaign. 4. Service continuity arrangements outlining staffing contingencies 5. Staff self- referral to physiotherapy 6. Increase in hygiene compliance as service now managed in house, Trigger notification of staff absence / return to work interviews and referral to Occupational health 7. Utilisation of the Covid-19 Absence App	N/A	3	4	Moderate
4	Staff absence (Holiday period)	Increase in staff absences (above average levels) due to holiday period.	2	3	Moderate	1. Staff rotas developed, reviewed and agreed in October by Service Directors. 2. Local staff bank co-ordination 3.Use of electronic rota, noting 2 systems currently being utilised	N/A	2	2	Moderate
5	Flu Vaccination	The Trust will not be able to achieve the target to vaccinate 100% of its workforce against flu.	1	3	Low	1. Combined occupational health & communications team awareness campaign 2. Flu Champions 3. peer Vaccinators	N/A	1	3	Low

Ref	Risk Theme	Description of the risk	The Trust Risk Assessment without controls			Existing Controls/ Capabilities	Additional Risk Treatment required	Residual Risk rating		
			L	C	Risk Rating			L	C	Risk Rating
6	Outbreaks	Flu/other circulating viruses impacting on the resources of a site(s), subsequently leading to reduced capacity.	4	4	High	1. Outbreak Plan 2. Hand Hygiene Policy 3. Patient Isolation Policy 4. Enhanced cleaning 5. Gastroenteritis Policy 6. WVT Infection control audits 7. Sepsis awareness packs	N/A	4	3	High
7	Increased demand on Operational Service Teams	Demand likely to outstrip capacity leading to performance targets not being met	2	3	Moderate	1. Service Escalation triggers and actions 2. On-call team 3. Site briefings/ conferences 4. Staffing strategies 6. GCCG Escalation Framework 7. Staff requirements managed in line with the demand modelling that has been developed.	N/A	1	3	Low
8	Bed capacity	Demand for beds likely to outstrip normal capacity	3	4	High	1. Robust Bed Management Process, Weekly MFSD meetings. 2. Availability to purchase private beds to extend capacity for mental health provision 3. Negotiate with commissioners to open assessment beds	N/A	2	3	Moderate
9	Covid-19 Specific	Second wave of pandemic	3	4	High	1. Surge planning workshops completed 2. linked to the corporate		2	3	Moderate
11	Covid-19 Specific	Local outbreak of Covid-19 (including organisational outbreak)	3	4	High	1. Local Ward bed management plans 2. LOMP 3. SHREWD 4. Demand and Capacity for bed management		2	3	Moderate
12	Covid-19 Specific	National Lock down	3	4	High	Work from home BCP implemented		2	3	Moderate
13	Covid-19 Specific	Local lock down	3	4	High	As above		2	3	Moderate

OPERATIONAL ESCALATION PLAN

Version	1.0
Author:	Sarah Birmingham
Date	16th August 2021

Contents

1.0 Introduction

This Surge and Escalation Plan has been developed to guide leaders and managers through periods of surge at any point in the year, including winter.

Surge occurs when, for any reason, there is a mis-match between demand and capacity which risks compromising essential patient care and safety.

Surge can occur in two ways;

- Within the Trust and individual service when internal escalation actions may be required to be put in place to support a system response.
- Across the system when system escalation actions may be required to be put in place to support a system response.

Surge may impact Priority 1 services, these are services that require a timely response and whose patients cannot be put on a waiting list. A list of P1 services can be found in Appendix 1.

1.1 Business Continuity Plan

All GHC operational services hold their own Business Continuity Plans which ensures that they can maintain service resilience and effectively manage risk and continuity of quality patient care in the event of disruption from local, regional, national or global incidents.

1.2 Related Documents

This document aligns with:

GHC Winter Plan
GHC On Call Pack
GHC Major Incident Plan
GHC Emergency Response Plan
GHC Business Continuity Plans

1.3 Aim & Objectives of the Plan

The overall aim of this surge and escalation plan is to provide a framework for GHC colleagues to use in order to manage and respond to surge in demand and capacity issues.

The objectives of the surge and escalation plan are as follows:

- To establish a shared understanding of surge and escalation issues across GHC managed services
- To establish a shared understanding of service prioritisation across GHC.
- To describe triggers in services that indicate escalation.
- To define organisational actions to be enacted in surge for response which can be utilised irrespective of situation duration, scale and type
- To define a mechanism for escalation in the event of surge.

1.4 Equality & Diversity

Participating services will ensure that the diverse needs of the community are appropriately assessed in response to surge and escalation situations and that suitable response measures, including warning and informing arrangements, are implemented relative to identified needs.

2.0. Approach to escalation

2.1 Definitions – levels of escalation

This surge plan follows the NHS England alert levels, comprising 4 distinct alert levels.

Table 2: Definition of Escalation Statuses	
GREEN	**Level 1: patient flow management** - The Local Health and Social Care System capacity is such that organisations are able to maintain patient flow and are able to meet anticipated demand within available resources. Commissioned levels of service will be decided locally.
AMBER	**Level 2: mitigation of escalation –** The Local Health and Social Care System starting to show signs of pressure. Focused actions are required in organisations showing pressure to mitigate further escalation. Enhanced co-ordination will alert the whole system to take action to return to green status as quickly as possible.
RED	**Level 3: whole system compromised** – Actions taken in Level 2 have failed to return the system to Level 1 and pressure is worsening. The Local Health and Social Care System is experiencing major pressures compromising patient flow further urgent actions are required across the system by all partners.
BLACK	**Level 4: severe pressure and failure of actions** – All actions have failed to contain service pressures and the local Health and Social Care system is unable to deliver comprehensive emergency care. There is potential for patient care to be compromised and a serious untoward incident is reported by the system. Decisive action must be taken to recover capacity.

2.2 Information

GHC uses a range of information sources to enable it to understand and share intelligence related to surge and escalation.

Source	Information	Access
SHREWD	Sets out key information relating to performance of organisation across the system	Link to SHREWD
Daily GHC sitrep	Collates data about bed capacity and pressures	Incident room
Operational Situation Report (SitRep)	Method of escalating issues and identifying possible solutions which cannot be implemented without wider support and agreement	Link to SitRep: https://app.glos-care.nhs.uk/covid19sitrep
Daily SPCA sitrep	Collates data about bed capacity, HomeFirst and flow.	

2.3 GHC Triggers and Actions

The tables below illustrate the agreed GHC escalation triggers

DEMAND

Metric	PRE-HOSPITAL Level 1 - Normal	Level 2	Level 3	Level 4	IN HOSPITAL Level 1 - Normal	Level 2	Level 3	Level 4	DISCHARGE Level 1 - Normal	Level 2	Level 3	Level 4
SPCA call volume per hour Weekday	8	10	13	<=15								
Weekend	3	5	6	7								
Rapid Response RAG rating (Referral rate in and nos in service)	1	2	3	4								
Number of patients on SPCA working list at time of report									<=10	11	12-14	>=15
Number of SPCA patients with no plan									0	1-5	6-11	>=12

CAPACITY

Metric	Level 1 - Normal	Level 2	Level 3	Level 4	Level 1 - Normal	Level 2	Level 3	Level 4	Level 1 - Normal	Level 2	Level 3	Level 4
SPCA Abandoned call rate	<5%	<8%	<12%	12%>								
MIiU longest wait	<3 hrs	3-4	4+ in 1 unit	4+ in 1+ units								

Rapid Response													
Total number of Physical Hospital beds available weekdays Saturdays Sundays						>=10 >=5 3	6-9 3-4 2	0-5 1-2 1	0 0 0				
Total number of Mental Health Hospital beds available weekdays Saturdays Sundays						Under development							
Total Number of Reablement Beds available Weekdays Saturdays Sundays						>=6 >=5 >=3	3-5 3-4 2	1-2 1-2 1	0 0 0				
Total Number of HomeFirst starts available Weekdays Saturdays Sundays	Under development												
Community Nursing	Under development												
IVT	Under development												
Beds closed due to Infection Control						0	1 ward /area	2-3 wards / areas	>4 wards/ areas				

No of Unfilled shifts (agency & Bank) - Community Services										1	2	3	4
No of Unfilled shifts (agency & Bank) - Community Hospitals						1	2	3	4				
MH Crisis	Under development												
MH Liaison	Under development												

3.0 Service level thresholds for escalation
3.1 Daily Service Assessment of Capacity & Demand

At time of surge all priority 1 services will undertake a daily assessment of their service in order to allocate an escalation level.

The purpose of assessment is to determine the service's capability to deliver routine, essential and critical services and identify when this has changed and for what reason.

Services will agree a set of triggers applicable to their service area set out below:

Service	Factor	Elements	Rationale for normal working
Community based services	% of available Capacity to receive routine, essential and critical visits	Number of • Units of activity • Caseload size • Staffing levels	Community teams work at capacity which is part of normal business
Minor Injury & illness Units (MIiUs)	% of workload being managed within targets	Number of • Breaches • Length of wait • Staffing capacity • Acuity of patients	100% of patients treated and discharged within 4 hours No clinical breaches
Community bed-based services	% of beds available	Number of • Admissions • Transfers • Discharges • Vacant beds	95% occupancy rate
Staff Absence	% of staff absence and impact on service delivery	Number of shifts not covered and impact on individual services	Staff Shortages: Level 1 – Managed within normal business

3.2 Rag Rating

A RAG (Red, Amber, Green) Assessment of Demand and Capacity has been designed to support report daily. An example of the RAG rating currently used by the GHC Rapid Response service is available within Appendix 1

3.3 Is Escalation occurring?

Escalation maybe experience due to internal pressures or external system pressures.

The process below guides the service response to escalation:
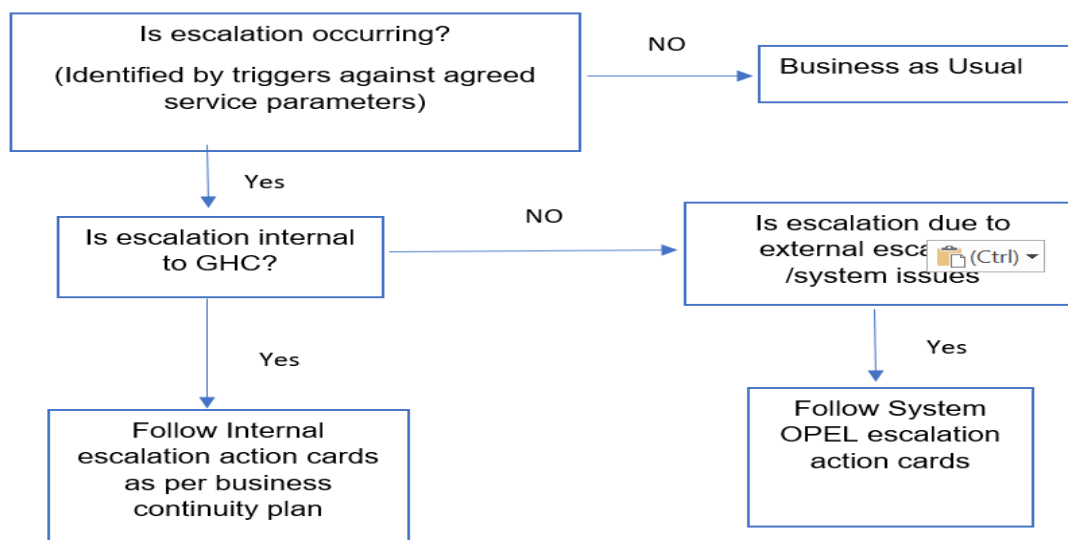
The following escalation action cards are available:

1. Internal Escalation response for P1 services
2. OPEL System escalation actions.

4.0 Service Prioritisation

During periods of escalation service prioritisation is a dynamic assessment and dependant on the nature and duration of the incident. The GHC service prioritisation descriptors are identified in the table below:

GHC: 3 levels of service/function prioritisation		
Level	**Descriptor**	**Maximum Tolerable Period of Disruption (MTPD)**
Priority 1 - (P1)	Plan to maintain services in all scenarios	**8 Hours**
Priority 2 - (P2)	Plan to maintain accepting referrals, triage/advice and wait list maintenance offering a service for urgent and priority patients only	**24 Hours**
Priority 3 - (P3)	Plan to cease service for duration of incident	**72 Hours +**

The GHC services currently identified as Priority 1 Services are available in Appendix 1

6.0 Daily sitrep

The purpose of the Situation Report (SitRep) is to provide managers and leaders with a method of escalating issues and identifying possible solutions which cannot be implemented without wider support and agreement.

Where possible decision making should be at grass roots by giving managers authority to act.

It also provides organisational system oversight and transparency of the situation as it develops. Link to SitRep: https://app.glos-care.nhs.uk/covid19sitrep

7.0 Incident Control centre

In the event of surge services can escalate their escalation level via contacting the Incident Room email: incident-room@ghc.nhs.uk

8.0 GHC Escalation Actions

Un the event of surge all identified GHC Priority 1 Services will implement a series of escalation actions cards in place which:

- Identify the triggers to levels of escalation (2,3,4)
- Identify the actions taken by the service in the event of escalation

An example of these escalation action cards in available in Appendix 3

In addition, in the event of external system escalation GHC services will enact the OPEL system escalation actions available within Appendix 4

Appendix 1 GHC Priority 1 Services

Service areas	Specialism	Service	Priority Rating
Hospitals	PH	Inpatients	1
Hospitals	LD & MH	Inpatients	1
Hospitals	LD	LDISS	1
Urgent Care	PH	Rapid Response	1
Urgent Care	PH	Integrated Assess Team	1
Urgent Care	PH	Minor Injury and Illness Units	1
Urgent Care	PH	Single Point of Clinical Access	1
Urgent Care	PH	IV Therapy	1
Urgent Care	PH	Evening and Overnight District Nursing	1
Urgent Care	MH	Contact Centre	1
Urgent Care	MH	Crisis incl. Street Triage	1
Urgent Care	MH	AMHP	1
Urgent Care	MH	Psychiatric Liaison	1
LTC	PH	Respiratory - Home Oxygen Service	1
LTC	PH	Homeless Healthcare	1
Sexual health	PH	Sexual Assault Referral Centre	1
Sexual health	PH	Pregnancy Advisory Service	1
Sexual health	PH	Sexual health - GUM/HIV	1
Dental	PH	Dental OOHs/Urgent	1
Therapy & Equip	PH	Podiatry - Inpatients	1
Therapy & Equip	PH	SALT - IP services	1
Therapy & Equip	PH	Integrated Community Equipment Service	1
Therapy & Equip	PH	Telecare	1
Adult Community	PH	Referral centre	1
Adult Community	PH	Reablement	1
Adult Community	PH	District Nurses	1
Adult Community	PH	Complex leg wound/lower limb	1/2
Adult Community	PH	Lymphoedema service	1/2
Adult Community	PH	Complex care at home	1/2
CYPs	PH	Children's Community Nursing Team	1
CYPs	PH	Children's' Complex Care Service	1
CYPs	PH	Physiotherapy - IP only	1
CYPs	PH	Occupational Therapy - IP only	1
CYPs	PH	SALT - IP only	1
CYPs	MH & LD	CAMHS VCS	1
CYPs	MH & LD	CAMHS LEVEL 2/3	1
Covid	Covid	Stock Team	1
Covid	Covid	Testing Team	1
Medical	Medical	Medical staffing MH / LD	1
Medical	Medical	Medical staffing PH	1
Facilities	Facilities	Facilities MH / LD	1

Appendix 2 Rapid Response Assessment of Demand and Capacity RAG

Countywide RAG rating for RR

Consider adding 2 points for each:

Lack of staff with the required level of competency on shift

Lack of locality staff resource e.g. Falls pick up /double up

Geographical restrictions; staff cannot get to areas quickly so reduce ability to respond to new referrals

Conditions prevent effective response e.g. weather

Y	0-6 pts	7-13 pts	14-20 pts	21-26 pts	27-35 pts
4 staff	5	10	15	20	25
5 staff	4	8	12	16	20
6 staff	3	6	9	12	15
7 staff	2	4	6	8	10
8+ staff	1	2	3	4	5

Patients in service at any one time

Consider adding 2 points for each patients who has very complex needs

The RAG (Red, Amber, Green) rating has been designed to help us all report daily

The Urgent Care Lead rates the current countywide RR status before 9.00 every weekday

The Urgent Care Red Lead rates the current countywide RR status before 9.00 weekends/BH and reports

Please note:

- Add 2 points on each axis if there are issues that affect the scoring e.g. 'X' axis on each very complex pts, and 'Y' axis on staffing issues

- Consider reporting on any foreseeable issues affecting the late and night shifts

Appendix 3 Rapid Response Internal Escalation Action Cards

Local escalation Level 2 Actions

	Trigger
	• Below minimum staffing levels as illustrated in the table below

Locality	Early Shift	Mid Shift	Late
North	2	1	2
South	2	1	2
Forest	1	1	1

• Urgent care service rated amber capacity to meet presenting demand.
• Limited capacity to take referrals and assess within expected timescales (20% above normal)
• Assessed increase in patient acuity with impact upon capacity.
• Requirement for RR to ensure resilience for system partners.

