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NHS
Gloucestershire Health and Care
NHS Foundation Trust

# TRUST BOARD MEETING

**PUBLIC SESSION**

Thursday 29 July 2021

**10.00 – 13.30pm**

To be held via Microsoft Teams

## AGENDA

| TIME | Agenda Item | Title | Purpose | | Presenter |
|---|---|---|---|---|---|
| **Opening Business** | | | | | |
| **10.00** | 01/0721 | Apologies for absence and quorum | Assurance | Verbal | Chair |
| | 02/0721 | Declarations of interest | Assurance | **Paper** | Chair |
| **10.05** | 03/0721 | Service User Story Presentation | Assurance | Verbal | DoNTQ |
| **10.25** | 04/0721 | Draft Minutes of the meetings held on:<br>• 27 May 2021<br>• 15 July 2021 | Approve | **Paper** | Chair |
| | 05/0721 | Matters arising and Action Log | Assurance | **Paper** | Chair |
| **10.30** | 06/0721 | Questions from the Public | Assurance | Verbal | Chair |
| **Performance and Patient Experience** | | | | | |
| **10.40** | 07/0721 | Quality Dashboard Report | Assurance | **Paper** | DoNTQ |
| **11.00** | 08/0721 | Learning from Deaths Q4 | Assurance | **Paper** | MD |
| **11.10** | 09/0721 | Performance Report | Assurance | **Paper** | DoF |
| **11.25** | 10/0721 | Finance Report | Assurance | **Paper** | DoF |
| **11.35am - BREAK – 10 Minutes** | | | | | |
| **Strategic Issues** | | | | | |
| **11.45** | 11/0721 | Report from the Chair | Assurance | **Paper** | Chair |
| **11.50** | 12/0721 | Report from Chief Executive | Assurance | **Paper** | CEO |
| **12.00** | 13/0721 | Systemwide Update | Assurance | **Paper** | DoSP |
| **12.10** | 14/0721 | Quality Strategy | Approve | **Paper** | DoNTQ |
| **12.25** | 15/0721 | Estates Strategy | Approve | **Paper** | DoSP |
| **12.40** | 16/0721 | Stroud Hospital Refurbishment BC | Approve | **Paper** | DoF/COO |
| **12.50** | 17/0721 | Southgate Moorings BC | Approve | **Paper** | DoF |
| **Governance** | | | | | |
| **13.00** | 18/0721 | Audit Committee Annual Report | Assurance | **Paper** | HoCG/Audit Cr |
| **13.05** | 19/0721 | Council of Governor Minutes – May | Assurance | **Paper** | HoG |

| TIME | Agenda Item | Title | Purpose | | Presenter |
|---|---|---|---|---|---|
| **Board Committee Summary Assurance Reports (Reporting by Exception)** | | | | | |
| **13.10** | 20/0721 | Audit and Assurance Committee (26 May) | Information | **Paper** | Audit Chair |
| | 21/0721 | Appointments and Terms of Service (1 June and 16 June) | Information | Verbal | Chair |
| | 22/0721 | Charitable Funds Committee (9 June) | Information | **Paper** | CF Chair |
| | 23/0721 | Resources Committee (24 June) | Information | **Paper** | Resource Chair |
| | 24/0721 | Quality Committee (1 July) | Information | **Paper** | Quality Chair |
| | 25/0721 | Mental Health Legislation Scrutiny Committee (21 July) | Information | **Paper** | MHLS Chair |
| **Closing Business** | | | | | |
| **13.25** | 26/0521 | Any other business<br>• Quality Account Approval | Note | Verbal | Chair |
| **13.30** | 27/0521 | **Date of Next Meetings**<br><br>**Board Meetings 2021**<br>Thursday 30 September<br>Thursday 25 November<br><br>**AGM 2021**<br>Wednesday 22 September | Note | Verbal | All |

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**AGENDA ITEM: 04.1/**0721

# MINUTES OF THE TRUST BOARD MEETING

**Thursday, 27 May 2021**

Via Microsoft Teams

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

**IN ATTENDANCE:**
Laura Bailey, Trust Governor
Lauren Edwards, Deputy Director of Quality and Therapies
June Hennell, Trust Governor
Bob Lloyd-Smith, Healthwatch
Gill Morgan, Chair, Gloucestershire ICS
Kate Nelmes, Head of Communications
Rachelle Reid, PA to the Chief Executive
Lavinia Rowsell, Head of Governance/Trust Secretary
Hilary Shand, Acting Chief Operating Officer
Sydney Walsh, Strategy and Partnership Team (Mgt Trainee)

## 1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to the meeting. Apologies for the meeting had been received from John Campbell and Helen Goodey.

## 2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

## 3. SERVICE USER STORY PRESENTATION

3.1 The Board welcomed Laura Canty to the meeting, who was in attendance to speak about her personal experience of post-natal depression and the Perinatal Service, to whom she was referred in 2018.

3.2 During her first pregnancy, Laura was diagnosed with pre-eclampsia at 34 weeks and had an emergency c-section. On returning home following the birth, Laura said that she and her partner went through the “Honeymoon period” and went out for dinner, to food festivals and everything seemed great. However, 2

weeks after the birth Laura said that she started getting more and more obsessed with dirt and cleaning and she started hating the family dog being around the baby. Her environment very quickly reduced to a few chairs, not able to sit on soft furnishings and she felt unable to leave the house. One night Laura decided that she wanted to end her, or her baby's life and that she simply could not be a parent. Family encouraged Laura to see her GP after 4 weeks, and she was very quickly referred to the Crisis Team, and onward to the Perinatal team. At week 12, Laura's consultant referred her to a mother and baby unit. Laura said that there were no spaces in Bristol but she was lucky to get a place at the Barberry Unit in Birmingham. Laura was at the unit for 10 weeks before starting periods of home leave and then ultimately being transferred back to the Perinatal Team in Gloucestershire. Laura worked with Occupational Therapists at the Barberry to have a goal when she started coming home for leave, with the first time to have Sunday lunch with friends.

3.3 Laura said that this had also been especially difficult for her partner; one day he has a fiancé, a new baby and a dog, and the next he's in an empty house alone. This had a real impact on their relationship. However, Laura informed the Board that since she was discharged, happily they got married and had travelled to Australia to see her husband's family. Laura is now a very active Expert by Experience for GHC and sits on the Gloucestershire Perinatal MH Network. She said that this offered her a real opportunity to reach out to other people and to express her views and experiences. Laura had also written a book about her experiences which had been published.

3.4 Steve Alvis thanked Laura for her very impressive and professional presentation. He said that it was pleasing to hear that she received a prompt referral from the GP, but he asked whether there was anything from her experience or from hearing from other people that might improve awareness and timeliness of people picking up this illness at an early stage. Laura said that education was key. She was lucky to have received a GP appointment with someone who recognised the concerns. There were routine GP follow up appointments for new mothers, but she said that these often focused on the baby and left little time to discuss any concerns the mother may have about her own wellbeing.

3.5 Sandra Betney said she was very pleased to hear about Laura's positive experience at the Barberry Unit as she had fought for extra beds to be provided at the unit when working in her previous role in Birmingham. Sandra asked about the handover of care that Laura had experienced when coming back to Gloucestershire services. Laura said that monthly meetings would take place at the unit with her Gloucestershire MH Nurse in attendance to discuss her care and the transition arrangements back to the Perinatal Service. She said that really good communication took place and her transition was seamless.

3.6 Paul Roberts said that there were some communities that did find it more difficult to get access to services or to get diagnosed and asked Laura whether this was something that was discussed by Experts by Experience. Laura said that this was discussed, with agreement that more was needed to reach those communities, such as Army wives and deprived communities. Trish Butler said that it was important to work closely with midwives and health visitors to try and

pick up and identify people from those communities who may need more assistance. However, she said that this outreach was not always possible due to capacity within the services.

3.7 Maria Bond thanked Laura for her presentation and said that there were so many people who could relate to her experiences. Maria said that Laura appeared to have had a good experience of services but asked whether there was anything that didn't go as well. Laura agreed that she had received a fantastic service and a good experience, however, she had heard from others that hadn't been as lucky. One learning point that Laura asked the Board to take on board related to the Crisis Team. She said that this was a great service, but it was always someone different who visited her every day, and therefore no continuity of care which meant that she needed to repeat herself and tell her whole story to a new person every day which wasn't helpful given her condition.

3.8 Marcia Gallagher said that the inclusion of the slides and photographs in Laura's presentation had made such an impact. Given the Trust's links with primary care, Marcia asked if there was an opportunity to share the story with pregnant mums. Laura said that she had presented on a number of occasions but this was mainly to people in training such as midwives and GPs. She had presented on her experiences to a group of expectant mums in the Forest of Dean recently and said that she would be very happy to talk to more people.

3.9 Sumita Hutchison said that there had been some reviews carried out looking at gender equality within the NHS and how women experience the NHS. She noted an earlier point where Laura mentioned that she had requested an appointment with a new GP ("a middle-aged woman who may have had children"), who had successfully picked up her condition and ensured a quick referral. However, thinking about the first GP contact that Laura had received, the Board noted that this had been a young male locum GP. Laura said that he had asked her to give it time and "see how you go". If it hadn't been for very insistent family members Laura would not have sought a second appointment. The Board agreed that there was some very important learning as a system to take on board here.

3.10 Amjad Uppal acknowledged the point raised about the continuity of care by the Crisis Team and assured Laura that he would feed this back to the Team and ensure it was considered. Amjad said that work to improve GP training was ongoing, with particular focus on MH diagnoses. He said that there was sometimes a very fine line between the presentation of women experiencing "baby blues" and those with post-natal depression. In response to this, Amjad Uppal invited Laura to attend and present at a Monday afternoon academic programme for doctors which he felt would be hugely beneficial.

3.11 The Board once again thanked Laura for attending and speaking so openly and professionally about her experiences. 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.

## 4. MINUTES OF THE PREVIOUS MEETING HELD ON 31 MARCH 2021

4.1 The Board received the minutes from the previous meeting held on 31 March 2021. These were accepted as a true and accurate record of the meeting.

4.2 The Board also received a copy of the formal written response to the public question asked at the March Board meeting regarding the Forest of Dean Hospital development.

## 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.

5.2 Ingrid Barker noted that it had been agreed at the previous meeting to present the Gender Pay Gap annual report to the Women's Leadership Network. This would be logged as a formal action. **ACTION**

## 6. QUESTIONS FROM THE PUBLIC

6.1 The Trust had received no written questions in advance of the Board meeting. No further questions were raised at the meeting.

## 7. CHAIR'S REPORT

7.1 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 March. 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.

7.2 Following the recent annual committee evaluation process and consideration of the outcomes of an internal audit on governance, the Trust's Committee structure has been reviewed in discussion with Board Members and in the context of the Trust's new 5-year strategic framework. The following changes have been agreed:

- That a dedicated People/Workforce Committee be established
- That oversight of performance reporting remains within the remit of the Resources Committee.
- That the terms of reference for all Committees be reviewed to embed Equality Diversity and Inclusion within each Committee's remit with oversight at Board level.

The terms of reference for the People/Workforce Committee were currently being developed. The resulting governance structure will be reviewed against the aims of the strategic framework to ensure that there is a governance space for all aims with consideration of our work on Better Health and Place, and People Participation. Consideration will also be given to the relationship between the Trust's governance structure and developing plans for changes to the Integrated Care System.

7.3 Ingrid Barker informed that the Board that the Trust had received a letter from the Patron and Chair of the Veterans Covenant Healthcare Alliance (VCHA)

advising that as a result of the hard work undertaken by Jonathan Thomas, Sophie Ayre and Andrew Mills in demonstrating the Trust's commitment to the Armed Forces Covenant, the Trust has received Accreditation as a Veteran Aware Hospital which recognises the Trust's work in identifying and sharing best practice across the NHS as an exemplar of the best standards of care for the Armed Forces community. This was an excellent achievement to be recognised in this way and Ingrid Barker joined Board colleagues in recognising and thanking those named colleagues for the work carried out to achieve this.

7.4 The Board noted that the local elections had now taken place and there were some new faces in the county, at the Local Authority and a new Police and Crime Commissioner. Ingrid Barker advised that she had written to those people new in post to welcome them and to provide a brief introduction to GHC.

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

## 8. CHIEF EXECUTIVE'S REPORT

8.1 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 March.

8.2 Paul Roberts opened his report by thanking and congratulating the teams at Stroud General Hospital and Cirencester Hospital for successfully passing the JAG assessment for the Stroud Endoscopy services. The JAG accreditation is only awarded to high quality gastrointestinal endoscopy services after a rigorous assessment process. This accreditation is hugely beneficial for our services and highlights the quality of work that these exceptional teams produce. Ingrid Barker informed the Board that she would write to these colleagues on behalf of Board to congratulate them. **ACTION**

8.3 Following our approval at the March Board meeting, our new Trust Strategy was launched for 2021 to 2026. The strategy – called 'Better Care Together' – was developed in partnership with our colleagues, volunteers, people we serve, carers, members, and a wide range of other stakeholders. It is our road map for the next five years and through it we pledge to put people at the heart of our services, focusing on personalised care by asking 'what matters to you?' rather than 'what is the matter with you?'. It describes our Mission and our vision, and it also details our four strategic aims – High Quality Care, Better Health, Great Place to Work and Sustainability – each of which are underpinned by measurable, specific goals and objectives. We will be using this framework to shape the ambitions and priorities of the organisation. Paul Roberts added that it was hoped that the Strategy would start to generate the enthusiasm and excitement again from colleagues across the Trust, looking at innovation and personalisation and looking at being the best we can be.

8.4 The Oliver McGowan Mandatory Training Trial in LD and Autism launched in Gloucestershire on 1st April with over 90 people attending the training on the first day. This training is named after 18-year-old Oliver McGowan, whose tragic death in 2016 highlighted the need for health and social care staff to have better training in learning disabilities and autism. It is part of a national commitment to develop a standardised training package, and GHC was one of four national

partners appointed to co-design and co-deliver the training as part of a national pilot. All the training is fully co-designed and co-delivered with people with a learning disability, autistic people, family carers and people working within learning disability and autism services. This training is now available for all staff within GHC to register with many training dates available throughout the remainder of the year. Paul Roberts advised that ways to ensure that all Board members could participate in training was being considered.

8.5 The Board noted that GHC launched its pilot of the NHS Leadership Academy's Reciprocal Mentoring programme in late November 2019. Since then, a number of colleagues have benefited from the programme and, in particular, from their reciprocal mentoring relationship. Nationally, the Leadership Academy are reinitiating the programme with 34 Trusts across England now participating in the programme. Inevitably, COVID has impacted our ability to make the level of progress at the pace we would have liked. The Leadership Academy paused the programme for much of 2020, while the Trust itself also temporarily paused much of its training and education activity at the same time. After a soft relaunch earlier this year and the most recent session on 19th May 2021, Paul Roberts said that it would be helpful to schedule a discussion with the Board with a view to gaining an explicit recommitment to growing and developing the programme as part of our strategic ambition of being a Great Place to Work. There is now a timely opportunity to recommit and set our future strategic ambition on our approach to reciprocal mentoring. The Board supported this, and it was agreed that a future Board development session could be used to carry out further discussions.

## 9. ORGANISATIONAL PRIORITIES UPDATE

9.1 The purpose of this report was to remind and update the Board on the short-term priorities adopted in 2019 and 2020, and to recommit to the balanced approach to delivering Trust priorities in 2021/22.

9.2 When Gloucestershire Health and Care NHS Foundation Trust was launched in October 2019 following the merger of 2gether and Gloucestershire Care Services it was impossible to predict the context in which it was to operate for most of the first twenty months of its existence. This context has clearly had significant implications for the pursuit of the priorities and ambitions identified through the merger process and on operational capacity to deliver priorities beyond the Covid response.

9.3 Nevertheless, the Board agreed several short-term priorities in September 2019 and a larger number in 2020 to ensure that an achievable strategic progress was made. In November 2020 the second wave of Covid had a further and arguably more significant impact on the Trust's capacity to deliver its wider ambitions; however, despite this, good progress has been made.

9.4 Paul Roberts said that organisationally the Trust had now moved to something looking more like business as usual. There was still a delicate balance to be had between individual recovery, service recovery and ambitions and this needed to sit behind the detailed objectives.

9.5 Marcia Gallagher said that she welcomed this report and found the format of the report very helpful in clearly setting out the progress made to date. She noted that the agreement of the MH Investment standard had been challenging and asked for an update on what the actual status of this was. Sandra Betney advised that the 2020/21 MHIS programme agreed with the CCG was smaller than in a normal non-Covid year. In 2021/22 the plan was to catch up on priorities and to have a full investment programme, in addition to the MH Recovery fund and Strategic Development fund. There would be really good investment in MH this year. Sandra Betney advised that despite less investment significant progress was made in 2020/21 on areas such as IAPT and Perinatal MH services.

9.6 Ingrid Barker said that it had been really helpful to have clear visibility of where the Trust was and where it is now. There was an appetite from the Board to get on with some of the more ambitious transformation work and the recommendation for the Board to recommit to a balanced approach was therefore supported.

## 10. REGROUP, RECONNECT, RECOVER

10.1 The purpose of this report was to provide the Board with an overview of the comprehensive approach to recovery across Gloucestershire Health and Care NHS Foundation Trust following the first and second wave of the Covid-19 pandemic.

10.2 Following the undertaking of recovery clinics across all Operational Directorates, recovery plans have been agreed and formalised that take into account the need to regroup, reconnect and recover. This has identified 4 major risk/issues across the organisation that may hinder recovery and impact upon the delivery of patient care. These include Colleague Wellbeing, Demand & Capacity, Workforce and Estates. The Directorates have RAG rated their ability to recover and identified mitigation working collaboratively with partners. Hilary Shand advised that a Recovery Task Force was in place and included both operational and corporate colleagues.

10.3 Sumita Hutchison noted that much as this recovery would take time and asked how the Trust was balancing the time needed for individual recovery against the system pressures to recover. Hilary Shand said that this had been discussed and agreed that there was a fine balance to see how this would all fit together. She said that it would be helpful to receive support from the Board to enable the necessary time to recover. There was a need to enable services to take their time, and a need to pace this work so it was truly effective. However, the balance between looking after our colleagues and being able to provide timely access to services to the people we serve was recognised.

10.4 Maria Bond said that it felt like the Trust had a real grip on the systems and management in place for what was a challenging programme. Maria Bond noted that there was an increased demand for services and asked whether the Trust was providing colleagues with everything that they needed, such as the estate, IT solutions etc, to make life as easy as possible in delivering these services. Hilary Shand advised that one of the key streams of this exercise was to identify things that would help with recovery, including practical help. The

Team was proactively listening and gaining an understanding of the day to day needs of services. It was noted that the process of wider communication to staff to let them know what we were doing had started, but that there was more that needed to be done.

10.5 Maria Bond asked how she as a NED would receive information about waiting times for the different services. Sandra Betney advised that the Trust has established a monthly Health Inequalities and Waiting List Forum to review ethnicity and demographic data across mental and physical health waiting lists, and data on waiting lists was provided regularly to teams. It was planned that waiting list data would be incorporated into the performance dashboard in future once certain data quality issues had been ironed out and this would then be visible regularly to Board members.

10.6 Ingrid Barker expressed her thanks and congratulations to Hilary Shand and Sarah Birmingham for their work and the huge progress made in this area. The involvement of service users and carers in the recovery clinics was also welcomed.

10.7 The Board noted the approach being taken by the Operational Directorate in order to Regroup, Reconnect and Recover, and noted the 4 key areas identified as risk and issues across the organisation.

## 11. INTEGRATED CARE SYSTEM UPDATE

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

11.2 A Commission has been set up by Gloucester City Council and is headed by local businessman and social entrepreneur Rupert Walters. Running for a year, it aims to identify areas where it can help to improve the lives and opportunities for those who experience racism and disadvantage because of their colour. The Commission members are made up of representatives from both major institutions and from ethnic minority communities within the city and will be tasked with putting together a strategy based on the findings of the Commission. Angela Potter advised that GHC was represented by the Strategy & Partnerships Directorate. The work programme has been now agreed by the Commissioners and will consist of seven focused events that will explore or investigate a particular issue, service, or experiences. The evidence provided will be used to inform recommendations in the Commission's final report, to be shared with the city's key organisations and decision makers. This development was welcomed by the Board.

11.3 It was noted that discussions were underway with regard to a timetable to recommence formal ILP activities within the Forest, but priority work areas had continued where possible. Angela Potter said that it was pleasing to note that a new Chair for the Forest ILP had been nominated, Phillipa Lowe.

11.4 Ingrid Barker said that she welcomed the breadth of coverage within this report. Gill Morgan, Chair of Gloucestershire ICS was in attendance at the meeting and Ingrid Barker invited Gill to provide the Board with an update on current developments and plans moving forward for the ICS. This included an update on the establishment of the new Boards and appointment processes, provider

collaboratives, and key tasks of the ICS come 1 April 2022, which included the safe close down of the CCG. Gill Morgan noted the earlier report received on Regroup, Reconnect and Recover, and said that supporting the whole system to recover was seen as a top priority to ensure that we could start to develop the innovative relationships we see at the heart of the ICS. The Board welcomed this update and thanked Gill Morgan for taking the time to attend and present.

## 12. SYSTEM OPERATING PLAN 2021/22

12.1 Sandra Betney informed the Board that work was continuing on the system operating plan submission, so it was not possible to provide greater detail at this time. A discussion around the key components of the plan had taken place at the last Resources Committee. Feedback had been received as a system from NHSI, and Regional and internal meetings had taken place in time for the next submission due next week.

12.2 A fuller update would be presented to the Board at the private session meeting later in the day, and it was hoped that we would be in a position to discuss the key implications of the plan at the next Resources Committee in June.

## 13. FREEDOM TO SPEAK UP REPORT

13.1 The Board welcomed Sonia Pearcey, Freedom to Speak Up Guardian to the meeting. Sonia was in attendance to present this report and to provide assurance to the Trust Board that speaking up processes are in place and remain open for colleagues to speak up, especially in these unprecedented times of Covid-19, and that speaking up processes are in line with national requirements.

13.2 This report for Q3 & Q4 2020-21 provided an update to the Trust Board, including an overview of the cases, national and regional updates and the proactive work undertaken by the Freedom to Speak Up Guardian.

13.3 It was noted that 25 cases were raised in Q3 and 30 in Q4, with a total of 120 cases for 2020-21, an increase of 74% on 2019-20.

13.4 The Board was asked to note that 12 colleagues had reported a detrimental effect from speaking up. Qualitative feedback was actively sought, and a recurring theme raised by colleagues related to speaking up to their line manager and the negative knock-on impact of this on working relationships. Sonia Pearcey advised that a new leadership development programme had been launched and there were some key training and development sessions available for colleagues on Freedom to Speak Up and culture.

13.5 In 2020-21 nurses accounted for the biggest portion (32%) of speaking up cases raised through the Freedom to Speak Up route.

13.6 Sonia Pearcey informed the Board that GHC had been ranked in the Top 20% of NHS Trusts (36 out of 220) in the Freedom to Speak Up index, published annually looking at specific questions arising from the Staff Survey. GHC was also performing above the national average, which was excellent news.

13.7 Sumita Hutchison noted the Board's ambitions to be the best and asked about the KPIs in place for Freedom to Speak Up. With regard to KPIs, it was noted that there were some clear KPIs and the Trust also looked at those measures such as the Friends and Family Test which were gathered with feedback direct from colleagues.

13.8 Sonia Pearcey said that the majority of colleagues did feel confident speaking up and the culture was now embedded in the organisation. There were approximately 40 FTSU Champions/advocates within the Trust.

## 14. DIGITAL STRATEGY 2021-2026

14.1 The purpose of this report was to present the Board with the Trust Digital strategy for approval. The Digital Strategy is one of the key enabling strategies supporting the overarching Trust strategy.

14.2 The digital strategy presented at the meeting was an evolution of work that had taken place since May 2019. What started life as the digital framework for the merging organisation has subsequently considered feedback from many stakeholders and the consequences of the Covid Pandemic. This has radically impacted on how NHS organisations and patients think about digital and provided opportunities to move forward in many areas such as remote consultations which has been built into the updated strategy. The Trust had also engaged with Experts by Experience and ICS colleagues in developing the strategy.

14.3 The digital strategy has introduced a new digital vision and moved towards a plainer English version removing the technical language that was utilised previously. This alongside the more visual look of the strategy will hopefully support a wider organisational engagement and understanding in the digital strategy and what is trying to be achieved over the next 5 years.

14.4 Marcia Gallagher said that she was delighted to see the strategy at the Board, and the details of the Trust's ambitions. Marcia referred to funding limitations and capital availability and asked for assurance as to how the strategy would be resourced. Sandra Betney advised that in terms of capital, the Trust had a well-resourced plan for infrastructure. There was a need to get better at looking at digital as an enabler and ensuring that large projects were clear at the outset about the benefits and potential cost savings of using digital intervention, such as moving towards paperless working and reduced travel time due to the use of MS Teams for meetings.

14.5 Steve Brittan congratulated Lee Charlton and the wider team for the strategy which had moved a long way since work first commenced. He welcomed the message that this was not simply an IT strategy, it was about changing the way we work as an organisation. He said that he was fully supportive of the work being carried out and the objectives of the strategy going forward.

14.6 In response to a question from Sumita Hutchison, Sandra Betney advised that proposals were being developed to ensure that colleagues could move frictionlessly and seamlessly between Trust sites and other partner organisations and not have to worry about network coverage and access to files. She said that there were 'friction' areas but that workstreams were in place

to address and manage these. Sandra Betney added that there was an active part of the ICS looking specifically at digital inclusion, which included things such as network coverage, access and patient preference.

14.7 The Board agreed that the digital strategy was a very readable and exciting document. It was clear about the aims and objectives, in particular on the benefits for the people we serve such as personalised care, population health management initiatives and work around inequalities. The Board approved the digital strategy and once again thanked colleagues for their huge efforts in producing this.

## 15. QUALITY DASHBOARD REPORT

15.1 This report provided an overview of the Trust's quality activities for April 2021. It was noted that key data was reported under the relevant CQC Domains – caring, safe, effective, responsive and well-led. The dashboard also contained the Q4 NED Audit of Complaints and Guardian of Safe Working data.

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

- Continued focus on complaints recovery plan including a redesign of complaint pathway management and delivery of a new internal quality indicator for 21/22 regarding time to completion of complaints. Good progress was being made in managing longer waiters and two new colleagues would be joining the Complaints team in the coming month. It was acknowledged that there were delays, however, feedback from complainants and the recent NED Audit of Complaints demonstrated that the quality of complaint investigations and the handling of complaints was of a high standard.

- Continued NTQ led focus on the prevention, identification and management of Pressure Ulcers building upon the lessons learnt from recent quality improvement work. This now includes targeted support and education into Community Hospitals.

- Appraisal rates have a slow recovery rate and additional work is being undertaken. Ongoing focus on recovery of mandatory training rates with particular attention on resuscitation and restrictive practices. Additional scrutiny of the effectiveness of the planned activity recovery work will be required via Quality governance structures.

- Significant pressures on mental health beds for both children and adults is noted and requiring additional support and management to address. The Director of Nursing, Therapies and Qualities (NTQ) has commenced additional work with Commissioners on this matter.

- Ongoing workforce vacancy pressures are noted with particular attention required for in-patient mental health areas. The Director of Human

Resources & Organisational Development is leading work on the matter. The NTQ team are leading work on international recruitment solutions and this is gaining pace.

15.3 Those Quality issues showing positive improvement:

- CPA recovery work has enabled further progress against the target with a 1.7% increase in month with the overall validated performance figure being 94.1% (0.9% from target).
- Greater understanding and identification of services requiring support with PU management as detailed within the dashboard. Early indicators are positive that this is an improving area
- There is ongoing improvement in staff Covid-19 vaccination rates with good progress made on closing the gap for BAME colleagues (67%)
- 149 compliments received regarding care provided by the Trust in April – above monthly average
- International Recruitment: 25 new physical health nursing colleagues are in the process of joining the Trust. 3 new mental health nursing colleagues are joining with additional recruitment underway in this area. The Trust has received additional funding to be part of a national project to develop direct entry into community services for international recruits.

15.4 John Trevains informed the Board that work was taking place with the Business Intelligence Team and future Quality Dashboards would include data around high-risk waiters to enable the necessary scrutiny and oversight of this important area.

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

## 16. PATIENT SAFETY REPORT – QUARTER 4

16.1 The Board received the Patient Safety Report for the period January to March 2021 which provided high level information with regard to patient safety incidents reported through the Trust's Datix Incident Reporting System. The report provided a summary of mental health and physical health Patient Safety Incidents reported during Quarter 4 2020/21, a summary of the prevalence of patient safety incidents by categories including level of investigation and provision of data for Mental Health and Learning Disability Hospitals, Physical Health Community Hospitals, MIIUs and community teams for mental health and physical health by quarter, demonstrating change.

16.2 The Board was asked to note that the Patient Safety Team aim to review 10% of the No and Low Harm Patient Safety Incidents. This has not always been achieved, particularly in Q2 due to redeployment of some of the team due to Covid-19. However, significant progress has been achieved during Q3 and Q4. In Q4 a total of 373 low and no harm incidents were reviewed (12.2%).

16.3 Amjad Uppal informed the Board that there had been 5 Mental Health and 1 Physical Health SIRIs reported during Q4 and a high-level summary of these incidents was presented.

16.4 Marcia Gallagher said that she welcomed the new format of the patient safety report. However, as a Non-Executive Director she said that she struggled to understand the direction of travel for patient safety. Referring to the prevalence of falls at Stroud hospital for example, she said that it would be helpful to include comparisons to be able to assess whether the position was deteriorating or improving. The Board agreed that it would be helpful to include trends within the report, as well as improved triangulation of data, and contextualisation such as the inclusion of bed numbers. **ACTION**

## 17. PERFORMANCE DASHBOARD

17.1 Sandra Betney presented the Performance Dashboard to the Board for the period April 2021 (Month 1 2021/22). This report provided a high-level view of key performance indicators (KPIs) in exception across the organisation. In opening the report, Sandra Betney encouraged Board members to focus on the Business Intelligence Team update included within the report, which set out the key infrastructure developments taking place over the coming months, which offered good assurance.

17.2 At the end of April, there were 8 mental health key performance thresholds and 13 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.

17.3 In mental health services, it was noted that Eating Disorder (ED) Services accounted for three indicators and two are within Children and Young Person Services (CYPS). The ED service continues to face major performance challenges due to a high number of referrals and high vacancy rate. The perinatal exception is similarly due to a higher referral rate, staff sickness and the eased induction of new staff. Recovery is however expected within the month through bank staffing support. The Board was assured that the Executive Team continued to closely monitor and review the service challenges, and a further focus on Eating Disorders would be provided to the Resources Committee.