	Action
1	Complete Service Assessment of Capacity & Demand
2	Service Directors enact directorate consolidation strategies to manage rotas.
3	Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible.
4	Prioritise referrals from Primary/Community Care
5	Rapid Response to triage all referrals directly
6	Liaise directly with clinical teams in OOH and MiiU to flow patients appropriately

Internal Escalation Level 3 Actions

All actions from Level 2 plus below

Trigger
• Below minimum staffing continues over 24 hr period • Unable to transfer patients to on-going services (delays of up to a week, involving several patients) • Limited ability to accept further referrals into Urgent care services with an impact upon response time. • System partners in extremist and RR capacity to be reallocated to support.

	Action
1	Review 24-hour staffing - increase staffing as required through within directorate deployment use of enhanced rates for internal bank
2	Additional staffing (bank/agency) to referring services to manage flow out of RR – IVT/ONDNS/HomeFirst/ ICT/Resp
3	Deploy operational managers to clinical work (DD UCASS, CL UCASS, OL UCASS)
4	Update DoS to reflect pressure
5	SWAST/GHT/PC update to advise of capacity
6	Implement GHC Operational Flow Hub to run alongside ICC. Implement additional afternoon (and evening if required) GHC Operational Flow meeting.
7	Stand down non-essential meetings and training.
8	Complete Operational Sitrep

	Trigger
	• Below minimum staffing continues over 48 hr period • Unable to transfer patients to on-going services (delays of up to a week, involving several patients) • Extreme weather preventing staff travel
	Actions
1	Staff deployed to maintain critical service provision only
2	Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible.
3	Enact 4X4 transport
4	Suspend all annual leave and request staff to attend workplace
5	Request Response team workforce
6	

Appendix 4 Organisational OPEL Actions for system Response

<table>
<tr><td>OPEL 2 Amber</td><td colspan="2"></td></tr>
</table>

NHS Specific OPEL Actions	
GHC Actions available to be implemented	
GHC Actions currently in place	✔

	Lead	Action	In Place
1	GHC	Escalation information to be cascaded to all community providers with the intention of avoiding pressure wherever possible. Maximise use of reablement/intermediate care beds	✔
2	GHC	All services (RR, DNs, CHs) to identify blockages to discharge and escalate to relevant Head of Service	✔
3	GHC	SPCA lead to call IDT to prioritise working list	✔
4	GHC	Community hospitals to bring forward discharges to allow transfers in as appropriate. Community hospitals to liaise with Social and Healthcare providers to expedite discharge	✔
5	GHC	Additional ward rounds to take place within community providers to expedite discharge and create capacity	✔
6	GHC	Community providers to lower admission/treatment thresholds wherever possible through implementation of previously agreed flexible working arrangements to alleviate pressure	✔
7	GHC	Apply flexibility regarding beds and staffing to increase capacity where possible	✔
8	GHC	Expedite rapid assessment by multidisciplinary team (MDT) including Social Care assessment	✔
9	GHC	Ensure all staff in MHLT are aware of escalation level and to reflect this within their working day and prioritisation of system.	✔
10	GHC	MHLT to ensure pathways are being used appropriately, confirm that guidance is accessible and communicate when information cannot be found	✔
11	GHC	Where possible, community-based services to increase support and/or communication to patients at home to prevent admissions.	✔
12	GHC	Expedite rapid assessment for patients waiting within another service e.g. ED	✔
13	GHC	For inpatients in acute hospitals prioritise MH assessments where delays are impacting on quality/capacity of service provision	✔
14	GHC	MHLT to ensure all referrals are verbally responded to within 2-hour target and subsequent response is in keeping with level of risk identified using risk matrix	✔

15	GHC	MHLT Manager to ensure that all patients awaiting review before discharge are to be prioritised so that they are seen within 4 hours where staffing capacity permits	✔

<table>
<tr><td colspan="4">OPEL 3 Red</td></tr>
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OPEL 3 Red   All actions from OPEL 2 plus below

	Lead	Action	In Place
1	GHC	Senior Nurses to review patients that could be moved with ongoing support requirements in order to realise capacity	✔
2	GHC	Mix sex breach requests to be sent to CEO for review and decision - CEO agreement only.	
3	GHC	Head of Services to escalate blockages to Deputy COO/COO	✔
4	GHC	SPCA - Prioritise discharge from relevant GHT site	✔
5	GHC	As able, Rapid Response to send staff into ED	
6	GHC	MIIU social media push to advise capacity	
7	GHC	Capacity Manager / Deputy Director to monitor escalation status, taking part in teleconferences as required.	✔
8	GHC	SPCA - call in bank staff to handle call volumes	
9	GHC	Assess and reprioritise any non- housebound DN visits	
10	GHC	Review all daily visit patterns to identify bi-daily options	
11	GHC	Review all non-urgent visits	
12	GHC	All community care teams to review all patients awaiting assessments (with single point of access) in order to expedite discharge or transfer where possible – this to include In-reach teams and community hospitals	✔
13	GHC	Community providers to continue to undertake additional ward rounds and review admission and treatment thresholds to create capacity where possible	✔
14	GHC	Community providers to expand capacity wherever possible through additional staffing and services, including primary care	✔
15	GHC	Community providers to consider the use of wider group of agencies (e.g. higher cost agencies) to increase staffing capacity	✔
16	GHC	Patients waiting at home for admission to be referred to Community Teams (by In-reach nurses) and/or single point of access and Emergency Medical Unit (EMU)	✔
17	GHC	Continue to expedite discharges, increase capacity and lower access thresholds to prevent admission where possible.	✔
18	GHC	Review all discharges currently referred and assist within whole systems agreed actions to accelerate discharges from acute and non-acute facilities, where possible.	✔
19	GHC	Community based teams to increase support to service users at home to prevent admission.	✔
20	GHC	Escalation to relevant on call manager	✔

21	GHC	Liaison with Social Care if delays relate to arranging MH Act Assessment	✔
22	GHC	Liaison/joint working with Social Care and Housing to identify appropriate accommodation/care packages	✔
23	GHC	Regardless of level of risk and within resource available will prioritise ED referrals	
24	GHC	MHLT manager to prioritise ED referrals and recruit additional resources from off duty staff and staff bank	✔
25	GHC	MHLT manager to recruit additional resources from off duty staff and staff bank.	✔
26	GHC	MHLT Manager to prioritise assessments in ED from 2 hours to 1 hour where staff capacity permits	✔
27	GHC	Close smaller MIIUs and reallocate staff to strategic MIIUs (Stroud, Cirencester, North Cotswolds & Lydney)	✔
28	GHC	Provide senior clinical support for weekends across Community Services and Community Hospitals Professional Leadership (Clinical) rota - with time off in lieu and payment for hours worked Provision of clinical leadership for all out of hours service provision Dial into escalation calls, link with shift/ward leads and available for clinical queries advice and guidance, based on site with a clinical team Inpatients ICT Home First DN Rapid Response SPCA	
29	GHC	Implement GHC Operational Flow Hub to run alongside ICC. Implement additional afternoon (and evening if required) GHC Operational Flow meeting.	✔
31	GHC	Review staffing levels and manage Staff shortages with flexible use of £100 incentive for the following staff groups: - RN - HCA - All Bank Staff	
32	Urgent Care	MIiU offering ED Streaming of 15 appointments for the Streaming Nurse in ED to use per day in MIIUs across working closely with system partners with implementation planned for 2 weeks' time	
33	Urgent Care	MIiU's supporting the supply of grab bags/ oximeters for Covid-19 Virtual Ward with the aim of less Covid-19 admissions and preventing undiagnosed deterioration.	✔
34	Urgent Care and Specialty Services	Post discharge Covid-19 Virtual ward, managing respiratory and non-respiratory patients.	✔
35	Urgent Care	CHST continue to offer seasonal Covid-19/ Flu vaccination as part of mass vaccine programme	✔
36	GHC	Hold internal meetings - 09:00 Flow meeting	✔

		- 12:30 Flow meeting - 16:00 GHC Covid-19 briefing, Monday and Friday	
37	GHC	Ensure Medical resilience in Hospitals particularly at weekends	✔
38	GHC	Ensure estates/facilities teams have resources	✔

OPEL 4 Black   Organisational level

All actions from OPEL 3 and 2 must be completed before escalation to OPEL 4

	Department	Actions	In Place
1	GHC	Hold daily virtual board rounds 3 times a week for Community Hospitals led by Hospitals Directorate with inclusion of the Demand and Capacity team and Adult Social Care colleagues	
2	GHC	Continue to flex criteria for admission to a Community Hospital.	✔ (Within IPC Guidelines)
3	GHC	Further caseload review and reprioritisation of therapy in community services. Divert therapists to support Home First.	
4	GHC	Weekend on call rota all Service Directors and Deputies with time off in lieu and payment for hours worked	
5	GHC	MH and PH Services On-Call Manager, have a second person on call rota in place with time off in lieu and payment for hours worked	
6	GHC	Enhance the ICC cover with second person on call, with time off in lieu and payment for hours worked	
7	GHC	Review lowering levels of care	
8	Urgent Care	Rapid Response to become a Receiver as well as a User on Cinapsis providing easy access to RR for SWAST to prevent admissions.	
9	Urgent Care	Review opening hours of SPCA at weekends	
10	Hospitals	Explore options of opening additional inpatient bed capacity across our estate, with mutual aid as required if demand increases during the preceding week.	
11	Hospitals	Gain agreement from the system to cease elective activity within and outpatients and redeploy staff to inpatient wards.	

12	Hospitals	Gain agreement from the system to cease elective activity including theatre, endoscopy and redeploy staff to inpatient wards.	
13	Hospitals	Increase non-clinical support on inpatient wards	
14	Adult Community	Complex care at home to support with Adult PH Community Health Teams under the Directions of the Service Director	
15	Adult Community	Further caseload review and reprioritisation of therapy. Divert therapists to support Home First model	
16	Adult Community	Redeployment to add capacity into Home First and reablement pathways	
17	GHC	Ensure IPC cover on site with time off in lieu and payment for hours worked	
18	GHC	Partial Closure of School Age Immunisation Service	
19	GHC	Partial closure of Public Health Nursing	
20	GHC	Redeploy colleagues from NQT to provide additional clinical rota to support colleagues	
21	GHC	Targeted short-term redeployment colleagues from NQT, finance and strategy and partnership's into HCA, admin and support worker rolls.	
22	GHC	Review of all current placement of RN and AHP colleagues across GHC and ensure colleagues are deployed as per priority.	

WINTER SCHEMES – OPERATIONS 2021

1.0   INTRODUCTION

The organisation recognises that there is a requirement to prioritise and strengthen services to manage internal patient flow efficiently and safely through the winter period 2021-22 and to fully support the Gloucestershire health and care system keeping people at home as much as possible, maintaining patient safety, privacy and dignity at all times.

2.0   BACKGROUND

This year there are a number of additional unique considerations and risk factors to mitigate which includes:

- the ongoing impact of waves 1, 2 and 3 of COVID-19 on service demand and capacity, on staffing and morale, with ongoing preparation for further waves,

- the impact from lockdown and social distancing predicted to result in a surge of serious respiratory illness specifically in the very young, the older person and the vulnerable, which requires additional precautionary measures,

- the estates refurbishment of Stroud MIIU, Jubilee ward, Southgate Moorings, Charlton Lane, Wotton Lawn,

- Increase in primary care demand by up to 40% to date and the roll-out of further vaccination programmes

Service developments that will further affect the capacity and resilience of our services include Ageing Well, development of the post-Covid service, complex emotional needs service, introduction of the hospital discharge service operating model.

The expected impact of these risk factors and challenges are;

- The ongoing risk of a depleted clinical workforce as a result of either Covid-symptoms / positive result itself or contact with a Covid-positive person, with consequent impact from prioritising services and of redeployment.

- Increased length of stay and number of medically fit patients within inpatient beds due to capacity constraints in adult social care and care provider agencies/homes with the consequent potential of impact on that patients' outcomes.

- Increase in acuity and dependency of patients, and increased risk of incorrect pathways being applied in response to whole-system distress.
- A reduced bed-base and waiting area/assessment area capacity to ensure Covid-security adding to system-wide pressures through reduced capacity and regular short-term closures.

- Increased number of Out of Area placements for our tier 4/most challenged clients in mental health resulting in impact on them, their families, and financial position of the Trust.

- Overcrowding in the Emergency Department (ED) resulting in system pull to provide more services from partners to strengthen all access routes and points.

- Increase in MH crisis presentations with consequent impact on provision of 136 suite on the crisis workforce.

- Increased demand on community nursing teams through primary care referrals, on SPAC and dental triage line.

Gloucestershire Health and Care NHS Foundation Trust – **TRUST BOARD PUBLIC SESSION – 30 Sept 2021**
AGENDA ITEM: 16.3 – APPENDIX 3 – WINTER SCHEMES – OPERATIONS 2021 Page 2

working together | always improving | respectful and kind | making a difference

2.0 LESSONS LEARNT

Lessons learnt from recovery check-ins:

Estates	- Snow Risks and access to 4X4 - Signing in process for all buildings – to support track and trace with staff - Need for confidential areas for virtual services - Covid secure venues/Space for teams	Digital	- Equipment needs - Clarity on emergency apps/tech use - IT infrastructure – equipment and connectivity - Attend anywhere – not good for **all** service users, limitations using from home - Digital services – staff and patient support/training needs
BI	- Updating team BCPs - IT downtime impacting digital services - Review of policies/procedures - Real time data access	Quality & Patient safety	- Local outbreaks – isolation guidance - Increasing acuity & dependency of patients – review staffing levels - Reduced staff training levels - PPE guidance/social distancing concerns - Specialist PPE delays - Social isolation/community engagement changes - Increased DNAs to virtual appointments
Corporate	- Workforce resilience required Redeployment planning - Training – including PPE training - Vulnerable staff – shielding continuing, support and meaningful employment required. - All colleagues supported and protected - School lockdowns – staffing plan/pay arrangements	Comms	- When/how/why to inform incident room - Emergency grab boxes and locations - Communication cascades - Action cards - Incident management training - Reporting structures clear with structured reporting format

Lessons learnt from winter 2021:

A staff survey was undertaken across the Trust in July 2021 forming the basis of this summary.

Which directorate do you work for?

Directorate	Percentage
Hospitals	26.83%
Urgent Care and Specialist Services	7.32%
Adult Community PH	17.07%
Adult Community MH & LD	7.32%
Children's Services	7.32%
Organisational Resilience	0%
Patient Flow	19.51%
Nursing, Therapies and Quality	7.32%
Corporate	4.88%
Other	2.44%
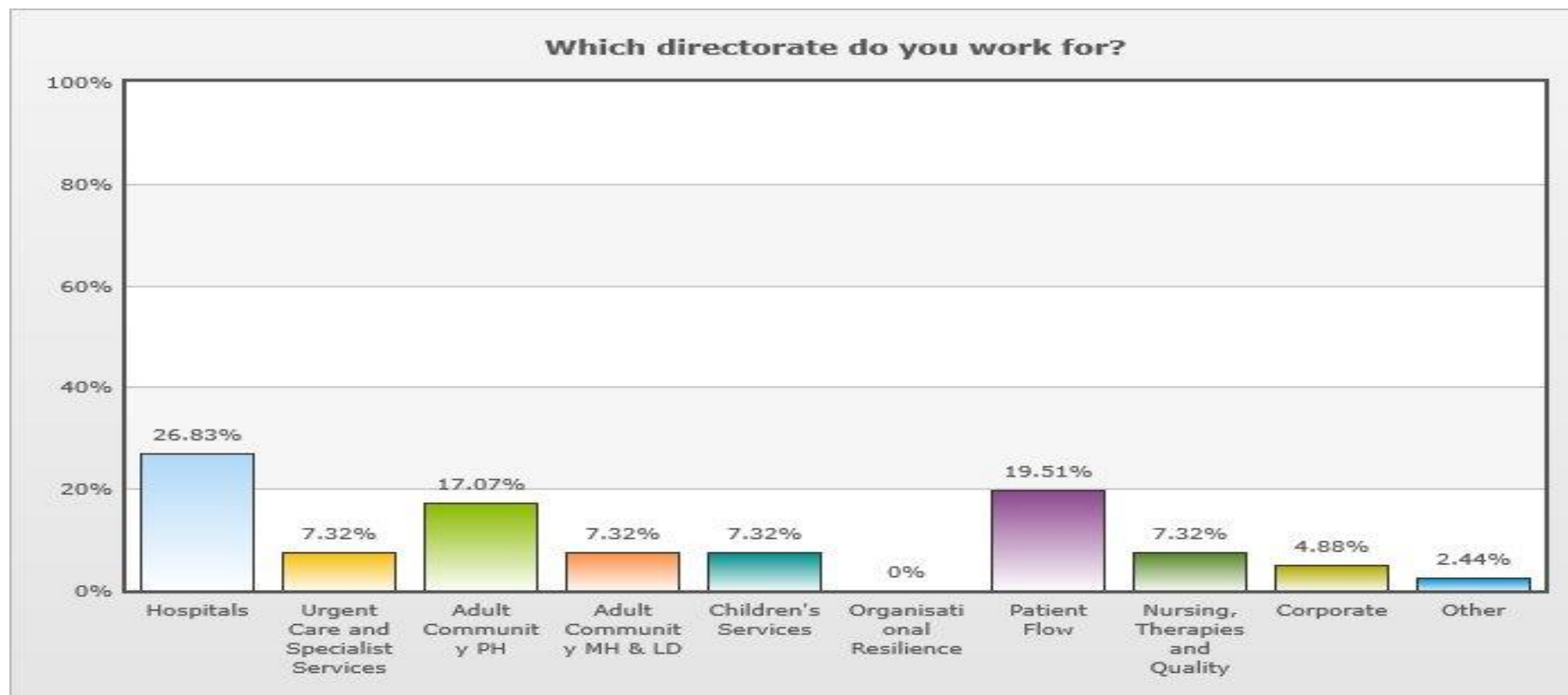
What went well:

Corporate
- Team working, team briefings
- Workforce = flexible working, good managerial support, redeployment of staff
- Advance planning and communications

Patient Flow
- System wide collaboration
- Patient flow team communications – internal meetings, bed tracker and situation reports.