17.4 There were 4 workforce performance indicators in exception this month that apply across the Trust. A manually produced visualisation presenting additional workforce activity indicators has been prototyped, however further tactical conversations need to be held in developing this presentation with data source owners to ensure reader value. Additionally, further data metrics such as Pulse survey results, annual leave consumption and agency usage needs to be incorporated. An early working draft is to be presented to Resources Committee in June 2021.

17.5 The Board was asked to note 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 is being resolved. These had not been highlighted for exception. A briefing paper outlining a proposal to manage ‘proxy’ indicators for 2021/22 is in final draft and would be presented at the next Resources Committee in June 2021.

## 18. PROVIDER LICENCE DECLARATIONS

18.1 In order to comply with NHSE/I regulatory requirements, the Board is required to make a number of declarations each year regarding compliance with the Trust's provider licence and the systems and processes for ensuring such compliance. The Board also needs to confirm that the Trust has and intends to keep in place systems and processes to implement appropriate standards of corporate governance. The individual declarations comprise:

- Corporate Governance Statement
- Governor Training declaration
- Systems for Compliance with Licence Conditions declaration

18.2 The Board's declarations must be made having regard to the views of Governors. Lavinia Rowsell advised that the appendices to this Board report were provided to the Governors at their Council meeting on 12 May. The Governors noted the report and no concerns were raised in respect of the systems and processes for compliance with licence conditions.

18.3 The Board received this report and supported the recommendations to:

a) Have regard to feedback received from Governors in respect of these declarations
b) Agree to make a declaration confirming compliance with each of the statements listed in the Corporate Governance Statement.
c) Agree to make a declaration of 'Confirmed' in relation to the Governor training declaration.
d) Agree to make a declaration of 'Confirmed' by the due date of 31 May in respect of systems for compliance with licence conditions (Condition G6) for the financial year just ended
e) Agree to publish on the Trust website the declaration in respect of systems for compliance with licence conditions (Condition G6) by 30 June.

## 19. CHANGE TO THE TRUST CONSTITUTION

19.1 As part of the recent Governors Review and Refresh work, the Council of Governors and the Trust Board supported the proposals around changes to the composition of the Council, in particular with regard to the reduction in Staff Governor positions. The revised composition and subsequent change to the constitution was approved at the November Council of Governor and Trust Board meetings.

19.2 The Medical, Dental and Nursing staff constituency reduced from 4 posts to 3 and this took effect from 1 January 2021. There is a provision within our constitution which states that of the 3 seats within the Medical, Dental & Nursing staff class – 1 must be reserved for a nurse, 1 for a doctor and 1 for a doctor or dentist. This specific provision about reserved seats was not updated at the time to accurately reflect the revised composition and meant that the Trust could only ever have 1 nurse representative on the Council. A small amendment to the constitution was therefore suggested, to ensure that one of the 3 seats was open to all staff within that constituency to apply.

19.3 The Board approved the revision to the Constitution and noted that the equivalent paper to this one had also been considered and approved by the Council of Governors at its meeting on 12 May 2021.

## 20. USE OF THE TRUST SEAL – QUARTERS 3&4 2020/21

20.1 The purpose of this report was to provide information to the Trust Board on the use of the Trust Seal, as required by the Trust's Standing Orders.

20.2 The Board noted that the Trust seal had been used 4 times during the reporting period October 2020 – 31 March 2021 (Q3 & Q4 2020/21).

## 21. MINUTES FROM THE COUNCIL OF GOVERNORS MEETING – MARCH 2021

21.1 The Board received and noted the minutes from the Council of Governors meeting held on 10 March 2021.

## 22. BOARD COMMITTEE SUMMARY REPORTS

### 22.1 Forest of Dean Assurance Committee

The Board received and noted the summary report from the FoD Assurance Committee meeting held on 16 April 2021.

### 22.2 Mental Health Legislation Scrutiny Committee

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

The Board was asked to endorse the reappointment of MHA Manager Ivars Reynolds until 31st March 2024. It was noted that the reappointment was made via the normal reappointment process of completion of self-assessment forms and two peer review forms, followed by a personal development review with Steve Alvis, Non-Executive Director. This endorsement was given.

### 22.3 Resources Committee

The Board received and noted the summary report from the Resources Committee meeting held on 29 April 2021.

### 22.4 Audit and Assurance Committee

The Board received and noted the summary report from the Audit and Assurance Committee meeting held on 6 May 2021.

### 22.5 Quality Committee

The Board received and noted the summary report from the Quality Committee meeting held on 11 May 2021.

## 23. ANY OTHER BUSINESS

23.1 There was no other business.

## 24. DATE OF NEXT MEETING

24.1 The next meeting would take place on Thursday 29 July 2021.

**Signed: ……..…..** **Dated: ……**

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

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**AGENDA ITEM: 4.2**

# MINUTES OF THE EXTRAORDINARY TRUST BOARD SESSION

**Thursday 15 July 2021**

Via Microsoft Teams

**PRESENT:**
Ingrid Barker, Trust Chair
Paul Roberts, Chief Executive
Sandra Betney, Director of Finance
Angela Potter, Director of Strategy and Partnerships
Dr. Amjad Uppal, Medical Director
Dr. Stephen Alvis, Non-Executive Director
Graham Russell, Non-Executive Director
Sumita Hutchison, Non-Executive Director
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
Steve Brittan, Non-Executive Director

**IN ATTENDANCE:**
Anna Hilditch, Assistant Trust Secretary
Lavinia Rowsell, Head of Corporate Governance/Trust Secretary
Kate Nelmes, Head of Communications
Margaret Dalziel, Acting Deputy Chief Operating Officer
Matt Blackman, Communications Manager
Andrew Paterson, Strategic Project Manager
Kevin Adams, Associate Director of Estates, Facilities and Medical Eqmt
Sally Clark, Executive PA to Director of Strategy and Partnerships
Chris Witham, Lead Governor
John and Mary Thurston, Friends of Lydney Hospital
Ken Brown, Forest Locality Reference Group
Caroline Smith, Gloucestershire CCG
Ellen Rule, Gloucestershire CCG
Cllr Terry Hale, Forest of Dean District Councillor
Albert Weager, Chair, Forest Health Forum
Bob Lloyd-Smith, Gloucestershire Healthwatch
Chris Brown, CEO, Forest Voluntary Action Forum

## 1. WELCOME AND APOLOGIES

1.1 The Chair welcomed everyone to this extraordinary meeting of the Trust Board. Apologies for the meeting had been received from Helen Goodey and Hilary Shand.

## 2. DECLARATIONS OF INTEREST

2.1 There were no new declarations of interest.

## 3. QUESTIONS FROM THE PUBLIC

3.1 The Board was asked to note that four 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.

**QUESTION 1** - Albert Weager, Chair, Forest Health Forum (received 12th July)

**My concerns are about ventilation adequacy. I am told plans incorporate existing regulations. My question is, are these up to standard having regard to COVID-19 and its transmission capability.**

*The Trust has employed Mechanical and Electrical consultants to support the design of the ventilation system at the proposed new hospital. This work will be completed with full consideration of ventilation requirements in light of Covid -19 with input from our Trust infection control specialists.*

*The detailed design work is currently being undertaken and will reflect latest guidance and best practice in infection prevention and control to ensure that the Air Handling Units are capable of providing the appropriate level of filtration and air exchanges at all times. The relevant national guidance, Health Technical Memorandum – HTM 03 parts a and b, was updated last week so we will be taking account of the latest national standards and learning from Covid-19.*

*The level of ventilation and air exchange requirements differ for individual parts of the hospital and the system will take full account of this. So for example – in our new endoscopy unit we will need to provide at least 10 air exchanges per hour and for it to be run under negative pressure system whilst the ward areas will have a slightly different level with at least 6 air changes per hour and negative pressure is not required.*

*Additionally, the Trust, through its Infection Prevention and Control development work is linking in with a national project at Leeds University on Covid ventilation studies and air handling to ensure we are using the best evidence and date guidance for our proposed new hospital*

**QUESTION 2 -** Brian Pearman (received 13th July)

**Regarding the Cinderford site I understand that there have been issues re GCC Highways traffic and water run off/potential flooding from the EA. The topography of the site has resulted in a move from a single storey building with all its benefits to a double storey building. Planning permission may not be as straightforward to justify your high level of confidence. Why was this site approved, including transfer of Dockham Rd health centre, relocating the skate park, and re-providing the MUGA, when it meant such a compromise to the design of the building. A site could have been provided free of charge in Lydney, already allocated in the Local Plan for employment, easy access from the A48 bypass and access to all major services.**

*The previous engagement work committed to taking forward the development of an independent Citizen Jury process to determine the location of the new hospital within the Forest. The recommendation from the Jury was for that the hospital should be located in Cinderford. This decision was accepted by the former GCS Trust Board and the Clinical Commissioning Group in August 2018.*

*At this point, although we were aware that there were potential sites in other parts of the Forest (and indeed 3 potential sites had been identified in Lydney) the option appraisal for sites was focused on those in Cinderford in line with the decisions made.*

*We undertook a detailed option appraisal to compare this site to any others available at the time in Cinderford and have provided details of the criteria used in this process in Table 5 in the Full Business Case itself. We believe that the selected site was (and remains) the best available site in the Cinderford area when considered against the key criteria specified by the Jury.*

*When entering into the land transaction we undertook a process of 'desk top' due diligence – looking at the recorded site information, as would be normal for any property purchase. This has subsequently been followed up by further invasive site investigations once we owned the site so we now understand in detail things such as the pre-existing mineworking and have been able to have dialogue with organisations such as Severn Trent Water who have advised on their expectations regarding water attenuation and drainage requirements to deal with the topography of the site and with the Highways agency regarding new access routes to the site.*

*These discussions could not have happened at the earlier stages of the process as we did not have all of the information regarding the size of the new hospital or the technical information obtained from our site investigation work. This process would have been the same for any site that we purchased. We also recognise that any site in the Forest of Dean could have presented similar or different challenges as is typical in any development of this size and scale.*

*Whilst there are benefits of a single storey option (including reduced circulation space from the removal of stairwells and lifts) in some ways this can result in longer distances between departments and also results in the need for central courtyards to allow natural light into rooms. With less internal rooms and a more compact design the two storey option provides a more effective solution in this regard.*

*With regard to planning permission we of course take nothing for granted. We have however appointed a planning consultant to support this element of the work and have worked closely with the planning authority to seek their views and understand the pre-requisites to any application.*

*In terms of the broader transfer of Dockham Rd health centre, relocation of the skate park, and upgrading of the MUGA, these were conditions applied to the site by stakeholders including Sports England and Cinderford Town Council which we were happy to support as public sector partners. We believe that each, in time, will add value to the community. The MUGA will be available year-round, the skate park will be in a more central location in Cinderford and benefit from lighting and the town council can utilise the Dockham Road premises to create a town centre green zone.*

**It also seems that compared to earlier anecdotal estimates of the cost of the new hospital the real cost has risen significantly.**

*There has been a considerable passage of time since the early estimates were undertaken and the current costings have been based on market rates, soft market testing and quotations and quantity surveyor judgement. Construction costs have risen dramatically over recent years for both materials and labour and building inflation has been driven by both Brexit and Covid. The costs in this business case reflect the latest market position and any scheme taken forward would be subject to the same market conditions.*

**What is estimated to be the value of the current Lydney and Dilke sites on the open market, and will any sums raised remain in the Forest or go into the County pot?**

*The Net Book Value (NBV) of the two existing hospital sites is £4.4m. The cash proceeds will be determined on sale and it is likely to be lower, although this depends on the market at the point of sale. The sale proceeds, currently estimated at £1.5m, contribute to the Trust's cash which funds the capital programme including the costs of the new hospital in full. Under current NHS guidance we are allocated a Capital Delegated Expenditure limit (CDEL) and the amount of cash we can spend has to be matched with a CDEL allocation.*

**In terms of Net Zero Carbon targets no account has been taken of the patient miles that will be required to access the hospital from Lydney and the Southern Forest where the bulk of the population increase is taking place. Apparently ignored by the Citizens Jury!**

*We did not do a total travel or sustainability estimate for all journeys as we do not have access to all the data necessary. We do recognise that for some, the new hospital will result in an increased travel distance whilst for others there may be a reduction in travel and benefits from increased reliability and service sustainability will hopefully also reduce journeys to services outside of the Forest. This would be the case for where-ever we placed the new hospital. We have appointed a transport consultant – Cotswold Transport Planning to work with us on developing our Travel Plan which whilst initially focuses on staff will also consider the sustainability and travel impact to the public.*

*The new hospital itself will deliver significant carbon reductions based on the modern heating and ventilation system.*

**On a general note I am concerned that the Lydney Hospital will close to facility the opening of the Cinderford building before any improvements take place to Primary Care in the town which is already under severe stress, and with a population likely to increase to approximately 16,000 in the next few years.**

*GHC has maintained a commitment that the current range of services provided at Lydney 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 CCG is working with primary care partners to take forward the development of improved primary care facilities 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 know we anticipate a new centre may open in 2025. Up to that point all existing health centre, and all its current community services run by GHC will continue to operate once the new hospital has opened.*

*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 3** - Sylvia Francis, West Dean Parish Council (Received 14th July)

**Will there be any eye clinics based at the new hospital as this is quite important for the older generations in the Forest of Dean community?**

*Gloucestershire Hospitals NHS Foundation Trust currently provide ophthalmology activity in the existing hospitals and we have therefore planned on the basis that this will continue to be provided in the new facility. In light of all the changes to delivery models for outpatient activity and some services taking forward more virtual activity we will be confirming with GHT the exact service provision closer to the opening of the new facility.*

**QUESTION 4** – John Thurston (Received 14th July)

**1 (a) There will be a gap in the service provision before the new hospital opens**

**(b) currently despite many rumours and consultations there are no concrete plans for either the service to be provided let alone the site or plans to build or people to run the necessary facilities in a new south Forest Medical Facility. There is an estimated date of 2025, which even if everything goes to plan is a gap of at least a year or two.**

**In absence of any other deliverable solution, we request that services continue to be provided from the existing (excluding inpatients) facilities at Lydney Hospital.**

*GHC has maintained a commitment that the current range of services provided at Lydney 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 Trust's business case is focused on the building of the new hospital and its case for change continues to demonstrate that a range of workforce and resilience benefits are achieved by continuing to develop the new hospital. It also assumes that disposal proceeds from the existing sites are required to support the capital programme which funds the new hospital. As such, it is not possible for the Trust to make the requested commitment.*

*The CCG is working with primary care partners to take forward the development of improved primary care facilities 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, as you mentioned we anticipate this new centre may open in 2025. Up to that point all existing health centre services, and all the current community services run by GHC from that facility will continue to operate once the new hospital has opened.*

*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*

**2 (a) As the relative costs between the options have changed was the initial decision still optimal?**

*The decision to move to a single hospital site was not solely based on costs, it included a range of other issues in the case for change as follows;*

- *More consistent, reliable and sustainable community hospital services eg. staffing levels, opening hours*
- *A wide range of community hospital services, including beds, accommodation to support outpatient services and urgent care services*
- *Significantly improved facilities and space for patients and staff*
- *Services and teams work more closely together*
- *Better working conditions for staff and greater opportunities for training and development to recruit and retain the best health and care professionals in the FoD.*

*The full range of these benefits cannot be achieved from working across both existing sites and any refurbishment we took forward would still result in a sub-optimal solution against many of the criteria identified. As such, we maintain that the single site solution remains the optimal way forward to best meet the case for change objectives identified.*

*It should also be noted that the costing figures referred to are not comparable. Building inflation and changes to the construction market have had a significant impact on the costs within the*

*business case and the other figures have not been refreshed and are therefore not at today's prices.*

**(b) should a more cost-effective site be found to suit the new local demographics?**

*The previous engagement work committed to taking forward the development of an independent Citizen Jury process to determine the location of the new hospital within the Forest. The recommendation from the Jury was for that the hospital should be located in Cinderford. This decision was accepted by the former GCS Trust Board and the Clinical Commissioning Group in August 2018.*

*We undertook a detailed option appraisal to compare this site to all others available at the time in Cinderford and have provided details of the criteria used in this process in Table 5 in the Full Business Case itself. We believe that the selected site was (and remains) the best available site in the Cinderford area when considered against the key criteria specified by the Jury.*

**(c) Notable that the reduction in annual premises cost is only £100k**

*Further clarification on this question would be sought from the questioner in order to provide a response.*

3.2 The Board noted that a further question had been received shortly before the meeting from Cllr Jeremy Charlton Wright. Due to timescales, it had not been possible to consider a response to this in advance of the meeting. However, assurance was given that a full formal response to all the questions received for this meeting would be provided in due course.

3.3 Ingrid Barker thanked those people who had submitted questions, and those in attendance at the meeting for their interest and engagement throughout.

## 4. FOREST OF DEAN HOSPITAL FULL BUSINESS CASE

4.1 Paul Roberts introduced this item by once again welcoming those people who had joined the meeting today and thanking them for their contributions in helping to shape the thinking about the future of health services in the Forest of Dean.

4.2 The new Hospital represented a major investment in healthcare infrastructure which was much needed in the Forest of Dean. It was recognised that there had been some contention about the developments, but since the key decision made some time ago to build one new hospital to replace the two existing sites in the Forest, Paul Roberts said that he felt that this business case set out a workable and affordable scheme that would be of huge benefit to the local population. He said that this was an exciting and overdue investment.

4.3 Paul Roberts advised that as a community trust, GHC did provide hospital services, but it was important to note that the emphasis was increasingly on the services that we provide for people in or close to their own homes.

4.4 Paul Roberts provided assurance that the whole development process had received robust scrutiny and challenge throughout, from partner organisations, key stakeholders, and Trust colleagues. A dedicated FoD Assurance Committee was established to oversee the development of the Business Case and had ensured that strong governance processes were in place.

4.5 Steve Brittan, Chair of the FoD Assurance Committee advised that due to the strategic importance of this development, it was agreed that sufficient time needed to be given to

review, scrutinise and challenge the proposals being put forward. The FoD Assurance Committee was set up 5-6 months ago and has drilled down into the detail of the design, site and highways considerations, risks to budget and value for money. The Trust through this committee had worked collaboratively with partners and appointed contractors to get to the final business case position.

4.6 Angela Potter presented the full Business Case to the Board. She started by thanking colleagues for the huge amount of work, time and effort that had been carried out to get to this final position, work which had been taking place over a number of years.

4.7 The Full Business Case (FBC) seeks approval for Gloucestershire Health & Care (GHC) NHS Foundation Trust to invest £23.9m in the development of a new community hospital to serve the people in the Forest of Dean. The scheme is funded from Trust's capital programme which is funded through cash reserves and the disposal proceeds of the Dilke and Lydney Hospital sites. This FBC represents the culmination of over five years of planning and preparation and is a significant step change in the ability to provide a modern, fit for purpose environment and enhanced service facilities for the people of the Forest and beyond.

4.8 Investment in this new facility will enable the re-provision of services, and subsequent closure of the existing two community hospitals, namely Lydney & District Hospital and the Dilke Memorial Hospital when the new hospital opens in 2023.

4.9 The new hospital is considered a key part of the wider system investment proposed in the Forest of Dean to address primary and community infrastructure needs. This investment will ensure that the Forest of Dean services support the delivery of place-based integrated care as part of the One Gloucestershire Integrated Care System's (ICS) plans.

4.10 This FBC is developed in line with the 5-case model as per HM Treasury guidance and includes the following sections:

**Section 1 - The Strategic Case** sets out the strategic context and the case for change, together with the supporting investment objectives for the scheme. The Case for Change remains consistent with that outlined within the Outline Business Case which was previously approved by Gloucestershire Care Services NHS Trust Board and builds on the extensive engagement and consultation processes that have taken place in relation to this programme. Five strategic investment objectives have been identified as part of this FBC.

**Section 2 – The Economic Case** demonstrates that the preferred option and associated investment meets the future needs of the service and demonstrates value for money (VFM) from the investment made. A Comprehensive Investment Appraisal (CIA) model has been completed which has confirmed that a cost to benefit ratio of 4.08 has been demonstrated confirming that the preferred option offers good value for money when compared with the business as usual option.

**Section 3 - The Commercial Case** demonstrates that we have taken a considered and viable approach to the procurement of our construction partner, Speller Metcalfe which was completed utilising the Gloucestershire County Council (GCC) procurement framework. We have worked collectively to develop a detailed schedule of accommodation and associated design that has undergone rigorous confirm and challenge and been the subject of soft market testing for pricing and cost packages. This has led to the development of the not to be exceeded price (NTBEP) for the construction elements of the costings at £16.5m excluding VAT with the overall value of the FBC at £23.9m including VAT. A clear schedule of works is in place to move this to a Guaranteed

Maximum Price (GMP) by November 2021 and there is an agreed construction contract structure to be entered into at this point.

**Section 4 – The Financial Case** confirms the Trust has the necessary funding arrangements to take forward this business case and support its five-year capital plan which includes the Forest of Dean new community hospital. Revenue affordability has been modelled and confirmed as affordable and we have confirmed that approval of this FBC will not have a negative impact on the overall financial standing of the Trust.

**Section 5 – The Management Case** demonstrates that the Trust has the appropriate governance arrangements in place to deliver the new hospital to time, quality and budget through the oversight of the Programme Board and the Forest of Dean Assurance Committee.

4.11 Angela Potter advised that the FBC demonstrates that the preferred option being taken forward from the OBC delivers a viable and affordable solution to meeting the requirements laid out in the case for change. The Trust has been presented a NTBEP price from its construction partner, Speller Metcalfe and we have confirmed that these costs are affordable from a capital and revenue perspective. The economic modelling demonstrates that the scheme offers good VFM when compared to business as usual. It is recognised that the business case is a multi-year scheme and that future year's capital envelopes are only released on an annual basis therefore we do not know the 22/23 or 23/24 position at this point in time. We have confirmed the associated phasing expenditure within our FBC and can confirm that the anticipated cost plan is within the available cash but that future capital envelopes will continue to pose a potential risk to the Trust.

4.12 The FBC was therefore commended to the Trust Board for approval to enable the progression of developing a new community hospital in the Forest of Dean. Following Trust Board approval this FBC will be shared with the ICS Board for wider consideration and support.

4.13 The Board noted that the Trust had reviewed the final costings for the scheme against the NHSEI approval thresholds contained within the Capital regime, investment and property business case approval guidance for NHS and FT providers. The scheme falls above the threshold for a material transaction and therefore we will continue dialogue with NHSEI colleagues as to next steps within their processes.

4.14 Ingrid Barker thanked Angela Potter on behalf of the Board for preparing and presenting this report and opened it up for Board questions before moving to consider the recommendations.

4.15 Graham Russell asked for top line assurance about the affordability of the project. Sandra Betney advised that extensive cash modelling had been carried out regularly. Assurance was received that the Trust would still have a capital buffer after the agreed expenditure for the forest hospital which could be used for maintenance and unexpected requirements.

4.16 Marcia Gallagher asked about access to the new hospital and asked for an outline of the work that had taken place to consider transport arrangements. Angela Potter said that the Trust had been working with the CCG on linking with local bus companies and looking at extensions to current bus routes and timetables. The new hospital would have a bus stop located adjacent to the site. Car parking facilities, electric vehicle charging points and secure cycle sheds had also been built into the plans. Cotswold Transport Planning had been commissioned to look at a travel plan, and the Trust would also be working with Forest voluntary driver schemes. Angela Potter acknowledged that transport was one of

the biggest concerns for Forest residents. She added that the Trust would continue to lobby transport providers.

4.17 Steve Alvis made reference to the benefits of having more staff located on one site, such as better facilities, interaction, clinical governance arrangements and resilience of care. Angela Potter added that a Clinical skills lab would be built as part of the hospital design which would mean that staff could carry out their training on site. Neil Savage said that colleagues had been involved throughout the design process and had been consulted with regard facilities, rest areas etc.

4.18 Sumita Hutchison referred to environmental sustainability and asked how the Trust could ensure that it was taking on board all national guidance. Angela Potter said that the Trust worked closely with its construction partner who had strong expertise in this area and would continue to undertake energy modelling and ensure that the design incorporated aspects such as solar panels and sustainable construction materials which would all work towards the Trust's net zero carbon targets.

4.19 Maria Bond referred to pricing and said that it was good to see a contingency built in of £800k. She asked whether this was a general contingency or if it was for something specific. It was noted that some of this would be used in case of any planning adjustments or additional works by Severn Trent.

4.20 Maria Bond noted that the hospital was now planned to be a 2 storey building, having moved away from the original single storey design. She asked whether the Trust had carried out any dialogue with the planners since this change had been made and whether there had been any issues raised. Angela Potter advised that the Trust had employed a planning consultant and that there continued to be dialogue with the local planners and no areas of significant concern had yet been raised. The current plans had also been shared with local residents and no negative feedback had been received. Angela Potter informed the Board that further stakeholder engagement would be carried out on the actual design of the hospital, and feedback received from previous engagement events would be taken into account.

4.21 Jan Marriott noted that community hospitals were still highly valued in Gloucestershire, and she asked that consideration be given around how the Trust could ensure that the "soul" of the 2 existing sites could be retained.

4.22 Steve Brittan asked how the business case had evaluated the benefit to the local community. Sandra Betney said that the Economic Case had been prudent and had not included the wider societal benefits. However, it was noted that the new hospital development would be using the local labour market including apprentices, local materials, and the local supply chain.

4.23 Graham Russell noted that the design incorporated single rooms with ensuite facilities and asked for the rationale behind this. John Trevains advised that most new hospital builds were moving in this direction rather than having "bays" as there was increased patient safety, dignity and patient flow, as well as improved infection control measures. It was noted that patients also often preferred single rooms.

4.24 Marcia Gallagher referred to the disposal of the Dilke and Lydney Hospitals, noting that the net book value was £4.4m. She asked about the feasibility of selling these sites and whether there was any concern about timing. Angela Potter said that the Trust was working with local stakeholders to try and understand local aspirations for future use. Discussions would continue.

4.25 The Board received and considered the recommendations set out in the report, and fully supported the following to:

- **Approve** the Full Business Case (FBC) for the development of a new community hospital in the Forest of Dean at a value of £23.9m and the confirmation that this is affordable in both capital and revenue terms.
- **Confirm** that this decision will result in the closure and relocation of services from the existing Dilke Hospital in Cinderford and the Lydney and District Hospital in Lydney when the new hospital opens in 2023.
- **Approve** the next phase of design development and the commitment of the associated expenditure in order to progress the detailed design and planning application through a Pre-Construction Services Agreements (PCSA) with our construction partner Speller Metcalfe at a value of c£925k + VAT.
- **Note** that scheme falls above the threshold for a material transaction and dialogue with NHSEI and ICS colleagues will continue as to appropriate next steps
- **Note** that the process to complete and submit the full planning application process will be taken forward on approval of this FBC

4.26 Ingrid Barker expressed her thanks again to colleagues for the huge amount of work and time that had been spent carefully considering and developing this business case. This decision marked a significant milestone to developing a fantastic new facility for the people of the Forest of Dean. The Trust would continue to work closely with stakeholders moving forwards to further develop specific plans, designs and service provision.

## 5. FOREST OF DEAN ASSURANCE COMMITTEE SUMMARY

5.1 The Board received and noted the summary report from the Forest of Dean Assurance Committee which had taken place on 23 June.

## 6. ANY OTHER BUSINESS

6.1 There was no other business.

## 7. DATE OF NEXT MEETING

7.1 The next meeting would take place on Thursday 29 July 2021.

**Signed: ……..** **Dated: ……**

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

# TRUST BOARD PUBLIC SESSION: Matters Arising Action Log – 29 July 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 | Action Description | Assigned to | Target Completion Date | Progress Update | Status |
|---|---|---|---|---|---|---|
| 27 May 2021 | 5.2 | Gender Pay Gap annual report to be presented at the Women's Leadership Network | Sandra Betney | 29 July | Complete | |
| | 8.2 | Ingrid Barker to write thanking and congratulating the teams at Stroud General Hospital and Cirencester Hospital for successfully passing the JAG assessment for the Stroud Endoscopy services. | Ingrid Barker | 29 July | Complete | |
| | 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 | September | Q1 Patient Safety report to reflect additional information when presented to the Board in September | |

**AGENDA ITEM: 07/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 2021**

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

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

**SUBJECT:** **QUALITY DASHBOARD – June 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 GHC Board members with a summary assurance update on progress and achievement of quality priorities and indicators across physical health, mental health and learning disability services.

**Recommendations and decisions required**

Board members are asked to:

- **Receive, note** and **discuss** the June 2021 Quality Dashboard

**Executive summary**

This report provides an overview of the Trust's quality activities for June 2021. This report is produced monthly for Board, Quality Committee and Operational Delivery and Governance Forum for assurance.

**Quality issues for priority development**

- 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
- There were 4 post-48-hour Clostridium Difficile (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 by IPC to understand in greater detail and this work will be reported upon when results are available.

- 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.

**Quality issues showing positive improvement**

- 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. The number of PU's in category 1&2 has decreased by 1, however, the numbers in Category 3 have increased by 6 with Category 4 reducing by 1. Further detail relating to occurrences is detailed within the dashboard. Early indicators are positive that this is an improving area and that initiatives taken to reduce PU's are effective.
- '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 1st$^{nd}$ dosage of vaccinations for Clinical staff being 82% and 72.8% for 2$^{nd}$ dosage.
- The sickness rolling average indicator was maintained under threshold of 4% this month.
- International Recruitment: 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.

**Are Our Services Caring?**

Board will note that 11 complaints were received in June which is the same as the previous month. Actions associated with the complaint's recovery plan continue with the number of complaints open for 10-12 + months reducing again this month. The 2 remaining 12 months plus complaints were finalised in month, these cases were very complex and involved a number of different teams, with one case relating to services in Hereford. This month 100% of complaints received in June 2021 were acknowledged within the 3-day target timeframe, thus returning this indicator to the desired 100% threshold. This month FFT levels of satisfaction remain below the 95% threshold but maintain their 2% points increase made in year to stay at 94% thus matching the 20/21 outturn and are improved on the 2019/20 outturn.

**Are Our Services Safe?**

Board are asked to note that incident reporting rates have reduced this month by 115 incidents and the percentage of patient safety incidents meeting moderate, severe and death thresholds decreased to 7.66% providing assurance that there was a marginal uplift in data last month rather than an increasing trend line, this will be kept under review.

**Are Our Services Effective?**

Board are asked to note that we have agreed Trust Quality Priorities for 2021/22 and these are now presented in the dashboard. Good progress continues to be made towards achieving the set targets within the National Childhood Measurement Programme which is on target to conclude at the end of the academic year. The Child and Adolescent Mental Health Services have completed a small-scale evaluation of the waiting list and have plans to implement a 'Waiting List Support Clinic'. This will be in addition to the triage service and the signposting already in situ to support demand.

**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 and plans are in place to re-open MIIU at the Vale next month.

**Are Our Services Well – Led**

Overall statutory and mandatory training compliance has dropped marginally this month to 88.3%. Restrictive Physical Intervention training continues to be an area of focus and is showing gains month on month this financial year. Appraisal training has shown a small increase this month and risen to 76.2% with sickness rolling 12-month rate being under the 4% threshold for the 2nd month running. There is continued focus on staff health and wellbeing with July being "Be Kind to Yourself month". This month we present the latest Guardian of Safe Working report (GOSW) to provide assurance and an evidence-based report in relation to the working hours and practices of junior doctors within the Trust.

**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 and bi-monthly reports to Quality Committee |

| | |
|---|---|
| **Appendices:** | |

| | |
|---|---|
| **Report authorised by:**<br>John Trevains | **Title:**<br>Director of Nursing, Therapies and Quality |

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

# Quality Dashboard 2021/22

# Physical Health, Mental Health and Learning Disability Services

**Data covering June 2021**

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

# Executive Summary

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?**

Eleven complaints were received in June, the same as the previous month and comparable to year on year data. The number of complaints open for 10-12 months continues to reduce in line with the recovery work and temporary reallocation of resources. The 2 remaining 12 month plus complaints were finalised in month, these cases were complex and involved a number of different teams, with one case relating to services in Hereford. At time of writing there are no 12 month plus complaints waiting 100% of complaints received in June 2021 were acknowledged within the 3-day target timeframe, thus returning this indicator to the expected 100% threshold. This month's FFT levels of satisfaction were still below the 95% threshold but maintain their 2% points increase made in year to stay at 94% thus matching the 20/21 outturn and improved on the 2019/20 outturn.

**Are our services SAFE?**

The number of incidents reported this month has decreased on the previous month. The percentage of patient safety incidents meeting moderate, severe and death thresholds has also decreased to 7.68%. There are currently 7 active SIRIs. Enhanced detail is provided again this month regarding ongoing developments to improve pressure ulcer management and there are continuing indicators of improvement in this area. We are pleased to report that zero C-19 deaths were reported by GHC inpatient services during June. There were no new cases of C-19 detected in GHC in June . As of 30/06/21, 82% of patient facing GHC staff have received their first vaccination for C-19 and 72.8% have received their second. Systems remain in place to vaccinate all eligible inpatients and vulnerable service users. We are reporting 4 Clostridium Difficile cases in June 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?**

This dashboard includes the new report for the 201/22 quality priorities. In 20/21 Trusts were not required to agree with commissioners quality priorities. whilst this requirement has not returned for 21/22, alongside the absence of CQUIN's, NTQ have set a range of priority indicators to support ongoing quality improvement and assurance in the Trust for the wellbeing of the patients we care for. Indicators and measures are being developed in Q1 &2 with services to report performance in Q's 3&4. Early Intervention and IAPT services continue to perform above threshold. The National Childhood Measurement Programme has recommenced and good progress is now seen towards achieving targets of 95% of children measured by the end of the academic year - Cumulative target (July 2021). The occupied bed days for "inappropriate" out of area Mental Health placements in June has increased to 200 days which relates to 10 patients. There has been a significant surge in demand for inpatient beds in month with increased levels of acuity and dependency observed amongst inpatients which has has resulted in a shortage of bed availability, this is reflected regionally and nationally. We are working with voluntary community partners to facilitate enhanced discharge support and a task and finish group with associated action plans to improve Adult Mental Health admission and discharge pathways is underway led by the Director of NTQ. 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 plans to implement a 'Waiting List Support Clinic'. This will be in addition to the triage service and the signposting already in situ to support demand.

**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 with zero reported in June, set against the challenges of increased demand for Community Hospital beds. Following agreement at the Health Overview and Scrutiny Committee Tewkesbury MIIU reopened on the 1st April 2021 and it is planned that the Vale MIIU will re-open on mid August 2021 with Dilke remaining closed . 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 a focus on scheduling reviews and ensuring the clinical systems are updated to reflect activity and improve data quality. Team managers are raising compliance with teams, assisted by Business Intelligence reports, and setting weekly schedules with early warnings for reviews that are due. In line with system partners and an easing of national lockdown requirements our inpatient units have enabled increased visiting, recognising the importance of human contact to patients whilst maintaining appropriate measures to keep everyone safe. The quality team is supporting operational colleagues regarding access pressures in services , as reported through resources committee.

**Are our services WELL LED?**

Overall statutory and mandatory training compliance has marginally declined this month to 88.3%. Due to C-19 disruption, Resuscitation and Restrictive Physical Intervention training continues to be an area of focus. There is monthly exception reporting in place for recovering training compliance. The focus on Physical Intervention training shows continued improvement month on month and the focus going forward will be on the areas with lower compliance and ensuring the improvements achieved are maintained. Appraisal compliance has increased again this month to 76.2% against a target of 90%. There is continued emphasis on appraisal completion over the coming months, including the re-introduction of appraisal training. Sickness absence levels have maintained their green RAG rating as they have remained at 3.9%. Staff health and wellbeing remains a priority. There is an informative portal in the staff intranet and this July is featured as, " Be Kind to Yourself Month". There are many activities for staff to engage with which are being delivered by virtual methods which included: On line cookery demonstration, Pilates, Yoga, Horticulture ,Mindfulness, Spiritual Care, Menopause issues, Diversity and Fitness taster sessions. Registered Nurse international recruitment continues with a total of 31 RGN's being appointed and 11 have now arrived in the UK. Further interviews for mental health nurses will take place in July. This month the latest Guardians of Safe working (GOSW) report statistics have been included that show there were 4 exceptions in period reported upon . This report is intended to provide the Trust's Quality Committee and Board with an evidence based report on the working hours and practices of junior doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

## Quality Priorities – 2021-2022 – (1)

Despite no national or local commissioning requirements for formal Trust quality priorities set within the Trust quality schedule for this year (due to national Covid-19 disruption impacts) we have agreed with our Trust Board to set the following 9 GHC Quality Priorities. This is to facilitate an ongoing focus on quality for the organisation to improve care for the people we seek to serve in Gloucestershire. Since the last update to Trust Board there has been further development of the quality priorities following on from the quality seminar and reflects work that was undertaken in quarter 1. In quarter 2 further work will develop and agree a range of metrics/thresholds using baseline assessments in order to inform our progress over quarter 3 & 4 (H1 & H2 are the reporting cycles for NHSE/I)

| | NHSE/I Reporting Period | H1 | | H2 | |
|---|---|---|---|---|---|
| | Quality Priority - GHC Reporting Period | Q1 | Q2 | Q3 | Q4 |
| 1 | Pressure ulcers (PUs) - with a focus on reducing incidence and severity through improvement in the recognition, reporting, and clinical management of PUs. Developing a PU collaborative within the One Gloucestershire Integrated Care System. | | Develop and agree metrics and/or threshold from baseline assessments | % Improvement on PU 1-4 | % Improvement on PU 1-4 |
| 2 | Falls prevention – with a focus on reduction in medium to high harm falls based on 2020/21 data. Developing a falls collaborative within the One Gloucestershire Integrated Care System. | | Develop and agree metrics and/or threshold from baseline assessments | % Reduction on medium to high falls | % Reduction on medium to high falls |
| 3 | End of Life Care (EoLC) – with a focus on refreshing the collaborative One Gloucestershire approach to improving EoLC across the county. This will support the 6 ambitions for Palliative and End of Life Care. This will include improving systems to identify those eligible using the Supportive and Palliative Care Indicators Tool (SPICT), improving the access to advance care planning and the ReSPECT V3 form, and increasing symptom management training for staff to support non-cancer patients. | | Develop and agree metrics and/or threshold from baseline assessments | % Improved fidelity to EoLC Pathway | % Improved fidelity to EoLC Pathway |
| 4 | Patient and Carer Experience – with a focus on incrementally reducing the time taken to provide a final response letter to people who have raised a formal complaint about Trust services. Improvement in completion times will be achieved quarter on quarter. | | Develop and agree metrics and/or threshold from baseline assessments | % Reduction in PCET response rates & resolution times | % Reduction in PCET response rates & resolution times |
| 5 | Friends and Family Test (FFT) – with a question to ask people for their views on the quality of their care, as highlighted in our 2020 CQC Adult Community Mental Health Survey action plan. | | Develop and agree metrics and/or threshold from baseline assessments | Develop FFT additional questions - quality of care | Increase our CQC Adult Community Mental Health Survey score |

## Quality Priorities – 2021-2022 – (2 )

Continued from previous page.

| | NHSE/I Reporting Period | H1 | | H2 | |
|---|---|---|---|---|---|
| | Quality Priority - GHC Reporting Period | Q1 | Q2 | Q3 | Q4 |
| 6 | Reducing suicides – with a focus on incorporating the NHS Zero Suicide Initiative, developing strategies to improve awareness, support, and timely access to services. We will work to the aspirations of the Zero Suicide Alliance to support the aim for zero suicides within our mental health inpatient units by 2022. | | Outline and agree workplan with the Southwest Partnership which will also look at AWOL etc | Staged implementation NHSE/I mandated Zero Suicide Plan for inpatient MH servies | Finalise 6 stategies of implementation and review patient safety data |
| 7 | Learning disabilities – with a focus on the Hospital/Personal Passport utilisation, and roll out of the Oliver McGowan Tier 1 and Tier 2 training programme. The Trust aims to train 90% of our workforce (circa 5000 people). | | Develop and agree metrics and/or threshold from baseline assessments | Tier 1 uptake improvement circa 50% | Tier 1 uptake improvement circa 90% |
| 8 | Children's services - transition to adult services with a focus on ensuring a safe and prompt transfer between services, developing pathways, standardising practice, and reducing delays in care. Fidelity to the care pathways will be evaluated through participation in the NCEPOD study. | | Develop and agree metrics and/or threshold from baseline assessments | Engage NCEPOD Study | NCEPOD Study result |
| 9 | Embedding learning following patient safety incidents – with a focus on sharing and learning from experiences and investigations to develop and improve standards of care. This will be measured through the numbers of post investigation embedding learning workshops delivered and the number of lessons learned bulletins issued. Alongside Implementation of the Civility Saves Lives initiative, with assurance measured against the project implementation goals and evaluation over the reporting period. | | Develop and agree metrics and/or threshold from baseline assessments | 5 completed embedded learning events | 8 completed embedded learning events |

# Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**COVID-19** (Whole Trust data, reporting nationally mandated Covid-19 focused safety and activity information)

| No | | Reporting Level | Threshold | 2020/21 Outturn | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar | 2021/22 YTD | R A | Exception Report? | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No of C-19 Inpatient Deaths reported to CPNS | | N-R | | 66 | 0 | 0 | 0 | | | | | | | | | | 0 | | | N/A |
| Total number of deaths reported as C-19 related. | | L-R | | 161 | 0 | 0 | 0 | | | | | | | | | | 0 | | | N/A |
| No of Patients tested at least once | | N-R | | 2004 | 281 | 298 | 306 | | | | | | | | | | 885 | | | N/A |
| No of Patients tested C-19 positive or were admitted already positive | | N-R | | 322 | 0 | 0 | 0 | | | | | | | | | | 2 | | | N/A |
| No of Patients discharged from hospital post C-19 | | N-R | | 271 | 9 | 0 | 0 | | | | | | | | | | 10 | | | N/A |
| Community onset (positive specimen <2 days after admission to the Trust) | | N-R | | 30 | 0 | 0 | 0 | | | | | | | | | | 0 | | | N/A |
| 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 | | | N/A |
| Hospital onset (nosocomial) probable healthcare associated -HOPHA (Positive specimen 8-14 days after admission to the Trust) | | N-R | | 10 | 0 | 0 | 0 | | | | | | | | | | 0 | | | N/A |
| 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 | | | N/A |
| No of staff and household contacts tested | | N-R | | 3123 | 65 | 76 | 342 | | | | | | | | | | 485 | | | N/A |
| No of staff/household contacts with confirmed C-19 | | L-R | | 323 | 0 | 0 | 28 | | | | | | | | | | 28 | | | N/A |
| No of staff self-isolating: new episodes in month | | L-R | | | 34 | 40 | 153 | | | | | | | | | | | | | N/A |
| No of staff returning to work during month | | L-R | | | 29 | 30 | 100 | | | | | | | | | | | | | N/A |
| No staff GHC who received Covid-19 vaccine first dose | | | | 4046 | 17 | 8 | 8 | | | | | | | | | | 33 | | | |

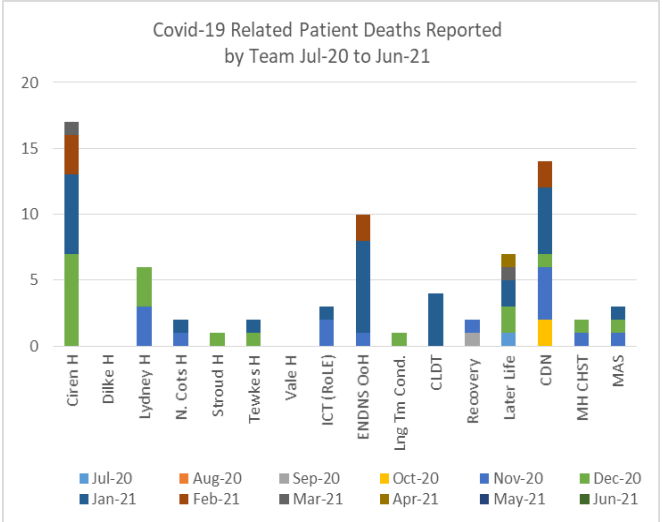
## Additional Information

### Patient Reporting

The number of Covid-19 (C-19) related inpatient deaths remains at zero for the third consecutive month with zero inpatient deaths meeting criteria for national reporting to CPNS being reported in April - June 2021. The number of community patient deaths reported as C-19 related also continues as zero. C-19 related patient deaths since July 2020 by team/hospital site are shown in the chart opposite, previous year data being included for comparison. One Gloucestershire NHS partners have agreed to declare a countywide serious incident for HOPHA and HODHA Covid-19 cases in our hospitals in response to NHSE/I guidance. The GHC Executive Sponsors for this are Amjad Uppal and John Trevains, a core project team has been established, HOPHA and HODHA Covid-19 cases at the Trust have been identified and the level of harm as a result of acquiring Covid-19 is being established for each case. Once levels of harm are known our Duty of Candour responsibilities will be better understood and the Trust's next steps can be planned for.

### Staff Testing

The number of staff and household contacts tested increased by 266 in June however the associated number for staff and household contacts testing positive only increased by 28 . There was similar increases in the number of of new episodes of staff self isolation which were increased by 113 and numbers of isolating staff returning increased by 70 cases in June compared to the previous month .



## COVID-19 - KEEPING PEOPLE SAFE – VACCINATION PROGRAMMES

- June data - 82 % “frontline” workforce received first vaccine; with 72.8% having received their second.
- 68% BAME colleagues received first vaccine and 61% received their second as at 30/06/2021 .
- 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 second dosages in case of a 3rd wave and Variants of concern .
- 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.
- Total ‘active’ bank staff is 857 – 350 of them have had their 1st jab (41%) and 302 their 2nd (35%). However, not all 857 will have worked even if they are ‘active’ and many will have had their vaccinations elsewhere, which has not fed through to reporting system

**Validated Data as of 30-6-2021**

| ROLE | TOTAL NUMBER June 2021 | 1ST VACCINE (up to 30/06/21) | % | 2nd VACCINE (up to 30/06/21) | % |
|---|---|---|---|---|---|
| All doctors/dentists | 128 | 111 | 87 | 97 | 75.8 |
| All qualified nurses, including students | 1467 | 1205 | 82 | 1063 | 72.5 |
| All other professional qualified staff | 775 | 651 | 84 | 597 | 77.0 |
| Support to clinical staff | 1755 | 1413 | 81 | 1245 | 70.9 |
| **TOTAL GHC CLINICAL STAFF** | **4125** | 3380 | 82 | 3002 | 72.8 |
| NHS infrastructure staff | 482 | 354 | 73 | 298 | 61.8 |
| **TOTAL GHC WORKFORCE** | 4607 | 3734 | 81 | 3300 | 71.6 |

## **COVID-19 - KEEPING STAFF SAFE** (Are services well led?)

**Personal Protective Equipment (PPE) and home testing**

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.

**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 directed us to use transparent masks but with additional guidance for colleagues on the considerations that they should have when determining if to use transparent masks. This is currently drafted as an action card and will be shared with NTQ senior leads for comment.

**Lateral flow (Asymptomatic testing)**

There has been a decision at a national level to move the provision of lateral flow kits to an 'individual pull' model. This means that colleagues will request their own lateral flow kits (7 tests at a time) to be delivered to their own home, collect from a test centre or a pharmacy. They will report these results via the national reporting tool. GHC will be provided with the number of test kits reported (as a total) and the number of tests reported (including results). The risks are that the process of ordering could result in reduced use of lateral flow. The Trust will also lose its oversight of the reporting process which will reduce the need for the weekly SITREP (stock team and incident team as backup) and reduced need for processes of receipt, storage and distribution of kits (stock team) but as yet, we don't know when or how the data from national submissions will be provided to GHC. There are currently 725 boxes of lateral flow in stock and we plan to utilise all of these (plus ensure that stocks that have been provided to teams but not yet provided to individuals) before moving to the individual pull model and gain learning from other Trusts through the Asymptomatic Testing Cell (regional).

**FFP3 fit-testing**

GHC Fit test compliance is now at 91%. The fit tester/co-ordinator has been recruited and commences her post in early August with bank fit test resource being available until end of July. The Trust have received a letter from the Department for Health outlining steps to be taken (below). Although this letter was directed to Acute Trusts, GHC will work towards delivering these steps. This will, at an operational level be co-ordinated by the Fit tester/co-ordinator within the stock team with a proposal on the governance arrangements to be described in a ' GHC Fit Test Strategy' to be shared with John Trevains by the end of July for comment, discussion and eventual endorsement.

1. Identify an FFP3 resilience lead/champion within the trust and develop an implementation plan
2. If not already doing so, start using ESR to record all fit testing outcome and usage data at an individual level. This should include all historical data and be updated with any new changes.
3. Increase the number of masks an individual is fit tested too and ensure the different masks are available to the user to wear interchangeably
4. Implement and support a fit testing solution to enable to above principles to be achieved for all existing staff and new staff who will be users of FFP3s.
5. Monitor progress against the above principles

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## 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 | | | | | | | | | | 4838 | | | |
| | % of respondents indicating a positive experience of our services | N - R | 95% | 94% | 92% | 94% | 94% | | | | | | | | | | 93% | | | |
| | Number of Compliments | L - R | | 1478 | 149 | 123 | 129 | | | | | | | | | | 401 | | | |
| | Number of Concerns | L - R | | 390 | 41 | 34 | 37 | | | | | | | | | | 112 | | | |
| | Concerns escalated to a formal complaint | | | 14 | 1 | 3 | 4 | | | | | | | | | | 8 | | | |
| | Number of Complaints | N - R | | 83 | 11 | 11 | 11 | | | | | | | | | | 33 | | | |
| | Number of open complaints (not all opened within month) | | | | 76 | 79 | 82 | | | | | | | | | | | | | |
| | Percentage of complaints acknowledged within 3 working days | | 100% | 96% | 73% | 91% | 100% | | | | | | | | | | 88% | | | |
| | Number agreeing investigation issues with complainant | | | | 15 | 17 | 13 | | | | | | | | | | | | | |
| | Number of complaints awaiting investigation | | | | 4 | 0 | 2 | | | | | | | | | | | | | |
| | Number of complaints under investigation | | | | 10 | 15 | 21 | | | | | | | | | | | | | |
| | Number of Final Response Letters being drafted | | | | 44 | 43 | 45 | | | | | | | | | | | | | |
| | Number of Final Response Letters awaiting final check before Exec sign-off | | | | 3 | 1 | 1 | | | | | | | | | | | | | |
| | Number of complaints closed | | | | 7 | 9 | 8 | | | | | | | | | | 24 | | | |
| | Number of re-opened complaints (not all opened within month) | | | | 5 | 6 | 6 | | | | | | | | | | | | | |
| | Current external reviews | | | | 4 | 4 | 4 | | | | | | | | | | | | | |

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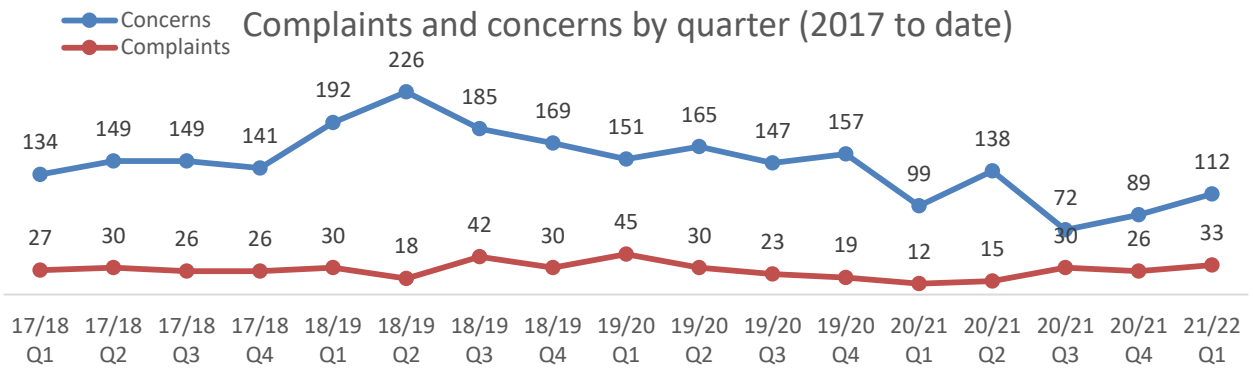
RAG Key: R – Red, A – Amber, G - Green

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

**Complaints, concerns and compliments**

- The average number of complaints received in June over the past four years is **8**. In June 2021 we received **11 complaints**.
- In June 2021, **8** complaints were closed: **1** was withdrawn, **1** was upheld, **3** were partly upheld, and **3** were not upheld
- **37** concerns were raised in June 2021, which is slightly more than the monthly average of 32 concerns during 2020/21.
- **129** compliments were received in June 2021, which very slightly more than the monthly average of 123 during 2020/21.




*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 will be undertaken in July 2021.

**Satisfaction with complaints/concern processes**

- **6** active re-opened complaints
- **36** concerns were closed in June 2021, **4** of which were escalated to a complaint

**External review**

- There are currently **4** complaints with the PHSO for external review.
- PHSO reviewed a complaint from 2019 and devised an action plan for the Trust to complete. All actions have now been completed, including an action related to carers assessments. Trust wide learning was shared June 2021's Patient Safety Report.

## 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.
- **100%** of the 11 complaints received in June 2021 were acknowledged within the 3-day target timeframe.

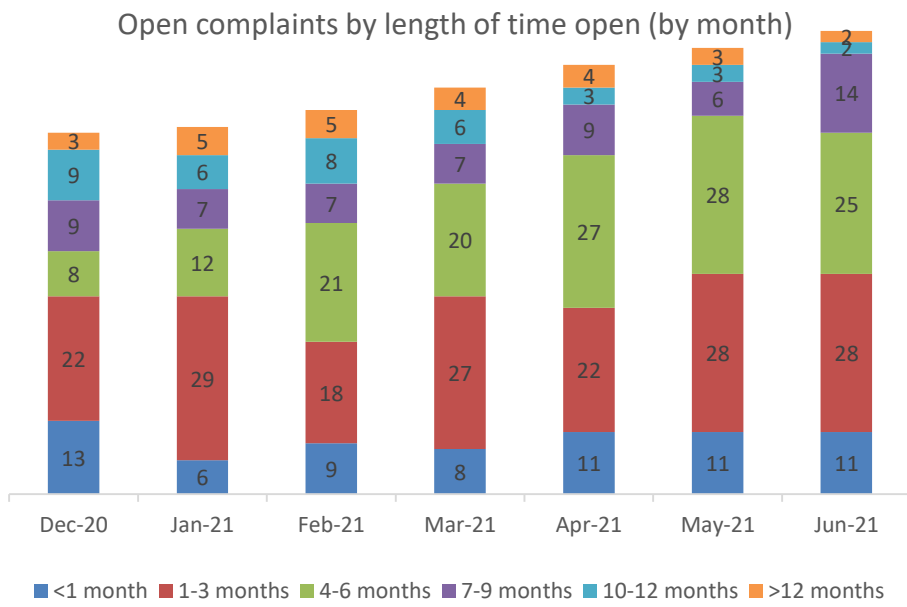
- Of the **82** open complaints, **9** do not have agreed response times. Of these:
  - **5** are in the very early stages of the complaint process and issues have not been agreed and so timeframes have not yet been set
  - **4** are complaints being managed by other NHS organisations, for which we are providing input/comments.

- Of the **73** complaints with agreed response dates:
  - **27** are within the agreed timeframe
  - **46** have exceeded the initially agreed timeframes, and of these:
    - **2** responses were due during the national pause
    - **44** responses were due following the end of the pause – 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 opposite shows the timeframes for all open complaints, inclusive of the 3 month national pause (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. 1 of these new post commenced duties in June 2021, second appointment anticipated in August 2021.

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.



## 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 | | | N/A |
| | Number of Serious Incidents Requiring Investigation (SIRI) | N - R | | 39 | 4 | 3 | 1 | | | | | | | | | | 8 | | | N/A |
| | Number of Serious Incidents Requiring Investigation (SIRI) where Medication errors caused serious harm | N - R | | 1 | 1 | 1 | 0 | | | | | | | | | | 2 | | | N/A |
| | Number of Serious Incidents Requiring Investigation (SIRI) regarding falls leading to fractures | N - R | | 3 | 0 | 1 | 0 | | | | | | | | | | 1 | | | N/A |
| | Number of Serious Incidents Requiring Investigation (SIRI) regarding pressure ulcers | N - R | | 2 | 0 | 0 | 0 | | | | | | | | | | 0 | | | N/A |
| | Number of Serious Incidents Requiring Investigation (SIRI) regarding suspected suicides | N - R | | 15 | 3 | 1 | 1 | | | | | | | | | | 5 | | | N/A |
| | Number of Serious Incidents Requiring Investigation (SIRI) regarding self harm or attempted suicide | N - R | | 10 | 0 | 0 | 0 | | | | | | | | | | 0 | | | N/A |
| | Number of Serious Incidents Requiring Investigation (SIRI) regarding mental health homicides | N - R | | 0 | 0 | 0 | 0 | | | | | | | | | | 0 | | | N/A |
| | Total number of Patient Safety Incidents reported | L - R | | 12474 | 985 | 1185 | 1070 | | | | | | | | | | 3240 | | | N/A |
| | % incidents resulting in low or no harm | L - R | | 93.41% | 92.99% | 91.05% | 92.34% | | | | | | | | | | 92.07% | | | N/A |
| | % incidents resulting in moderate harm, severe harm or death | L - R | | 6.59% | 7.01% | 8.95% | 7.66% | | | | | | | | | | 7.93% | | | N/A |
| | % falls incidents resulting in moderate, severe harm or death | L - R | | 2.75% | 1.10% | 2.17% | 2.78% | | | | | | | | | | 2.06% | | | N/A |
| | % medication errors resulting in moderate, severe harm or death | L - R | | 0.83% | 0.00% | 1.64% | 0.00% | | | | | | | | | | 0.58% | | | 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 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | | N/A |

| | | | |
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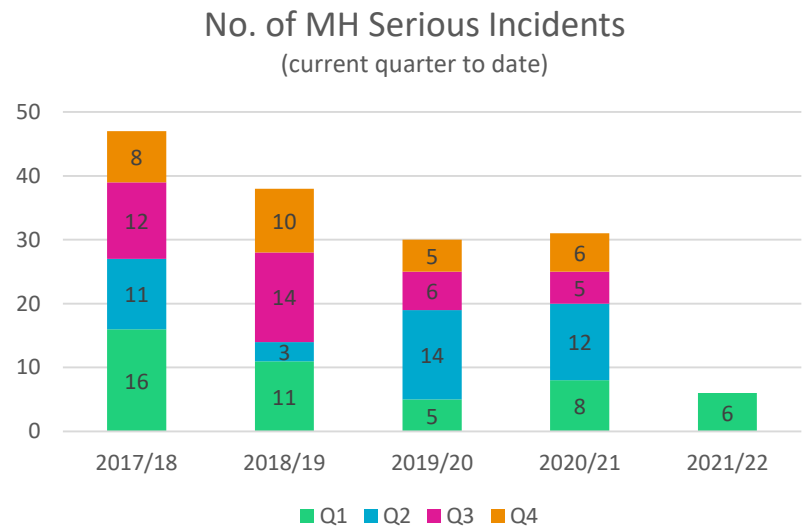
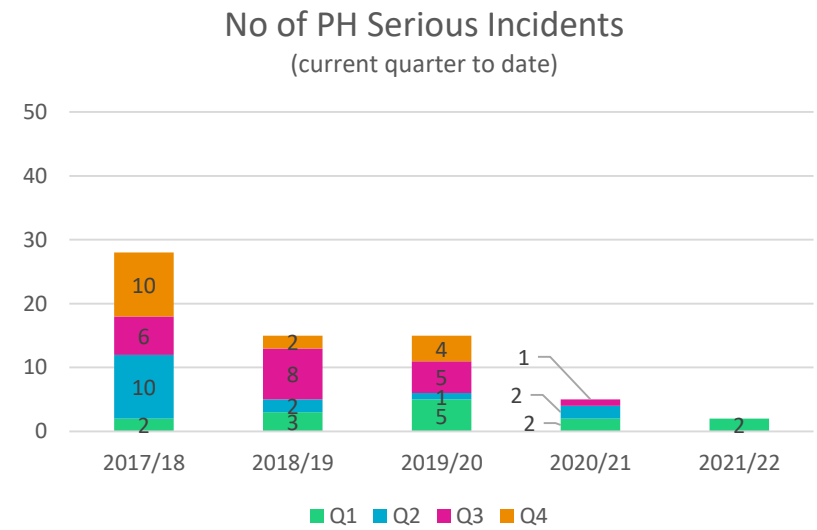
## CQC DOMAIN - ARE SERVICES SAFE? – additional information

One SIRI was declared in June 2021, a Forest of Dean Recovery Team patient. 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 will analyse and report significant departures from benchmarking trends. 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.




There are 7 active SIRIs. Two active SIRI investigation are likely to complete outside of statutory time frames. An extended submission date for both final report have been agreed with commissioners, citing (1) complexity and (2) engagement with the family of the deceased at a pace to suit them rather than the process. 3 SIRI final reports, (2 mental health and 1 physical health), were completed and submitted to commissioners during June 2021.