EPR
- Support with transport network
- Weather preparation

Digital
- Digital services – enabling working from home and team working
- Equipment to work from home

Quality & Patient Safety
- PPE guidance was clear and succinct
- Patient flow – prioritising decision making with clinical decision matrix
- IP&C
- Vaccine roll out

Gloucestershire Health and Care NHS Foundation Trust – **TRUST BOARD PUBLIC SESSION – 30 Sept 2021**
AGENDA ITEM: 16.3 – APPENDIX 3 – WINTER SCHEMES – OPERATIONS 2021   Page 5

working together | always improving | respectful and kind | making a difference

What could be improved this year?

Corporate
- Staffing redeployment plans now
- Workforce – recruitment and retention
- Clear communication of all contingency planning
- Robust communications across all teams

EPR
- Weather planning – floods, snow, heatwaves
- Support transport network and awareness of access to transport

Digital and IT
- More support for teams to continue to work from home
- Digital solutions readily available

Quality & Patient Safety
- PPE availability
- Staff wellbeing and value
- Weather appropriate uniform options for community staff

There is strengthened operational oversight and grip this year with the full development of the patient flow team and the Incident response team all of which work 7/7. This daily/weekly oversight is depicted below with the links to the System-wide processes.
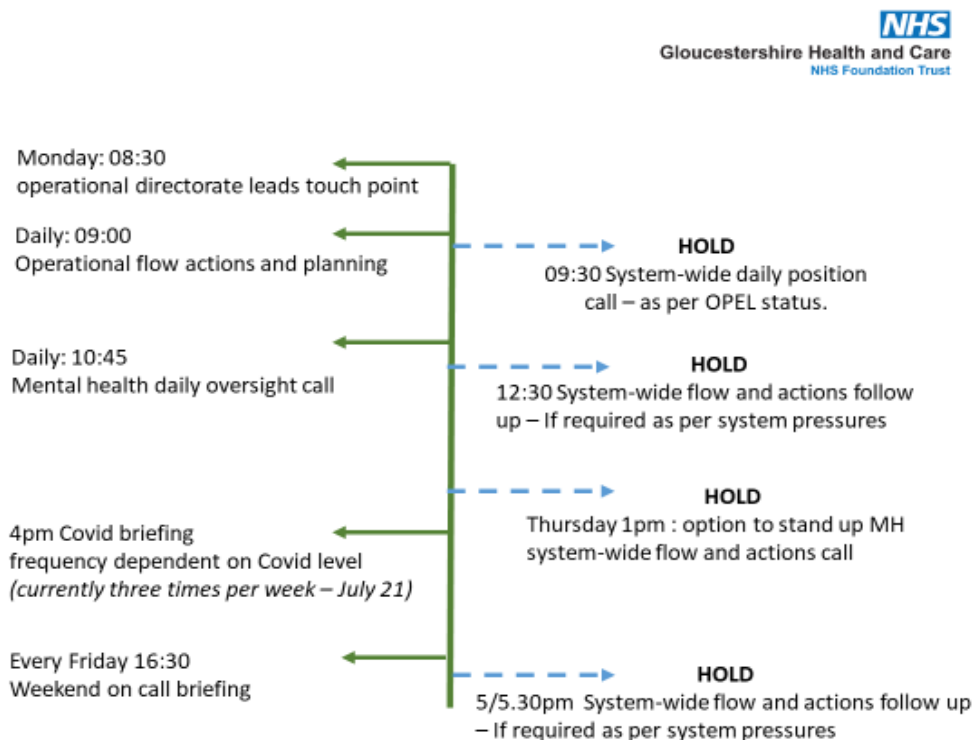
4.0 RISK MANAGEMENT IN PLACE (not an exhaustive list – for example)

Demand & Capacity:

- MiiU telephone clinical triage, SPAC and Dental line providing a CAS function to navigate patients into appropriate services
- Minor Injury Service operating 7 days per week with bookable appointment function
- Rapid Response service in place countywide supporting Acute Trust as well as Primary Care
- In reach into the acute by Rapid Response and ONDN to expedite discharges,
- HAT in place to identify patients for discharge into community/primary care services
- Robust on-call arrangements
- Introduction of BH working for senior managers/clinicians in key services
- Integrated teams working across the 7-day period
- Discharge integrated team in place at WLH
- Covid-team in place corporately to coordinate provisions

Staffing:

- Close management of the rotas and vacancy situation is in place and will continue to ensure early identification of potential pressures.
- Forward planning for staffing supported by block booking of bank and agency staff
- Full implementation of and adherence to Allocate
- Enhanced HR workforce support to target specific areas of pressure
- Close systems working to focus the right staff into the right places when in surge
- Flexibility of roles with generic and specialist skills being developed

IPC: (see corporate paper for full details)

- Face, Space, Mask message to continue with social distancing within all areas
- Robust Flu Immunisation Programme in place
- Flowcharts and action cards in place to manage outbreaks or positive results in patients or contacts
- Identification of red and green wards and staff

5.0   WINTER SCHEMES

Following a thorough and collaborative exercise with all Services, ten schemes have been identified and prioritised as outlines in accompanying spreadsheet.

These have been discussed with GHC COO and Dep COO to ensure alignment of priorities so that the top three schemes deemed as Priority 1(Critical) are also reflected in their scheme priorities for overall system prioritisation.

These schemes are:

1. Development of a Community Assessment Unit for older people within our PH community bed base.
2. Increasing Home First capacity to meet system demand.
3. Continuation of clinical telephone triage by MiiU senior clinicians, alongside the resetting of extended hours into MiiU in order to establish booked appointments system.

The other seven schemes deemed as priority 2 (Essential) are:

4. Develop IV Therapy team provision into 7/7 (establishment Sat and Sun matched to Mon-Fri).
5. Provision of HF/Reablement therapy service over the weekends and BH to continue ongoing care and commence treatment plans for new starters on this pathway.
6. Enhance the MLHT resource to provide support into ED in order to case find and reduce front-door pressures with increased risk of admissions.
7. The use of e-learn to deliver online groups for all LTC services.

8. Discharge coordinators into all PH wards as implemented during wave 1 of Covid providing immediate impact on patient flow.

9. Weekend ward clerks into all PH wards as implemented during wave 1 of Covid enabling release of nursing and therapy staff from admin duties and Covid screening of visitors.

10. The development of generic rehab/HCA roles into the wards ate weekends in order to support reductions in length of stay and improve care offered to patients.

6.0 NEEDS IDENTIFIED OUTSIDE OF THE SCOPE OF WINTER SCHEMES

Tab 2 on the accompanying Excel spreadsheet outlines the Service requests from corporate functions or external providers as listed below;

- The development of sub-acute pathways – this is being enacted in partnership with GHC and the GHC Patient Flow team.
- Requirement to implement cover arrangements for the Maxwell (136) suite in order to release capacity within the Crisis team. This is being progressed with a working group led by Dep Service Director and supported by the interim Dep COO.
- Adding resilience to MiiU workforce capacity through training of urgent care practitioners – this is being progressed within the services.
- Wider use of telehealth for LTC – being developed by UCASS.
- Enhanced Bank staff training for specialist services such as MiiU, Dental, Community Nursing.
- Estates support to base Rapid Response team in Cotswolds base.
- Renewed focus on Best practice Board rounds across the Hospitals.
- Re-establishment of care navigators form GCC Stood down during Covid 1 within the PH Hospital wards.

Gloucestershire Health and Care
NHS Foundation Trust

REPORT TO: **TRUST BOARD PUBLIC SESSION – 30 September 2021**

PRESENTED BY: Sandra Betney, Director of Finance/ Deputy CEO

AUTHOR: Paul Griffith-Williams, Information Governance Manager/DPO

SUBJECT: **SENIOR INFORMATION RISK OFFICER (SIRO) ANNUAL REPORT 2020/2021**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐   Endorsement ☐   Assurance ☒   Information ☐

The purpose of this report is to:

To provide assurance to the Board on the effectiveness of controls for Information Governance, data protection and confidentiality and to document the Trust's compliance with legislative and regulatory requirements.

Recommendations and decisions required

Following review by the Audit and Assurance Committee, the Board is asked to:
- **Note** the Annual SIRO report
- Take **assurance** that the Trust has effective systems and processes in place to maintain the security of information it holds and controls.

Executive summary

The Senior Information Risk Owner is responsible for ensuring that organisational information risk is identified and managed across the organisation. This Annual Report provides assurance on practice, progress and developments around Information Governance, Clinical Coding and Health Records, Data Quality and Cyber/Data Security.

It should be noted that the Trust was able to achieve the DSPT submission (self-assessment) of 'exceeding standards' for the 2019/2020 year with the Trust meeting the 95% mandatory training target for Data Security and Awareness Training.

Covid 19 has significantly impacted on the information governance environment during the year. The move by Trust services to more digitally based delivery models led to an increase in demand for advice and support from the IG team and a more agile way of working requiring the approval of 20 Data Protection Impact Assessments. The pandemic did have a negative impact on the Trust's ability to respond to all requests for information within the required timeframes with 91 of 273 being over time.

This report provides assurance that robust governance mechanisms are in place to ensure that the Trust remains legally compliant with a complex range of national guidance and legislation.

Following consideration by the Audit and Assurance Committee at its meeting on the 12 August 2021, the report has been updated to include addition information and context around the risk of Phishing emails (paragraph 4.5) to aid the understanding of the risk in this area.

Risks associated with meeting the Trust's values
• IG breaches can result in the disclosure of sensitive patient and staff information.
• IG breaches can result in significant financial penalties and have a negative impact on the Trust's reputation if breaches occur.

Corporate considerations	
Quality Implications	Ensure the quality of information available to delivery patient care
Resource Implications	Can result in financial penalties if IG breaches occur
Equality Implications	

Where has this issue been discussed before?
Information Governance Group

Appendices:	Appendix A – Information Governance Structure

Report authorised by: Sandra Betney	Title: Director of Finance/Deputy CEO

with you, for you

ANNUAL SIRO REPORT – 2020/2021

INTRODUCTION

This is the first annual report from the Senior Information Risk Owner (SIRO) for Gloucestershire Health and Care NHS Foundation Trust (GHC). The purpose of the report is to provide assurance to the Board on the effectiveness of controls for Information Governance, data protection and confidentiality. This assurance is provided by the SIRO who has executive responsibility for information risk and information assets.

Throughout 2020/2021 there has been continuing progress with embedding and improving the effectiveness and profile of the Trust's Information Governance structures and processes (appendix A), which have continued to evolve the meet the needs of the recently merged organisation.

This report provides assurance that robust governance mechanisms are in place to ensure that the Trust remains legally compliant with a complex range of national guidance and legislation whilst also achieving an ability to ensure operational effectiveness so that progress is not undermined or damaged by poor Information Governance (IG) practices.

Recognising the breadth of the legislation, this SIRO report is divided into the following four sections.

- Section 1: Information Governance
- Section 2: Clinical Coding and Health Records
- Section 3: Data Quality
- Section 4: Cyber / Data Security

Each section reports on the progress and achievements in 2020/21, a summary is provided below:

Key highlights 2020/2021

- The Information Governance Group and met six times and approved 20 Data Protection Impact Assessments to support services in moving to more digital/remote methods of service delivery during the Covid-19 Pandemic

- The 19/20 final submission for the Data Security and Protection Toolkit was assessed as 'exceeding standards.'

- There have been no data breaches that have met the threshold for onward reporting to the Information Commissioners Office

- The Trust achieved the requisite 95% mandatory target for Data Security and Awareness training

- There have not been any significant health records incidents or losses reported

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1.0   INFORMATION GOVERNANCE

The arrangements for Information Governance are managed and overseen by the Information Governance Group (the Group), which reports to the Trust Board via the Audit and Assurance Committee. The IGG is chaired by Head of Corporate Governance. Membership comprises the Senior Information Risk Owner, Caldicott Guardian and Data Protection Officer and directorate representatives.

1.1   Information Governance Group and IG Team

The Group's role is to oversee and guide the strategic direction of IG within the Trust, ensure IG compliance, support best practice and ensure that all Trust information is:

- Confidential and Secure;
- Of High Quality;
- Relevant and Timely; and,
- Processed Lawfully, Transparently and Fairly

In 2020, the Covid-19 pandemic required the Group to adopt a more flexible and agile way of working to meet and increased demand for advice and support from Trust Services as they moved to a more digitally based delivery model. The Group has met six times during the year. Following each meeting a report is provided to the Audit and Assurance Committee.

During 2020/2021, the group has:

- Established a Governance framework (**Appendix 1**);
- Set a work plan for the group to formalise and focus activity;
- Reviewed the asset register and the assigned asset owners;
- Reviewed the data flows;
- Reviewed and approved the interim and final submission for the 19/20 Data Security & Protection Toolkit (DSPT) submission;
- Reviewed and approved the interim 20/21 DSPT submission;
- Reviewed and approved 20 Data Protection Impact Assessments (DPIA); and,
- Reviewed and agreed the Trust's training analysis for IG.

The IG team has delivered operational support, advice and guidance to staff at all levels in the Trust. It also represents the Trust's information governance interests at the ICS level being an active member of the Gloucestershire Information Governance Group, and the South West Strategic Information Governance Network. The IG Team also delivers the Data Protection Officer (DPO) role for the Trust and supports the Trust's full compliance with data protection legislation and good practice.

1.2   Data Security and Protection Toolkit

The Trust submitted the 19/20 DSPT interim and final submissions within the required timescales. The 19/20 final submission was assessed as exceeding standards. The Trust has submitted its interim 20/21 DSPT submission and is on track to submit 'standards met' in June 21.

1.3   Breaches and near misses

There have been no breaches that have met the threshold for onward reporting to the Information Commissioners Office (ICO). There have however been three near misses that have been reported to the SIRO and Caldicott Guardian for review and consideration.

1.4 Subject access requests & Freedom of Information

This year continued to be a busy year for Subject Access Requests (SARs) and Freedom of Information Requests (FOIs). Although the total number of SARs in physical and mental health were down on previous years, this was a difficult year give the impact of the C19 pandemic which necessitated remote working and a change in working practices, principally a move to a more digital process for gathering and reviewing information. Additionally, services were stretched with their responses and support to the C19 pandemic resulting in not all FOIs and SARs being answered in time. Where they were not, requesters were advised of the delays.

Team	Total Requests	Total over time
FOI	273	91
SAR Mental Health	282	10
SAR Physical Health	504	2

The FOI team identified the following themes from requests received in year. These are being considered to identify if there is anything that can be published that would provide more publically available information thereby reducing the need for FOIs in the future.

Service Area	Theme
Finance	Agency spend.
IT	Systems used, contact dates, structure charts.
Procurement	Confirmation of service contracts, contract start and end dates.
Recruitment	Staff recruited in what areas, what recruitment companies used, highest paid agency staff.

1.5 IG Training Standard 95%

The Trust achieved the requisite 95% mandatory target for Data Security and Awareness training in compliance with the DSPT. This was evidenced by the training team from the training system, Care to Learn.

The SIRO, Caldicott Guardian and the DPO have undertaken update training specific to their roles in year. Additionally, the IG Group has reviewed and signed off the Trust's

IG training needs analysis.

1.6 Summary of DPIAs completed and any high risks identified

The Group has reviewed and approved 20 DPAI's in year. There have not been any residual high-risk processing issues identified that needed onward reporting to the ICO.

1.7 Information Asset Registers

The Trust maintains an information asset register that is regularly reviewed. The asset register contains assigned Information Asset Owners (IAO). The Trust's SIRO has written to all IAO line managers this year to ensure that they are aware of which colleagues are IAOs and to that they are provided sufficient time to complete their duties.