Regarding all patient safety incidents:

- The total number of patient safety incidents reported decreased from May 2021 (1185) to June 2021 (1070).
- The percentage of patient safety incidents resulting in moderate or severe harm and death decreased from May (8.95%) to June (7.66%).
- The percentage of falls resulting in moderate and above levels of harm increased from May (2.17%) to June (2.78%). 1 moderate and 1 severe harm fall were reported in May and 3 moderate harm falls and no severe harm falls were reported in June.
- The percentage of medication incidents resulting in moderate and above levels of harm decreased from May (1.64%) to June (0.00%).
- To note, there have been some minor adjustments to total numbers of patient safety incidents for previous months due to reclassification of some incidents following review by operational managers and/or the Patient Safety Team. These adjustments did not substantially change the percentages reported against different levels of harm.

# Quality Dashboard

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% | 98.8% | 98.8% | | | | | | | | | | 98.0% | G | | |
| | Number of post 48 hour Clostridium Difficile Infections (C Diff) | N | 1 | | | 2 | 4 | | | | | | | | | | 6 | R | | |
| | Number of C Diff cases (days of admission plus 2 days = 72 hrs) - avoidable | N | 0 | | | 0 | 0 | | | | | | | | | | 0 | N/A | | |
| | Number of MRSA Bacteraemia | N | 0 | | | 0 | 0 | | | | | | | | | | 0 | N/A | | |
| | Total number of developed or worsened pressure ulcers | L - R | 61 | 797 | 84 | 66 | 70 | | | | | | | | | | 220 | R | | |
| | Total number of Category 1 & 2 Acquired pressure ulcers | L - R | 56 | 698 | 75 | 58 | 57 | | | | | | | | | | 190 | R | | |
| | Number of Category 3 Acquired pressure ulcers | L - R | 0 | 70 | 8 | 5 | 11 | | | | | | | | | | 24 | R | | |
| | Number of Category 4 Acquired pressure ulcers | L - R | 0 | 29 | 1 | 3 | 2 | | | | | | | | | | 6 | R | | |

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

4 post 48-hr Clostridium Difficile (C. Diff) cases were detected in June. The cases were identified at Coln ward, Jubilee ward at Stroud , North Cotswold Hospital and Abbey ward at Wotton Lawn. The post infection meetings have not yet taken place in relation to these incidents, however, are planned as per protocol. There has been an noticeable increase in C. Diff toxin positive nationwide, GHNHSFT have also had an increase in the number of cases .The Infection Prevention and Control team are reviewing 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.

The Trust has reported fewer skin integrity incidents this month and there are a reduced number of pressure ulcers considered avoidable under our care. 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' described within the previously shared improvement plans for Gloucester and Forest & TNS, the community managers from Forest & TNS & Gloucester are sharing their progress with the remaining Integrated Community Team (ICT) managers and are leading the work to embed this across all ICT's. The Clinical Pathway Lead (CPL) has continued to host educational webinars highlighting PU categorisation and encouraging an interactive approach from participants and active feedback. Attendance at a national conference has expanded networks and evidenced the national increase in incidence and severity of PU's . This aligns with our regional involvement in the emerging community benchmarking collaborative.

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 the CPL in order for all PU Datix reports to be screened for accuracy prior to final submission.

| | | | |
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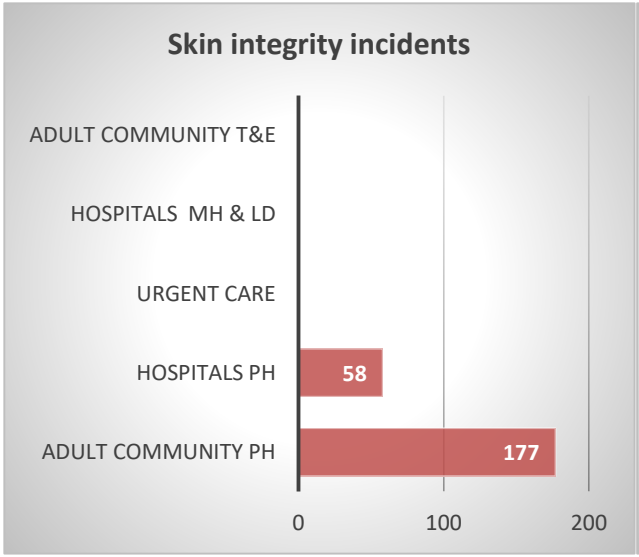
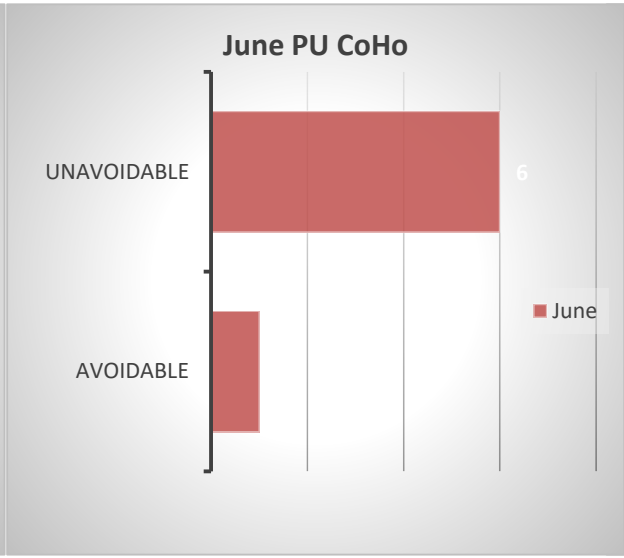
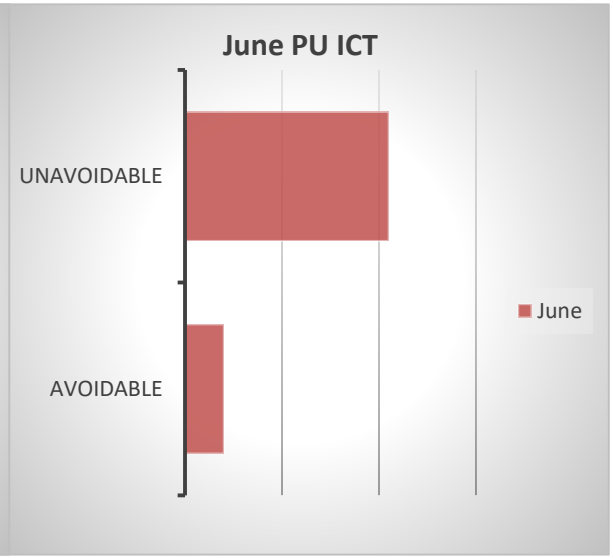
**CQC DOMAIN - ARE SERVICES SAFE?** Trust Wide Physical Health Focus
**Pressure Ulcers – June 2021 Additional Information**




**Bar chart showing skin integrity incident reports per service.**

- Adult community PH: **177**
- Hospitals PH: 58
- Urgent care & specialist services: 1
- Hospitals MH & LD: 1
- Adult comm. Therapy & Equipment 1

**Bar chart showing PU's developed or worsened under GHC care (acquired) in our Community Hospitals in June 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.)
- 6 unavoidable
- 1 avoidable

**Bar chart showing data reported in community PH in June 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.)
- 21 unavoidable
- 4 avoidable

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## CQC DOMAIN - ARE SERVICES RESPONSIVE?

### Minor Injury and Illness Units

| | | 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 Feb Figure |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Time to initial assessment for patients arriving by ambulance (95th percentile) | N - T | <15 m | 0:14 | 0.14 | 0.12 | 00.16 | | | | | | | | | | .14 | G | | |
| **Referral to Treatment physical health** | | | | | | | | | | | | | | | | | | | | |
| | Podiatry - % treated within 8 Weeks | L - C | 95% | 96.0% | 96.6% | 96.6% | 96.8% | | | | | | | | | | 96.7% | G | | |
| | ICT Physiotherapy - % treated within 8 Weeks | L - C | 95% | 89.8% | 97.0% | 95.4% | 93.8% | | | | | | | | | | 95.4% | G | | |
| | ICT Occupational Therapy Services - % treated within 8 Weeks | L - C | 95% | 93% | 96.1% | 96.7% | 96.9% | | | | | | | | | | 96.6% | G | | |
| | Paediatric Speech and Language Therapy - % treated within 8 Weeks | L - C | 95% | 94,8% | 97.2% | 95.6% | 96.5% | | | | | | | | | | 96.5% | G | | |
| | Paediatric Physiotherapy - % treated within 8 Weeks | L - C | 95% | 96.0% | 99.2% | 99.6% | 98.9% | | | | | | | | | | 99. 3% | G | | |
| | Paediatric Occupational Therapy - % treated within 8 Weeks | L - C | 95% | 97.8%% | 95.7% | 98.9% | 97.9% | | | | | | | | | | 97.6% | G | | |
| | Single Point of Clinical Access (SPCA) Calls Offered (received) | L - R | 3,279 | 28960 | 3101 | 2920 | 2825 | | | | | | | | | | 8846 | R | | |
| **Mental Health Services** | | | | | | | | | | | | | | | | | | | | |
| | CPA Review within 12 Months | N - T | 95% | 91.8% | 94. 7% | 92.4% | 90.2% | | | | | | | | | | 92.4% | R | | |
| | Admissions to hospital gate kept by CRHTT | N - T | 95% | 99.5% | 95.2% | 100% | 100% | | | | | | | | | | 98.4% | G | | |

### Additional information

**MIIUs**

- There were minor variances in the ambulance arrival to initial assessment times observed in Cirencester and Lydney affecting this indicator. This was down to administration delays and retrospective logging of the initial assessment on SystmOne. Matron's have been supporting colleagues with reminders about recording and will monitor activity levels in July.
- Dilke remains closed due to Covid-19 secure restrictions and reflects the physical environment and the inability to maintain social distancing between the booking in and waiting areas.
- Vale remains closed and will open Mid August due to delays in PCN vaccination team moving to new base.

**Mental health**

- CPA compliance slightly decreased compared to the previous month's figure of 92.4% .There are 93 CPAs outstanding with 51 of the cases being within the Recovery Service , and 10 within Eating Disorders. 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. In parallel GHC are working with the Integrated Care System (ICS) to develop a universal minimum standard for high quality care in the community to move away from the current CPA classifications. The aim is to develop a more flexible, responsive and personalised approach to care with the support from the multiple partners that make up the Mental Health Integrated Community Team. NHSE/I have directed CCG's and providers to review the CPA metrics in order to reduce reporting requirements and impact on teams. The shift will release time to develop the integrated approach and universal approach to mental health community care.

| | | | |
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# Quality Dashboard

NHS
Gloucestershire Health and Care
NHS Foundation Trust

## 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 | RAG | Exception Report? | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Community Hospitals** | | | | | | | | | | | | | | | | | | | | |
| Bed Occupancy - Community Hospitals | | L - C | 92% | 88.9% | 93.2% | 92.5% | 96.7% | | | | | | | | | | 94.2% | A | | 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% | 88.8% | 44.4% | | | | | | | | | | 75.0% | 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% | 53.6% | 52.2% | | | | | | | | | | 53.4% | G | | |
| Admissions to adult facility of patient under 16yrs | | N - R | | 1 | 0 | 0 | 1 | | | | | | | | | | 1 | N/A | | |
| Inappropriate out of area placements for adult mental health services | | N - R | Occupied bed days | 1742 | 82 | 100 | 200 | | | | | | | | | | 382 | G | | |
| **Children's Services – Immunisations** | | | | 2020/21 Academic Year | | | | | | | | | | | | | | | | |
| HPV Immunisation coverage for girls aged 12/13 years old (1st Immunisation) | | N - T | 90%* | 11.9% | 44.4% | 55.7% | 80.2% | | | | | | | | | | 80.2% | | | |
| **Childrens Services - National Childhood Measurement Programme** | | | | 2020/21 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%* | 21.9% | 35.9% | 64.2% | 87.4% | | | | | | | | | | 87.4% | G | | |
| Percentage of children in Year 6 with height and weight recorded | | N - T | 95%* | 0% | 9.0% | 75.8% | 83.9% | | | | | | | | | | 83.9% | G | | |

### Additional Information

**Early Intervention in Psychosis** – There were 5 non compliant cases in month, with 3 related to data quality issues which are due to be rectified. The 2 other cases reflect patient complexity with one person being too unwell and declined to attend and although assessed 2 weeks later this is outside the KPI. The second person was assessed within 7 days, however, required a further period of assessment which included an allocation of a care coordinator which resulted in a short delay and impacted on the KPI.

**Children's Services -** National Childhood Measurement Programme (NCMP) is progressing at pace as can be seen in the positive differentials between April and June of 51.5% reception height & weight and 74.9% Y6 Height & weight, clinical activity is scaling up and the nationally supported agreement which is to complete 10% NCMP for Reception and Year 6 by the end of the current academic year is on target. The GHC School Nursing service remains committed to providing system partners with data to support development of the local obesity strategy.

**HPV -** The forecasted delivery is changing daily due to social isolation and school declines however all activity is either scheduled in school or has been reassigned to a community delivery model .The academic year finishes 20/07/21 and then whole programme then reverts to a countywide community model in GHC and community estates.

**Length of stay (bed days) -** The occupied bed days for inappropriate out of area Mental Health placements in June was 200 days which relates to 10 patients (8 x acute & 2 PICU admission beds). There remain a significant surge in demand for inpatient beds in month and the levels of acuity and dependency has resulted in a shortage of bed availability, this picture is mirrored regionally and nationally. GHC were awarded improvement funds to support early discharge and have developed discharge planning support with a number of Voluntary Community Providers who are providing networking links and crisis management planning. This represents some early work to the developing Integrated Care System approach being explored with the CCG.

# Quality Dashboard

Gloucestershire Health and Care NHS Foundation Trust

## 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 | RAG | Exception Report? | Benchmarking Report |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of eligible children who receive vision screens at or around school entry.(Cumulative target) | | 95%* | 93.1% | 35% | 61.4 | 82.8 | | | | | | | | | | 82.8% | G | Y | |
| Number of Antenatal visits carried out | | | 530 | 47 | 51 | 51 | | | | | | | | | | 149 | R | | |
| 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 | | | | | | | | | | 94.4% | A | Y | |
| Percentage of children who received a 6-8 weeks review. | | 95% | 95.9% | 98.3% | 97.2% | 97.6 | | | | | | | | | | 97.7% | 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% | | | | | | | | | | 80.3% | 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% | | | | | | | | | | 82.2% | 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% | | | | | | | | | | 75.8% | R | Y | |
| Percentage of infants being totally or partially breastfed at 6-8wks(breastfeeding prevalence). | | 58% | 56.0% | 61.3% | 59.2% | 60.1% | | | | | | | | | | 60.2% | 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% | | | | | | | | | | 82.8% | 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 | | 196 | 174,9 | 186.0 | 187 | 188 | | | | | | | | | | 187 | R | | |
| Average Number of Community Hospital Beds Closed | | 0 | 21.1 | 10.0 | 9 | 8 | | | | | | | | | | 9 | R | | |

### Additional Information

**New Birth Visiting (NBV):**

- NBV are offered F2F with a telephone/virtual consultation available on request. Robust exception reporting is completed regarding babies not seen within the mandated timeframe.

**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.
- These figures show a small decline from last month . For all children classified as 'Universal ', virtual appointments via Attend Anywhere are being offered for developmental reviews.
- To improve take up following 1st DNA contact details are cross referenced and a review undertaken to see if there needs to be a different offer of appointment .

**Percentage of children who received a 12-month review by the time they turned 15 months:**

- There has been an increase in the number of children that have been seen by the time they are 15 months of 3.2%. These contacts are optional for parents and although team members offer the appointments, this is not always taken up by the parents.
- There was a reduction in the number of declines from last month of 38.5% down to 17% which is a good trajectory going forward .
- 2nd appointments following a DNA are currently offered within 15 months against the usual standard of 12 months, this is expected as part of service recovery, in June there was a 21% DNA rate of the first appointment .

**Percentage of children who received a 2-2.5-year review by 2.5 years:**

- 50% of parents have declined this contact which is the same rate as the previous 2 months however the DNA rate is 22% which is a decrease on last month' figure . The virtual offer has not increased rates of acceptance of the developmental review as was anticipated, to mitigate this as lockdown eases and estate space allows, the service will be returning the 2-year Ages & Stages Questionnaire (ASQ) to face to face with an additional intervention called Early Language Identification Measure (ELIM) to use alongside ASQ.
- The service continues to scope non GHC sites to support the delivery of the F2F offer.

## 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% | | | | | | | | | | 88.2% | A | | |
| % of Staff with completed Personal Development Reviews (Appraisal) | L - I | 90% | 70.4% | 71.2% | 72.5% | 76.2% | | | | | | | | | | 73.3% | R | | |
| Sickness absence average % rolling rate - 12 months | L - I | <4% | 4.80% | 4.3% | 3.9% | 3.9% | | | | | | | | | | 3.9% | A | | |
| Sickness absence % monthly rate | L-T | <4% | New | 3.55% | 4.4 | 4.28% | | | | | | | | | | 3.55% | G | | |

### 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 is still short **of** the 90% training compliance target. There are still topics and/or service areas where figures remain lower than required and work is continuing to ensure any deficits are rectified in a timely manner; this includes work with the Trust's Staff Bank.
- The Trust's overall training compliance figure minus staff bank is 92.7%
- Sickness absence has dropped to below 4% to 3.9% rolling rate for the second month running .

**Resuscitation and Restrictive Physical Intervention training**

- The focus on Physical Intervention training shows continued improvement of the training compliance figures. The focus going forward will be on the areas with lower compliance and ensuring the improvements achieved are maintained.
- 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 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | April | May | June | April | May | June | April | May | June | April | May | June |
| Wotton Lawn Hospital | | | | | | | 74% | 74% | 83% | 71% | 76% | 77% |
| Charlton Lane Hospital | 64% | 79% | 89% | 74% | 84% | 92% | | | | | | |
| Berkley House | 59% | 75% | 71% | 77% | 85% | 88% | | | | | | |

**Health and Wellbeing Hub**

This group has a broad representation of colleagues from across the Trust with data and themes being collated and monitored through the hub . There is an informative portal in the staff intranet and this July is planned to be featured as, " Be Kind to Yourself Month". There are many activities for staff to engage with which are being delivered by virtual methods which include : On line cookery demonstration, Pilates, Yoga, Horticulture ,Mindfulness, Spiritual Care, Menopause issues, Diversity, Fitness taster sessions.

## CQC DOMAIN - ARE SERVICES WELL LED?

**Safe Staffing Mental Health Inpatient – June 2021**

| | Code 1 | | Code 2 | | Code 3 | | Code 4 | | Code 5 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Ward Name | Hours | Exceptions | Hours | Exceptions | Hours | Exceptions | Hours | Exceptions | Hours | Exceptions |
| Dean | 0 | 0 | 17.5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| Abbey | 180 | 23 | 17.5 | 2 | 0 | 0 | 0 | 0 | 0 | 0 |
| Priory | 195 | 24 | 32.5 | 3 | 0 | 0 | 15 | 1 | 0 | 0 |
| Kingsholm | 15 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Montpellier | 80 | 9 | 85 | 10 | 0 | 0 | 0 | 0 | 0 | 0 |
| Greyfriars | 180 | 23 | 15 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Willow | 45 | 6 | 67.5 | 9 | 0 | 0 | 0 | 0 | 0 | 0 |
| Chestnut | 60 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Mulberry | 60 | 8 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Laurel | 0 | 0 | 0 | 0 | 45 | 6 | 0 | 0 | 0 | 0 |
| Honeybourne | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Berkeley House | 82.5 | 9 | 205 | 21 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total In Hours/Exceptions | 897.5 | 112 | 440 | 48 | 45 | 6 | 15 | 1 | 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

| MENTAL HEALTH & LD | | | | |
|---|---|---|---|---|
| Ward | Average Fill Rate | Absence | Vacancy WTE HCA | Vacancy WTE RMN |
| Dean Ward | 152.00% | 15.21% | 2.30 | 2.80 |
| Abbey Ward | 106.67% | 7.28% | 0.00 | 10.50 |
| Priory Ward | 107.56% | 5.80% | 0.00 | 12.20 |
| Kingsholm Ward | 105.28% | 8.70% | 1.69 | 2.78 |
| Montpellier | 106.92% | 1.16% | 4.20 | 1.90 |
| PICU Greyfriars Ward | 152.36% | 8.39% | 3.60 | 4.10 |
| Willow Ward | 112.62% | 7.70% | 0.00 | 0.00 |
| Chestnut Ward | 105.37% | 6.12% | 3.35 | 0.00 |
| Mulberry Ward | 119.28% | 5.41% | 0.30 | 2.60 |
| Laurel House | 100.00% | 5.33% | 1.07 | 1.40 |
| Honeybourne Unit | 104.44% | 6.18% | 0.60 | 1.20 |
| Berkeley House | 98.33% | 3.37% | 0.00 | 0.00 |
| Totals (June 2021) | 114.24% | 6.72% | 17.11 | 39.48 |
| Previous Month Totals | 120.54% | | | |

| Physical Health | | | | |
|---|---|---|---|---|
| Ward | Average Fill Rate | Absence | Vacancy WTE HCA | Vacancy WTE RN |
| Coln (Cirencester) | 118.08% | 8.97% | 0.00 | 4.10 |
| Windrush (Cirencester) | 107.73% | 10.36% | 0.00 | 3.32 |
| The Dilke | 109.03% | 10.36% | 1.80 | 0.00 |
| Lydney | 102.13% | 8.06% | 0.00 | 5.53 |
| North Cotswolds | 110.38% | 10.44% | 0.00 | 1.99 |
| Cashes Green (Stroud) | 99.71% | 5.14% | 1.80 | 0.00 |
| Jubilee (Stroud) | 111.92% | 3.95% | 2.70 | 0.63 |
| Abbey View (Tewkesbury) | 93.69% | 10.17% | 0.60 | 1.75 |
| Peak View (Vale) | 116.31% | 8.52% | 2.08 | 2.73 |
| Totals (June 2021) | 107.66% | 8.44% | 8.98 | 20.05 |
| Previous Month Totals | 107.57% | | | |

**Mental Health and Learning Disability Inpatients**

- The International Recruitment project continues and 3 x RMNs have been appointed for Wotton Lawn. Expectation arrival is in Q3.and Q4. We continue to source 12 week block bookings for RMN's from framework agencies to ensure continuity of care and fulfil the named nurse role.
- Code 3 relates to short terms absence, however, the unit manager picked up the registered nurse shift hours above to ensure continuity and safe care, although this impacted on some of operational duties. Code 4 relates to last minute absence of an agency nurse. The ward was supported by allied health professionals to support ward activity, however, was under the nominated staffing levels. All were escalated to Matrons for oversight as part of the local protocol and safety checks.

**Physical Health**

- The International Recruitment project continues and to date, 30 RGN's have been appointed, of these , 9 have arrived in the UK.
- 7 nurses have taken and passed the OSCE, 4 have received their NMC PIN numbers and 3 are awaiting them. 2 nurses are due to undertake their OSCE training in July

**Staffing Data – Absence/Vacancy Data Quality Notice**

- Additional staffing data is available for this reporting period, however, the workforce and finance systems are still transitioning data and there remain variances between systems. The quality team are collaborating with colleagues to data cleanse to ensure future data reflects operational understanding of workforce metrics for teams.

**CQC DOMAIN – ARE SERVICES WELL LED? - Quarter 1 - Guardian of Safe Working Report 2020/21**

**PURPOSE**

The 2016 national contract for junior doctors encourages stronger safeguards to prevent doctors working excessive hours. It was agreed with the BMA that a 'Guardian of Safe Working Hours' will be appointed in all NHS Trusts employing trainees (junior doctors) to ensure safe working practice. The role of 'Guardian of Safe Working Hours' is independent of the Trust management structure, with the primary aim to represent and resolve issues related to working hours for the junior doctors employed by it. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and/or employer, as appropriate; and will provide assurance to the Trust Quality Committee and Board or equivalent body that doctors' working hours are safe. The Guardian's Quarterly Report, as required by the junior doctor's contract, is intended to provide the Trust's Quality Committee and Board with an evidence based report on the working hours and practices of junior doctors within the Trust, confirming safe working practices and highlighting any areas of concern.

| **Reporting time period April 2021 – June 2021** | **Guardian of Safe Working Hours: Dr Sally Morgan** |
|---|---|
| **Number of doctors in training** (all on 2016 contract) | In April to June (Q1) 2021 there were 36 doctors in training posts.<br><br>• 12 higher trainees<br>• 6 CT3s<br>• 2 CT2s<br>• 3 CT1s<br>• 5 GP trainees<br>• 4 FY2s<br>• 4 FY1s<br>• FY doctors rotated posts in May 2021 |
| **Exceptions in this period** | • **17 on call shifts covered** by our own junior staff acting as locums due to sickness.<br>• **3 on call shifts covered** by agency locums due to sickness<br><br>• **4 exception reports in this time period**<br>• **3 by one CT1, 1 by FY2, both posts in WLH**<br>• **3 relating to hours worked** (needing to stay late due to clinical work load)<br>• **1 relating to pattern of work** (covering WLH) – this has since been raised as issue with Medical Lead and the Clinical Director to ensure adequate cover arrangements in place at WLH when trainees take leave<br>• None requiring work schedule reviews<br>• **2 resolved with TOIL, 2 outstanding**<br><br>**There was a Junior Doctors forum held via Microsoft Teams on 30th April 2021.** |

**AGENDA ITEM: 08/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 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 2020/21 QUARTER 4**

| | |
|---|---|
| **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:**

The purpose of this report is to Inform the Board of the mortality review process and outcomes during 2020/21.

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 which covers 2020/21.

**Executive summary**

- This report summarises the year's activity regarding Learning from Deaths.
- During 2020/21 there were 829 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 (30 April 2021) none of these deaths are judged likely to have been due to problems in the care provided

by the Trust. However, learning has been obtained from serious incident investigation and mortality review of these deaths, the learning is presented in this report.

- One, representing 5.3% 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. This related to a mental health homicide that took place in 2019 and previously reported to Trust Board, the outcome of which has been shared with both the victim's and the perpetrator's family with whom there was positive engagement, as well as NHSE/I. Significant learning from this has been achieved and continues to be developed. A learning assurance event is due to take place on 1st July 2021

- Covid-19 related inpatient deaths following definite and probable nosocomial infections will be subject to further Gloucestershire system-wide review and investigation in line with guidance. Work is currently underway and due attention is being paid to communicating with relatives and duty of candour requirements.

- The format of this report is currently under review, and looking forwards will be presented as a concise slide deck from the end of Quarter 1 2021/22 whilst still retaining the mandated requirements.

**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?**

| **Appendices:** | None |
|---|---|

| **Report authorised by:** Dr Amjad Uppal | **Title:** Trust Medical Director |
|---|---|

## 1.0 INTRODUCTION

1.1 The purpose of this report is to inform the Trust Board of the mortality review process and learning outcomes during 2020/21.

1.2 The Board is asked to note that from 1 April 2020, Gloucestershire Health and Care NHS Foundation Trust (GHC) reports both mental health and physical health mortality data in a combined manner; facilitated by the joint Datix system, which went live on 1st April 2020.

## 2.0 OVERVIEW

2.1 During 2020-2021, there were 829 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. This comprised the following number of deaths, which occurred in each quarter of that reporting period:

336 in the first quarter;
182 in the second quarter;
177 in the third quarter;
134 in the fourth quarter.

2.2 By 8th April 2021, 42 case record mortality reviews and 14 comprehensive investigations had been carried out in relation to the 829 deaths included above. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

16 in the first quarter;
21 in the second quarter;
14 in the third quarter;
5 in the fourth quarter.

2.3 Zero, 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. However, there is learning obtained from these investigations and reviews, which is highlighted in Section 3 of this report.

2.4 By 8th April 2021, 14 case record reviews and 5 investigations completed after 31st March 2020 related to deaths which took place before the start of the reporting period. These were deaths that occurred in the 2019/20 reporting period, however the reviews and investigations were concluded in the 2020/21 reporting period.

2.5 1, representing 5.3% 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. This related to a mental health homicide that took place in 2019, the outcome of which has been shared with both the victim's and the

perpetrator's family with whom there was positive engagement, as well as NHSE/I. Significant learning from this has been achieved and continues to be developed. A learning assurance event is due to take place on 1st July 2021.

2.6 The numbers in paragraphs 2.3 and 2.5 have been estimated using Comprehensive Investigations and Structured Judgement Review (SJR).

2.7 For any deaths meeting Serious Incident a full Comprehensive Investigation is carried out, including Root Cause Analysis. Comprehensive Investigations are subject to full panel review chaired by the Medical Director or Deputy Medical Director.

2.8 For patient deaths subject to the Mortality Review process (case record reviews), the Royal College of Psychiatrist's SJR Mortality Review Tool 2019 is employed to review mental health patient deaths. For learning disability patient deaths, a similar Trust-developed SJR tool is utilised which pre-dates the Royal College of Psychiatrist's SJR. This approach has been maintained to allow consistency with the Learning Disability Mortality Review programme. Finally, for physical health patient deaths, a range of questions based on SJR tools is being used to assess the standard of care provided to patients that die during an inpatient stay at a community hospital.

2.9 Case record reviews are discussed at Mortality Review Group (MRG) meetings chaired by a Clinical Director or Quality Lead (Mortality, Engagement and Development). The community hospital MRG meetings also extend an invitation to the County Medical Examiner.

2.10 The case record review and investigation figures given above do not include current ongoing reviews and investigations.

## 3.0 Learning

The Trust has identified the following learning points and themes in relation to serious incident investigations and mortality reviews.

### 3.1 Communication

3.1.1 Subsequent to mortality reviews of patients receiving End of Life Care (EoLC) in the Trust's seven community hospitals, quality of referral and transfers from the acute trust has remained a theme throughout 2020-21. The need for improved communication between Gloucestershire Hospitals NHS Foundation Trust's (GHNHSFT) Onward Care Team and GHC's Demand and Capacity/SPA Teams has been identified as a contributory factor to poor quality discharges/transfers by NHSE/I's Emergency Care Improvement Support Team (ECIST). A new piece of work has commenced in March 2021, which should improve the quality of transfers from GHNHSFT going forward. ECIST are working with GHNHSFT and GHC on a quality improvement project and are developing a 90-day improvement plan. Telephone reviews (between GHNHSFT and GHC) of all patients awaiting transfer have now been introduced twice daily. From a clinical perspective, this should ensure that GHC:

- Have up to date information about patients, irrespective of the length of time between referral and transfer;
- Have a more accurate reason for transfer, e.g. EoLC rather than rehabilitation.

3.1.2 As a result of the investigation into the death of a patient who suffered an unwitnessed fall at one of our inpatient facilities, and who passed away later the same day at the acute trust, difficulties in multi-agency communication between the mental health services and other providers were identified, and although it was not considered to be contributory to the outcome for the patient, the investigation felt there to be areas for learning and improvement. The Multi-Agency communication difficulties will be raised at the "One Gloucestershire Patient Safety Group". The case will also be shared with the Gloucestershire Safeguarding Adult Review sub group to consider the following:

- Multi agency working in relation to hospital discharge planning (sharing of information).
- Recognising when to undertake a mental capacity assessment, particularly with someone thought of as 'eccentric'.
- Highlighting the need to use the Safeguarding Escalation Process for example when a professional has doubts about someone's capacity to make a specific decision.