1.8 Data Processor update any issues, contractual updates on compliance with GDPR

In year there has been only one issue that was raised with a data processor. This related to a 'TPP' SystmOne update release. That release enabled for patient appointments at GHC to be visible and cancelled by patient. The Trust has since turned off the enabled cancelations, however they are not able to turn off the share for patient appointments. The Trust has fully tested the impact of the release and concluded there was no other special category data, journal notes or confidential information that had been put at risk by this release.

1.9 Data Flows

The Trust maintains a list of its data flows and information asset owners are developing their own to feed into the Trust's flows register. The Group has reviewed the flows register this year and agreed that all known flows were identified and mapped.

2.0 CLINICAL CODING AND HEALTH RECORDS

2.1 Privacy Officer

There have been 28,958 privacy officer checks performed between April 2020 and February 2021. Of the checks carried out 69 resulted in queries being raised with staff as to why patient records were accessed. 67 reasons for access were received with 2 queries outstanding. No concerns have been raised following the responses received from staff.

There have been 6,776 Summary Care Record privacy officer checks performed between April 2020 and February 2021. 2,167 queries raised as to why patient records were accessed. The Privacy Officer was unable to check 6 queries with 2 members of staff as they had left the Trust.

2.2 Clinical coding report

Finished completed episodes for coding are out sourced to Capita who review

episodes across the Trust's services and ensure they are coded correctly. Coding is received every two weeks and usually resolved in the intervening two-week period. Where there remain uncoded episodes these are usually resolved with the next list issued.

- Mental Health; predominantly the coding team relies on nursing summaries to code episodes as there is a significant delay in doctor's discharges summaries being available.

- Sexual Health; there have been issues with coding sexual health episodes. As such monthly coding reports are provided back to the service so that coding can be completed at a later date. There have also been issues around codes not available in Lillie to fully reflect the stay.

- Physical Health; there have been episodes that were unable to be coded in year. This has primarily been down to data quality or insufficient data in the patient's journal.

These issues have all be highlighted to the relevant teams in the Trust and the coding team continues to work with Trust on improving coding.

There have not been any significant issues that have warranted escalation.

2.3 Health records

There have not been any significant health records incidents or losses reported.

The records team has destroyed 17,704 records in line with the Records Management Codes of Practice (RMCoP) for deceased Patients. Additionally, 954 records have been destroyed that were non-active notes, in line with the RMCoP. The Trust is currently working through uploading paper records to a digital format. As part of this programme 18 records have been uploaded and the hard copy destroyed. These numbers will increase as the team works through paper records of deceased and non-active notes.

A new RMCoP was released by NHS X in October 2020 and all GHC records are retained in line with this guidance.

2.4 Summary of audits which have Data Privacy/Quality implications

This year has been an exceptional year for the team and the Trust due to the C19 pandemic. Actions to cope with the emerging spread of the virus resulted in the suspension of clinical audit by the Trust. This was to enable and facilitate delivery of the C19 programme for the county in line with the National and Trust priorities.

The audit programme recommenced on 1 April 2021 and will report findings into the Regulatory Compliance Group and then on to the Improving Care Group. Any actions that are identified within the audit programme are overseen by the audit team. This will result in the majority of cases in a re-audit to assess improvement and fidelity to the standard we have agreed upon. Any significant issues that have implications on the Trust's compliance with Data Protection Legislation will be raised with the SIRO, Caldicott Guardian and DPO who in turn will share with the IGG.

3.0 DATA QUALITY

3.1 Policies

The Trust has a suite of IG related policies that were reviewed in 2019 as part of the merger process. They have not been reviewed in year as there has been no legislative change to reflect therein. The Business Intelligence team however did introduce a Data Quality Policy that was reviewed by the Group and ratified and signed off by the SIRO.

3.2 Business Continuity/Disaster Recovery

The Trust has an incident response policy that forms the back bone of its disaster recovery and business continuity planning. The policy has been tested in year through our response to the C19 pandemic. Additionally, with there has been the following network access issue that was managed:

> National HSCN network outage; this resulted in the loss of HSCN network access for the whole of the country. The GHC network relies upon the secure HSCN network connection for our community settings to access our network over Direct Access. As such critical clinical systems and email was not available to large parts of the Trust. This did not affect internal network connections on primary sites. The GHC IT team was able to reroute other systems such as email and internet quickly. This did not however resolve all issues for community teams accessing patient data and some community hospitals accessing patient data and drug charts. Drug charts were emailed where 4g connection was available at sites. Where this was not possible alternative options were implemented. There was no harm reported as a result of the loss of the HSCN network.

A full review of the incident was completed with a number of recommendations made to improve resilience and business planning.

3.3 Business Intelligence (BI)

We recognise that, as with any large organisation managing multiple corporate and clinical systems, there will be underlying data quality issues, both stemming from business as usual data entry errors or oversights. There are published data quality reports which can feed audit and help monitor operational practice to mitigate this issue however there are far fewer active data quality monitoring reports within Physical Community Health at this present time. BI manage the portfolio of these reports; however, it is a combination of the Nursing, Quality and Therapies Directorate and the Operations Directorate that monitor compliance and undertake audits.

It has recently come to light that there are wider Physical Community Health data quality issues which stem from the architectural design of the clinical systems (predominantly SystmOne), and the maintenance of the hard-coded mapping of system data extracts into the data warehouse. It is initially estimated that 10-11% of events are not flowing into the appropriate monitoring table, however at this point it's unclear as to how much of this is patient level or administrative and therefore less impactful. Additionally, it is recognised that there are almost 300k open referrals within the data warehouse with many without events, or attributed to services such as Health Visiting and MIIUs. This does not present an accurate reflection of caseloads. Therefore, as part of the harmonisation and wider integration of systems there is a

longer-term strategy being developed to tactically improve and develop a more sustainable and accurate data process. This requires holistic engagement with operational services, Business Intelligence and Clinical Systems Teams to ensure that the right pace is applied and such a sizeable improvement can be effectively delivered without impacting day to day priorities. This will undoubtedly be through a phased approach of staged improvements and as the status improves, will allow for the reintroduction of Physical Health Data Quality audit monitoring reports.

The national data opt out applies to the use of *confidential* patient information for research and planning purposes. It *does not* apply where anonymised data is used. Organisational compliance has been extended to the end of September 2021.

Although the majority of our *identifiable* data use is for direct patient care (acceptable) and any planning or development reporting uses *confidential* data (also acceptable); we do need to be aware of the policy and ensure that we have a plan and a technical solution and process in place for instances such as research where future disclosures should have data opt-outs applied. We will then be able to implement the technical solution in readiness or for future use. We currently maintain a full BI reporting suite that maintains pseudonymised data (through clinical system or NHS numbers) with the following exceptions that use patient identifiable information however it can be confirmed that these are used for direct patient care and clinical monitoring, *not* research or planning purposes;

- Bed Management Report - Digital Whiteboard (Name and Age)>> Secure to bed management team and select senior operational managers to manage patient flow and went through a DPIA process
- C19 Pathology Details Results report (Patient Name) >> Secure to senior management and pandemic response leads
- Covid Self Isolation Details (Staff Names) >> Secure to workforce team and select senior operational managers to manage workforce management and assure service delivery

Access to reports of this nature are currently managed through named authorisation groups within the BI reporting server tool but as this is difficult to sustain safely, going forward it will need to be linked to a more robust, ESR linked AD. This is expected from June 2021 and is being led by IT.

Alongside the possible need for Research projects, the Stroke & Rehab service are being supported with an exercise that adopts the national data opt-out process. The MESH client that the National Opt-out relies upon was already setup within the legacy GCS organisation so is still available to GHC. This will give the organisation an opportunity to pilot the technical solution in readiness to deploy an established and tested process for any requirements from September 2021; ensuring compliance.

3.4 **ESR**

There was one system security breach involving personal data for employees within GHC caused by a central team change release on 3 Jan 2021. This was reported through the Trust's Datix System and the SIRO informed accordingly. The incident was unlikely to result in a risk to individuals due the type of data shared and recipients involved. It was assessed by the provider as not meeting the threshold for onward reporting to the ICO.

Data quality audits and reviews are carried out monthly using system reports. There are no emerging themes or trends following these reviews.

4.0   CYBER/DATA SECURITY

4.1   Access Controls

The Trust has an established process for starters and leavers access to IT and clinical systems. The leaver process is automated based on an ESR report from workforce on a weekly basis. The process disables the account and archives it in leavers accounts. In the last year we have seen an increase in new accounts due to the C19 response. There have been 1466 new accounts set up, while there have been 1322 leavers processed. There are no outstanding starter or leavers. It is recognised that this process does not suitably cover inter organisational moves, this is reliant on leads notifying IT of the access changes needed. Going forward it is planned this will be linked to a more robust, ESR linked Active Directory link. This is expected from June 2021 and is being led by IT.

4.2   Cyber report

The Countywide IT service is responsible for managing the cyber response for the ICS. CITS provides, on a quarterly basis, cyber security updates to the ICS Digital Executive steering Group, which the SIRO is a member. These reports are then shared with the GHC Digital group. GHC has however retained two cyber leads to ensure that GHC needs are met, such as Cyber Essentials Plus, which the Trust was recertified for again this year. Part of the recertification involved a penetration test of relevant GHC systems, additionally a vulnerability scan was carried out by the CITs managed Nessus, the report is currently being developed by CITs. All CAREcerts are assessed and actioned by the server team, along with CITs where there is an ICS network implication. There is one CAREcert that is outstanding for GHC that is going through the test phase.

4.3   Data Destruction

- IT equipment - there have been no reported issues around data destruction or disposal. The contract is held with Hewlett Packard (HP), and was reviewed in year. Devices are collected by HP who in turn issues reports of what has been destroyed, recycled etc. All with data is wiped/destroyed to the required standard. There were approx. 8 collections in the last 12 months, for which we have received certification of destruction or disposal.

- Print waste - the contract is held and managed through the Trust's estates team. All print waste is shredded on site. The contract has been reviewed this year and extended for a further year. There have not been any significant issues reported by the contractor, or sites. There were some minor teething issues with the opening up of the Trust's Invista offices where secure waste bins on site had their keys left in them, however this was addressed and no confidential waste was put at risk as a result. Certificates of destruction are provided by the supplier.

4.4.   Cyber data security risks

The Digital Group manages the cyber security risks for the Trust. The assessment is made with risks identified from the CITs data along with GHCs own cyber risk knowledge from their cyber leads. The risk is notified to and managed by the Digital Group through its risk register, the top three risks are currently:

Risk	Information/Mitigation
Email Phishing	GHC has seen over 144,000 thousand phishing emails sent to ghc.nhs.uk throughout 20/21 to individual or shared mailboxes (report from O365). Four identified successful attacks initiated via Phishing emails causing multiple credentials to be compromised and required IT intervention to remediate and reduce spread further. The Trust has, multi factor account authentication, Azure ID protection on all office 365 accounts, KnowBe4 second chance installed, MS Defender on all end points, annual phishing test, annual data security training and cyber awareness training in place.
Staff Education /Training	Staff Cyber Awareness training was proposed to be made mandatory but this was rejected at the GHC Digital Group due to the current volume of existing mandatory training. Cyber eLearning currently only completed by those involved in a Cyber Breach. There are currently global phishing comms (email/intranet/screensavers) shared regularly, and an annual Phishing simulation.
Unsupported Software	Unsupported software identified by Cherwell Asset Management and removed or updated.

4.5 **Phishing**

GHC's Advanced Threat Protection (ATP) identified and stopped 144,000 phishing emails from being delivered to GHC individual or shared mailboxes:

- On average the Trust receives 95,000 emails per week;
- 2,769 emails received per week were phishing emails, which equates to 3% of emails received per week; and,
- Of the phishing emails received 175 emails were not blocked by ATP, equivalent to 0.18% of all emails received per week.

There are currently no comparable local phishing stats for GHC to benchmark against, however the annual Anti Phishing Working Group report found there to have been an average of 46,561 phishing emails received per month by organisations in 20/21.

Of the phishing emails not blocked by ATP four resulted in remedial action being taken by IT to protect our network and data.

- April 20, 30 devices were removed from the domain and fully scanned;
- May 20, Qbot malware, multiple devices required removal from the domain and wiping or replacing;
- May 20, Phishing email purporting to be form finance was clicked by 100 staff,

resulting in the removal of all the emails from all recipients and 100 accounts being reset; and,

- Sept 20, compromised email account for a partner organisation SGMind resulted in 125 GHC password resets and 20 GHC devices removed from the domain and wiped.

IT are currently reviewing MS defender for O365 to protect against malicious links.

4.6 Patching

Windows Servers Update Service (WSUS) has issued 766 patches in year for Microsoft operating systems and software on workstations and servers. Which have been pushed out to all end points. There are currently no unpatched devices registered with WSUS. Due to the C19 work from home agenda, patching of endpoint devices has had to be managed through a combination of staff working from home attending GHC sites to install updates through WIFI and through a manual push using Direct Access (DA). Due to the data costs associated with pushing data over DA the manual push through DA was carried out on a two-month rolling programme, which meant that last year no device was more than 60 days out of date with patches. Any updates with errors were managed through the IT support desk and on-site technicians. The 'KACE' patch management system was utilised for non-windows patching.

4.7 Unsupported software

The Trust currently holds 82 devices or servers that are running unsupported software. The devices are due to legacy partner systems that will not work on newer software. The servers are part of an older servers' estate that is the process of replacement, this risk is however being mitigated by additional security software. As part of the rolling programme to update unsupported software to supported models the Trust has replaced all existing windows 2007 software on devices and removed the out of support Adobe flash player for all devices.

There is however an inherent risk that GHC carries as part of the Countywide IT set up as other ICS partners, on the network, are running different software on their server and device estates.

IG Structure and Assurance Framework

Gloucestershire Health and Care
NHS Foundation Trust
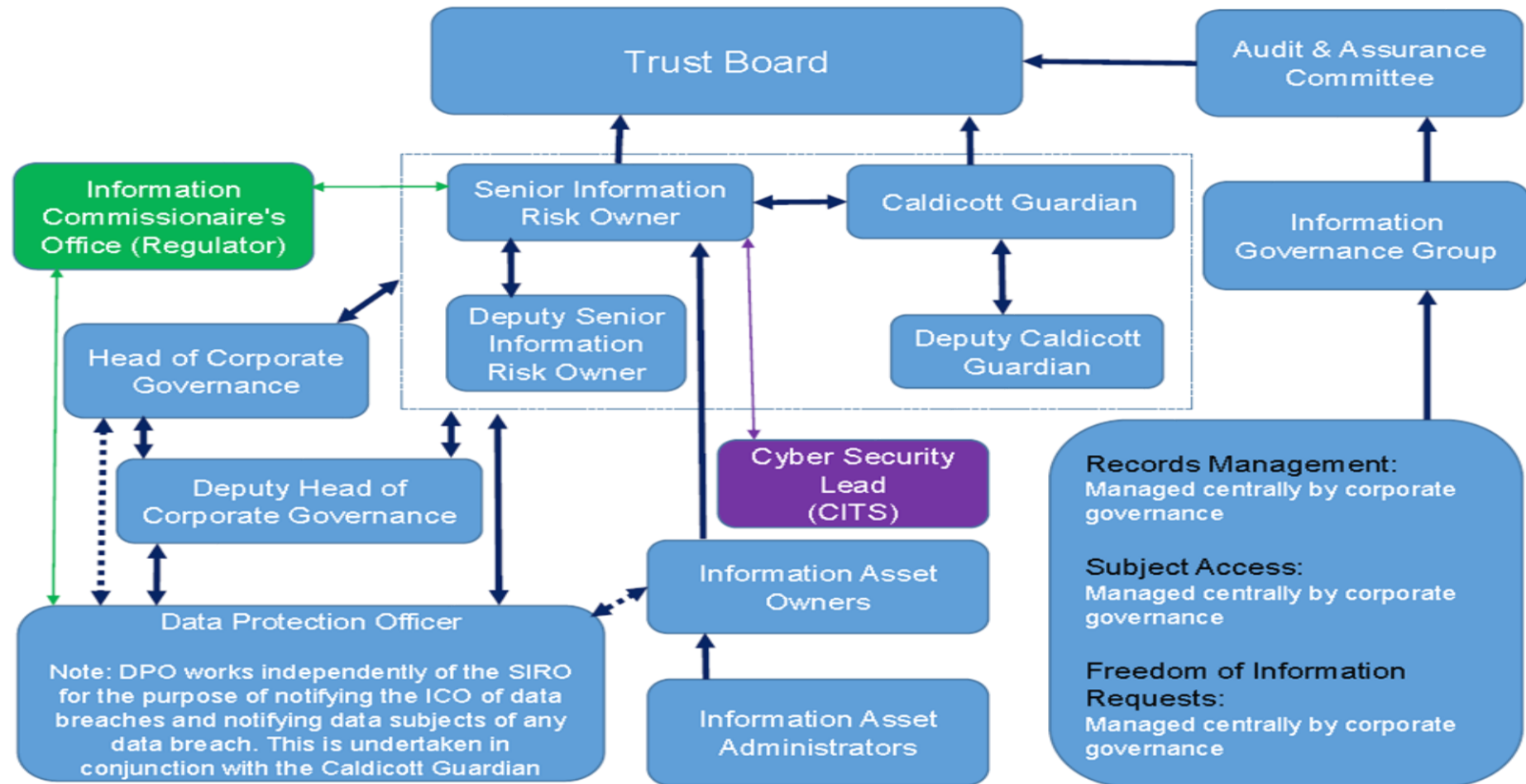
REPORT TO:	**TRUST BOARD PUBLIC SESSION – 30 September 2021**
PRESENTED BY:	Lavinia Rowsell, Head of Governance/Trust Secretary
AUTHOR:	Lavinia Rowsell, Head of Governance/Trust Secretary
SUBJECT:	**DEVELOPMENTAL REVIEW OF LEADERSHIP AND GOVERNANCE USING THE WELL-LED FRAMEWORK**

This report is provided for:

Decision ☐   Endorsement ☒   Assurance ☐   Information ☐

The purpose of this report is to:

Set out a proposed approach for the delivery of the next developmental review of leadership and governance using the Well Led Framework.