3.1.3 Following investigation into a suspected suicide of a patient open to a mental health community team by sodium nitrate highlighted challenges in obtaining information from system partners. This acknowledged that each organisation who had supported the patient had its own information governance processes, which prevented partners from sharing relevant information in a manner to support the delivery or care and investigating incidents. GHC have undertaken to make arrangements with these organisations to agree a protocol for sharing relevant and appropriate information in a timely way.

3.1.4 Following an investigation into the death of a patient open to a mental health community team who had reduced their antipsychotic medication against medical advice, and after an alternative therapist had suggested that their symptoms could be treated without medication, it was recommended that staff are reminded to be proactive in asking for details of any private therapists. If appropriate and with consent, they should consider contacting the therapist to discuss the provision of safe and holistic care. Staff are also recommended to share with carers (with the patient's consent) decisions which are made against medical advice, so that carers can be alert to the associated risks.

3.1.5 Post investigation into the suspected suicide by asphyxiation of a patient open to a mental health community team, staff were reminded of the importance of carrying their mobile phone during lone visiting and having an appropriate voicemail message when out of hours. The mobile phone policy is currently under review, and where necessary, will be updated and recirculated.

3.1.6 After a mortality review into the death of a patient who was on the caseload of both mental health and physical health services provided by GHC, it was identified that clinicians working in the individual services were not fully aware

of the interventions being provided by the discreet teams involved. Work is underway to improve the knowledge that teams have of the scope of services that the trust provides post-merger, and how information sharing between the services can be maximised.

### 3.2 Risk

3.2.1 As a result of an investigation into the suspected suicide of a Mental Health Intermediate Care Team (MHICT) patient who was found deceased two weeks' after discharge, all individuals supervising colleagues have been reminded of the need to ensure that patients with a pattern of increasing risk should continue to be managed by the supervisee, whether trainee or non-training grade.

3.2.2 Following the investigation into the death by asphyxiation by helium gas of a patient open to a mental health community team, staff have been encouraged to make clear assessments of risk when a patient discloses the possession of a suicide kit, and to remain up to date with latest developments in methods of suicide and the associated potential lethality.

3.2.3 Subsequent to the death of a patient who ended their life on a family holiday whilst receiving extended support from MHICT, GHC will continue to review the Trust's risk assessment policy and practices, ensuring that complex and fluctuating risks are captured and considered when agreeing appropriate risk management plans.

3.2.4 During the investigation into the suspected suicide by asphyxiation of a patient open to a mental health community team, it was found that documentation from other statutory agencies and providers revealed that the patient's partner had a criminal history which was not known at the time to the clinical team. 5 days prior to the patient's death, the risks had changed significantly as the patient had been subject to assault from her partner. The Trust's Safeguarding Team will:

- Raise awareness and remind all staff across the Trust of the 'Gloucestershire safeguarding Adult Board Escalation Protocol'.
- Remind all staff of the across the Trust of the Domestic Abuse pathway and GHC Domestic Abuse Policy, including advice for completion of the DASH form.
- To advise staff on where training is available for working with Domestic Abuse and Sexual Violence (internal to GHC and externally in Gloucestershire).

3.2.5 As a resulting action following the death of a patient at one of our inpatient facilities via ligature (bed linen) tied to the bedroom door, GHC is continuing its work with regard to installing electronic countermeasures (door top sensors).

3.2.6 Following the investigation into the suspected suicide of a mental health inpatient by ingestion of sodium nitrate:

- Staff have been reminded that clinicians can still engage in conversation with family members to hear their concerns without breaching patient confidentiality, even if no consent to share information has been given.

- GHC has highlighted to staff that how online pro-suicide resources can impact on the risk to vulnerable individuals, and also raised at the Gloucestershire Suicide Prevention Strategy.

3.2.7 Post investigation into the suicide of a patient open to a community mental health team, where the patient had expressed concern regarding her menopausal state and its impact upon her mental health, the investigation recommended that a focused learning project be undertaken to consider the impact of all stages of menopause, to include the impact of menopause on mental state and emotional deregulation when assessing risk.

### 3.3 Training

3.3.1 After the suspected suicide by asphyxiation of a patient open to a community mental health team, the Resuscitation and Training Team have now included in training packages guidance for mental health community team colleagues and clarity as to when resuscitation should be commenced in the community.

3.3.2 Following the suspected suicide of a patient who had been assessed by a Liaison Team and then referred to a Crisis Team, the overriding duty to attempt resuscitation for all patients who do not clearly demonstrate signs of life extinct was noted. The potential merits of including training on Recognition of Life Extinct (RoLE) during resuscitation training will be discussed with the Resuscitation and Training Team Lead.

3.3.3 Subsequent to the review of a death of a community mental health patient, which occurred at an acute hospital, it appeared to the Mental Health (MH) MRG that the cause of death recorded on the death certificate was disputed. The highlighting of this disputed cause of death has facilitated the MH MRG to enquire with the Medical Examiner Service regarding training for mental health doctors that complete death certificates more frequently, i.e. those who treat patients at older adult inpatient sites.

### 3.4 Recording and Documenting

3.4.1 As a result of the investigation into the death of a patient who sustained an unwitnessed fall at one of our inpatient facilities and who passed away later the same day at the acute Trust, the system of recording on RiO (electronic record notes) when a patient makes an allegation of abuse or neglect against a member of staff should be reviewed to capture evidence that a patient's allegations are clearly recorded and responded to in terms of their Care Plan and to ensure a safeguarding chronology is available.

3.4.2 Following mortality review of patients on the End of Life Shared Care Pathway (EoL SCP) at one of our inpatient facilities, the MH MRG has recommended that once a patient has been placed onto the EoL SCP, then the EoL SCP booklet becomes the patient's primary document, taking over from RiO, as agreed across the Integrated Care System. If doctors have written an in-depth and detailed account of a discussion or assessment on RiO, they should also write a short couple of sentences in the EoL SCP booklet and can refer to the more detailed account on RiO, so that other clinicians know there is more detail to be found on RiO.

3.4.3 Post-investigation into the death of a Crisis Team patient who was found hanged at home, it was found that a telephone call that the patient made to the Crisis Team on the day of his death was not recorded, as the extension had not been added to the recording loop. A quarterly audit will be carried out to ensure that all Crisis Team extensions that should be recorded are added to the recording loop.

3.4.4 Following the death of a patient open to a community mental health team who died of their injuries following an unsuccessful suicide attempt, community mental health teams will provide detail in the medical record with respect to timings of contact with patients.

3.4.5 After an investigation into the suspected suicide by asphyxiation of a patient open to a community mental health team, it was recommended that consideration to be given to usual protocol for recording notes following assessment and reviews by medical staff, specifically with regard to reliance on Medical Secretaries copying and pasting risk relevant updates from dictated clinic letters into the RiO record.

3.4.6 The investigation into the suspected suicide of a mental health inpatient by ingestion of sodium nitrate resulted in staff being reminded that risk assessment is a dynamic process and that:

- All risk incidents and events should be documented in the appropriate section of the risk assessment within a timeframe that is reasonably practicable.
- Factors increasing risk (aggravating factors) should all be clearly documented in the relevant section of the risk assessment. These should include actuarial factors, clinical factors, and protective factors, as per Trust policy. Factors decreasing risk (mitigating factors), including factors that protect against suicide, should also be thoroughly documented.
- All risk management plans should be clearly documented in the formal risk assessment document.
- The Risk History tool should be used by all who have interventions with a patient, including in-patient unit staff.

3.4.7 Following the suicide of a patient open to a community mental health team, the investigation noted the lack of a formal telephone message system within the team for messages, but noted that there was no breakdown of communication. The investigation recommended a robust telephone messaging system to be implemented within the team office, noting that this work has been completed and tested in another locality.

### 3.5 Service Development

3.5.1 Following the death of a patient open to a community mental health team who died of her injuries following a suicide attempt, the investigation supported the ongoing development of a Complex Needs Service currently commissioned and being piloted in the county. The investigation recommended that when patients are supported by the Gloucestershire High Intensity Network (GHIN) programme and mental health services, regular meetings and the development

of shared care plans with shared goals and shared priorities are recommended. Co-ordination of the GHIN contact with patients under the care of mental health services will sit within the Complex Needs Service.

3.5.2 An investigation relating to the death of a patient who ended their life on a family holiday whilst receiving extended support from the MHICT, recommended that reviews into the provision of advice for carers of a person with Emotional Unstable Personality Disorder be undertaken. This is forming part of the project plan for the Complex Needs Service, as described in the previous paragraph.

3.5.3 Following the suspected suicide of a MHICT patient who was found deceased two weeks after discharge, the investigation recommended that Service Leads clarify the overlap and interplay between primary care mental health services (IAPT and MHICT Nursing) and secondary care mental health services (often Recovery Teams) to address the perceived gap in service provision. The MHICT Nursing Group now meets monthly to review supervision. Future transformation is currently paused due to the pandemic. The investigation highlighted that where a patient is transferred between mental health teams, especially between the primary/secondary care divide, those teams must have active dialogue, preferably involving the patient, and each be involved in the plan to be followed by the receiving team in line with the host principle in place across the Trust. Teams have been reminded of this via team meetings and locality forums.

### 3.6 End of Life

3.6.1 Subsequent to mortality review of EoL patients by the Mental Health (MH) MRG and Physical Health (PH) MRG:

a) The MH MRG noted that recognising when to place a patient onto EoL SCP can be complex. The MH MRG has advised the use of various indicator tools, e.g. SPICT, for recognising the most appropriate time. The MH MRG also advises that should a patient's condition improve, it is perfectly acceptable to take the patient off the EoL SCP.

b) MH MRG noted the excellent work by an HCA in preparing and maintaining the EoL facilities and the positive impact this has had upon patients and their loved ones. MH MRG has recommended that this approach is widened to all wards at Charlton Lane Hospital. The Charlton Lane Matron has identified a lead individual to take the work forward.

c) PH MRG has recommended that staff ensure family members with dementia are engaged with as much as they are able to process, supporting inclusive and participative care. Mental Health MRG are currently considering how to best support Community Hospitals with this recommendation.

d) PH MRG has made the following recommendations regarding ReSPECT forms:
- ReSPECT forms should be reviewed as part of patient clerking and also ideally every time the patient's situation changes, including discharge.

- ReSPECT forms document recommendations only, thus clinical decisions can override recommendations.

e) Following concerns raised by Community Hospital ward staff regarding some out of hours GPs being reluctant to prescribe EoL medication, PH MRG was made aware that similar concerns had been raised amongst community colleagues delivering EoL care at home. PH MRG has fed back to the Deputy Clinical Chair of Gloucestershire CCG and to the Care UK Governance Lead. In response, Care UK has now facilitated training sessions for the out of hours GPs from the Palliative Care Consultant.

f) MH MRG has recognised the need for a second EoL room at Charlton Lane Hospital and recommended the exploration of charities to support the renovation. This worked is currently delayed due to the pandemic.

g) MH MRG has recommended a review of nurse handovers regarding palliative care patients to ensure that all the relevant information and plans are handed over. MH MRG will forward the recommendation to the newly formed EoL Quality Improvement Group for consideration.

h) Due to some confusion regarding the dosing of glycopyrronium bromide for use during EoL SCP of patients suffering end stage dementia, MH MRG has sought clarification from Palliative Care Consultant for dissemination amongst ward staff.

### 3.7 COVID-19 pandemic related

3.7.1 Following the investigation into the death of a patient with a personality disorder who ended their life on a family holiday whilst receiving extended support from MHICT augmented by the a community mental health team, it was found that during the first wave of the pandemic, MHICT had a large and complex caseload which staff found challenging. After the first wave, the Trust reviewed future provision for primary mental health care in the event of further restrictions due to a second wave. When the second Covid-19 wave hit in late Autumn/Winter, learning was utilised from the first wave and the Trust did not step-down MHICT services or redeploy staff from MHICT teams.

3.7.2 In one case where a community mental health team patient took their own life 13 days after discharge from one of the Trust's inpatient facilities, the investigation found that it was clear that Covid19 had impacted upon the delivery and consistency of care from third party providers but did not significantly impact on the care delivered by Trust staff and services, with staff exercising due diligence in adhering to policy and best practice guidelines.

3.7.3 Following the investigation into the death of a patient who sustained an unwitnessed fall at one of the Trust's inpatient facilities and who passed away later the same day at the acute Trust, the investigation recommended:

- A short introductory video about the hospital was prepared, which can be shared with families, carers and friends at times when access to the hospital

is limited. Filming for this video has now been completed and is due to be circulated.

- Developments to improve communication pathways between inpatient wards and families/carers/friends will be continued in preparation for further restrictions or periods of lockdown due to Covid-19. This includes solutions involving the use of technology to extend visiting opportunities.

3.7.4 After review of patients on the EoL SCP, the MH MRG noted the excellent decision that the Trust Ethics Committee made to allow families to visit their loved ones on the ward during the height of the first wave of the pandemic, which led to much enhanced patient and family satisfaction during very difficult circumstances. It was recommended that this be carried forward to further periods of restrictions and this was indeed implemented by the Trust during the second wave across all inpatient settings.

3.7.5 Following mortality review of Covid-19 positive patients on EoL SCP PH MRG has:

a) Recommended that review of the Advanced Care Plan should be undertaken upon patients receiving a Covid-19 positive result, and that anticipatory medication should be prescribed to provide as many options as possible to nursing staff out of hours;
b) Recommended that Midazolam and Morphine can be used for symptomatic treatment and are not necessarily EoL treatments only;
c) Recognised the immense care and compassion displayed to two patients, a husband and wife, who were facilitated to spend the last few hours together in a 2 bedded bay before the wife's sad passing. PH MRG has reassured ward staff that where safety can be maintained, PH MRG would support clinical decisions made which display humanity and compassion to patients and their families as part of EoL care;
d) Recognised and highlighted the importance of maintaining effective relationships with relatives and that when done well, it helps loved ones to, wherever possible, accept the prognosis and come to terms with the outcome.

3.7.6 Covid-19 related inpatient deaths following definite and probable nosocomial infections will be subject to further Gloucestershire system-wide review and investigation in line with guidance. Work is currently underway and due attention is being paid to communicating with relatives and duty of candour requirements.

## 4. LEARNING DISABILITY MORTALITY REVIEW

4.1 Learning Disability Mortality (death) Review (LeDeR) have now caught up with the back-log of cases to review in Gloucestershire. Percentages below are correct as of 12 April 2021:

| Year | CLOSED | Open | ON HOLD | Grand Total | % Completed |
|---|---|---|---|---|---|
| 2017 | 46 | | | 46 | 100% |
| 2018 | 49 | | | 49 | 100% |
| 2019 | 46 | | | 46 | 100% |
| 2020 | 49 | 3 | 5 | 57 | 86% |
| 2021 | | 8 | 4 | 12 | 0% |
| Grand Total | 190 | 11 | 9 | 210 | 90% |

4.2 The Trust awaits the end of the 2020-21 Q4 reporting period for the annual 2020/21 LeDeR report containing learning themes. Learning themes identified during the 2019/20 reporting period are:

a. Focus on improved communications between professionals and with family/carers.
b. Focus on early detection of deteriorating physical health, including sepsis. This will mean continued close partnership working with West of England Academic Health Science Network.
c. Focus on referral to the eating and drinking pathway.
d. Continued focus on improving uptake of the annual health checks and flu vaccinations.
e. Focus on encouraging the ReSPECT form to be completed earlier on for people who are considered palliative, so there is a baseline in place to review frailty and advanced care planning with individuals, their family and carers.
f. Greater inclusion of people with lived experience in the work programme, including attendance at steering groups, quality assurance panels, and other training events.
g. Share the learning – plans to host an action from learning event during 2020/21.

4.3 LeDeR has made several recommendations for NHSE and DHSC in terms of policy making. The full LeDeR 2019/20 annual report can be accessed here: http://www.bristol.ac.uk/sps/leder/resources/annual-reports/

4.4 LeDeR have made no specific recommendations regarding the care and treatment provided by the Trust during 2019/20.

## 5. SUMMARY

5.1 GHC is committed to the National Quality Board's (2017) Learning from Deaths guidance. The Trust ensures that it seeks to actively learn and implement changes in practice identified from reviews of death. The Trust is an active supporter of the LeDeR programme in Gloucestershire.

5.2 All GHC staff are required to notify, using the Datix system, the deaths of all mental health patients, both inpatient and community (which comprises any individual open to a GHC community mental health caseload at the time of their death together with those who die within 30 days of discharge), and also deaths of all physical health inpatients.

5.3 Deaths recorded on Datix are collated for discussion at the MRG meetings chaired by a Clinical Director and Quality Lead (Mortality, Engagement and Development). Patient deaths meeting serious incident criteria are subject to a comprehensive investigation with panel review chaired by the Medical Director and Deputy Medical Directors. All deaths of patients with a learning disability are reported through the appropriate LeDeR process, and deaths of people under the age of 18 are reported through the current child death reporting methodology.

5.4 Learning from death continues to provide vital guidance. GHC is fully committed to recognising the need to improve services following learning from events, both nationally and locally, such as Gosport, Mid Staffordshire and the LeDeR programme, alongside our own local Serious Incident investigation and mortality review processes.

**AGENDA ITEM: 09/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 2021**

**PRESENTED BY:** Sandra Betney, Director of Finance and Deputy CEO

**AUTHOR:** Chris Woon, Deputy Director of Business Intelligence

**SUBJECT:** **COMBINED PERFORMANCE DASHBOARD JUNE 2021 (MONTH 3)**

| | |
|---|---|
| **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 June (Month 3 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.

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 the Business Intelligence Management Group (BIMG) and will more widely account for performance indicators in exception. Example of this include CAMHS, Eating Disorders (both June) and CYPS Community (July).

**Recommendations and decisions required**

The Board are asked to:

- **Note** the aligned Performance Dashboard Report for June 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
- **Agree to a recommendation** that;
  - A*dministrative,* 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.

**Executive summary**

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

**Mental Health & Learning Disability Services (National & Local)**

The Board's attention is requested to review the 9 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Eating Disorder (ED) Services account for four indicators. The 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. A Regroup, Reconnect, Recover update is provided at the end of the Local Requirements narrative.

**Physical Community Health Services (National & Local)**

In addition, attention is drawn to the 9 key performance thresholds in exception within the dashboard (with associated narrative) that were not met for the period. Within these, four are within CYPS and three within Wheelchair Services. 'Time to initial assessment for patients arriving by ambulance (95$^{th}$ percentile)' is a data entry issue that will be corrected. This item would not be escalated if the recommendation above is agreed. A Regroup, Reconnect, Recover update is provided at the end of the Local Requirements narrative.

**Trust Wide Services**

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).

Tactical plans are being held to develop further workforce performance metrics within the performance dashboard. 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 Resources Committee in August 2021. Additionally, interactive operational workforce (appraisal and sickness) and interactive budget management dashboards are now being deployed across the Trust after a comprehensive validation phase.

There were 11 complaints recorded in June 2021 which is above SPC control limits. This is not presented in exception within the report as there is not a defined threshold for performance monitoring (indicator known as having a 'proxy threshold'). Complaint activity is monitored through the Quality 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 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. These include;

- **7** Number of Serious Incidents Requiring Investigation (SIRI)
- **8** Number of SIRI where Medication errors cause serious harm
- **11** % incidents resulting in moderate harm, severe harm or death
- **12** % falls incidents resulting in moderate harm, severe harm or death
- **13** % medication errors resulting in moderate harm, severe harm or death
- **18** Safer staffing fill rate – community hospitals
- **22** Total number of acquired pressure ulcers
- **33** MIIU number of breaches of 4-hour target

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.

**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 been discussed before?** |
|---|
| BIMG 15 July 2021 |

| **Appendices:** | |
|---|---|

| **Report authorised by:** | **Title:** |
|---|---|
| Sandra Betney | Director of Finance and Deputy CEO |

Gloucestershire Health and Care NHS Foundation Trust

**Snapshot Month**
June

# Performance Dashboard Report & BI Update

Aligned for the period to the end June 2021 (month 3)

This performance dashboard provides a high level view of Key Performance Indicators (KPIs) in exception across the organisation for the period. Highlighted indicators are underperforming against their threshold or are outside normal variation control limits that warrant escalation and senior oversight. Additionally, confirmed data quality or administrative issues that are being imminently resolved will inform any escalation decision. A full list of all indicators (in exception or otherwise) are available within the dynamic 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 Service Recovery Action Plan (SRAP) which outlines appropriate risk and mitigation will be commissioned and monitored through BIMG. For example, specific updates have been provided by operational services in June and July 2021 for two areas with consistent performance challenges; Children and Young People's Services (CYPS including CAMHS) and Eating Disorder Services.

**Business Intelligence Update**
Althought there are currently high demands, Business Intelligence services continue to deliver key infrastructure development tasks and ensured the continuity of business critical reports during the period. Some development projects delays beyond BI's control - such as the server migration project and maintenance of the SystmOne data warehouse - are impacting the delivery of wider plans.

The following high profile tasks continue to be the focus;

- Server migration to allow for reconfiguration and resolve licensing concerns
- Finance (Integra) reports were deployed to users in July 2021.
- Service level recovery and operational planning is being supported and prioritised wherever possible through robust business partnering
- Operational engagement continues to establish a project 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. This project is called *'SystemOne Simplicity; Improving accuracy, consistency and quality assurance'.*
- Engagement with the e-rostering supplier to establish a new data extract continues
- Ongoing stakeholder feedback for the Draft Performance Management Framework has been collated and will inform the development of a second draft.
- Measuring What Matters Board Seminar learning being collated to inform
- Further Workforce Performance Indicators are in development. Further data source items need to be incorporated offering further service level granulation. The first development phase will be presented next month.
- Initial operational Workforce (ESR) reports covering sickness, appraisals and headline vacancies to be published in early August 2021.
- Tableau subscriptions and alerts are now in place, allowing users to setup regular visualisation mail-outs and performance led notifications.

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; automated benchmarking observation, SRAP alerts and data quality alerts (2021/22).
- Internal service KPI review (2021/22 Q2/Q3)
- 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 waulity and raised analytical productivity and efficiency (2021/22 Q4)
- Delivering System Data Flows; Introduce new data sources into data warehouse 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)

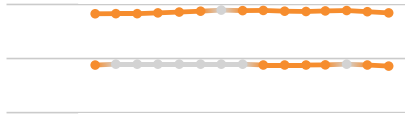
**PLEASE NOTE THAT THE DELIVERY OF THIS BI DEVELOPMENT TIMETABLE CONTINUES TO ADAPT TO BUSINESS DEMANDS, SPECIFICALLY REGARDING THE PANDEMIC RESPONSE AND RECOVERY.**

# Performance Dashboard: *Mental Health & Learning Disability - National Requirements (NHSI & DOH)*

Gloucestershire Health and Care NHS Foundation Trust

## KPI Breakdown

### Mental Health - National Requirements Gloucestershire

| | | JUNE | | 21/22 | | |
|---|---|---|---|---|---|---|
| **1.04** | Care Programme Approach - formal review within12 months | 90.1% | 95.0% | 92.4% | 95.0% |  |
| **2.21** | No children under 18 admitted to adult in-patient wards | 96.1% | 100.0% | 98.2% | 100.0% | |

**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 June is 90.1% (93 cases) against a performance threshold of 95% and is below Statistical Process Control (SPC) limits. Most of the cases are within Recovery (51), Eating Disorders (10), Assertive Outreach (6) and Early Intervention (6).

There is a Service Recovery Action Plan 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.

**2.21: Admissions of Under 18s to Adult Inpatient Wards [Hospitals MH]**
There were 2 admissions of under 18s in June.

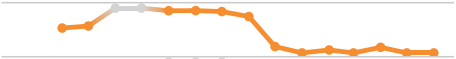
A young person aged 15 and previously known to services was admitted to Wotton Lawn with psychotic presentation. They were transferred 6 days later to a Tier 4 Unit. The other admission, also to Wotton Lawn, was a young person, nearing their 18th birthday with psychotic presentation and under the care of our Early Intervention Service. They were transferred 4 days later to a Tier 4 Unit.

# Performance Dashboard: *Mental Health & Learning Disability - Local Contract (Including Social Care)*

Gloucestershire Health and Care NHS Foundation Trust

## KPI Breakdown

### Mental Health & Learning Disabilty - Local Contract

| | | JUNE | 21/22 | |
|---|---|---|---|---|
| **3.07** | CPA Review - 95% of those on CPA to be reviewed within 1 month (Review within 13 months) | 94.0% / 95.0% | 96.0% / 95.0% |  |
| **3.25** | % of CYP entering partnership (treatment) in CYPS have pre and post treatment outcomes and measures recorded | 51.5% / 100.0% | 50.0% / 100.0% |  |
| **3.32** | CPI: Referral to Assessment within 4 weeks | 66.6% / 90.0% | 83.9% / 90.0% |  |
| **3.35** | Adolescent Eating Disorders - Routine referral to NICE treatment start within 4 weeks | 0.0% / 95.0% | 6.6% / 95.0% |  |
| **3.37** | Adolescent Eating Disorders - Urgent referral to NICE treatment start within 1 week | 0.0% / 95.0% | 12.9% / 95.0% |  |
| **3.39** | Eating Disorders - Wait time for adult assessments will be 4 weeks | 57.8% / 95.0% | 59.5% / 95.0% |  |
| **3.40** | Eating Disorders - Wait time for adult psychological interventions will be 16 weeks | 88.8% / 95.0% | 71.0% / 95.0% |  |

**<u>Performance Thresholds not being achieved in Month</u>** - *Note all indicators have been in exception previously within the last twelve months. 3.07 has been in exception but retrospective data entry now presents compliant periods within the visualisation above.*

**3.07: CPA (Care Programme Approach) – Formal review within 13 months [Community MH Services]**
Performance for June is 94.0% 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 55 where the CPA review is not recorded as having taken place within 13 months. Of these, 31 were within the Recovery service and 8 within the Eating Disorders Service.

There is a Service Recovery Action Plan 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.

**3.25: CYPs entering partnership have pre and post treatment outcomes and measures recorded [CYPS MH]**
June is reported at 51.5% against a local performance threshold of 100%.

A target of 100% was set by NHS England as an ambition across all CAMHS services and a local target set at 100% to reflect this. It has now been recognised that this is not achievable, and local agreement has been reached with Commissioners to reduce this in line with the pre-COVID CQUIN target to 50%. The threshold in the performance report will be updated once a contract variation has been received.

The service has developed individual caseload trackers for each evidence-based intervention that is being delivered and ROMS (Routine Outcome Measures) reporting is included within this for each Intervention Lead to review. Further development is required to flow the new Goal-Based ROMS into the data warehouse to allow inclusion within the caseload trackers and the Mental Health Data Set. There is a ROMS action plan which is monitored within the Operational Directorate Governance Forum (ODGF).

**3.32: CPI (Complex Psychological Intervention): Referral to assessment within 4 weeks [Community MH Services]**
June performance is reported at 66.6% against a performance threshold of 90% and is below Statistical Process Control (SPC) limits.

There were 9 non-compliant cases in June. Two clients were offered appointments within 4 weeks but did not attend. The remaining 7 clients were seen within 6 to 9 weeks after referral.
The service continues to operate with a shortage of staff due to vacancies and long-term sickness. The service is experiencing issues with recruitment and vacancies have been advertised on several occasions and for extended periods. The service has engaged with HR (Human Resources) to support and raise profiles. Extended hours are being offered to existing staff, staff bank used where possible and job specifications being adapted to offer preceptorships (supported transition bridge to becoming skilled).

**3.35: Adolescent Eating Disorders: Routine referral to NICE treatment within 4 weeks [Community MH Services]**
June performance is reported at 0% against a performance threshold of 95%. There were 2 non-compliant cases in June.

**3.37: Adolescent Eating Disorders: Urgent referral to NICE treatment within 1 week [Community MH Services]**
June performance is reported at 0% against a performance threshold of 95%. There were 9 non-compliant cases in June.

**3.39: Adult Eating Disorders: Referral to Assessment within 4 weeks [Community MH Services]**
June performance is reported at 57.8% against a 95% performance threshold. There were 8 non-compliant cases reported in June.

**3.40: Adult Eating Disorders: Assessment to Treatment within 16 weeks [Community MH Services]**
June performance is reported at 88.8% against a 95% performance threshold. There was 1 non-compliant case reported in June.

**Note on 3.35, 3.37, 3.39 & 3.40 – Eating Disorders waiting times**
The service continues to recruit to the current vacancies with successful candidates due to take up posts over the coming months. The service is now expecting to be at, or very near, full establishment by mid-August 2021.The current wait profile for the service at the end of June indicates that 78.4% (360) of all patients waiting for assessment, are waiting over 4 weeks and waiting times will continue to increase until newly recruited staff are fully in post.

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 43.7% of referrals received in June 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. Day treatment has been closed temporarily and staff capacity used to accommodate the increase in urgent referrals and is likely to remain closed until at least September 2021, however the service is looking at a temporary model for patients that would benefit from tailored group interventions.

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 July 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 has a development and improvement plan which focuses on all areas of recovery and has been actively engaging with commissioners to ensure that the staffing establishment can meet business as usual demands. The latest capacity mapping work shows that the team require 5 additional WTE (whole time equivalents) to keep up with current demands.

**Mental Health Services: Regroup, Reconnect, Recover Update**
Operational Services have been RAG rated by Service Directors in relation to the risks associated with their ability to deliver post-Covid service recovery. Services with a predicted recovery plan in place that would take 12 months+ to recover to pre-Covid levels have been identified.

There are 6 services within Mental Health Services that, based on current trajectories, have been identified as taking 12 months+ to recover. The services are:

- Eating Disorders
- ASC
- ADHD
- Memory Assessment Service
- CAMHS Level 2/3
- CAMHS Learning Disabilities

Work has taken place throughout June/ July to establish the pre-covid baseline for each of these services from Quarter 3 (October to December) 2019, clarifying service demand, the number of those waiting and the length of waits period pre-covid. This exercise was then repeated to ascertain the post-Covid position for Quarter 1 (April to June) 2021. This is enabling a better understanding of recovery to be achieved and the focus for recovery actions. A number of these services had challenging historic wait times pre-covid which have now been extended post-covid including some with increased referrals. Some of these services are now subject to service redesign as pre-covid models of service delivery were not optimum to secure effective and timely delivery. This work and reporting is now being further developed to inform recovery focus, progress and improvements.