Recommendations and decisions required

The Board is asked to **endorse** the proposed approach to the review.

Executive summary

The Trust's mission is to '***enable people to live the best life they can'*** and to achieve 'outstanding care' status. To do this we need to continually strive to raise the bar on performance across the organisation, including the Board. The Board has a duty to conduct its affairs effectively and demonstrate measurable outcomes that build and maintain patient (service users, carers and family), public and stakeholder confidence that GHC is providing high quality, sustainable care.

In-depth, regular and externally facilitated developmental reviews of leadership and governance are seen as good practice across all sectors. Rather than assessing current performance (as   reflected in the CQC assessment of well led), these developmental reviews focus on continuous improvement and seek to identify the areas of leadership and governance that would benefit from further targeted development work to secure and sustain future performance.

NHS England and NHS Improvement strongly encourages all providers to carry out externally facilitated reviews, every three to five years. The paper sets out the proposed approach for the review. Planning will commence with a Board self-assessment exercise in November 202 with the review taking place in Q1 of 2022/2023.

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Risks associated with meeting the Trust's values
A lack of capacity and capability to lead the organisation effectively will impact the ability to deliver the strategic ambitions as set out in the Trust Strategy.

CQC inspection framework for all registrants includes an assessment of current performance of well led, which is explicitly linked to the well-led framework. Failure to demonstrate that the Trust is well led and has robust governance processes in place may lead to enforcement and regulatory actions.

Corporate considerations	
Quality Implications	None
Resource Implications	Cost associated with the commissioning of the external review will be built in 2022/2023 budget.
Equality Implications	None

Where has this issue been discussed before?
Chair and Chief Executive

Appendices:	

Report authorised by: Lavinia Rowsell	**Title:** Head of Governance / Trust Secretary

DEVELOPMENTAL REVIEW OF LEADERSHIP AND GOVERNANCE USING THE WELL-LED FRAMEWORK

1.0   INTRODUCTION

1.1   The Trust's mission is to '***enable people to live the best life they can'*** and to achieve 'outstanding care' status. To do this we need to continually strive to raise the bar on performance across the organisation, including the Board. The Board has a duty to conduct its affairs effectively and demonstrate measurable outcomes that build and maintain patient (service users, carers and family), public and stakeholder confidence that GHC is providing high quality, sustainable care.

1.2   NHSI guidance strongly encourages Trusts to carry out externally facilitated, developmental reviews of their leadership and governance using the well-led framework every three to five years, in line with corporate governance guidance in many other sectors.   Rather than assessing current performance (as reflected in the CQC assessment of well led), these developmental reviews focus on continuous improvement and seek to identify the areas of leadership and governance that would benefit from further targeted development work to secure and sustain future performance.

1.3   External developmental reviews were last undertaken in both 2Gether NHS Trust and GHC prior to the Trust merger and then externally reviewed as part of the pre-merger process. Given the recent circumstances with the Covid-19 pandemic and in order to allow the governance and leadership of the new post-merger Trust to fully bed in, it is recommended that the first review of the merged Trust, GHC takes place in Q1 2022/2023. In the meantime, the internal and external audit functions will continue to keep governance under review and update the Audit and Assurance Committee and the Board through their annual processes.   Additionally, reviews against the required governance standards will continue to be completed as part of the annual report and the provider license reporting processes. Any specific areas of concern can also be considered through the Internal Audit Annual Plan.

2.0   WELL-LED DEVELOPMENTAL REVIEW PROGRAMME

2.1   The well-led developmental review programme has six steps:

Figure 1: Overview of well-led review.

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2.2 **Self-Review**

2.2.1 Background

Self- review is an important first step in preparing for the externally facilitated developmental review. It is important to assess ourselves to provide insight, both for ourselves as a Board and the external facilitator, into how we gauge our own leadership and governance performance and identify any particular areas of interest, areas for development, or concern either within or outside the eight areas. Confirmation that the Board knows itself – strengths and weaknesses, and has in place plans to respond to weaknesses and to share good practice is at the heart of effective self-review.

Figure2: Well-led Framework Eight KLOE

There is clear guidance on 'what good looks like' and key documents / reports that may be used as part of the assessment published by both NHSI and by the CQC in their inspection framework. Rating each of the KLOEs (Key Lines of Enquiry) using good practice examples in the framework will help ensure a focus on continuous improvement rather than a compliance checklist.

2.2.2 Proposed Timing and Format of Self-Review

It is proposed that the Board undertake this self-review collectively as part of the Board Seminar Programme. A preparatory self-assessment will be undertaken by a small working group comprising members of the Trust's CQC team, Trust Secretariat and nominated members of the Board (Marcia Gallagher - Senior Independent Director and Chair of the Audit and Assurance Committee and John Trevains – Director of Nursing, Therapies and Quality) to propose provisional ratings for discussion, testing, challenge and confirmation by the wider Board.

2.3 **Setting the Scope for the External Developmental Review**
Following the self- review, the Board will be asked to agree the scope for the facilitated developmental review, keeping in focus that its purpose is to drive continuous improvement.

As part of this process the Board may choose to omit components of the framework (e.g. one or more of the eight KLOE) where it considers there is clear evidence, ideally externally verifiable, that it is already achieving or exceeding the expectations set out within the framework. The Board may however choose to keep in such an area if it wishes to explore how it could develop the identified practice in other areas or in other trusts. The Board may also wish to include other development areas outside the framework, for example, issues arising from internal/external audit.

Again, it is suggested that the small working group develop a proposal for the Board to consider, challenge, review and approve.

2.4 Commissioning an External Developmental Review

External facilitation is a key part of developmental reviews: it provides objectivity and challenge that may not available in house. This can be delivered through an external facilitator or a process of peer-review.

The appointed external facilitator or peer review team is required to be independent and be able to provide robust and reliable judgement of the Trust leadership and governance. They should also be able to demonstrate:

- credibility and experience in carrying out leadership and governance reviews
- be multidisciplinary with a broad range of skills relevant to all aspects of Board leadership and governance, such as strategic planning, quality governance, cultural assessment, organisational development and management information and analysis
- experience in supporting healthcare providers to develop their leadership and governance with an understanding of continuous quality improvement and methodologies
- knowledge of the healthcare sector, and the internal and external challenges faced by providers knowledge of the regulatory framework in which providers operate
- ability to manage the review process, providing a credible and detailed plan of the proposed project governance regime including the approach to the quality assurance of the work, risk management, reporting and escalation lines, and evidence of clear leadership for the work with a named individual.

A specification will be drafted using the national template and, subject to decision by the Board, a final draft will be set.

An options appraisal will be undertaken regarding the delivery approach.

2.5 Board Reporting and Action Planning

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The external facilitator should be commissioned to work with the Board to prioritise the review findings, and agree recommendations and developmental actions in response. These should be detailed in a formal report to the Board.

2.6 Notification to NHS Improvement

Once the action-planning is done, the Trust is required to send NHS Improvement a letter confirming that the completion of the review, any material issues that have been found and/or any areas of good practice that could be shared with others, for example through a case study.

2.7 Delivery of Improvement Programme

The most important part of the process is the implementation of any leadership and governance improvement actions that arise from the review.

3.0 NEXT STEPS AND TIMELINE (PROVISIONAL)

Stage	Date by	Who
Governance arrangements in place	Mid- September	
Board briefing	September Board	Head of Corporate Governance
Self-Assessment Preparatory Work	Mid-October	Working Group - members of the Trust's CQC team, Trust Secretariat, nominated members of the Board (Marcia Gallagher and John Trevains
Board Self-Review – facilitated workshop	Early November	Board
Draft External Developmental Review Scope developed	Start November	Working Group (membership as above)
External Developmental Review Scope debated and agreed by Board Consider use of peer reviews as part of external facilitation team	End Nov	Board
Commissioning external developmental reviewer - Undertake procurement exercise	January / February	Lead by Head of Corporate Governance, supported by procurement team

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Stage	Date by	Who
- Chose external facilitator, managing conflicts of interest.		Chair, CEO, Head of Corporate Governance, SID, DirNT&Q
Detailed review	April / May	Board
Board report and action planning	June	Board
Letter to NHSI	July	Head of Corporate Governance
Update on Action Plan Monitoring	September	Head of Corporate Governance/Board

4.0 REFERENCES

NHS England » Well-led framework

Well-led_guidance_June_2017.pdf (england.nhs.uk)

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REPORT TO:	**TRUST BOARD PUBLIC SESSION – 30 September 2021**
PRESENTED BY:	Sandra Betney, Director of Finance & Deputy Chief Executive
AUTHOR:	Informatics Team
SUBJECT:	**DIGITAL UPDATE**

If this report cannot be discussed at a public Board meeting, please explain why.	N/A

This report is provided for:
Decision ☐   Endorsement ☑   Assurance ☐   Information ☐

The purpose of this report is to:

To get endorsement / feedback on the first Trust digital update to enable a regular quarterly paper to be provided to the board. The digital agenda is increasingly important and this report will hopefully provide the wider view of the breadth of work ongoing in this area.

Recommendations and decisions required

The Board is asked to:
- **Endorse** the content of the Digital Update

Executive summary

With the Digital agenda increasingly important to the NHS and Gloucestershire Health and Care NHS foundation Trust (GHC) this year saw the release of the new GHC Digital Strategy.

It was felt that with the ambition this strategy is attempting to deliver and with the importance of Digital to both this organisation and the ICS it would be useful to provide a regular board update on progress against the strategy and the delivery of digital services.

This is the first report that will hopefully provide this wider view on the breadth of work ongoing in this area.

Risks associated with meeting the Trust's values
It is important that the trusts digital work reflects the wider strategic vision of the trust to ensure alignment with what the organisation wants to achieve over the next 5 years.

Corporate considerations	
Quality Implications	Implementing the digital agenda should impact on all aspects of the trust and its patients including quality, resource and health inequalities
Resource Implications	Implementing the digital agenda should impact on all aspects of the trust and its patients including quality, resource and health inequalities
Equality Implications	Implementing the digital agenda should impact on all aspects of the trust and its patients including quality, resource and health inequalities

Where has this issue been discussed before?
As part of the work on the Digital strategy it was discussed at the resource committee and at the board that it would be useful to get wider oversight of the digital agenda with a more regular board report provided against progress.

Appendices:	N/A

Report authorised by: Sandra Betney	**Title:** Director of Finance & Deputy Chief Executive

Why…

With the Digital agenda increasingly important to the NHS and Gloucestershire Health and Care NHS foundation Trust (GHC) this year saw the release of the new GHC Digital Strategy.

It was felt that with the ambition this strategy is attempting to deliver and with the importance of Digital to both this organisation and the ICS it would be useful to provide a regular board update on progress against the strategy and the delivery of digital services.

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Gloucestershire Health and Care
NHS Foundation Trust

DIGITAL GHC

Empower people: Provide convenient access to services and health information for people to self manage and support personalised care.

Enable clinicans: Build a digitally skilled workforce with the right technology training and infrastructure in place to deliver efficient, high quality, responsive and innovative services.

Integrate systems: Work in collaboration with partners to improve system wide health and care transformation to improve planning and delivery of services through the greater use of shared data.

Revolutionise information: Delivering secure, robust and reliable data analytics that can be easily and rapidly accessed across the organisation and health care system.

Build the future: Provide convenient access to services and health information for people to self manage and support personalised care.

To become a fully digital Trust

Our vision means that we intend to integrate digital solution into every interaction to improve the quality and experience of care. We have identified five strategic aims that will help us in our journey.

Empower People; Enable clinicians; integrate systems; Revolutionise information; Build the future

Digital

Projects & Change

- **Site Moved progressed** including site moves to Rikenel, Jubilee ward, informatics team to EJC, IAPT to Eastgate House   .
- **Care Home Digital Consultation** pilot progressing with GHC mental health services
- **Video Conferencing Renewal progressing**
- **Cannon Devices Refresh,** Ensuring multifunction devices are up to date across the estate
- **Workstation on wheels** replacements have been rolled out across and physical health community hospitals.

Corporate Systems

- **Centros Go Live** One finance system for the whole trust
- **System Interoperability** Work progressing om Care to Learn and Rostering interface with ESR.
- **MultiFactor Authentication** deployment pro gressing for trust staff
- **GHC CCTV system Upgrade progressing**
- **Corporate Systems review**, corporate systems managed in line with GHC standards and policies
- **ELearn with University of Gloucestershire** Further work to complete finance model before sign off
- **Prism System** BAU and financing elements being worked through

Applications & Development

- **Covid App** provided to all staff to update lateral flow tests results
- **Case note tracker** application created replacing legacy application that was no longer supportable
- **HR Recruitment App** created to digitise the current manual process
- **MIU Escalation App** texting functionailty to mobiles and pagers being tested
- **Childrens Speech & Language Therapy,** Website update, guidance materials and digital assessment work progressed
- **Speech and Language Therapy** Apps signed off through Orcha platform review .

Innovation Workstream

- **Cinapsis review** looking at how we can get the best use of this Realtime guidance tool in GHC and in the ICS
- **Malinko Demonstration** A tool that enables efficient use of staff visit scheduling for community staff – Work progressing to create a business case .
- **Orcha Demo (app library)** GHC group setup to look at how best to use this platform for GHC staff and patients
- **SYstemOne Demo of systems improvements** including Bridend and Communications Annexe
- **OxeVision Review** Understanding the benefits of remote monitoring and how this could be used within the trust

CS

Training

- **Trainers moved to remote training** within a few weeks of lockdown
- **Adapted to changes in clinical induction** going to weekly sessions
- **Created numerous training videos and eLearning**
- Taken on training for **SoelHealth**
- Trainers have **cross trained on systems** so have a good mix of knowledge
- Provided support for **EPMA project**
- **Tasking workshops** set up and running
- **Wholesale review of training offer started**

2nd Line/Admin

- Took on regular **configuration tasks** for **SystmOne** and **Lilie** from the Change and Development Team
- Taken on **support for SoelHealth**
- **Herefordshire services decommissioning support**
- **Learned SystmOne and Lilie** and can now fully support all systems
- **Letter changes due to merge**
- Provided support for **Totalmobile project**
- Provided support for **EPMA project**
- Took on **management of SystmOne releases**
- **Overseen 2 Sexual Health System releases**

RA & Audit Team

- **RA Team redeployed 65 Rio Users and 296 SystmOne users** from their normal Smartcard roles to the redeployed roles.
- **Assisted with TACS cards solutions** for electronic prescribing rollout
- **Worked with Operational leads to introduce a new JUYI role** for non-qualified patient-facing staff to have access to JUYI.
- **Assisted with EPS project** so patients can have their prescriptions sent directly to a nominated Pharmacy
- **Assisted with recent Decommissioning of PAS project**, ensuring that GHC users were given access to ICE or Sunrise instead of PAS

Change & Development

- **e-RS (formerly Choose and Book)** delivered to Mental Health Services
- **Post-COVID Service set up**
- **Link to ICE Pathology results embedded within RiO**
- **Oversaw PAS decommissioning**
- **Process embedded for managing unidentified patients in clinical systems**
- **WhatsApp** for connecting young people rolled out for childrens cervices
- **Electronic correspondence to GPs** now available from IAPTus
- **ePMA** rolled out to Mental Health Inpatient wards

586

Change & Development service requests and incidents completed since April 2021

IT

Server

- **Change of Internet lines at EJC (6D to Gamma)** - involving the reconfiguration of outgoing internet traffic and incoming reverse proxy traffic .
- **Virtual Smartcards** - Test and configure desktop software to support virtual smartcards.
- **2G IT SQL Migration** - Migrate the older ex-2G SQL servers into one data warehouse cluster.
- **RightFax server migration** - Migrate and merge RightFax servers into one fully supported GHC server.
- **Decommissioning of 2G Server infrastructure**
- **Hyper-V installation at Cirencester** to improve Disaster Recovery and failover provision
- **Web Filtering applied through Microsoft Advanced Threat Protection** – which secures the client side
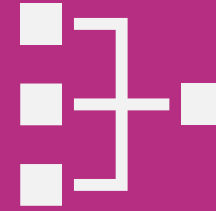
Infrastructure

- **Telephony Consolidation** – Phase 1 involves the provisioning of back-end equipment
- **Local Area Network Upgrade** is continuing site survey being undertaken and delivery of new equipment.
- **Mobile Device Management system** migrating from MobileIron to Microsoft's solution, INTUNE.
- **Telephone survey tool** for Dental is being progressed
- **Telephony call flow** for Central Referral Line has been created

Ticket Reduction

- **Email functionality improved** by importing email archive files into Office 365 .
- Further **deployment of SIM enabled laptop** to all collegues
- **A separate Wi-Fi network for mobile devices**
- **P:Drives are being migrated to OneDrive**, making personal files more accessible and enhancing capabilities.
- **Home working guides** updated and shared.
- **Softphones implemented** for colleague's home working to simplify the process.