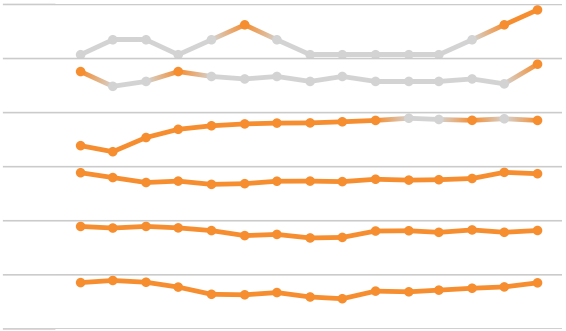
# Performance Dashboard: *Physical Health - National Requirements*

Gloucestershire Health and Care NHS Foundation Trust

## KPI Breakdown

## Physical Health - National Requirements

| | | JUNE | 21/22 |
|---|---|---|---|
| 14 | Number of post 48 hour Clostridium Difficile Infections | 300.0% / 100.0% | 200.0% / 100.0% |
| 38 | Time to initial assessment for patients arriving by ambulance (95th percentile) | 133.3% / 100.0% | 102.2% / 100.0% |
| 84 | % of live births that receive a face to face New Birth Visit within 7- 14 days by a Health Visitor | 93.2% / 95.0% | 94.4% / 95.0% |
| 86 | % of children who received a 9-12 month review by the time they turned 12 months | 82.2% / 95.0% | 80.4% / 95.0% |
| 87 | % of children who received a 12 month review by the time they turned 15 months | 82.8% / 95.0% | 82.1% / 95.0% |
| 88 | % of children who received a 2-2.5 year review by 2.5 years | 81.4% / 95.0% | 75.8% / 95.0% |



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

**14. Number of post 48-hour Clostridium Difficile Infections [Community Hospitals]**
There were 3 cases in June. There has been an noticeable increase in C.Diff toxin positive nationwide, GHNHSFT have also had an increase in the number of cases.

One patient was transferred to Coln Ward for Rehab but was subsequently transferred back to GRH following a further fall. The patient was recorded as C.Diff positive the day before the fall occurred. The second case was a transfer from GHNHSFT following treatment for hospital acquired pneumonia. The patient developed further Hospital acquired pneumonia whilst on Jubilee Ward. The patient tested positive for C.Diff and has had three courses of antibiotics. The third case of C.Diff was a patient who was transferred from GHNHSFT following surgery for fractured neck of femur, treated with two courses of antibiotics post-operatively. The patient had been prescribed three different laxatives whilst in GHNSFT, transferred to North Cotswold Hospital for rehab. The patient tested positive for C.Diff a week into their admission at NCH.

The IP&C team are in the process of reviewing the C.diff policy and will relaunch once approved. They are also undertaking a review of the cases shortly to see if there are any themes. The IP&C team are supporting clinical teams to help to reduce HOHA (Hospital Onset Healthcare Associated) cases. There appears to be a national rise in C.diff cases but need to understand possible reasons. The C.diff documentation is being reviewed by the ICS (across the county).

**38: Time to initial assessment for patients arriving by ambulance (95th percentile) [Minor Injuries and Illness]**
The 95th-percentile time for ambulance arrivals to initial assessment was 00:20 mins in June 2021, this is above the 00:15mins threshold. The above-threshold times occurred in Cirencester and Lydney MIIUs. The service confirmed this is due to retrospective logging of the initial assessment time due to delay in writing notes and the patients were assessed within the expected timeframe. The Matron for MIIUs will remind staff to ensure times are entered accurately in SystmOne and data validation will be completed to adjust the time reported. The June figure is within SPC Chart control limits based on 2018/19 and 2019/20 data but presented in exception as it is a National indicator.

**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]**
93.2% of eligible children received a face to face New Birth Visit by a Health Visitor in June 2021 compared to a target of 95%. 431 out of 462 reviews were completed within the target timeframe 7-14 days. 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. 96% were seen by day 30.

Unless a family decline the Health Visiting Service completely the offer of a new birth visit will be made and all children will be seen. If the children are in NICU, a home visit will be agreed with the parent as close to when the baby is discharged as possible. Three of the families that were inaccessible to the HV within timeframe have since been seen. Four families that were not seen within timeframe have also now been seen and had an assessment.

At the outturn of 2019/20, GHC performed at 91.5% against a 86.8% National benchmark. GHC continues to perform favourably in 2021/22 compared to these 19/20 National Benchmarking comparisons when digital interventions are included.

**86: Percentage of children who received a 9–12-month review by the time they turned 12 months. [Children and Young People Service]**
82.2% of eligible children received the 9-12 month visit by a Health Visitor in June 2021 compared to a target of 95%. 432 out of 525 reviews were completed within the target timeframe 9-12 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.

The parents of all children within the cohort were offered the opportunity to receive a 9-12mth and 2-year review. For all children classified as Universal, virtual appointments via Attend Anywhere are being offered for developmental reviews. This will be reverted to face to face offers dependent upon an estate within the locality being available and it being COVID secure. The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video). The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

At the outturn of 2019/20, GHC performed at 84.8% against a 77.0% National benchmark. GHC continues to perform favourably in 2021/22 compared to these 19/20 National Benchmarking comparisons when digital interventions are included.

**87: Percentage of children who received a 12-month review by the time they turned 15 months. [Children and Young People Service]**
82.8% of eligible children received the 9–12-month visit (by the time they were 15-months old) by a Health Visitor in June, compared to a target of 95%. 367 out of 443 reviews were 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.

Most of the cohort not seen by the time they are 15 months is mainly due to parental decline of the review. The service has completed a total of 877 'catch up' developmental reviews where parents have requested to delay their child's developmental review initially and then accepted the offer when comfortable to do so. The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video). The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

At the outturn of 2019/20, GHC performed at 90.2% against a 83.6% National benchmark. GHC continues to perform satisfactorily in 2021/22 compared to these 19/20 National Benchmarking comparisons when digital interventions are included.

**88: Percentage of children who received a 2-2.5-year review by 2.5 years [Children and Young People Service]**
81.4% of eligible children received the 2-2.5-year mandated contact by a Health Visitor in June, compared to a target of 95%. 431 out of 529 reviews were completed within the target timeframe of 2-2.5 years. 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.

All UP (Universal Partnership) and UPP (Universal Partnership Plus) are seen Face to Face (F2F) in the home setting for a full family health needs assessment. As lockdown eases and estate space allows, the service will be returning the 2-year ASQ (Ages and Stages Questionnaire) to face to face with an additional intervention called Early Language Identification Measure (ELIM) to use alongside ASQ. The virtual offer has not increased rates of acceptance of the developmental review as was hoped.

The performance figure now includes all modes of contact (i.e. Face to Face, telephone and video). The service continues to promote the Attend Anywhere offer and ensure all staff have access and are competent in using the software.

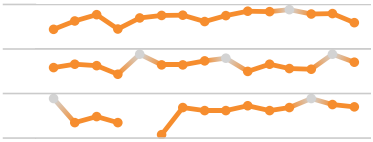
At the outturn of 2019/20, GHC performed at 83.5% against a 78.6% National benchmark. GHC continues to perform favourably in 2021/22 compared to these 19/20 National Benchmarking comparisons when digital interventions are included.

# Performance Dashboard: *Physical Health - Local Requirements*

Gloucestershire Health and Care NHS Foundation Trust

## KPI Breakdown

## Physical Health - Local Requirements

| | | JUNE | 21/22 | |
|---|---|---|---|---|
| 67 | Wheelchair Service: Adults: New referrals assessed within 8 weeks | 62.7% (90.0%) | 74.7% (90.0%) |  |
| 69 | Wheelchair Service: Under 18s: New referrals assessed within 8 weeks | 80.0% (90.0%) | 81.4% (90.0%) | |
| 71 | Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral | 76.9% (92.0%) | 81.8% (92.0%) | |

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

**67: Wheelchair Service: Adults: New referrals assessed within 8 weeks [Adult Community Services]**
19 out of 51 new adult referrals were assessed outside of the 8-week threshold in June. Performance is 62.7% and below the target of 90%.

There is an improving trajectory for waiters, with 111 patients waiting over 8 weeks, of which 48 are over 18 weeks. This compares to 146 over 8 weeks and 102 over 18 weeks in Dec 2020. It is anticipated that all over 18 week waiters will be cleared by Dec 2021.

**69: Wheelchair Service: Under 18s: New referrals assessed within 8 weeks [Adult Community Services]**
2 out of 10 new under 18 referrals were assessed outside of the 8-week threshold in June. Performance is 80% and below the target of 90%.

There is an improving trajectory for waiters, with 9 patients waiting over 8 weeks, of which 2 are over 18 weeks who are in complex situations with clear plans in place. This compares to 11 over 8 weeks and 4 over 18 weeks in Dec 2020. There is a plan to meet our KPI thresholds by Dec 2021.

**71: Wheelchair Service: Under 18s: Equipment delivered within 18 weeks of referral [Adult Community Services]**
3 out of 13 equipment were not delivered within 18 weeks of referral in June. Performance is 76.9% compared to a target of 92%.

There is an improving trajectory for adult and Under 18 (year old) waiters, with 95 patients waiting over 18 weeks of which 17 are Under 18 years old. This compares to 172 over 18 weeks of which 27 were Under 18 years old in Dec 2020. It is anticipated that all over 18 week waiters will be cleared by Dec 2021.

**Additional Commentary for 67, 69 & 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.

The Dashboard figures now show:

- Urgent referral assessments in June are slightly higher than the 12 month average of 11 per month.
- 100% performance for the adult and under 18 'urgent referral to assessment' KPI, with the exception of June, January and February, where the target was missed by only by only one exception per month. 12 month performance is above the 95% target at 97.5%.
- February to June has seen an increase in routine assessments, particularly for adults, as colleagues have returned to the service from long term sickness and have created the capacity to address longer routine waits.
- Total numbers waiting for handover have reduced in June after having remained level since January 2020.

It should also be noted that routine referral and handover KPIs are much more stable over the last 6 months and there are now single figure referral numbers transferred from the old system (BEST) waiting for assessment or handover.

**Physical Health Services: Regroup Reconnect Recover Update**
Operational Services have been RAG rated by Service Directors in relation to the risks associated with their ability to deliver post-Covid service recovery. Service with a predicted recovery plan in place that would take 12 months+ to recover to pre-Covid levels have been identified.

There are 9 services within Physical Health Services that, based on current trajectories, have been identified as taking 12 months+ to recover. The services are:

- Respiratory – Home Oxygen Service
- Pulmonary Rehab
- Diabetes
- Heart Failure
- Cardiac Rehab
- Adult MSK
- Wheelchair Assessment Service
- Children's S&LT

• Children's Immunisation

These services use SysmOne to record their activity, and so work is currently underway to improve and standardise service reporting by the BI team with operational services. Work will be carried out in August/ September to establish the pre-covid baseline for each of these services from Quarter 3 (October to December) 2019, clarifying service demand, wait times and numbers waiting at the period pre-covid. This will be repeated to ascertain the post-Covid position from Quarter 1 (April to June) 2021. This is enabling a better understanding of recovery to be achieved and the focus for recovery actions. A number of these services had challenging wait times pre-covid which have now been extended post-covid including some with increased referrals. Some of these services are now subject to service redesign as pre-covid models of service delivery were not optimum to secure effective and timely delivery. This work and reporting will be further developed to inform recovery focus, progress and improvements.

# Performance Dashboard: *Trust Wide Requirements*

Gloucestershire Health and Care NHS Foundation Trust

## KPI Breakdown

### Trust Wide Requirements

| | | JUNE | 21/22 | |
|---|---|---|---|---|
| **77** | Mandatory Training | 88.4% (90.0%) | 88.2% (90.0%) | |
| **78** | % of Staff with completed Personal Development Reviews (Appraisal) | 71.1% (90.0%) | 71.1% (90.0%) | |
| **78a** | % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only | 76.1% (90.0%) | 73.3% (90.0%) | |

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

**77: Mandatory Training [Trust Wide Workforce]**
Performance was 88.3% in June, below the target of 90%. Performance is below the SPC chart lower control limit based on 2018/19 and 2019/20 data. Mandatory training figures include Bank Staff.

The work that services/ teams have been doing to help re-instate training compliance levels continues to show improvement to the Trust overall compliance figure, although it is still just short of the Trust's 90% training compliance target. There are still some topics and/ or service areas where figures remain lower than required and work is continuing to ensure any deficits are rectified in a timely manner; this includes work with the Trust's Staff Bank. The Trust's overall training compliance figure minus staff bank is 92.7%.

**78: % of Staff with completed Personal Development Reviews (Appraisal) [Trust Wide Workforce]**
Performance in June was 71.1% 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.

**78a: % of Staff with completed Personal Development Reviews (Appraisal) Active Assignments Only. [Trust Wide Workforce]**
Performance in June was 76.1% 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.

**Commentary for KPIs 78 and 78a**
The Workforce team continues to encourage appraisals to be completed and recorded on the Electronic Staff Record (ESR) and 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. Bookings have been made by colleagues to attend the appraisal conversation training.

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NHS Foundation Trust

**AGENDA ITEM: 10/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 2021**

**PRESENTED BY:** Sandra Betney, Director of Finance and Deputy CEO

**AUTHOR:** Stephen Andrews, Deputy Director of Finance

**SUBJECT:** **FINANCE REPORT FOR PERIOD ENDING 30th June 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**
Provide an update of the financial position of the Trust.

**Recommendations and decisions required**

- The Board are asked to **note** the month 3 position
- **Approve** the revised capital programme

**Executive summary**

- Final audited accounts were submitted by the 29th June deadline
- There were no material movements to the accounts. The year end surplus remained at £47k
- The Trust has a H1 plan of break even
- The Trust's position at month 3 is a surplus of £42k
- The Trust is forecasting a H1 position of break even
- The cash balance at month 11 is £58.2m
- Capital expenditure is £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
- It should be noted that these changes require the Estates Strategy to be updated before it is published
- Future years of the programme have also been amended to reflect rephrasing and the inclusion of some leases due to IFRS16
- The Trust has spent £0.468m on Covid related revenue costs between April and June

| |
|---|
| |

| **Risks associated with meeting the Trust's values** |
|---|
| Risks identified within the report. |

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | |
| **Resource Implications** | |
| **Equality Implications** | |

| **Where has this issue been discussed before?** |
|---|
| |

| **Appendices:** | |
|---|---|

| **Report authorised by:** | **Title:** |
|---|---|
| Sandra Betney | Director of Finance and Deputy CEO |

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NHS Foundation Trust

# Finance Report
# Month 3

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

# Overview



- Final audited accounts were submitted by the 29th June deadline
- There were no material amendments to the accounts and the year end surplus for GHC remained at 0.047m
- 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 3 the Trust has a small surplus of £21k and a six month forecast position of break even in line with the plan
- The Trust has recorded Covid related expenditure of £0.468m for April to June
- 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 proposed by the Capital Management Group.
- Adjustments to future years have also been made including the inclusion of potential future leases
- The Board is asked to approve the proposed revised capital programme
- 21/22 Capital plan is £15.993m and spend to month 3 is £0.980m which is £1.257m less than the year to date plan to NHSI
- Cash at the end of month 3 is £58.2m
- The Trust has begun preparation work for the implementation of IFRS 16 across the NHS. This Reporting Standard affects the way organisations record leases, or lease components of a contract

# GHC Income and Expenditure

Gloucestershire Health and Care
NHS Foundation Trust

| Statement of comprehensive income £000 | 2021/22 | 2021/22 | 2021/22 | | | | 2021/22 |
|---|---|---|---|---|---|---|---|
| | Mth 1-12 | Mth 1-6 | Mths 1-3 | | | | Mth 1-12 |
| | Original Plan | NHSI H1 plan | Original Plan to date | NHSI H1 plan to date | YTD Actual | Variance | Full Year Forecast |
| Operating income from patient care activities | 220,598 | 112,680 | 55,150 | 56,340 | 57,800 | 1,460 | 225,360 |
| Other operating income | 6,700 | 5,634 | 1,675 | 2,817 | 1,229 | (1,588) | 11,268 |
| Employee expenses | (170,274) | (84,531) | (42,569) | (42,266) | (43,605) | (1,340) | (169,062) |
| Operating expenses excluding employee expenses | (53,533) | (32,454) | (13,383) | (16,227) | (14,755) | 1,472 | (64,908) |
| PDC dividends payable/refundable | (2,701) | (1,353) | (675) | (677) | (648) | 29 | (2,706) |
| Other gains / losses | 0 | | | | | 0 | 0 |
| **Surplus/(deficit) before impairments & transfers** | **790** | **(24)** | **198** | **(12)** | **21** | **33** | **(48)** |
| impairments / exceptional items* | 0 | 0 | 0 | 0 | | 0 | 0 |
| Remove capital donations/grants I&E impact | 100 | 24 | 25 | 12 | 0 | (12) | 48 |
| **Surplus/(deficit)** | **890** | **0** | **223** | **0** | **21** | **21** | **0** |
| Adjust (gains)/losses on transfers by absorption/impairments | **0** | 0 | **0** | 0 | **0** | 0 | 0 |
| **Revised Surplus/(deficit)** | **890** | **0** | **223** | **0** | **21** | **21** | **0** |

Note. The variance compare 'Revised NHSI HI1 plan to date' against 'Actual'
It is assumed forecast is to plan at six and 12 months while further analysis is undertaken

# GHC Balance Sheet

Gloucestershire Health and Care
NHS Foundation Trust

| STATEMENT OF FINANCIAL POSITION (all figures £000) | | 2020/21 | 2021/22 | 2021/22 | Mths 1-3 2021/22 Year to Date | | | | 2021/22 |
|---|---|---|---|---|---|---|---|---|---|
| | | Actual | Original Plan | Revised NHSI H1 plan | Original Plan ytd | Revised NHSI H1 plan ytd | Actual | Variance | Full Year Forecast |
| **Non-current assets** | Intangible assets | 488 | 488 | 488 | 488 | 488 | 346 | (142) | 488 |
| | Property, plant and equipment: other | 109,796 | 119,881 | 115,135 | 111,970 | 111,970 | 109,329 | (2,641) | 119,881 |
| | NHS receivables | 276 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Non-NHS receivables | 316 | 0 | 0 | 0 | 0 | 251 | 251 | 0 |
| | **Total non-current assets** | **110,876** | **120,369** | **115,623** | **112,458** | **112,458** | **109,926** | **(2,532)** | **120,369** |
| **Current assets** | Inventories | 718 | 418 | 568 | 668 | 668 | 718 | 50 | 418 |
| | NHS receivables | 6,077 | 5,877 | 5,977 | 6,044 | 6,044 | 7,052 | 1,008 | 5,877 |
| | Non-NHS receivables | 5,928 | 5,928 | 5,928 | 5,928 | 5,928 | 4,523 | (1,405) | 5,928 |
| | Cash and cash equivalents: | 52,333 | 38,340 | 44,547 | 50,001 | 49,211 | 58,164 | 8,953 | 38,340 |
| | Property held for sale | 0 | 0 | 0 | 0 | 0 | | 0 | 0 |
| | **Total current assets** | **65,056** | **50,563** | **57,020** | **62,641** | **61,851** | **70,457** | **8,607** | **50,563** |
| **Current liabilities** | Trade and other payables: capital | (5,108) | (3,108) | (4,108) | (4,775) | (4,775) | (2,674) | 2,101 | (3,108) |
| | Trade and other payables: non-capital | (23,762) | (20,262) | (22,012) | (23,179) | (23,179) | (30,308) | (7,129) | (20,262) |
| | Borrowings | (107) | (107) | (107) | (107) | (107) | (107) | 0 | (107) |
| | Provisions | (3,526) | (1,526) | (2,526) | (3,193) | (3,193) | (3,524) | (331) | (1,526) |
| | Other liabilities: deferred income including contract liabilities | (2,273) | (773) | (1,523) | (2,023) | (2,023) | (2,620) | (597) | (773) |
| | **Total current liabilities** | **(34,776)** | **(25,776)** | **(30,276)** | **(33,276)** | **(33,276)** | **(39,233)** | **(5,957)** | **(25,776)** |
| **Non-current liabilities** | Borrowings | (1,363) | (1,363) | (1,363) | (1,363) | (1,363) | (1,337) | 26 | (1,363) |
| | Provisions | (1,423) | (1,423) | (1,423) | (1,423) | (1,423) | (1,423) | 0 | (1,423) |
| | **Total net assets employed** | **138,370** | **142,370** | **139,580** | **139,037** | **138,247** | **138,390** | **144** | **142,370** |
| | | | | | | | | | |
| **Taxpayers Equity** | Public dividend capital | 126,578 | 126,578 | 126,578 | 126,578 | 126,578 | 126,578 | 0 | 126,578 |
| | Revaluation reserve | 6,826 | 6,826 | 6,826 | 6,826 | 6,826 | 6,826 | 0 | 6,826 |
| | Other reserves | (1,241) | (1,241) | (1,241) | (1,241) | (1,241) | (1,241) | 0 | (1,241) |
| | Income and expenditure reserve | 6,207 | 10,207 | 7,417 | 6,874 | 6,084 | 6,227 | 144 | 10,207 |
| | **Total taxpayers' and others' equity** | **138,370** | **142,370** | **139,580** | **139,037** | **138,247** | **138,390** | **144** | **142,370** |

Creditors action plan in place to reduce level of trade and other payables

# 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** | | 665 | | 0 | |
| Add back: Depreciation on donated assets | 127 | | 0 | | 21 | | 126 | |
| **Adjusted Operating surplus/(deficit) per I&E** | **(76)** | | **2,800** | | **686** | | **126** | |
| Add back: Depreciation on owned assets | 8,734 | | 6,500 | | 1,545 | | 6,204 | |
| Add back: Impairment | 5,006 | | 0 | | | | | |
| (Increase)/Decrease in inventories | 0 | | 300 | | (0) | | 300 | |
| (Increase)/Decrease in trade & other receivables | 5,722 | | 200 | | 771 | | (1,221) | |
| Increase/(Decrease) in provisions | 492 | | (1,500) | | (2) | | (1,669) | |
| Increase/(Decrease) in trade and other payables | 7,758 | | (1,500) | | 3,463 | | (4,073) | |
| Increase/(Decrease) in other liabilities | (1,409) | | 0 | | 347 | | 24 | |
| Net cash generated from / (used in) operations | | **26,227** | | **6,800** | | **6,810** | | **(310)** |
| | | | | | | | | |
| **Cash flows from investing activities** | | | | | | | | |
| Interest received | 9 | | 0 | | 4 | | | |
| Purchase of property, plant and equipment | (10,769) | | (17,993) | | (952) | | (11,721) | |
| Sale of Property | 0 | | 0 | | | | | |
| **Net cash generated used in investing activities** | | **(10,760)** | | **(17,993)** | | **(948)** | | **(11,721)** |
| | | | | | | | | |
| **Cash flows from financing activities** | | | | | | | | |
| PDC Dividend Received | 679 | | **0** | | 0 | | | |
| PDC Dividend (Paid) | (1,170) | | **(2,800)** | | 0 | | (1,962) | |
| Finance Lease Rental Payments | (363) | | **0** | | (31) | | | |
| | | **(854)** | | **(2,800)** | | **(31)** | | **(1,962)** |
| | | | | | | | | |
| **Cash and cash equivalents at end of period** | | **52,333** | | **38,340** | | **58,164** | | **38,340** |

# Covid 1

Gloucestershire Health and Care
NHS Foundation Trust

- The Trust has spent £468k up to 30th June 2021
- The Trust has received system COVID funding for the In Envelope expenditure
- Out of envelope income has been included at £186k

| *For periods up to and including 30/06/2021 (M3)* | Plan 21/22 £ | YTD Plan £ | YTD costs £ | Full Year Forecast £ |
|---|---|---|---|---|
| Expand NHS Workforce - Medical / Nursing / AHPs / Healthcare Scientists / Other | 507,832 | 126,958 | **97,911** | **346,643** |
| Vaccine Program - Local Vaccination Service | 0 | 0 | **21,302** | **85,208** |
| Remote management of patients | 186,000 | 46,500 | **46,500** | **186,000** |
| Existing workforce additional shifts | 223,440 | 55,860 | **24,313** | **72,090** |
| Decontamination | 82,510 | 20,628 | **19,156** | **37,156** |
| Backfill for higher sickness absence | 223,440 | 55,860 | **28,591** | **92,832** |
| Remote working for non patient activites | 186,000 | 46,500 | **46,500** | **186,000** |
| National procurement areas | 72,000 | 18,000 | **0** | **0** |
| Other | 174,000 | 43,500 | **0** | **0** |
| **TOTAL IN ENVELOPE EXPENDITURE** | **£1,655,222** | **£413,806** | **£284,273** | **£1,005,929** |
| **Out of Envelope Expenditure** | | | | |
| COVID-19 virus testing (NHS laboratories) | | **0** | **159,652** | **638,610** |
| Vaccine Program - Vaccine Centres | | | **23,863** | **95,452** |
| **TOTAL OUT OF ENVELOPE EXPENDITURE** | **£0** | **£0** | **£183,515** | **£734,062** |
| **Out of Envelope Income** | | | | |
| COVID-19 virus testing (NHS laboratories) | | | **-£159,653** | **-638,611** |
| Vaccine Program - Vaccine Centres | | | **-£26,689** | **-106,756** |
| | | | | 0 |
| **TOTAL OUT OF ENVELOPE INCOME** | **£0** | **£0** | **-£186,342** | **-£745,367** |

# Capital – Five year Plan

Gloucestershire Health and Care
NHS Foundation Trust

| Capital 5 year Plan | Original Plan | Updated Plan | 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 |
| **Land and Buildings** | | | | | | | | |
| Buildings | 3,563 | 4,737 | 619 | 4,737 | 1,500 | 2,500 | 2,500 | 1,000 |
| Backlog Maintenance | 5,657 | 3,831 | 259 | 3,831 | 0 | 2,876 | 1,250 | 1,393 |
| Urgent Care | 750 | 750 | 4 | 750 | 0 | 0 | 0 | 0 |
| LD Assessment & Treatment Unit | | | | | | 2,000 | | |
| Cirencester Scheme | | | | | | 5,000 | | |
| | | | | | | | | |
| **Medical Equipment** | 1,569 | 2,221 | 57 | 2,221 | 0 | 130 | 1,030 | 1,030 |
| | | | | | | | | |
| **IT** | | | | | | | | |
| IT Device and software upgrade | 200 | 200 | 2 | 200 | 600 | 600 | 600 | 600 |
| IT Infrastructure | 1,086 | 1,086 | 43 | 1,086 | 996 | 1,300 | 1,300 | 1,300 |
| | | | | | | | | |
| Unallocated | 168 | 168 | 0 | 168 | 0 | 0 | 2,300 | 2,300 |
| **Sub Total** | **12,993** | **12,993** | **985** | **12,993** | **3,096** | **14,406** | **8,980** | **7,623** |
| | | | | | | | | |
| Forest of Dean | 3,000 | 3,000 | (5) | 3,000 | 16,000 | 3,500 | 0 | 0 |
| | | | | | | | | |
| **Total of Original Programme** | **15,993** | **15,993** | **980** | **15,993** | **19,096** | **17,906** | **8,980** | **7,623** |
| Disposals | | | | | (1,349) | (2,454) | (2,000) | 0 |
| Donation - Cirencester Scheme | | | | | 0 | (5,000) | 0 | **0** |
| | **15,993** | **15,993** | **980** | **15,993** | **17,747** | **10,452** | **6,980** | **7,623** |

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

Revised 21/22 plan with increased building scheme costs and new xray equip.

# Risks

Gloucestershire Health and Care
NHS Foundation Trust

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 | 800 | 0 | 800 | 1 | 3 | 3 |
| Efficiencies need to be higher than assumed (0.9% more) | 950 | 950 | 0 | 3 | 3 | 9 |
| | | | | | | |
| **Risks 22/23** | **22/23 Risks** | **Made up of: Recurring** | **Made up of: Non Recurring** | **Likelihood** | **Impact** | **RISK SCORE** |
| IFRS 16 cost implications not fully funded | 1,300 | 1,300 | 0 | 2 | 3 | 6 |
| | | | | | | |
| Total of all risks | **4,313** | **3,513** | **800** | | | |

with you, for you

NHS

Gloucestershire Health and Care

NHS Foundation Trust

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

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**AGENDA ITEM: 11/**0721

| | |
|---|---|
| **REPORT TO:** | **TRUST BOARD PUBLIC SESSION – 29 JULY 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 planned changes of Non-Executive Directors

**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 planned changes of Non-Executive Directors
- Governor activities – including updates on changes in Council of Governor membership
- Working with our system partners
- Working with our colleagues
- National and regional meetings attended and any significant issues highlighted

It is highlighted that as the move out of lockdown continues that the Chair and Non-Executive Directors will be moving back to more face to face visits and quality visits where appropriate.

| **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** (Pages 11-13)<br>Non-Executive Director – Summary of Activity – 1st May – 30th June 2021 |
|---|---|

| **Report authorised by:**<br>Ingrid Barker | **Title:**<br>Chair |
|---|---|

# 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

### 2.1 Non-Executive Director (NED) Update

**Maria Bond's** term of office concludes on 30th September and she will therefore be stepping down from her Board position as part of the regular renewal and refresh process within Board membership. We will be saying our formal farewell to Maria at the September Board, but I would like to record here the Board and my thanks for the important contribution Maria has made: first to the 2gether Board, and then on the GHC Board following the merger. Her contribution, as Chair of the Quality Committee, in shaping the Committee to focus effectively on both mental and physical heath, was significant as we moved forward as a merged Trust and during the pandemic.

A recruitment process has been under way to identify a successor and following a competitive interview process, I am very pleased to announce that we have appointed **Mr. Clive Chadhani** who will be joining the Trust on 1st October 2021. Clive is a FCCA qualified Finance Director with over 26 years global finance work experience within different industry sectors. Clive has agreed to begin some induction activities ahead of his formal start date and we look forward to welcoming him to the Trust and to the Board.

The Non-Executive Directors and I continue to hold our **monthly meetings** and virtual meetings were held on 22nd June and 20th July.

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:**

**Extra-ordinary Trust Board – 15th July**

An extra-ordinary meeting of the Trust Board was held on 15th July to consider the Final Business Case for the new community hospital in the Forest of Dean. Following approval by Board, the Trust will now seek planning permission for the new 24 bed hospital in Steam Mills Road, Cinderford, with a view to starting construction in early 2022. Further information is available on the Trust's website using this link https://www.ghc.nhs.uk/about-us/fod-hospital/

This major investment in a modern, fit for purpose new facility is an important development for both the Trust and the Forest of Dean. We will continue to engage with local people and key stakeholders as we take the next steps in delivering this project.

**Board Strategy:**
The Trust launched it's new "**People Strategy**" on 6th July. This is our five-year strategy confirming the Trust's goals, aims and ambitions for its 5,400 strong workforce, made up of more than 40 different professions. The Trust's 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". The Trust's aim is to be a "Great Place to Work". More information can be found on the Trust's website.

I am delighted that this cornerstone strategy has been put in place and know that the Board is committed to taking it forward and ensuring that the key resource of the Trust, our colleagues, are empowered and supported to achieve their best for our communities.

**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:

**Wednesday 16th June** – two Board Seminars were held - High Quality Care (a.m.) and Measuring What Matters (p.m.). These were two insightful sessions which included input from the teams involved to allow us to be both strategic but grounded in an understanding of current practice. We look forward to taking the issues raised to the next stage.

## 3. GOVERNOR UPDATES

- I attended a meeting of the **Nominations and Remuneration Committee** on 30th June where the Committee considered the outcome of the appraisals for the Non-Executive Directors for the period 2020-2021.

- I continue to meet on a regular basis with the **Lead Governor Chris Witham,** and we met on 17th June and 8th July. 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 14th July where matters covered included the recommendations of the Nomination and Remuneration

Committee held on 30th June; an update on out of area placements for mental health inpatients; Receipt of the Annual Report and Accounts for the Trust. The meeting was followed by a helpful Development Session on the Trust Strategy, focusing on Quality Care and a Better Place to Work.

- A **Membership and Engagement Committee** was held on 23rd June and matters discussed included a report on public membership statistics; a Membership and Engagement Strategy Action Plan; discussion around developing opportunities for membership and engagement activity and a support pack for Governors. The next meeting is due to be held in September. The enthusiastic support of Committee members to take forward effective membership engagement is much appreciated.

- **Governor changes**:
  Josephine Smith's Term of Office as a Public Governor representing Tewkesbury ended on 14th July and she was thanked for her contribution to the Council over the period she has served.

  I am pleased to welcome to new Governors Andy Holness (Public Governor - Tewkesbury) and Rebecca Halifax (Appointed Governor - Gloucestershire County Council).

## 4. NATIONAL AND REGIONAL MEETINGS

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

- **NHS Providers Board** – 2nd June - where we discussed important policy and national operational issues, along with current challenges and opportunities. Having served eight years as a Trustee, this was my last meeting. I am succeeded as the community sector chair representative by Mary Elmore of Cambridgeshire Community Trust. I am pleased to note that Gloucestershire Hospitals NHSFT Chief Executive, Deborah Lee, has also been elected to the Board.

- **NHS Confederation Virtual Annual Conference** –15-17 June. I attended the morning session on Tues 15th June for the opening speech by the new Confederation CEO, Matthew Taylor and also the keynote address by Sir Simon Stevens. I also attended a Chair's session on Weds 16th June.

- **NHS Providers Chairs and CEOs Network** – I attended a meeting on 1st July where we were joined by Sir Simon Stevens, Chief Executive of NHSE/I, who is shortly stepping down from this position. We also heard from Samantha Jones, a former NHS Trust CEO and newly appointed health adviser to the Prime Minister and received a strategic policy update from Chris Hopson, Chief Executive of NHS Providers.

- **NHS Providers Community Provider Chairs Networking session** – 8th July – where we discussed community sector priorities.

- **NHS Providers Community Network** – 8th July – matters included a strategic policy update from Matthew Taylor, Chief Executive of the NHS Confederation; an update from Matthew Winn, Director of Community Health at NHS England and a panel session on place-based partnerships.

- **South West NHS Provider Chairs meeting** – 9th July

- I have recently been invited to be a **Member of the NHS Executive Search Chair and Chief Executive Advisory Board** and attended its inaugural meeting on 9th July.

- **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. Our Non-Executive Director, Dr. Steve Alvis, recently hosted a session on primary care.

- **NHS Confederation Mental Health Network** – meetings take place weekly and I attend when my diary permits. At the most recent meeting we received a briefing from Mental Health Chair lead, Claire Murdoch.

## 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:

- **Health Overview and Scrutiny Committee (HOSC)**:

    - **15th June** - following the local government elections in May, a virtual induction HOSC was held on 15th June. The Committee appointed a new Chair, Cllr Andrew Gravells MBE and Deputy Chair Cllr David Drew. The HOSC meeting on 15th June was intended as an induction session for the new committee, but also received a presentation from Healthwatch Gloucestershire; an update on the Gloucestershire Integrated Care System (ICS) which included updates on Covid-19 emergency response and the Forest of Dean Community Hospital consultation development. The Committee also received an update on the Fit for the Future Programme including recent proposals for developing specialist hospital services in the county.

    - **13th July** – this meeting was held at Shire Hall, Gloucester, with COVID secure restrictions in place, including numbers of attendees. I attended along with the Trust's Chief Executive and matters included an update on the Covid-19 emergency in Gloucestershire; a review of Temporary Services Changes and an update on Fit for the Future Consultation Programme.

- The **County's ICS Health Chairs** continue to meet virtually and we held meetings on 15th June and 13th July.

- Along with a number of the Trust's Non-Executive Directors, I attended a meeting of the **ICS NED Network** organised by the Clinical Commissioning Group, on 15th June.

- 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 17th June and 15th July. 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.

- On 7th July, along with other members of the ICS Board, I attended a virtual meeting with the **Chief Executive and Chair of the NHS Confederation.**

- On 21st July I attended a meeting arranged by the **University of Gloucestershire** to discuss the **City Campus** (ex-Debenhams) along with various Gloucestershire health system partners.

## 6. WORKING WITH THE COMMUNITIES AND PEOPLE WE SERVE

- On 24th June I chaired a quarterly meeting with the **Chairs of the county's Leagues of Friends**. Angela Potter, the Trust's Director of Strategy and Partnerships, was also in attendance. Updates were given on the Trust's response to COVID-19; the Integrated Care System; Fit for the Future; the 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, despite the constraints of the pandemic. I would like to place on record my grateful thanks to **Graham Hewitt, the Chair of Fairford and Lechlade Communities Trust,** who will be stepping down from the Chair's position shortly. He will continue in his role as public governor so will not be lost to the Trust.

- The Chief Executive, the Director of Strategy and Partnerships and I held a meeting on 6th July with **Mark Harper MP** to update him on developments with the new Forest of Dean Hospital.

- Following recent appointments to the County Council's Health Overview and Scrutiny Committee, I have held discussions with the following **HOSC Members**:

**Cllr Andrew Gravells MBE (Chair of HOSC**) – I held a virtual meeting with Cllr Gravells on 6th July to congratulate him on his new appointment and brief him on current matters. We have agreed to hold our usual annual informal briefing between the Trust and HOSC Members in October.

**Cllr David Drew** (Deputy Chair of HOSC) – a presentation and visit to Stroud services is being planned for Cllr Drew and Stroud Councillor Helen Fenton on 25th August.

**Cllr Gill Mosely** (new Gloucestershire County Councillor, Newent Town Councillor and Member of the Forest of Dean District Council) – where I updated her on the latest developments on the Forest of Dean hospital.

- **Calls with the Chairs of the Leagues of Friends for the Forest of Dean hospitals** - Lydney (Mary Thurston) and Dilke (Bob Young) – to update on proposals for the new Forest of Dean Hospital, ahead of Trust Board discussions on 15th July.

- I was delighted to be invited to the **Bishop of Gloucester's Annual Garden Party** at Bishopscourt in Gloucester on Fri 23rd July. This is always a lovely occasion and presents a good opportunity to catch up with a wide range of third sector partners.

## 7. ENGAGING WITH OUR TRUST COLLEAGUES

- **NHS 73rd birthday celebrations – 5th July 2021**

The NHS as a whole was honoured to be awarded **The George Cross by Her Majesty The Queen** to mark its public service over seven decades. The award recognised all NHS staff, past and present, across all disciplines and all four nations.

As part of the national celebrations, Paul Roberts, CEO, wrote to Trust colleagues to thank everyone for their incredible contributions over the course of the last unprecedented year and for upholding the values of the NHS in such a magnificent way. I, along with the County's Health Chairs, recorded a video message of thanks to all colleagues.

- Following feedback from ICS Partners and colleagues, I carried out the **Chief Executive's annual appraisal** on 1st June 2021.

- An **Appointment and Terms of Service Committee** was held on 1st June 2021 to consider the appointment process for the Chief Operating Officer following the resignation of John Campbell, as updated in the Chief Executive's Report.

- As part of my informal visits to Trust services, I visited **Charlton Lane Hospital** on 3rd June and **Hope House and the Sexual Assault Referral Centre (SARC)** on 21st July. My grateful thanks to Modern Matron, Steve Ireland (Charlton Lane), Lead Sexual Health Nurse, Adam Godwin, Crisis Worker Karen Lowden

and SARC/VANS Co-ordinator Claire Raven (Hope House and SARC) for sparing time during their business schedules to accompany me on my visits.

- As part of the **Big Health and Wellbeing Week** which took place from 21st to 25th June, the Chief Executive and I were pleased to be asked by event organiser **Simon Shorrick** to launch the Big Health Check Day on Monday 21st June. This year due to the pandemic the week's events all took place via Zoom. This is the thirteenth year of the Big Health event and the aim of the Big Health Week is to deliver an inclusive week with the theme of staying healthy and active, to meet friends, to have fun, to reduce health inequalities for people living with a learning disability, a physical disability and / or mental health problems, and help people to help themselves through activities arranged.

- As part of Armed Forces Week, the Trust was officially awarded its **Veteran Aware Accreditation** on 23rd June during a visit to Trust Headquarters by Deputy Lord Lieutenant, Colonel Andy Hodson. A brief ceremony at Edward Jenner Court was attended by some of the Trust's Veterans and the Accreditation was received by myself, along with the Chief Executive, and Community Services Manager, Jonathan Thomas, the Trust's Veterans Steering Group Lead. More information can be found via GHCcomms@ghc.nhs.uk

- Continuing with my rotational attendance at Board Committees, I attended the **Resources Committee** on 24th June.

- A **Summer Diversity Celebration** organised by Firoza Shaikh, HR/OD Engagement Manager, was held online on 15th July for colleagues to celebrate the diversity and range of experience across the Trust. I gave a short introduction, highlighting how diversity and inclusion is at the heart of the Trust and its values. This was an excellent event and was recorded so I would encourage those of us who were unable to be there to watch it on 'catch up'.

- **Formal Quality Visits** in person by myself and the NEDs had to be put on hold throughout the pandemic. However, with restrictions now easing a schedule of formal in person Quality Visits for myself and the Non-Executive Directors is now currently taking place and outcomes will be reported to Committee and Board meetings.

- Non-Executive and Executive Director informal "**pairing" meetings** continue to take place and I was pleased to meet with the Interim Chief Operating Officer, Hilary Shand, on 22nd July.

- 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 need to be 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 1** for the summary of the Non-Executive Directors activity for May and June 2021.

## 9. CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided.

Appendix 1

## Non-Executive Director – Summary of Activity – 1st May to 30th June 2021

| NED Name | Meetings with Executives, Colleagues, External Partners | Other Meetings | GHC Board / Committee meetings |
|---|---|---|---|
| Dr. Stephen Alvis | Team Talk<br>Governor<br>Medical Director<br>MHAM Individual Review meeting (2)<br>Trust Chair<br>Joint Director of Locality Development and Primary Care<br>Quality Visit to Berkeley House<br>Senior Leaders Network | NHS Reset Chairs meeting<br>NHSP Governance and Quality Committee (2)<br>Good Governance Institute webinar (4)<br>NHSP Digital Inclusion event | Quality Committee<br>NEDs meetings (4)<br>FoD Assurance Committee<br>Trust Board<br>Board Seminars (3)<br>ATOS Committee |
| Maria Bond | Director of Nursing, Quality and Therapies (4)<br>Internal Auditors pre-meet (2)<br>External Auditors pre-meet (2)<br>Director of Strategy & Partnerships ref FoD economic modelling<br>Chief Executive<br>Expert by Experience<br>Senior Leaders Network (2)<br>Medical Director (2)<br>Head of Corporate Governance/Trust Secretary<br>Interim Chief Operating Officer<br>Quality Visit – Charlton Lane Hospital<br>MHAM Appeal Hearing<br>ICS NED Network<br>Reciprocal Mentoring meeting | NHS Reset Chairs meeting (2)<br>Action on ACES conference<br>Good Governance Institute ref Mental Health | Board Seminars (3)<br>Audit and Assurance Committee (2)<br>Quality Committee<br>Trust Board<br>Council of Governors<br>NEDs meetings (4)<br>Board Briefing (FoD)<br>ATOS Committee (2)<br>FoD Assurance Committee |
| Steve Brittan | Task and Finish Group (ref UoG)<br>Sustainability Manager<br>Director of Strategy and Partnerships (4)<br>Internal Auditors pre-meet (2) | Digital Workshop<br>NHS Reset Chairs meeting<br>HSJ Webinar – Digital Priorities<br>NHS Providers Digital Inclusion meeting | Board Seminars (3)<br>Audit and Assurance Committee (2)<br>Council of Governors<br>NEDs meetings (4) |

| NED Name | Meetings with Executives, Colleagues, External Partners | Other Meetings | GHC Board / Committee meetings |
|---|---|---|---|
| | External Auditors pre-meet (2)<br>Trust Chair (3)<br>Vice-Chair<br>Senior Independent Director<br>Estates Strategy workshop<br>Director of Finance/Dep CEO<br>ICS NED Network | | Board Briefing (FoD)<br>Trust Board<br>ATOS<br>Resources Committee<br>Forest of Dean Assurance Committee |
| Marcia Gallagher | Trust Chair (2)<br>Internal Auditors (pre-meet) (2)<br>External Auditors (pre-meet) (2)<br>NHSI/E Regional Director<br>Director of Finance<br>Internal Auditors<br>Joint Director of Locality Development and Primary Care<br>Julie Mackie<br>Longlisting for NED recruitment<br>CYPS Delivery and Governance Forum<br>ICS NED Network<br>Quality visit to Dilke Hospital<br>Senior Leaders Network<br>NED recruitment – longlisting | NHS Reset Provider Collaboratives<br>Good Governance Institute seminars (2) | Board Seminars (3)<br>Audit and Assurance Committee (2)<br>Council of Governors<br>NEDs meetings (4)<br>Trust Board<br>ATOS Committee (2)<br>Nom and Rem Committee |
| Sumita Hutchison | Meeting with Staff Governors (3)<br>Estates Strategy workshop<br>Director of HR & OD (2)<br>Director of Strategy & Partnerships (pre-meet for Charitable Funds Committee)<br>Interview Panel – Dep Director HR<br>Diversity Network | Complaints Audit<br>South West Wellbeing Guardian meeting<br>NHS Confederation Annual Conference<br>Freedom to Speak up event | Board Seminars (3)<br>Staff Governor session<br>Quality Committee<br>Council of Governors<br>NEDs meetings (4)<br>Board Briefing (FoD)<br>Trust Board<br>Charitable Funds Committee<br>Resources Committee |

| NED Name | Meetings with Executives, Colleagues, External Partners | Other Meetings | GHC Board / Committee meetings |
|---|---|---|---|
| Jan Marriott | CH Clinical Director and Community Hospitals Association<br>FTSU Guardian<br>Cheltenham Governors and Cheltenham Partnership Leads<br>Non-Executive Director<br>Director of Nursing, Therapies and Quality (2)<br>Director of HR&OD<br>NED<br>ICS NED Network<br>Mental Health Operational Group<br>Quality Visit to Wotton Lawn Hospital<br>Consultant Psychiatrist Interview Panel<br>County MCA meeting | | Board Seminars (3)<br>Quality Committee<br>Council of Governors<br>NEDs meetings (4)<br>Trust Board<br>ATOS Committee (2)<br>Resources Committee |
| Graham Russell | Director of Strategy and Partnerships<br>ICS pre-meet with Chair and CEO<br>Chief Executive<br>Quality Visit to Charlton Lane Hospital<br>Trust Chair<br>NED recruitment – discussions with candidates<br>ICS NED Network | Mental Health and Housing Seminar<br>NHS Providers Digital Inclusion event<br>Gloucestershire Community Mental Health event | Board Seminars (3)<br>Audit and Assurance Committee (2)<br>Council of Governors<br>FoD Assurance Committee (2)<br>Estates Strategy<br>ICS Board (2)<br>Trust Board<br>NEDs meetings (4)<br>Charitable Funds Committee<br>ATOS Committee (2)<br>Resources Committee<br>Nom and Rem Committee |

**AGENDA ITEM: 12/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 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**

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| **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 and members of the public on my activities and those of the Executive Team.

**Recommendations and decisions required**

The Board is asked to **note** the report and **Approve** the Modern Slavery Policy.
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**Executive Summary**

The Executive team and I remain working collaboratively and adaptably as we continue to respond to the ever-changing situation presented by the continuing pandemic. Whilst we follow government guidance as it is issued, particularly given the removal of lock-down restrictions on 19th July, we note the advisory and permissive nature of the guidance and continue to prioritise ensuring that all colleagues are working in a safe environment. It is likely that guidance will further change in the coming weeks and our priority will remain that of ensuring staff and service users understand the safety requirements within our services and that a safe environment is maintained.

The Trust continues to make progress on key programmes and projects including the recent approval of the Forest of Dean full business case, significant and welcome Mental Health investments, Covid-19 service recovery, an extension to our home first service (Enhanced Independence Offer), Equality, Diversity and Inclusion (EDI) initiatives, and following on from the May Board meeting the launch of the Trust's People Strategy.

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| 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.<br><br>As well as updates on the activity and focus of the CEO this report provides an update on the **Trust's People Strategy** is provided as well as an update on the **Trust's Modern Slavery Policy**, and changes to the **Executive Team**. |

| **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 authorised by:**<br>Paul Roberts | **Title:**<br>Chief Executive Officer |
|---|---|

# CHIEF EXECUTIVE OFFICER AND EXECUTIVE TEAM REPORT

## 1.0 CHIEF EXECUTIVE CONTEXT AND ENGAGEMENT

### 1.1 Covid-19

Transmission levels have continued to rise slowly but steadily in the past few weeks with levels in our county initially among the highest in the South West and above the national average. Thankfully, hospitalisations, while rising, have not reached the levels they did earlier in the year, mainly because of the successful vaccination roll out. The 19th July was the date when most of the remaining Covid-19 restrictions were moved from mandatory requirements to advisory or personal or organisation-based decisions. We continue to consider what this means for our colleagues, teams and services and will be doing what we can to keep everyone safe and healthy.

Discussions with the Executive Team and Senior Managers have established that it is prudent to continue with the existing application of Covid-19 secure guidance and local IPC guideline implementation. Following the Gloucestershire ICS IPC leads review of best practice, the current Gloucestershire Covid-19 infection rate and the need to continue to maintain the safety of our patients, families and colleagues, the following local guidance will be maintained from 19th July 2021.

*Established IPC protective practises within Gloucestershire NHS Healthcare environment (clinical and administrative) regarding wearing a mask, social distancing and enhanced hand hygiene will continue. This will be of course under regular review and will respond to future changes in national guidance and community infection rates*.

The Trust will continue to meet to develop further health and safety plans regarding transition on receipt of anticipated national guidance. We will continue to provide regular updates in light of any changing guidance or infection prevalence through our standard Trust communication routes. I would like to thank colleagues for their cooperation and understanding.

The co-incidence of the intense pandemic recovery programme, the third Covid-19 wave and the additional demand that appears to have resulted from the pandemic have meant that the system, as with the rest of the country, has been under considerable pressure over recent weeks. We have been dealing with significant demand in primary care, urgent and emergency care and planned care in hospital and community settings.

### 1.2 Internal engagement and developments

Since May I have continued to do a number of **service visits** (in person – where this can be done safely). Recently I have based myself at **Vale Community Hospital**, **Pullman Place, Hope House, North Cotswolds Community Hospital** and **Southgate Moorings**. Each day spent in these locations has been a very valuable experience providing substantial insight into colleagues' experiences with their working environment and how they address the challenges presented by the ever-changing circumstances. I value the opportunity to be able to continue to meet with

colleagues and patients, and to be on hand to discuss any topics or issues they would like to raise.

We are delighted that GHC has been named a **Veteran Aware** Trust, in recognition of our commitment to driving improvements in NHS care for veterans, reservists, members of the armed forces and their families. Veteran Aware Trusts are leading the way in improving veterans' care within the NHS as part of the Veterans Covenant Healthcare Alliance (VCHA). The Chair and I were very pleased to be present for the presentation of the Veteran's Aware accreditation by Deputy Lord Lieutenant, Colonel Andy Hodson. A brief ceremony was held at Edward Jenner Court and was attended by some of the Trust's very own Veterans. We continue to work to ensure that we provide the best possible care and experience for veterans and their families.

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: Be Kind to You Month (during July we are encouraging colleagues to consider a range of activities to support their wellbeing and reinforce the importance of taking time out to focus on themselves – whilst recognising the difficulties in this. There have been cookery demonstrations, exercise classes and mindfulness activities to name but a few), the Summer Diversity Celebration, the Big Health and Wellbeing Week, online fraud training, overseas recruitment, and more. 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.

Virtual **Senior Leadership Network** (SLN) meetings were held on 29th June and 27th July. These provided an excellent opportunity to update the SLN on Trust and national developments. The June session featured a service recovery story relating to Speech and Language Services presented by Sarah Birmingham, Deputy Chief Operating Officer. Maddy King, Organisational Development Expert, also provided a useful update on the THRIVE leadership programme. Neil Savage, Director of HR & OD, further updated the group on our People Strategy and health and wellbeing. The feedback from these sessions continues to be overwhelmingly positive.

After careful deliberation with the recruitment team, **Corporate Induction** as of July is switching from taking place weekly to fortnightly. The hope is that once it is safe to do so and in line with government guidance we may be able to resume face-to-face inductions. As and when this is allowed, the recruitment team will prepare for these sessions to take place at Invista. For now, they will continue to be virtual, but are nonetheless 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.

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 three times a week. 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 (especially as we enter into phase 3), and are able to assess resilience in these key areas on a regular basis and put in place any actions required.

A half day **Executive Development session** was facilitated by the **Kings Fund** for the Executive Team on 16th July. This session helped to develop the Executive Team's skills for individual recovery and wellbeing, reflected on service recovery, and spent time reconnecting with the leadership agenda.

### 1.3 Forest of Dean Hospital

On 15th of July the **Trust Board approved the Forest of Dean Hospital full business case**. The plans, including artist impressions, have now been shared publicly so that people can comment on them. The next steps will be 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. Further updates are provided in the Systemwide Update provided by the Director of Strategic Partnerships.

### 1.4 Mental Health focus

As was widely predicted mental health services for children young people and adults have been under significant pressure in recent months. Demand has increased as has complexity and there continue 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.

My own focus on mental health has be 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. 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. As well as making a number of key decisions about specialist services we have also been exploring the potential shape of the provider collaborative to reflect the recent White Paper and healthcare Bill.

In Gloucestershire I now chair the **Community Mental Health Transformation Programme Board**. The CMHT meeting held virtually on 23rd June discussed the terms of reference, governance structure, work streams and design development of the Gloucester City project, as well as future projects. The Programme Board has been set up to work alongside a "People's Participation" Board to ensure that there is equal

input into the development of community services from people who use services. This is facilitated by Inclusion Gloucestershire.

John Trevains and I met Assistant Chief Constable Jon Stratford and Deputy CEO of the Gloucestershire Police and Crime Commissioner, Ruth Greenwood on 10th June to discuss the relationship between the police service and mental health services in the light of an incident in 2020. We had a productive and positive discussion. I have also had an introductory meeting with Superintendent Emma Davies and Inspector Sarah Simmons of the Local Policing Cheltenham & Tewkesbury Gloucestershire Constabulary to discuss the **Community Mental Health Transformation**, held on 9th July. The local police are keen to join with our efforts respond to the community mental service health challenges and transformation.

On the 5th July I chaired a "round table" meeting to reflect on the role and pressures in our **Mental Health Liaison Services**. This meeting was attended by relevant stakeholders who work in MHLS as well as members of the Executive Team. We discussed a number of priorities including the need to develop a better framework for measuring the impact and outcomes of the service.

I attended the bi-monthly national NHS England **Mental Health Trusts CEO meeting**, chaired by Claire Murdoch. These useful sessions provided discussions on mental health as lockdown eases, and a presentation from Jake Mills, Founder and CEO of Chasing the Stigma – Hub of Hope (mental health charity) on their initiatives and innovative partnership with the NHS to provide accessible mental health services.

I had many informative meetings to discuss Mental Health initiatives across the South West including a meeting with NHS England's National Mental Health Director Claire Murdoch, 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 regional mental health strategy is useful to our local focus as it enables me to be aware of and influence developments across the region.

### 1.5 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 first meeting was held on 14th July and discussed the scope of the panel, how best to be impactful, key areas of focus, and key enablers who will assist with achieving goals. I look forward to the influential work this panel will contribute to in tackling inequalities.

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.

I chair the monthly **Gloucestershire Covid-19 Vaccination Equity Group.** This group, which supports the equitable uptake of Covid-19 vaccinations across Gloucestershire, has been doing incredible work for vaccine hesitant communities. Through innovative communications, community engagement and outreach this group has made a positive impact in ensuring the Covid-19 vaccine is accessible to all individuals. Their efforts have greatly helped to reduce vaccination hesitancy. The group continues to meet monthly to assess vaccine equity across all cohorts within Gloucestershire as vaccine rollouts continue and as we head into phase 3 of the pandemic.

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 24th June featured a perceptive presentation on Ethnic Minority Action Planning, an update on creating equitable recruitment and promotion practises with a deep dive into disparity ratios, and presented an interim Equality and Inclusion Strategy Action Plan. We are also the sponsors of the Leading for Inclusion Programme mentioned below.

I regularly attend the **SW Regional Chief Executives** meeting. On 8th July, we were presented with the launch of the **Leading for Inclusion Programme.** This programme aims to make the South West the best and most inclusive place to work. The programme will nurture, challenge and extend our collaboration and impact as we work with an ambitious vision for equity across the region. It should help to deepen understanding of what is possible and develop the insights and knowledge of leaders so that we can go beyond what we have achieved so far.

On 10th June I attended a **virtual discussion for the Gypsy, Roma, Traveller community** which 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.

On 15th July the Trust held the **Summer Diversity Celebration**. All colleagues from across the Trust were invited to celebrate being part of the GHC team. The event was a celebration of diversity and the range of experiences and people who we are lucky to have as colleagues. Participants were encouraged to discuss any key issues affecting them. I was able to welcome all participants to the event. This provided a good opportunity to discuss the value of working together, and how proud I am of the diversity of people within the wider GHC Team. This session really demonstrated and celebrated the importance of diversity and inclusion throughout the Trust and throughout our everyday lives as well.

I gave a welcome and introduction at the opening of the **Big Health and Wellbeing Week.** This event that used to be held face-to-face, adapted to virtual this year and expanded to a full week of events (12 years previously this event was held over a single day). The celebratory event aimed to reduce health inequalities and support the health and wellbeing of people with learning and other disabilities.

Involvement in this breadth of celebration, reflection and transformation activities demonstrates the commitment of the Trust to ensuring Equality, Diversity and Inclusion are at the core of how we operate.

### 1.6 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)** and the **Accountable Officer for Gloucestershire Clinical Commissioning Group (GCCG)** to keep abreast of any issues facing our partner organisations. I also continue to have regular meetings with senior officers and Leaders at Gloucestershire County Council, including Sarah Scott, **Executive Director of Adult Social Care and Public Health,** we have reinstated our informal operational senior team meetings to share common priorities and issues**.**

I have attended the monthly **ICS Board**, **ICS Executive** and **ICS CEO Meetings**, which continue to focus 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.

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 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.

I continue to attend the bi-weekly **Gloucestershire MP briefings**, led by CEOs of the Gloucestershire NHS organisations and senior County Council officers and Leaders. These continue to largely focus on the latest developments in the management of the Covid-19 pandemic including providing updates on vaccination mobilisation and PPE. Elective diagnostics recovery, system flow delivery and primary care updates are also provided at these meetings.

I chair the **ICS Diagnostic Programme Board**, which met on 8th July. The Board is continuing to progress the important work on developing local proposals for potential **Community Diagnostic Hubs** (CDH). The current focus of these efforts is in the development and coordination of networked diagnostic services which are equitable and consistent; aiming to get the right patient to the right test, in the right location, in the fewest number of visits (and referrals) and in the shortest amount of time. The aim is to maximise the limited diagnostic capacity through triage, stratification and prioritisation which is personalised and sustainable across Gloucestershire whilst seeking to invest / innovate and expand existing services so that they meet current and future demands.

I attend the monthly **Community Chief Executives Network** meetings. The meeting held on 30th June featured an informative presentation from the Integrated

Communities System Director, Helen Childs on Delivering Ageing Well UCR during a pandemic with a case study from Cornwall and the Isles of Scilly's response.

The **Health and Overview Scrutiny Committee** Induction Session to welcome new members took place on 15th June, which I attended virtually. On 13th July the Chair and I attended the Health Overview and Scrutiny Committee meeting at Shire Hall. At this meeting Sarah Scott, Executive Director of Adult Social Care and Public Health, provided a Public Health COVID-19 update. There was also a review of temporary service changes as well as an update provided on the Fit for Future Programme.

I am **truly grateful to our entire workforce**, both clinical and support, who have worked brilliantly and flexibility to serve our patients and communities. I am incredibly proud of all of my colleagues for their hard work and dedication throughout this tough year and I am confident that our Trust team will continue to work together as we navigate phase 3 of the pandemic.

## 2.0 LAUNCH OF THE TRUST'S PEOPLE STRATEGY

I am delighted to report that we have launched our 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."

Our aim is to be a "**Great Place to Work**".

Being a great place to work means: "Taking care of our people, with a strong focus on their health and wellbeing. Our organisation will celebrate diversity, ensure real inclusivity and enable everyone to reach their potential. We will make sure colleagues are heard, valued and influential. We will develop a culture where working life can be passionate, vibrant and inspiring. This will help us to attract new people who are as great as those we already have, and we will make sure that those already with us, want to stay."

We have a number of actions and programmes in place or planned to realise our people ambitions, and these include a commitment to 6 key Commitments or areas we will focus on:

1. Model Recruitment and Retention
2. Health and Wellbeing
3. Great Culture, Values and Behaviours
4. Strong Voice
5. Equality, Diversity and Inclusion
6. Full Potential

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. In line with our values

we will continue to listen and work in partnership with colleagues as well as patients, carers, and communities. We recognise 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.

## 3.0 MODERN SLAVERY POLICY

There is a mandatory requirement for the Trust to have a public statement by the Board on our 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. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Trust (GHCNHSFT) 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.

It was confirmed that there had been no specific actions or initiatives during 2019/20; the statement has been updated to provider greater assurance that this is very much a continuous element for the Procurement team. The updated statement is provided for approval by the Board and publication on the Trust's website.

The Trust's full Modern Slavery Policy can be found here:
https://www.ghc.nhs.uk/equality-and-diversity/

## 4.0 EXECUTIVE TEAM CHANGES

**John Campbell – Chief Operating Officer**
I would like to formally record that John 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 are saddened but respectful and supportive of his decision. I am sure we would all want to wish him well for his next venture to which, I have no doubt, he will make an important contribution.