Digital Instructors

- **IT equipment ordering portal**
- **Video support guides**
- Delivering **"Improve your digital skills" sessions**
- **Creation and support of " Tech Champions"** group which includes wider Trust colleagues in testing new IT technology and systems
- **Management of Audio Visual Equipment** in all meeting rooms
- **Improving digital inclusion** across the county
- **Cyber Campaign** to promote Cyber Awareness across the Trust

IT

GHC IT & Clinical Systems
☎ 0300 421 8122
✉ GHCIT@ghc.nhs.uk
clinicalsystems.help@ghc.nhs.uk

Start ⊙

OLA Statistics
April 21 - June 21

September 2020 >> August 2021

Ticket Stats

- Tickets opened: **61,036**
- Tickets closed: **61,1103**
- First time fix: **88%**

Phone Stats

- Calls received: **58,004**
- Service level: **91% answered**
- AV speed of answer: **28 secs**
- Av handling time per call: **5 mins 30 secs**

Laptops Issued

- Stock stats are unavailable for the first part of the time period
- Av of **62** laptops issued **per month.**
- Approx **744** laptops issued **in total**

Email Activity

7.4M activities ▼ 0.3%

Number of send and receive actions over the selected time period
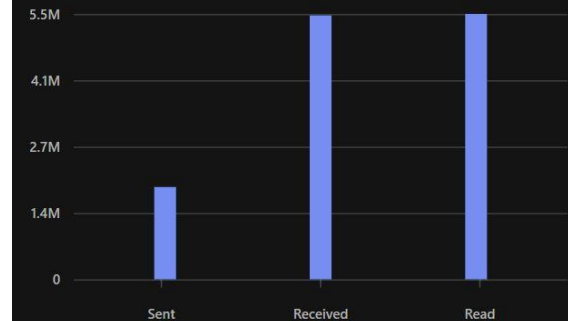
MS Teams Activity

Microsoft 365 usage reports show how people in your business are using Microsoft 365 services.
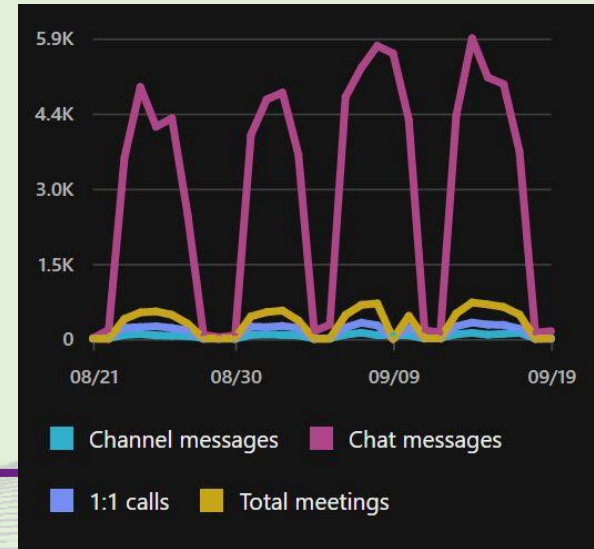
Active users

Usage >> Past 90 days

GHC Digital Strategy Progress

Empower People

Digital Front door for Children's mental health scheduled to go live in early 2022

Electronic patient appointment booking systems reviewed and preferred solution chosen

ICS Digital inclusion workstream stood up with three sub projects in GHC started

A range of Apps looked at to support digitally enabled self-care including speech and language therapy and MSK

Orcha – Digital Apps library signed off at the regional level with Gloucestershire ICS project to implemented started August

ICS – Video Conferencing review started to progress next steps in this area

Enable Clinicians

Technology Champions setup with 90 active members and monthly meetings and technology reviews/ testing with MFA recently tested, Find time, Desktop Encryption and 365 Defender testing

GHC Digital workforce task and finish group setup to deliver a roadmap to progress this key area

ICS Digital inclusion workstream stood up with three sub projects in GHC started

A range of Apps looked at to support digitally enabled self-care including speech and language therapy and MSK

Orcha – Digital Apps library signed off at the regional level with Gloucestershire ICS project to implemented started August

GHC Digital Strategy Progress

Integrate Systems

Clinical system's vision project first area complete with sign off to proceed with area's 2 and 3 looking at the potential options to progress with system changes and integrations

Electronic patient appointment booking systems reviewed and preferred solution chosen

E-Rostering system rationalisation project progressing

University of Gloucestershire Digital workstream meeting being finalised

GHFT System information available on the local shared care record with social care information shortly

Revolutionise Inform

Centros finance information available through Tableau to all budget holders

System One Simplicity project moved forward to support improved reporting clarity on data reporting for clinical services

Projects signed off and progressing to include corporate system information within the Trust Datawarehouse including Rostering and Care to Learn

Build the Future

Programme of work to review Automation opportunities with Finance

Electronic Prescribing rolled out in Mental Health hospitals

Electronic Document Management system project progressing for Mental health documents

ICS Wide Area Network project signed off and progressing with GHC leading for the county

Digital

Projects & Change

- **Digital Inclusion** Tablets for patients to interact with services benefits of progress reviewed
- **CYPH Digital Front Door** Project to go live after initial pilot with a small number of schools.
- **Cyber Soultion confirmed** Immutable backup option confirmed and bid progressed
- **Student system access options** assessment for GHC complete with proposal put forward
- **Digital Workforce Roadmap,** GHC Digital workforce roadmap completed after initial workshop review
- **Communication Tools** confirmed preferred solution for supporting wider communication alerts for staff
- **Microsoft Software Utilisation progressing** fast track work to look at the use of SCCM for application patching

Corporate Systems

- **Costmaster** Planning progressing for Costmaster Integration
- **Datix System r**eview the option of moving Datix to the new cloud based offering
- **GHC BMS system Upgrade progressing**
- **Tableu** Expansion and wider use of Tableu across the trust
- **Room Booking System** review completed, and options paper presented

Applications & Development

- **Pauls Open Door** Application created to support secure anonymous messaging
- **GHC App review for Cloud possibilities** Review project to look at the use of externally hosted servers for internally developed applications
- **Analytics Tool,** scoped for the use of GHC applications
- **E-Consent App for Covid** created to support covid roll out for 12-to-15-year olds
- **ICS Working Well Hub** Project implemented including website and application for recording progress
- **Trust Membership App** updated to increase functionality

Innovation Workstream

- **Remote Monitoring** Several tools and options looked at to support the trust in this area
- **Scheduling Tool** Options paper pulled produced after the Malinko Demo.
- **SYstemOne Mobile working** development and pilot of Bridgend tool as opposed to disconnected mobile working
- **Population Health Management** Development of a technical roadmap
- **Remote working solution** proposed and piloted
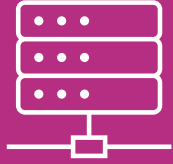- **Self-care digital information** library system review to take place
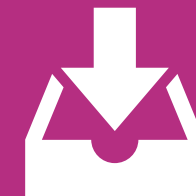
CS

Projects

- **SystmOne Simplicity project**
- **Simplifying lists** to adhere to the National Dataset
- **Clinical Systems Vision Project** Options
- **Service review** of clinical IT solutions
- **RiO e-observations project**
- **Recording observations on tablet devices**
- **Electronic Document management project**
- **PH documents linking directly to trusts EPRs**
- **Support for School Aged Immunisations Project**
- **Rationalising Role** based access project
- **Virtual smartcards project**
- **Gemplus project** to upgrade old smartcards

Developments

- **School Aged Immunisations Team to go live on RiO**
- **Automated link from SystmOne** MIUs to SHREWD
- **Home First/Reablement Service** to go live on SystmOne
- **Persisting Physical Symptoms Service** to go live on SystmOne
- **Completion of PWC internal Audit for CS OLA** and support processes
- **Redesign of training packages**

IT

Server & Infrastructure

- **Wide Area Network upgrade** - Improving links to connected sites
- **Local Area Network upgrade**– Replacement project to so reliable secure and robust equipment is in place
- **Windows Server 2019 migration** - Implement latest server operating system for a more advanced security platform
- **Pager replacement** - Implement newer communication technology
- **Implementation of warm standby infrastructure at Cirencester** - Robust solution for disaster recovery with minimal downtime
- **Mobile Device management Review and INTUNE migration**

IT Systems Management

- **Review of Supplier Contracts and Supplier agreements** -Collate and evaluate contracts ensuring best value
- **Consolidation of IT Management applications** - Assess endpoint asset management solutions
- **Cyber penetration testing**-Identifying areas of weakness that can be improved to secure the trusts IT environment

Improving User Experience

- **Endpoint equipment refresh** - Deploy 300 laptops to clinical colleagues, replacing desktop devices for a mobile working ethos. Replacement of Workstation on Wheels devices ensuring wards have reliable and high performing laptops
- **Mobile Device management Review and INTUNE migration**-Streamlining the management of mobile devices with improved security protection and patch deployment
- **Improved mitigation of Cyber threats** -Threat protection policies implementation secure data

IT Skills Development

- **British Computer Science project** - SFIA PLus framework to upskills and validate IT skills within IT team
- **Skills Matrix**
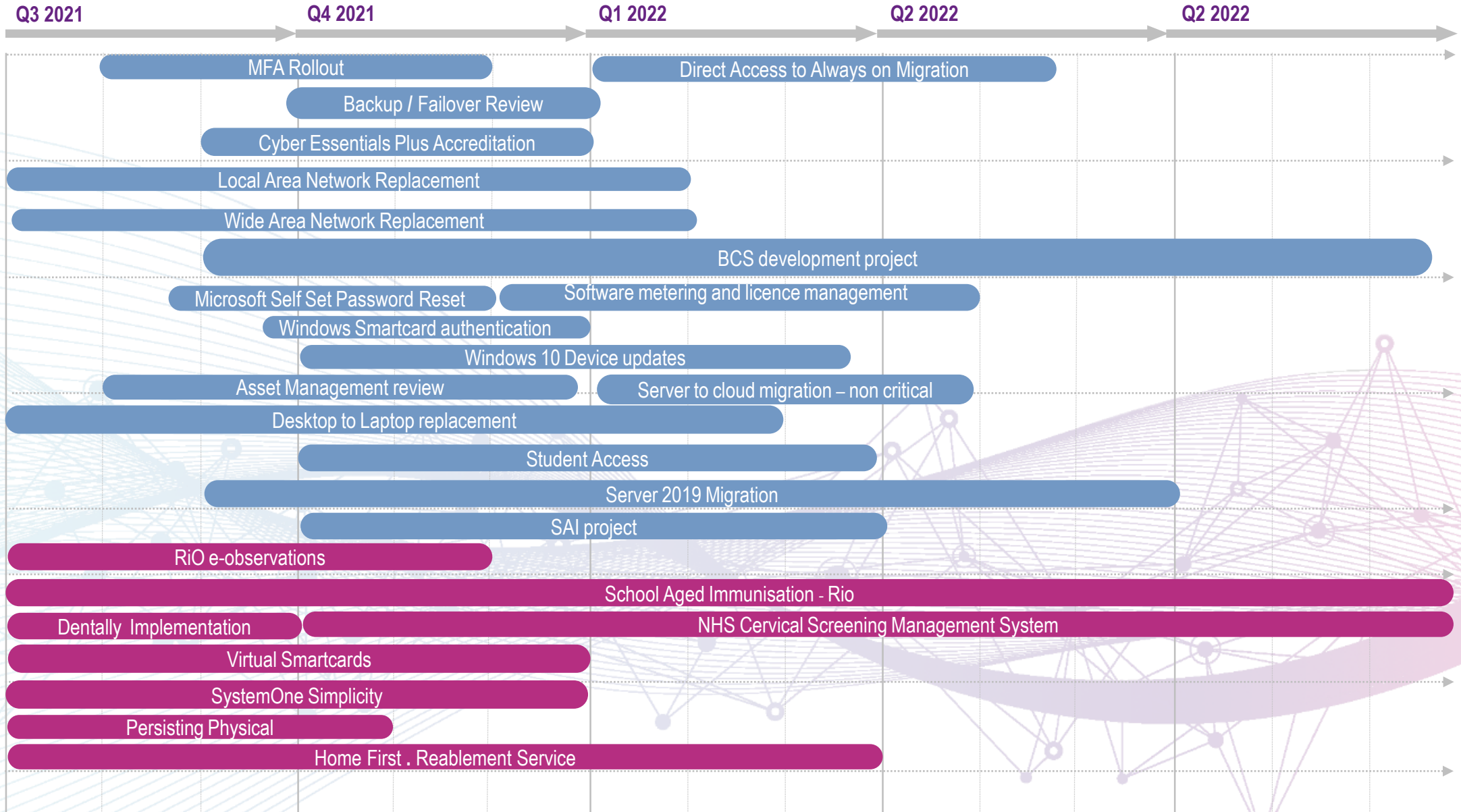- **Roles and responsibilities**
- **Skip meetings**

12 Month Road Map

IT Systems	Clinical System

Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q2 2022

IT Systems
- MFA Rollout
- Direct Access to Always on Migration
- Backup / Failover Review
- Cyber Essentials Plus Accreditation
- Local Area Network Replacement
- Wide Area Network Replacement
- BCS development project
- Microsoft Self Set Password Reset
- Software metering and licence management
- Windows Smartcard authentication
- Windows 10 Device updates
- Asset Management review
- Server to cloud migration – non critical
- Desktop to Laptop replacement
- Student Access
- Server 2019 Migration
- SAI project

Clinical System
- RiO e-observations
- School Aged Immunisation - Rio
- Dentally Implementation
- NHS Cervical Screening Management System
- Virtual Smartcards
- SystemOne Simplicity
- Persisting Physical
- Home First . Reablement Service

ICS

Our ICS Digital Vision

• We will work together to deliver digital convergence and collaboration across the ICS and to ensure that digital technology is one of the key drivers facilitating service transformation and sustainability.

• We will invest in a sustainable and underpinning technical infrastructure to support the delivery of transformational service changes, driven by care professionals and focused on empowering people to take control of their own health and care.

Our Delivery Goals

1. Deliver a modern flexible infrastructure
2. Provide a holistic view of the citizen's direct care needs
3. Join up intelligence
4. Provide streamlined systems and tools
5. Offer people and their circle of care consistent and usable digital access

Empower The Person

- **Mental Health Children's and Young People Digital front door project** completing initial stage of readiness.
- **GHC online consultation levels remain some of the highest in the country**, however, there has been a steep drop off of video consultations for both secondary care providers in the last quarter, in line with the national trend (-18% in GHC and – 45% in GHT for last 2 months)
- **GP Online enquiries increased 16% to 172k for Q1, with 1 to 1 SMS increasing 20% and GP video consultations steadily dropping another 35%.**
- **The NHS App is now seeing a dramatically increased uptake**, following the inclusion of Vaccination information (from 3.7 – 5.2% of the county's registered GP population in 3 weeks)
- **Empower the Person Roadmap drafted for review.** E-learning rehab proposal drafted and reviewed at ICS Digital Executives.
- **Digital Inclusion Group initial plan drafted.**
- **Contract awarded to supplier with BNSSG for Autism pathway** Discovery work package.

- **Shared Care Record** – Children's Social care system - GCC to complete configuration to connect to Staging environment to complete testing. -Acute PAS - Connection of live PAS system to shared care record Staging environment completed.
- **Cinapsis** – GHC Rapid Response configured as specialist service for paramedic triage calls. Gloucestershire partnered with BSW & BNSSG to procure 3-year contract for Advice & Guidance via Clinical Communications framework. Regional funding secured for contract first year
- **Primary Care Data Warehouse** - EMIS data feed implemented & penetration testing completed. Activity underway to implement data feed for additional purposes i.e. commissioning and population health management.
- **Care Homes and Hospices** - Options appraisal completed for Hospice access to SystmOne. Business case drafted but not yet finalised.
- **PACS regional sharing on-hold** as now superseded by regionally funded Insignia solution.
- **E-Messaging and Correspondence** - Cheltenham MIU are live with sending discharge summaries electronically to GP Practices
- **Outpatient letters to GPs now nearing completion**
- **IAPT letters to GP undertaking further issue fixing** , following pilots

Clinical Information Sharing

ICS

Providers in Gloucestershire

- **Electronic Prescribing System (EPS4) utilization** - Outstanding tasks to be completed at Blakeney and Rendcomb
- **GHC Mental Health Services -** implemented a new system to send letters to registered GP practices electronically via the MESH and received into the document workflow in EMIS.
- **GPIT Futures** - Regular meetings with the procurement team who are following up procurement routes.
- **Evaluation of batch messaging and reminders solutions has started .**
- **Primary Care I.T. Infrastructure projects** – Scheduling for Office 365 Deployment and GP Cabinet Upgrade have been arranged
- **Hospital Discharge Service on EPR** –Usage is being monitored to ensure compliance.
- **Digitising the Sepsis Pathway alignment with the** implementation of EPR into ED.
- **TCLE** went live in late June with a revised scope
- **Continuing to support the Cheltenham MIIU transition** back to a consultant-led service
- **GHT Data Centre Refurbishment -** Slippage on a number of milestones has put the completion date at risk.
- **GHT SQL Migration & Windows 2003 Upgrade** – Re-planned to accommodate resource availability.
- **GHT N365 Transition and Change -** Continuing data validation to identify 'true' user base.

Digital Workforce

- **Phase 4 workforce narrative was submitted**
- **Chartered Institute of IT skills profiling programme plan** being developed.
- **Digital & Data team audit** for the ICS completed

Infrastructure & Cyber Security

- **Cyber Security** – Cyber Security Plan in progress. Increase in Advanced Threat Protection & Sophos detections owing to penetration testing Proof of Concept work by cyber team. Virtual Cyber Response Exercise completed with support from NHSD & police.
- **Wide Area Network Refresh** – Sign-off for BT solution given at ICS to join up with the GP and GCC partners in the county to create a new one countywide network.

GCC

- **Organisational design** - a new Assistant Director for Digital & ICT Karl Grocock commenced in May
- **Commence critical remediation project work** to support technical roadmap.
- **Network** – detailed WAN / LAN design signed off; complete Shire Hall fibre refresh; network implementation commenced.
- **Liquid Logic Adults** - System successfully went live across the whole of adult social care and partners on 29th March 2021.

Project Milestones Status

Network Refresh

Sign-off for ICS to join up with the GP and GCC partners in the county to create a new one countywide network with BT soultion.

Regional Shared Care Record

National requirement that all ICS areas have a shared care record in place. Key targets for September 2021 and March 2022. Devon & Cornwall procurement completed. Programme implementation has been initiated. Somerset and Bristol leading on exploring a technical approach.

Cyber Security Plan

Cyber Security Plan in progress. Increase in ATP & Sophos detections owing to penetration testing PoC work by cyber team. Virtual Cyber Response Exercise confirmed for 4th June, with support from NHSD & police.

Office 365 deployment by October 2021

GCCG & Primary Care - Scheduling for Office 365 Deployment taking place. AMBER status is the result of the completion of Tranche 1 being at risk owing to the slow run rate.
GHT – Continuing data validation to identify 'true' user base for inclusion in the migration.

GHC – Completed

Advice & Guidance deployment

BAU transition plan and Outpatient evaluation required before further roll out to new specialties. New functionality for ERS integration and signposting ahead of calls under development.

Discharge Summaries to GP's

This work to send electronic comms to GPs through inpatients, outpatients and emergency departments nearing completion.

Digital Update 2021 - Sway Edition

GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST

COUNCIL OF GOVERNORS MEETING

Wednesday 14 July 2021

Held via Microsoft Teams

PRESENT:	Ingrid Barker (Chair)	Nic Matthews	Katie Clark
	Jo Smith	Chris Witham	Graham Hewitt
	Tracey Thomas	Ruth McShane	June Hennell
	Anneka Newman	Laura Bailey	Katherine Stratton
	Said Hansdot	Dan Brookes	Jenny Hincks
	Julie Clatworthy	Rebecca Halifax	

IN ATTENDANCE: Andy Holness, Shadow Public Governor
Graham Russell, Non-Executive Director/Deputy Chair
Jan Marriott, Non-Executive Director
Lavinia Rowsell, Head of Corporate Governance & Trust Secretary
Gillian Steels, Trust Secretary Advisor
Marcia Gallagher, Non-Executive Director
Maria Bond, Non-Executive Director
Paul Roberts, Chief Executive
Neil Savage, Director of HR & OD
Steve Alvis, Non-Executive Director
Steve Brittan, Non-Executive Director
Sumita Hutchison, Non-Executive Director

1. WELCOMES AND APOLOGIES

1.1 Apologies were received from Sarah Nicholson, Mervyn Dawe, Karen Bennett, Kizzy Kukreja and Juanita Paris.

1.2 Ingrid Barker welcomed Rebecca Halifax and Andy Holness to the meeting. Rebecca had commenced in post on 1st July as an Appointed Governor representing Gloucestershire County Council. Andy Holness would be formally commencing as a Public Governor for Tewkesbury on 15th July, replacing Jo Smith when her term ended.

1.3 Ingrid Barker expressed her thanks and good wishes to both Anneka Newman and Jo Smith for which this would be their final Council meeting. Anneka would be standing down after her first term as a Staff Governor representing Medical, Dental & Nursing colleagues on 1 August 2021. Jo Smith would be coming the end of her final term as a Public Governor for Tewkesbury later today. The Council expressed their thanks to Anneka and Jo for their contributions and commitment to the roles.

2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes from the previous meeting held on 12 May 2021 were agreed as a correct record.

4. MATTERS ARISING AND ACTION POINTS

4.1 The actions from the previous meeting were either complete, on-going or included on this meeting's agenda.

5. APPOINTMENT OF A NON-EXECUTIVE DIRECTOR

5.1 The purpose of this report was to seek the agreement and approval of the Council of Governors to the appointment of a Non-Executive Director.

5.2 At its February 2021 meeting, the Nominations and Remuneration Committee received and endorsed a report on the way forward with the recruitment of a NED with a background in finance/accounting. This appointment would ensure that appropriate succession planning arrangements were in place for the Chair of the Audit and Assurance Committee.

5.3 The Trust subsequently commissioned Gatenby Sanderson, an Executive Search agency, which has previously successfully assisted in sourcing applicants and supporting long listing, short listing and pre-interview processes for potential appointees. Gatenby Sanderson worked in partnership with the Trust and the position was advertised nationally on job-boards and through social media.

5.4 Interviews for the position took place on Thursday 1st July via Microsoft Teams. The interview panel comprised; the Chair of the Board, 3 Governors (members of the Nominations and Remuneration Committee), 2 Non-Executive Directors (including the Chair of the Audit & Assurance Committee) and the Chief Executive (in an advisory capacity). Discussion groups took place on the morning of 1st July in advance of the interviews consisting of Governors, Experts by Experience and senior Trust managers. One to one conversations had also taken place with each of the 3 shortlisted candidates with Sandra Betney, Director of Finance and Graham Russell, Deputy Trust Chair and Chair of the Resources Committee.

5.5 Having taken into account the feedback from the discussion groups and individual meetings, and undertaken a rigorous interview, the recommendation to the Council of Governors was the appointment of Clive Chadhani as a Non-Executive Director.

5.6 Ingrid Barker informed the Council that the panel agreed that we had three appointable candidates, each bringing their own strengths and distinctive experience. It was agreed that the candidate recommended by the panel would be a good 'fit' with the rest of the board, bringing a strong commercial background and perspective which would benefit the skill mix of the team.

5.7   The Council of Governors supported the recommendation and approved the appointment of Clive Chadhani as a Non-Executive Director of the Trust from 1st October 2021 for an initial period of 3 years, at an annual remuneration of £14,000.

5.8   Graham Hewitt had participated in one of the discussion groups with the candidates. He said that it had not been made clear to the discussion groups that the appointment was specifically for the chair of the Audit and Assurance Committee, and they had also not been made aware that each of the candidates was attending a range of sessions in the morning. Graham said that this would have been helpful to have known in advance by way of being able to plan for appropriate questioning. Graham Hewitt added that he had not seen the collective feedback that the group had submitted to the interview panel and queried therefore whether this had been received and considered. Neil Savage provided assurance that verbal feedback from each of the discussion groups was received and this had been taken on board, with some of the interview questions amended in response to this feedback. However, it was agreed that the process would be reviewed next time to ensure that a clearer briefing was provided for discussion participants and consideration would also be given as to whether collective feedback from the groups would be submitted in written form, to ensure this was available for the record. Ingrid Barker thanked Graham Hewitt for his helpful feedback, which was always encouraged to ensure improvements could be made.

6.   REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

6.1   Chris Witham, Lead Governor presented this report to the Council, summarising the key business conducted at the meeting of the Nominations and Remuneration Committee held on 30 June. He provided strong assurance to the Council that the Committee ensured best practice that was in line with national guidance.

Chair's Appraisal 2020/21

6.2   The Committee received the outcome of the appraisal of the Trust Chair for 2020/21. Marcia Gallagher, Senior Independent Director was in attendance to present the report which highlighted the key themes emerging from the feedback received from Directors, Governors and stakeholders which formed the basis of the appraisal process with the Chair. It also identified areas that have arisen out of that feedback that might contribute to development plans for the forthcoming year. Assurance was received that the appraisal had been conducted in accordance with guidance issued by NHSE/I in April 2021.

6.3   This was a positive appraisal and was a real tribute to Ingrid Barker's performance that she had continued to engage in a number of national and local forums over the past year. This was Ingrid's second year as Trust Chair and her leadership during Covid had been greatly valued. Ingrid had taken the sensible approach with Board colleagues to focus on achievable targets during what was an extremely challenging year. Ingrid has a strong and effective

working relationship with the Chief Executive, and positive feedback was received from the Chair of the Gloucestershire ICS and the Chair of Gloucestershire Hospitals Trust who valued Ingrid's support and engagement.

6.4   The Committee received the key objectives for the Chair for 2021/22, noting that these personal objectives were aligned with those of the Chief Executive and the new Trust Strategy.

6.5   The Committee thanked Marcia Gallagher for the report, which was well written, clear and thorough. The report contained a good balance of celebratory strengths whilst ensuring that the process carried out had been appropriately rigorous and robust.

6.6   The Committee formally noted the outcome of this year's Chair appraisal process, noting that this would also be submitted to NHSE/I.

Non-Executive Director Appraisal 2020/21

6.7   The Committee also received the outcome of the appraisal of the Non-Executive Directors for 2020/21.

6.8   Appraisal meetings for all NEDs took place in April 2021. In advance of each meeting, NEDs were asked to undertake a self-review focusing on their achievements over the past year and previously agreed objectives. Following the meeting, a summary of the discussion, proposed objectives and development plans were shared with each NED and signed off by both parties. The Committee received assurance that the appraisals had been conducted in accordance with guidance issued by NHSE/I in April 2021.

6.9   Appraisals were completed for Marcia Gallagher, Graham Russell, Maria Bond, Sumita Hutchinson, Jan Marriott, Dr. Stephen Alvis and Steve Brittan. Ingrid Barker informed the Committee that this had been a positive round of appraisals, and there were no areas of concern to raise with the Committee.

6.10   The Nominations and Remuneration Committee noted the outcome of this year's NED appraisals process and agreed to report formally to the full Council that this information had been received.

Other Business

6.11   The Committee received a report which provided an update on changes to the membership of the Council of Governors and an update on progress with Governor elections. A verbal report was also received providing an update on progress and current timelines for the recruitment for a Non-Executive Director.

7.   RECEIPT OF THE ANNUAL REPORT AND ACCOUNTS 2020/21

7.1   The purpose of this report was to present the Council of Governors with the final draft Annual Report and Accounts 2020/21, to meet their statutory duty to "Receive the Trust's Annual Accounts and any report of the Auditor on them".

7.2   The Annual Report was Laid before parliament on 9th July and would be formally presented to the AGM taking place on Wednesday 22nd September 2021.

7.3   As done in previous years, the Trust would be arranging a briefing session for Governors to learn more about the Annual Report and Accounts, with the session led by Marcia Gallagher (Chair of Audit & Assurance Committee), Sandra Betney (Director of Finance) and a representative from our External Auditors. It was proposed that this session be scheduled at the end of August, and Governors would be notified of the date and invited to attend in due course. **ACTION**

7.4   Governors were asked to note that Marcia Gallagher has been invited to lead the next Holding to Account session at our Council of Governors meeting in September, in her role as Chair of the Audit & Assurance Committee.

7.5   The Council of Governors formally received the Annual Report and Accounts 2020/21.

8.	**BED MANAGEMENT – OUT OF AREA UPDATE**

8.1   The Council welcomed James Wright (Associate Director of Quality Assurance and Clinical Compliance) and Leon Meek (Deputy Service Director - Hospitals Directorate) to the meeting who provided the Governors with a briefing on Out of Area (OOA) Placements. This was in response to a long-standing action requested by Mervyn Dawe, Public Governor for Stroud.

8.2   **How often does an out of county placement occur?**
Current data informs us that on average at least 3 people will be placed in OOA Placements each month.

8.3   **For what reason does such a placement occur?**
Historically, the majority of OOA Placements occurred due to the requirement for more specialised care such as Psychiatric Intensive Care Units (clinical presentation). However, due to a recent surge in demand for mental health services nationally there has been an increase in Working Age Adult OOA Placements.

8.4   **What is the average cost of a stay and length of stay?**
The average daily costs of OAA Placements vary depending on the clinical requirement (PICU/Acute) but on average placements cost the Trust £50k per month.   The average length of stay for people in OOA placements is 18 days.

8.5   **Who is responsible for transport costs for the service user?**
The current transport cost to facilitate an OOA placement is funded by the Trust, but the recently observed increase in activity and the impact of this is being discussed with Gloucestershire Clinical Commissioning Group.

8.6   In terms of supporting discharge, it was noted that GHC had recently submitted a bid to the local CCG as part of the Mental Health Investment Fund to support discharge projects from hospital to prevent readmissions. GHC were awarded £477k and a number of projects have evolved, working with Voluntary sector organisations which are now operational as of 1st July 2021.

8.7   An Allied Health Professional/Peer Support: Supporting Discharge Service had been set up and early feedback from this service has been very positive from both service users and staff and has the potential to not only expedite discharges from hospital but support with reducing readmissions. Graham Hewitt noted that the service had only become operational from 1 July and asked who the feedback had been received from and some examples of what people had reported as being positive. Leon Meek said that the information had been received directly from the cohort of individuals currently being supported by the scheme. He said that people had provided feedback that this service had helped them to understand the discharge process better and had given them more confidence about being discharged. The assessing team and community teams worked with the service users and their families on the care plans and the Trust had worked with service users to co-produce information leaflets on discharge pathways and OOA placements. This feedback from service users and their direct experiences would be used to further develop services.

8.8   A pilot Hotel Discharge service had also been set up and this service has an operational policy in circulation, that could support service users leaving hospital utilising a short-term accommodation solution. Laura Bailey asked whether this service would relate more to older people. Leon Meek advised that the service supported working age adults currently, however, this had been set up as a pilot scheme so could be used as a learning opportunity to potentially expand to older age adults.

8.9   Julie Clatworthy asked about the units the Trust used to place PICU patients and sought assurance around the checks carried out. James Wright advised that most OOA placements were made with Cygnet or The Priory. The Trust had developed good working relationships with these providers; however, he offered assurance that in advance of every OOA placement, the Trust carried out assessments of quality and safety, and spoke to the hospitals directly to confirm current CQC ratings and performance. James Wright added that where possible the Trust tried to arrange placements as close to the patient's home as possible.

8.10   Ingrid Barker thanked James Wright and Leon Meek for attending and presenting to the Council. Governors were invited to contact James and Leon directly if they had any further questions about this important area of Trust work.

9.   ANY OTHER BUSINESS

9.1   There was no other business.

10. DATE OF NEXT MEETING

10.1 The next meeting would take place on Wednesday 8 September 2021 at 10.00am.

COUNCIL OF GOVERNORS
ACTIONS

Item	Action	Lead	Progress
12 May 2021			
9.1	Consideration be given to providing Governors, particularly Public Governors with ID badges and Trust email addresses for correspondence.	Anna Hilditch	**Email addresses Progressing** New user forms completed and submitted. Awaiting notification from IT.
14 July 2021			
7.3	Briefing session for Governors on the Annual Report & Accounts to be arranged, with the date circulated inviting attendance.	Anna Hilditch	**Complete**. Session taking place on 2 September 2021.

Gloucestershire Health and Care
NHS Foundation Trust

AUDIT & ASSURANCE COMMITTEE SUMMARY REPORT

DATE OF MEETING 12 August 2021

COMMITTEE GOVERNANCE	• Committee Chair – Marcia Gallagher, Non-Executive Director
	• Attendance (membership) – 100%
	• Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

INTERNAL AUDIT

The Committee received and considered the following Internal Audit Reports:

- Accounts Payable. Report Classification: Medium risk. Two medium findings, two low risk findings. The review considered the key processes and procedures carried out by the Trust in relation to the accounts payable and supplier on boarding process.

- Data Security and Protection Toolkit (DSPT). Report Classification: Low risk. One medium finding, three low risk findings and one advisory rated finding.

The Committee reviewed and was satisfied with progress being made against the internal audit plan and with implementing audit recommendations.

COUNTER FRAUD BRIBERY & CORRUPTION

The Committee received the Counter Fraud, Bribery and Corruption Progress Report which provided an update on the progress of Counter Fraud activity against the approved workplan.

It was highlighted that an exercise to consider the Trust's approach of salary overpayments was being undertaken which would be done as a countywide exercise.

The Committee was informed that the mandatory NHSI National Procurement exercise which was being rolled out by the Cabinet Office to all central organisations;
would be examining purchase order (PO) spend against non-PO spend during the pandemic and the compliance against procurement notices.

The Committee received the final report on the proactive counter fraud exercise looking at the usage of Estates Vehicles. The report set out a number of findings including that the management controls around the use of estates vehicles required review. It was reported that all recommendations had been accepted by management and implemented.

BOARD ASSURANCE FRAMEWORK

The Committee **received** and **considered** the Board Assurance Framework (BAF), providing assurance on the management of the Trust's strategic risks.
It was reported that there had been a reduction in the risk ratings for two of the risks; *Resources Targeted at Acute Care* and *National Economic Issues.*

CORPORATE RISK REGISTER

The Committee received the Corporate Risk Register and was informed of seven new risks. Seven risks had scores reduced and three risks had been closed. The Committee discussed in detail and a number of risks were referred to the relevant Governance Committee for further consideration. The Committee **noted** the information and assurance provided.

FINANCE COMPLIANCE REPORT

The Committee received the Finance Compliance Report, which provided an update on actions taken under delegated powers. The Committee received an update on progress with aged debtors.

The Committee was informed that the Better Payment Practice report for month 4 would be submitted to NHSE/I on 16 August.

STANDING FINANCIAL INSTRUCTIONS & SCHEME OF DELEGATION UPDATES

The Committee **endorsed** the proposed amendments to the Standing Financial Instructions and Scheme of Delegation which were required following changes to government procurement regulations. The amendments lowered the threshold value at which NHS Trusts must undertake a full procurement tender exercise from £181k to £122k with effect from the 16 August 2021.

ANNUAL REPORTS

The Committee received the following Annual Reports:

- **SIRO Annual Report:** The Committee took **assurance** that the Trust has effective systems and processes in place to maintain the security of information and **endorsed** the report for submission to the Trust Board.

- **Health & Safety Annual Report:** Providing assurance that the organisation has in place the processes and structures to lead Health and Safety at Work as set out by the Health & Safety Executive.

- **Security Management Annual Report:** Providing assurance that the risks associated with Security Management were being managed and mitigated. The report also highlighted the forthcoming new standards for violence prevention and reduction.

REVIEW OF THE ACTIONS ARISING FROM LESSONS LEARNED PROJECT – WOTTON LAWN

The Committee received a verbal update on the Review of Actions Arising from Lessons Learned Project – Wotton Lawn. All actions had been progressed with the majority of actions completed. It was reported that the project implementation review had been put in to place to ensure the outcomes of the original brief had been achieved.

OTHER ITEMS

The Committee:
- **Received** and **noted** the Final Internal Audit Plan 2021/22.
- **Received** and **noted** the Internal Audit Progress Report.
- **Received** and **noted** the External Audit Progress Report
- **Received** the Counter Fraud, Bribery & Corruption Annual Report, Functional Standard Return and Board Survey Report (Results).
- **Received** and **noted** the Counter Fraud Referral Benchmarking Report.

- **Received** the BAF Review against PwC Comparator Report and **considered** the areas of discussion highlighted, and **agreed** the proposed actions to take them forward through discussion at the responsible governance committee.
- **Received** the Review of External Auditor Effectiveness and **noted** the outcome of the assessment.

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:
- **Note** the contents of this summary.

DATE OF NEXT MEETING	11 November 2021

APPOINTMENT AND TERMS OF SERVICE COMMITTEE SUMMARY REPORT
DATE OF MEETING
25 AUGUST and 1 SEPTEMBER 2021

COMMITTEE GOVERNANCE	• Committee Chair – Ingrid Barker, Trust Chair • Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

25 AUGUST 2021

CLINICAL EXCELLENCE AWARDS (CEA)

The Committee received a report setting out the process and outcome from the 2019/20 CEA process. A total of 34 Consultants were eligible to apply for awards and 8 applications were received. Prior to application forms being sent out, a letter was sent to all eligible consultants from the Chair of the Trust to encourage applications, particularly from female and Minority Ethnic consultants. Support and communications were provided by the Medical Staffing department and the Director of HR and OD. Dr Amjad Uppal, Medical Director, also gave a training presentation on this to potential applicants at the Continuing Medical Education training session. The number of applications was unfortunately lower than usual; however, given the pressures of Covid this was not unexpected. Further consideration would be given to providing additional support and encouragement to applicants for future rounds. The Committee was pleased to note that those applications received were of a high standard and were representative in terms of gender and ethnicity.

The Committee reviewed the report and endorsed the Employer Based Award Committee recommendations to award the CEAs as listed, in line with the scheme.

EXECUTIVE REMUNERATION POLICY

At its meeting in March 2021, the Committee considered, and approved in principle the proposed Executive Remuneration Policy subject to consultation with members of the Executive Team. The policy aimed to provide a clear framework and ensure transparency with regard to remuneration arrangements for Executive Directors, following good practice and mirroring the national guidelines and directives set out by NHSI regarding Executive Director and VSM remuneration. This consultation had now taken place, with all members of the Executive Team having been provided with the opportunity to comment on the policy. No further amendments had been received and the Committee was therefore content to approve the policy.

EXECUTIVE DIRECTOR PERFORMANCE REVIEWS 2020/21

The Committee received a report providing a summary of the 2020/21 appraisal of members of the Trust's Executive Team which had been conducted in line with the Trust's appraisal policy. It is the responsibility of the Chief Executive to complete the annual appraisals and report to the Appointments and Terms of Service Committee. This report summarised the appraisal process, the outcome of the appraisal conversations and agreed/draft objectives for each Director. The Committee received and discussed the appraisal summaries, noting the

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key objectives set for the Executive Directors for the coming year. Assurance was received that the Chief Executive carried out regular 1:1 meetings with Executive colleagues.

EXECUTIVE DIRECTOR PORTFOLIOS

This report provided a summary of the outcome of the review of Executive Director portfolios undertaken in discussion with members of the Executive team, individually and collectively and considering recent performance review discussions. The Chief Executive informed the Committee that he was satisfied that the report clearly represented the current portfolios held by each Executive Director and that the portfolios were appropriately distributed across the team. The Committee noted that an annual review of the portfolios would be carried out.

CHIEF EXECUTIVE PERFORMANCE REVIEW 2020/21

The Committee received a report providing a summary of the 2020/21 appraisal of the Chief Executive which had been conducted in line with the Trust's appraisal policy. It is the responsibility of the Trust Chair to complete the annual appraisal and report to the Appointments and Terms of Service Committee. This report summarised the appraisal process, the outcome of the appraisal conversation and agreed objectives for the coming year.

1 SEPTEMBER 2021

RECRUITMENT TO THE POST OF CHIEF OPERATING OFFICER

The Committee received an update from the CEO on the recruitment and selection process for the new Chief Operating Officer (COO). It was reported that the post had been offered to David Noyes, subject to Fit and Proper Person and standard NHS Employment checks.

The Committee endorsed the appointment of David Noyes to the post of COO, and the remuneration package which would include access to the Trust's relocation expenses policy. It was noted that the candidate had a 6-month notice clause but that early release was being sought. A start date would be confirmed as soon as possible,

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ACTIONS REQUIRED BY THE BOARD
The Board is asked to:
- **Note** the contents of this summary.

DATE OF THE NEXT MEETING	17 November 2021

Gloucestershire Health and Care NHS Foundation Trust – **TRUST BOARD PUBLIC SESSION – 30 September 2021**
AGENDA ITEM: 22 – APPOINTMENTS AND TERMS OF SERVICE COMMITTEE SUMMARY – Aug & Sept 2021   Page 2

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RESOURCES COMMITTEE SUMMARY REPORT

DATE OF MEETING 26 August 2021

COMMITTEE GOVERNANCE	• Committee Chair – Graham Russell, Non-Executive Director
	• Attendance (membership) – 66%
	• Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

FINANCE REPORT – MONTH 4

The Committee received the Finance Report for month 4. The month 4 position was a £40k surplus with a six-month forecast of break even. The Trust had spent £0.639m to date for all covid related costs. Of this amount, £0.62m was out of the envelope expenditure. It was reported that the covid allocation was significantly higher than what was required and it was expected this would be reduced in H2. It was anticipated that this would have a significant impact on the Trust's position.

Backlog maintenance had been brought forward in order to replace schemes which had slipped. The Committee was assured there would be no high-quality impacts or significant items being moved from the current financial year and that colleagues from the Nursing, Quality and Therapies directorate had been involved in discussions regarding this.

Brokerage agreed with NHSI had agreed an additional £2m allocated to the Forest of Dean (FoD) scheme for the current financial year. Sandra Betney asked the Committee to consider whether the £2m should be used for the FoD scheme or be re-allocated to be used on backlog maintenance, and noted that this would be dependent on approvals relating to the FoD scheme,

PERFORMANCE REPORT – MONTH 4

The Committee received the Performance Report for month 4 which provided a high-level view of the key performance indicators in exception across the Trust.

Discussions had taken place at the Business Intelligence Management Group (BIMG) and it had been agreed that the Performance Dashboard would include a new section focussing on recovery going forward, and additional proxy indicators had been agreed by the Trust Board.

The Committee **acknowledged** the ongoing impact of the pandemic and service recovery on operational performance. The Committee **noted** the report as a **significant level of assurance** that the Trust's contract and regulatory performance measures were being met or that appropriate service action plans were being developed to address areas requiring improvement.

SOUTH WEST PROVIDER COLLABORATIVE LEARNING DISABILITIES AND AUTISM

The Committee received the South West Adult Secure Learning Disability and Autism Provider Collaborative report; providing the background and progression of the New Care Models agenda and development of the Provider Collaborative arrangements, specifically focussing on the South West Adult Secure Learning Disability and Autism Collaborative.

The Committee was informed that the collaborative for Adult Secure Learning Disability & Autism Services would formally go live from the 1 October 2021; subject to appropriate NHSE

approvals. It was reported that the risk share arrangement had been adjusted from 14% down to 12%. This was following the proposal to change from a weighted mental health population basis to a normalised population basis. The Committee **endorsed** the Provider Collaborative arrangements, with the caveat that how it aligned with the Gloucestershire Strategy be added prior to submission to Trust Board.

SARC TENDER UPDATE

The Committee was informed that the Trust had successfully passed the assessment process for the SARC tender; and noted that it was the only trust to do so.

The Committee welcomed the news and acknowledged that it was good news for the service. The Director of Finance informed the Committee the service would begin in April 2022.

OPERATIONAL RESILIENCE & CAPACITY PLAN (INC WINTER PLAN)

The Committee received the Operational Resilience and Capacity Plan which provided overall details of the operational resilience and sustainability plans and tools implemented through periods of service disruption be that surge, adverse weather conditions, pandemics and any other interruption requiring business continuity, escalation or enhanced preparatory plans to be put in place. The plan outlined the processes for ensuring capacity, including System level reporting. This included the out of hours arrangements and the 4x4 arrangements to ensure resilience. The Committee received the Escalation Plan, and it was noted that this was an internal document which had been developed for the first time. The escalation plan outlined the approach to internal and external escalation policies from a Trust position. The Committee was informed that the plan would be used to guide colleagues through the use of a daily assessment, capacity and the implementation of service escalation action cards. The action cards would identify triggers to escalation and actions in which the service would enact in the event of surge.

The Committee **endorsed** the three documents presented, and **noted** the contents of the operational schemes submitted to the A&E Delivery Board in priority order for system-wide support and funding. The Committee thanked the Operational Team for their work.

HR POLICIES & PROCEDURES UPDATE

The Committee was informed that the Learning and Development Policy had been agreed through the Joint Negotiating and Consultative Forum (JNCF). It was also reported the Counter Fraud and Corruption Policy and the Supporting Attendance Policy had both been updated.

OTHER ITEMS

The Committee:

- **Received** the Internal Business Plan for quarter 1, noting the huge achievement in progressing objectives to date. A proposed refresh of objectives at the end of quarter 2 was **noted**.
- **Received** and **noted** an update on the People Strategy, acknowledging the huge amount of work that had been carried out.
- **Received** and **noted** the progress with taking forwards the Staff Survey Action plan; and **noted** the results of the most recent Staff Pulse Survey, noting that the Health and Well Being Hub were considering next actions to take forward with Executive and Communication support; and **noted** the Staff FFT ratings, and took **assurance** that the Trust is continuing to engage with colleagues and progress the actions identified as an output of the 2020 Staff Survey results.
- **Received** and **noted** the Risk Register and the Board Assurance Framework

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:

- **Note** the contents of this summary.

DATE OF NEXT MEETING	28 October 2021

QUALITY COMMITTEE SUMMARY REPORT

DATE OF MEETING 02 September 2021

COMMITTEE GOVERNANCE	• Committee Chair – Maria Bond, Non-Executive Director
	• Attendance (membership) – 100%
	• Quorate – Yes

KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard for July 2021, which provided a summary assurance update on progress made and achievements of quality priorities and indicators across physical health, mental health and learning disability services.

The Committee was informed that the ligature works at Wotton Lawn had to be paused due to pressures; however, a plan was in place for this to commence again this month [September].

The Director of Nursing, Therapies & Quality reported whilst recruitment remained a significant issue, he was happy to share the news that the first mental health national recruit had landed in the country and a further circa 10 nurses would be joining Wotton Lawn.

The Director of Nursing, Therapies & Quality referred to the further decrease in CPA Compliance, detailed within the report and expressed disappointment with the lack of progress. The Committee was informed that operational colleagues were reviewing this and assured the Committee that further action would be taken to ensure compliance. The Committee would receive a further update at the next meeting.

The Committee **received, noted** and **discussed** the July 2021 Quality Dashboard Report.

CLINICAL PRESENTATION – FOSTERING AND VULNERABLE CHILDREN SUPPORT

The Committee received a clinical presentation about Fostering and Vulnerable Children Support which was presented by the Pathway Lead for Children in Care.

The Committee was informed of the Fostering Development project, which involved aiming to improve the understanding and skill bases of newly approved GCC foster carers and understanding the impact that adverse childhood experiences on the emotional and relational needs of children in care.

There would be the opportunity to share the presentation and the work done at the Mental Health Summit, which would be chaired by Ingrid Barker, Trust Chair.

The Committee thanked David Hinchcliffe, Pathway Lead for Children in Care for the presentation and praised his valuable work.

LEARNING FROM DEATHS REPORT

The Learning from Deaths Report was received, which informed the Committee of the mortality review process and outcomes for quarter 1 2021/22.

The Medical Director reported during quarter 1 2021/22, 129 Trust patients died. None of the patient deaths during the reporting period, were judged more likely than not to have been due to problems in the care provided to the patient.

This was comprised of the following numbers of deaths which occurred in each month of that reporting period.
- 37 in April
- 59 in May
- 33 in June

This report would be presented to the Trust Board in September.

EXPERTS BY EXPERIENCE IN QUALITY GOVERNANCE - UPDATE

The Committee received the Experts by Experience (EbyE) in Quality Governance update, providing a summary of learning identified by having an Expert by Experience in attendance at the Quality Committee; and also outlining the next steps for the Trust with regards to people participation.

The Committee was informed that Angela Potter, Director of Strategy and Partnerships had presented a draft proposal of the People Participation Plan at the EbyE Working Group. The Committee noted that this would be received by the Trust Board in November. Dan Beale-Cocks would be in attendance.

The Committee noted the learning obtained through having an Expert by Experience in attendance at the Quality Committee.

The Committee received assurance that the Trust was progressing an organisation-wide position with regards to people participation.

MEDICAL APPRAISAL & REVALIDATION ANNUAL REPORT

The Committee received the Medical Appraisal and Revalidation Annual Report, providing a summary of the work which had been undertaken by the Trust to support the safe provision of clinical services through the medical practitioners working to this Designated Body aligned with national policy. This report would be presented in full to the Trust Board in September.

OTHER ITEMS

The Committee:
- **Received** and **noted** the Risk Register and the Board Assurance Framework and the assurance and information provided.
- **Received, reviewed** and **noted** the information relating to quarterly patient safety incident reporting.
- **Received, noted** and **discussed** the Whole Trust Quality Management report and supported further work which was described.
- **Received** and **noted** the contents of the Quality Assurance Group summary report.
- **Received** and **noted** the Research and Development Annual report.
- **Received, noted** and **discussed** the Allied Health Professionals update for quarter 1 2021; and agreed for the report to progress to the Board.

ACTIONS REQUIRED BY THE BOARD
The Board is asked to:
- **Note** the contents of this summary.

DATE OF NEXT MEETING	04 November 2021