In terms of next steps, the **Chief Operating Officer** role is a significant and important one for the Trust and we have commenced a recruitment process so that an

appointment can be made as soon as possible. In the meantime, I can confirm that **Hilary Shand** has agreed to continue to act up as Interim Chief Operating Officer with the continued support of executive and senior colleagues.

## 5.0 CONCLUSION AND RECOMMENDATIONS

The Board is asked to **NOTE** the report and the assurance provided and **APPROVE** the Modern Slavery Policy.

**AGENDA ITEM: 13/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 2021**

**PRESENTED BY:** Angela Potter, Director of Strategy & Partnerships

**AUTHOR:** Angela Potter, Director of Strategy & Partnerships

**SUBJECT:** **INTEGRATED CARE SYSTEM UPDATE**

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|---|---|
| **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:

- An update on the reconvened Health Overview and Scrutiny Committee
- Update from the Health & Well-being Board
- Progress report from the Integrated Locality Partnerships
- HealthWatch Gloucestershire's Annual Report and highlights 20/21
- One Gloucestershire ICS Accountable officers report is attached for information

**Risks associated with meeting the Trust's values**

None

| **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. |

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|---|---|
| **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. |

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| **Appendices:** | Appendix 1 - ICS Board Minutes<br>Appendix 2 - One Gloucestershire Accountable Officer Report<br>Note: Board members please note these are in the Reading Room on Diligent |

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| **Report authorised by:**<br>Angela Potter | **Title:**<br>Director of Strategy & Partnerships |

# INTEGRATED CARE SYSTEM UPDATE REPORT

## 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. Health Overview and Scrutiny Committee (HOSC) Activities

A new HOSC Committee has been formed following completion of the recent election process. The Chair has been confirmed as Cllr Andrew Gravells. It held its first formal meeting on the 13th July 2021. The agenda covered a review of the temporary services changes that the Trust has instigated as part of the Covid-19 pandemic response and an update on Fit for the Future.

The following recommendations were supported;

- The Minor Injury and Illness units will work towards a plan of normal re-opening i.e. extension of hours until 11pm in appropriate units (with the exception of Dilke – which needs to remain closed due to Covid Secure environmental issues). There is an exercise underway by operational colleagues to understand the impact of taking this forward on the clinical triage services that we have put into the units as a response to Covid which appears to be offering significant system benefit.
- The Stroke beds at Vale were extended from 14 to 20 in September 2020. Again, this has 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 will be brought back in due course.

## 2. Health & Well-Being Board

The Health & Well-Being Board has met on the 20th July. The following key areas of discussion were of particular note;

- Update on the health inequalities work, particularly the vaccine equity work and the ongoing impact of Covid-19. The Board also recognised that whilst there is a wide range of activity taking place to tackle health inequalities, this activity needs to be brought together strategically into a more coherent whole. As such, a Health Inequalities Panel has now been established to coordinate and align current action; ensuring priorities for strengthening this work are agreed, impact is monitored and learning is shared. Additionally, it will ensure a sustainable, community-centred, whole systems approach to reducing health inequalities is taken forward.
- Anchor Institutions work - A virtual event in the autumn has been supported to launch the *Gloucestershire Anchors Partnership Programme*. The intention is that this will serve as a call to action, and be an opportunity to share local and national examples of good practice and to gather views about how we can

collectively maximise the benefits from this approach. The Trust is fully engaged in this work and will support the event moving forward.

- A focus on children's services including the work of the Children's Wellbeing Coalition and the Adverse Childhood Experience work particularly around trauma informed care and feedback from an extremely successful Ambassadors networking event held in May.

## 3. Wider ICS and Partner updates:

3.1 Healthwatch Gloucestershire have released their Annual Report for 2020/21 which can be found at https://www.healthwatchgloucestershire.co.uk/news/hwg-annual-report-2020-21-published/

In its latest Annual Report, Healthwatch Gloucestershire explains how it worked throughout the year to understand people's health and care needs, and how it used public feedback to help services respond and improve care for local people. The report also identifies the most common issues people raised, and outlines work planned for 2021-22.

Healthwatch Gloucestershire published 6 reports and made 27 recommendations for improvement to health and social care providers in 21/22. The most common areas of comment and enquiry raised with Healthwatch Gloucestershire last year were GP services (34%), dentistry (20%), Covid-19 vaccinations (12%), patient transport (3%) and care at home services (3%).

3.2 Investment in Greener Fire Engines

Gloucestershire Fire and Rescue Service (GFRS) has received funding worth £3.7m over the next few years through Gloucestershire County Council's (GCC) capital programme to secure 12 new vehicles. The vehicles will be more environmentally-friendly using greener technology, so the amount of emissions produced will be significantly reduced and will reduce service risks due to vehicle failure as the old fleet becomes more unreliable.

3.3 Home-Start UK report on the impact of Covid-19 on families

Home-Start UK have released findings from a piece of national research *Home Is Where We Start From* that has focused on measuring the impact of Covid-19 pandemic on parents of young children. They heard from over 1200 parents they support about the issues that have affected them the most.

Poverty, mental health issues and the social development of children were found to be the three main concerns for parents of young families. Findings revealed that families are facing unprecedented challenges, with the pandemic acting both as a magnifier of existing disadvantage, as well tipping more people, who were just about managing before, into poverty.

3.4 Quayside House

Two GP practices (GP Health Access and Severnside Medical Practice who were formerly Gloucester City Health) have relocated into Quayside House in Gloucester which opened on the 12th July. It will serve around 18,000 patients, as well as

providing a pharmacy and office space. The new health centre has been built on land owned by Gloucestershire County Council and cost £5.3m. It is part on an ongoing regeneration of the Quayside area which is bringing high quality services, investment and job opportunities to the city.

3.5 Digital Projects in Gloucestershire

Through its Digital Innovation Fund Gloucestershire County council has £200,000 worth of grants available to community or voluntary groups and charity organisations to fund digital and technology-led initiatives.

This is the second year of the fund and applications have been accepted up to £20,000 per project or greater if they are Collaborative partnership bids. There has been a push to address digital exclusion and help people remain independent and projects are welcomed that aim to supporting adults in Gloucestershire by:

- Improving literacy, including digital literacy
- Preventing a decline in independence, health or wellbeing
- Encouraging digital access opportunities amongst Black and Minority Ethnic communities
- Providing equipment and support to those with disabilities and sensory impairments

## 4. Integrated Locality Partnerships Updates (where appropriate)

**Gloucester ILP**

Angela Potter, Director of Strategy & Partnerships has currently picked up the Chair for this ILP. Wider partnership presentations were given at the June meeting with a focus on health inequalities including the Matson Community Health Equalities Partnership Group who are currently exploring community engagement approaches.

Work has also progressed on the Community Builders project across the City and a map of community builders and social prescribing services in Gloucester City has been produced along with initial work taking place to develop an Engagement Strategy. It was recognised that as this project further develops, there may an opportunity to align this work as a work stream within the Health Equality work.

**Stroud ILP**

Stroud District Council reported they have been awarded funding to deliver a summer activity programme for CYP in receipt free school meals. Plans are also being developed to take forward a health and wellbeing program working with local schools to be delivered September through to December.

There remains a focus on Healthy Lifestyles and physical activity: working with partners to restart physical activity offers and linking with physiotherapy services to improve partnership working.

**Cotswolds ILP**

Update received from Young Gloucestershire and *Infobuzz* regarding local services and digital developments which recognised that not all young people need a counsellor, sometime just someone to talk too.

A review of the CYP data for Cotswolds noted increased referral rates into CAMHS. Further data to be explored and opportunities to connect young people with their communities and increase resilience will be considered.

**Forest ILP**

The group have had their first reconvened meeting since the Covid pandemic. A new interim chair is in place - Philippa Lowe from FOD District Council and it gave members the opportunity to review and refresh connections and consider what the priority pieces of work need to be across the Forest.

## 5. Focus on Patient, Carer and Staff feedback and engagement

5.1 Healthwatch Gloucestershire have completed a review into access and the information provided by GP surgeries during Covid. People reported that there were a number of routes to get access to primary care and indeed both face to face and telephone consultations available. A number of recommendations have been included in the report particularly around e-consult and the choice and range of appointment types to suit individual need.

5.2 Inclusion Gloucestershire are undertaking a survey that has been co-designed with people with a variety of lived experiences to capture the views of disabled people and those with mental health conditions to help inform their organisational strategy for the next few years. The survey closes on the 20th July and we look forward to seeing the results which will be shared in due course and will continue to support GHC is our partnership working with Inclusion Gloucestershire. Inclusion Gloucestershire want to encourage as many people as possible to complete it.

The survey can be completed by people who do not have lived experience themselves but those people are asked to consider the questions from their experience of disabled people and those with mental health conditions.

## 6. One Gloucestershire ICS Accountable Officer report

This report is available as **Appendix 1**. The report provides a general overview of the Covid position and latest data plus an update from the clinical programme groups and ongoing activities across the system.

Additionally, there is a focus on social prescribing as a means of enabling GP's and other health professionals to refer people to a range of local, non-clinical services. It recognises that people's health needs are met by a range of environmental, social and economic factors thus social prescribing seeks to help address people's needs in a holistic way.

Gloucestershire has been selected as a pilot hub site to work with the National Centre for Creative Health to share good practice and move forward our strategic thinking for social prescribing.

**Angela Potter**
Director of Strategy & Partnerships

with you, for you

Gloucestershire Health and Care
NHS Foundation Trust

**AGENDA ITEM: 14/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 2021**

**PRESENTED BY:** John Trevains, Director of Nursing Therapies & Quality

**AUTHOR:** John Trevains, Director of Nursing Therapies & Quality

**SUBJECT:** **DRAFT "GHC QUALITY STRATEGY 2021-2026"**

| | |
|---|---|
| **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 the draft GHC Quality Strategy – a key part of the emerging Trust Five-Year Strategy – for consideration, comment and agreement in principle prior to it being formatted for launch via our Trust Communications Team.

**Recommendations and decisions required**

The Board is asked to:

- **Review** and **Endorse** the final draft GHC Quality Strategy – Attached in **Appendix 1**
- Provide any further comment or amendments prior to it being reformatted in the style of the Trust strategy format.

**Executive summary**

This 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-centred, responsive and respectful care. ".

We want our Trust to be a learning organisation. We will focus on delivering the highest possible quality care, meeting the health and care needs of people using our services, and improving the health outcomes of the population we serve. This strategy seeks to provide a high level guide for the organisation in achieving these aims.

For the purposes of review and for Board colleagues assurance, final changes have 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.

Please do note that the attached version for approval it is not yet formatted in the style, colour theme and images recently agreed for the main Trust strategy. If the Board approve the content and approach it will be professionally formatted in line with the Trust Strategy with associated infographics.

**Risks associated with meeting the Trust's values**

No significant risks identified

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | This strategy is focused on enabling innovative improvements and maintaining robust assurance regarding the Trusts quality of care delivery |
| **Resource Implications** | Delivery is largely expected to be completed within existing resources with potential one off funding opportunities expected to be considered to support emerging implementation plans |
| **Equality Implications** | Our Quality Strategy presents a number of opportunities for the Trust to improve quality considerations and monitoring within equalities and associated responsibilities |

**Where has this issue been discussed before?**

- Board Development Session 16th June 2021
- Engagement and development events
- Quality Committee April & June 2021
- Executive Committee updates
- Quality Directorate team meetings and discussions

| **Appendices:** | Appendix 1 - Draft Quality Strategy |
|---|---|

| **Report authorised by:** | **Title:** |
|---|---|
| John Trevains | Director of Nursing , Therapies and Quality<br>Director of Infection Prevention and Control |

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NHS
Gloucestershire Health and Care
NHS Foundation Trust

# Quality

## GHC Quality Strategy 2021 – 2026

## Better Care Together – with you, for you

**An easy read version of this document is available at XXXX – insert web link to easy read version**

**This strategy is also available in different languages at - XXXXXX**

## WELCOME

**We want to be considered an outstanding organisation by everyone – people using services, their families and carers', our colleagues, local communities and our system partners.**

Gloucestershire Health and Care NHS Foundation Trust colleagues are passionate about delivering the very best care for the population we serve and the people who use our services. This is what drives our shared ambition to **achieve 'outstanding' care status**. To achieve this at a consistent level for all our services is no easy task; it will require a strong commitment to undertake Trust wide culture change. Our organisation has a solid foundation on which to build and we will become 'outstanding' by **listening, learning and working together** on a continuous improvement journey.

**How we will reach 'outstanding' status:**

We want to make sure that we are meeting the health and care needs of all our communities. We will achieve this by **becoming a learning organisation[1].** What people will see is that:

- we are doing everything we can to make ***everyone's*** health and care experience the best it can be, delivering safe and effective services;
- our **colleagues, our most precious asset**, are valued, work in safe and secure environments, are supported and empowered to act when things can be improved;
- the **people we serve** are heard, included, involved and empowered;
- we **embrace transparency, accountability and knowledge**, celebrate success, share learning and actively seeking to improve.

**How our Quality Strategy will achieve these things:**

Our Quality Strategy sets out our quality ambitions, strategic goals, priorities, and the approaches we will take to measure our progress. It does not sit in isolation but is one of **six integrated enabling strategies** delivering Gloucestershire Health and Care NHS Foundation Trust's (GHC) strategy: **'Our Strategy for the Future 2021-2026'**.

By developing this Quality Strategy, we are making clear our commitment and approach to **empower the people** at the heart of our services: Our colleagues will have the **freedom, skills, tools and resources** to work in partnership with the people we serve to **improve and innovate safely** towards defined quality goals.

Our journey will include:

- Becoming a **true learning organisation** to improve patient safety, experience and clinical effectiveness. This will include embedding the national **Patient Safety Strategy** and developing our **Quality Improvement Hub**.
- Treating people who use our services and each other with dignity and respect. This will be delivered by embedding agendas such as **Civility Saves Lives** and **Freedom to Speak Up** across our Trust.

[1] 'A promise to Learn – a commitment to act: Improving the safety of patients in England 2013

- **Empower our workforce** to deliver outstanding care by supporting the professional development of colleagues, giving them the mandate, tools and resources to innovate and improve.
- Expanding how we **work in partnership and collaborate** with the population we serve and as an active partner in One Gloucestershire Integrated Care System, enabling us to deliver personalised care, improve services and develop new models of care that reflect local need.

## Our Quality Strategy at a glance:

Our Trust Strategy - 'Our Strategy for the Future' 2021-2026 - sets out our vision and aims that will be delivered by enabling strategies.

Our vision:

**Working together to provide outstanding care**

Our four strategic aims:

**Better Health; High Quality Care; Great place to work; Sustainability**

Our 6 enabling strategies:

**Quality, People, Digital, Estates, Research & Innovation, Finance**

This enabling Quality Strategy outlines how our quality goals will contribute to achieving our Trust's vision and aims

**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 changes that matter to people.

Our three ambitions ensure our goals and priorities are quality focused.

**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-centred, responsive and respectful care.

GHC Quality Management System (QMS) is the method we use to deliver quality care.

Quality **planning**, **control**, **assurance, improvement and participation** are the five elements of our QMS process. Participation means that people experiencing care and all our staff are actively encouraged to be involved in the continuous cycle of improvement to ensure consistently high quality care.

Our Trust values underpin all our behaviours and attitudes.

**working together**

**always improving**

**respectful and kind**

**making a difference**

Our strategic goals:

1. **Become a true learning organisation, with people participation at our core.**
2. **Treat people who use our services, their families and carers, and each other with dignity and respect.**
3. **Develop and empower our workforce to deliver outstanding care.**
4. **Work in partnership to consistently deliver safe and effective personalised care.**
5. **Drive a just culture which promotes safety through people being supported to speak up.**
6. **Be an active partner in the One Gloucestershire Integrated Care System, ensuring that new models of care reflect local need and address inequalities.**

## INTRODUCTION

Gloucestershire Health and Care NHS Foundation Trust formed in 2019 following the merger of two high-performing Trusts and is built upon an ambition to improve the lives of people with physical and mental health needs, and supporting people with learning disabilities in our communities. This is our first Quality Strategy as a new integrated Trust. Created through collaboration: by listening to colleagues and people who use our services; by reviewing feedback from our community, commissioners and system partners. This strategy represents how we want to **progress: openly and together**.

We want our Trust to be a **learning organisation.** We will focus on delivering the highest possible quality care, meeting the health and care needs of people using our services, and improving the health outcomes of the population we serve. Developed against the backdrop of a global health pandemic, Covid-19 has impacted not only on the health and well-being of our colleagues and the population that we serve, but also the way in which we deliver services. This enabling strategy highlights our creativity, passion, expertise and our commitment to learn from experiences. Our quality pledge and ambitions aim to put **quality, equality and learning** at the heart of our service.

**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.

**Our three 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-centred, responsive and respectful care.

We have used an **appreciative inquiry** approach throughout this document to illustrate the stories of real people. Each story represents a **learning journey**: identifying what works well and what we want to develop to help us be even better, so that we can achieve our ambitions.

Our ambitions are associated with strategic goals developed through consultation and collaborative processes. These align with our Trusts' **People** and **Digital** strategies and are supported by our **Quality Improvement** and **people participation** implementation frameworks.

The **GHC Nursing, Quality and Therapy** directorate teams are the key enablers that work closely with all Trust services, the population we serve, our Integrated Care System (ICS) partners, and national bodies to support delivery of our Quality Strategy.

## WHAT IS QUALITY?

*We are using the NHS and WHO definition of quality care*[2]. Simply put: **It is care that meets standards to ensure it is effective, safe and provides as positive an experience as possible.**

Quality is concerned with setting and assessing standards that tell us if healthcare is **high quality**, can achieve good **health outcomes** and **meets the needs** of people we serve. Care can only be considered high quality when all three pillars of quality - **safe, effective and experience** – are present and includes ensuring care is patient-centered, timely, efficient, and equitable.

### How do we deliver quality care?

**Safe**

Delivering health care that minimises risks and avoids causing harm.

Provide accessible care that is timely, geographically reasonable and in a setting where skills and resources are appropriate to meet the needs of people.

**Effective**


Providing services based on evidence, produce a clear benefit and improve health outcomes for individuals and communities, based on need.

Delivering health care that is efficient, maximising resource use and avoids waste.

**Experience**

Delivering health care that is person centred, based on partnership working that takes into account the preferences and aspirations of individuals and the cultures of their communities.


Providing care that is responsive to diverse-ability and does not vary in quality because of a persons characteristics such as gender, race, ethnicity, geographical location or socioeconomic status.

### Defining Quality does not guarantee success.

We know that **outstanding care** does not happen by accident but **by design and from working together.** Key to delivery of our plans is to develop a **GHC 'Quality Management System'** approach to embed a culture of learning: a culture where people **listen, think, feel and act** '**quality**' - promoting openness and learning, continuous improvement and service transformation. This includes working closely with colleagues to embed a positive culture of continuous improvement by resourcing a **Quality Improvement Hub**, expanding training programmes and creating more opportunities for people to **participate and collaborate** with citizens, communities and our established **Experts by Experience** programme.

### Quality standards and reporting

This strategy has set quality ambitions and strategic goals based on the three pillars of quality to ensure that there is a clear quality focus. Each year we publish quality reports, providing an over view of our quality achievements, reporting on issues identified through our quality management system, and setting specific annual quality improvement goals. Our quality reporting structure will provide a way for us to set progressive implementation plans, adapt plans based on experiences and learning, and monitor progress against our strategic goals.

[2] WHO, 2006: 'Quality of Care: A process for making strategic Choices in Health systems')

## WHO ARE WE?

Gloucestershire Health and Care NHS Foundation Trust provides a range of services for the population of Gloucestershire and the surrounding areas, providing physical health, mental health and learning disability services.

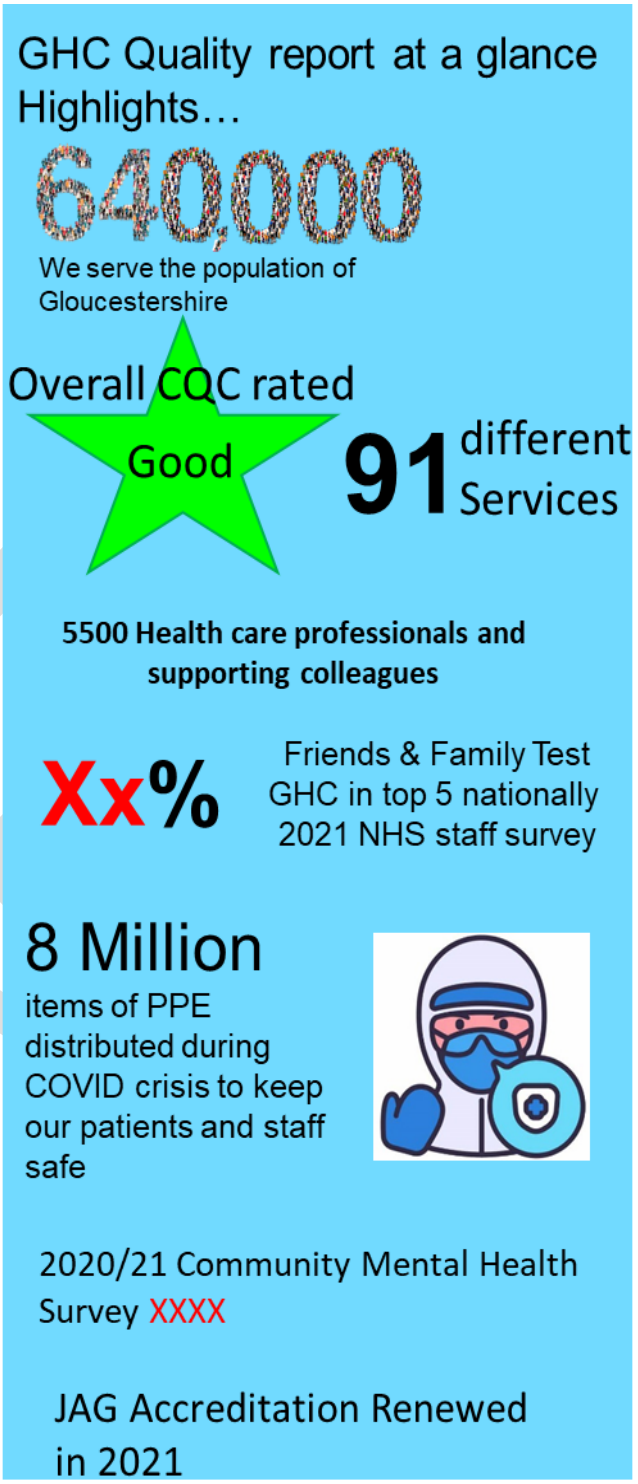
### Our services

We work with people of all ages who need support and treatment in both hospital and community settings.

The majority of our services are provided in a person's usual place of residence or close to where they live, and we support people to avoid a hospital admission whenever possible.

Our services cover the county of Gloucestershire. We work out of health centres and children's centres, community venues such as libraries or schools, as well as in people's own homes or place of residence. We also provide services from our seven community hospitals, our learning disability unit and our two specialist mental health hospitals.

Many of our services are delivered in partnership and we work closely with our partners in the **One Gloucestershire Integrated Care System**. This includes: Gloucestershire Hospitals NHS Foundation Trust acute hospital services; Primary Care and GP services; Gloucestershire Council and Local Authority social care and community services; local community groups, voluntary, charity sector services; Ambulance, Housing and Commissioning groups – to name a few of our partners.




Please visit our website to find out more about our services and quality reports: www.ghc.nhs.uk

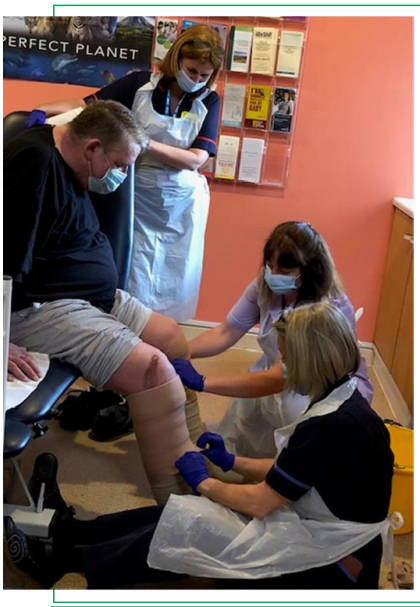
Trust Strategy: Our Strategy for the Future 2021-2026
Quality Strategy – this document
Annual Quality Account (2020-21)
2021/22 Trust Quality Priorities

## OUR SERVICES AT A GLANCE

Gloucestershire Health and Care NHS Foundation Trust provides 91 different types of clinical services delivering all age physical health, mental health and learning disability services to the population of Gloucestershire and surrounding areas.

- One stop teams providing care to adults with mental health problems and those with a learning disability;
- Intermediate Care Mental Health Services (Primary Mental Health Services and Improving Access to Psychological Therapies
- Specialist services including Early Intervention, Mental Health Acute Response Service, Crisis Resolution and Home Treatment, Assertive Outreach, Managing Memory, Children and Young People Services; Eating Disorders, Intensive Health Outcome Team and the Learning Disability Intensive Support Service
- Two Psychiatric and a Learning disabilities & Autism inpatient care centres (total number of beds XXXXX)
- In-reach services into acute hospitals, nursing and residential homes and social care settings;
- Community services in peoples' homes, community clinics, outpatient departments, community hospitals, schools and GP practices;
- Seven community hospitals (total 196 beds) , provide nursing, physiotherapy, reablement and adult social care in community settings and minor injury & illness units
- Health visiting, school nursing and speech and language therapy services for children
- Other specialist services including sexual health, heart failure, community dentistry, diabetes, intravenous therapy (IV), tissue viability and community equipment.

**What's working well**: This is a great example of joint working within the ICS, caring for mental and physical health with fantastic results to ensure a quality care experience.




Andrew was depressed and fed up with ongoing problems with his legs. His condition affected every aspect of his life, he needed to use a mobility scooter, struggled to mobilise around his flat and rarely went out of the house. He got so desperate he said he just wanted someone to "cut his leg off".

Colleagues in the GHC Lymphoedema Service completed a joint visit with Andrew at his GP surgery, suggesting a new treatment and different techniques for applying effective compression therapy with the Practice Nurse.

Three months later Andrew says he feels like a new man! 2 and a half stones lighter, 25cm diameter loss from his calf - not only is he physically better, able to walk to local shops, less breathless and able to see his toes again - he says he feels so much better in himself. Andrew said he didn't used to take care of himself when his leg was so swollen, but now wants to make himself look better so had a haircut and wearing clothes he hasn't worn for years. Andrew said he now feels more confident when out and about.

**Even Better If…**

- More of our services worked in an integrated way enabling efficient and holistic care delivery.
- We work more effectively as an integrated Care System to address health inequalities.
- All our staff use Quality Improvement as part of our approach to continuous improvement.
- More people jointly produced care plans with a focus on 'what matters to me?'.
- We had more options for people to access services as part of addressing access inequalities

## OUR JOURNEY SO FAR

In developing our Quality Strategy, we have spent time reviewing and reflecting on our journey so far. We have engaged with and listened to people about their thoughts, concerns, and ideas about high quality care in our Trust.

### Engagement and co-production

This strategy has been developed collaboratively with Experts by Experience, our colleagues and critical friends through workshops, questionnaires and virtual opinion sharing tools. We place high importance on the learning, contributions and feedback obtained and have included all the key areas identified in this strategy:

- Improving access and equity of services, removing barriers to access;
- Developing our workforce, ensuring they are happy, confident, have capacity and capability to deliver effective care;
- Patient safety and safeguarding;
- Partnership working across the One Gloucestershire Integrated Care system;
- Consistent partnership working between patients, their families and carers, and our practitioners;
- Learning from experiences to develop and improve models of care.

**National and Local context for our Strategy**

There are a number of local and national drivers for change that have influenced our direction of travel and the priorities we have included in our strategy. These include:

- Delivering the shared ambitions of the NHS England Long Term Plan, the One Gloucestershire Integrated Care System and the 2021 NHS White Paper *Integrating care: next steps to building strong and effective integrated care systems across England*
- Supporting NHS People Plan (2021) workforce development and transformation alongside Health Education England Nursing, Allied Health Professionals (AHP).
- Together with operational colleagues and commissioning partners we will focus on delivering 2 of the 5 national Improving Care Programmes: Managing Deterioration; and Mental Health transformation.
- Implementation of new Patient Safety Strategy (2019), PHSO NHS Complaint Standards (2021), and Violence Prevention and Reduction Standards (2021).

We recognise the difficulties of delivering a new Quality Strategy in the challenging times we all currently live in, both personally and professionally:

- National and local recovery from the impacts of the Covid-19 pandemic.
- Different organisational priorities, timeframes and levels of resource will make it difficult to deliver solutions for large- and small-scale system changes and complex issues.
- Re-energising our colleagues to continue or start transformation, service integration and improvement drives as part of our merger, ICS and national priorities.
- Ongoing issues that continue to place a strain on our services and across Gloucestershire's health and care system, including: our growing and ageing population; increasing health inequalities; national and local shortages of health and care workforce; and operating community services in a large rural and urban geography.
- Our Trust provides services where the nature of work means colleagues are at a greater risk of experiencing abuse, aggression and violence.

We will aim to reduce the risks these challenges might pose to our plans by:

- Working closely to support our operational and corporate services in their plans to prioritise welfare, professional development and develop support options for all our colleagues;
- Applying learning from our Covid-19 experience about making changes, ensuring colleagues and people we serve have the freedom, skills, tools and resources to improve and innovate safely.
- Remaining committed as an organisation to understand, develop, influence and lead in our roles as an Anchor Institution and an ICS partner.
- Responding to learning and guidance from our Quality Management System, local and national groups, adapting our plans and priorities to ensure we are doing the right things.
- Supporting safe and secure working environments by managing risks in accordance with the Violence Prevention and Reduction Standards.

## Our quality journey so far…


## Where we want to be…


NB – graphic for this section is in development and will feature the following points:
2019 post merger- Quality Governance structure
2020 CHA & Parliamentary awards
2020- Establishing the Pillar 1 testing team
2020 – Delivering services through the Pandemic wave 1 & 2
2020 Trust recognised in WHO welling in healthcare
2020 – Internationally recognised research in safe use of PPE in mental health services
2020 integrated PH, MH and LD quality dashboard
2021 Covid vaccinations
2021 – Oliver McGowan training launched
2021- New International Recruits arriving in GHC & one of 6 national pilot sites for community nurse recruitment in partnership with the QNI and NHSE

**Then Milestones**

2021 Quality Improvement groups established in PU, EoL
2021 first embedding learning event
2021 Develop and Test Quality maturity index tool
2021 August- Civility Saves Lives Launch
2022 Launch People Quality Forum
2022 New Public Health Service Ombudsmen complaints standards launched
2022/23 Establish EbE for all sites
2022/23 Launch QMS
2023 Achieve Quality maturity Index targets
2024 CQC outstanding

# OUR QUALITY AMBITIONS AND STRATEGIC GOALS

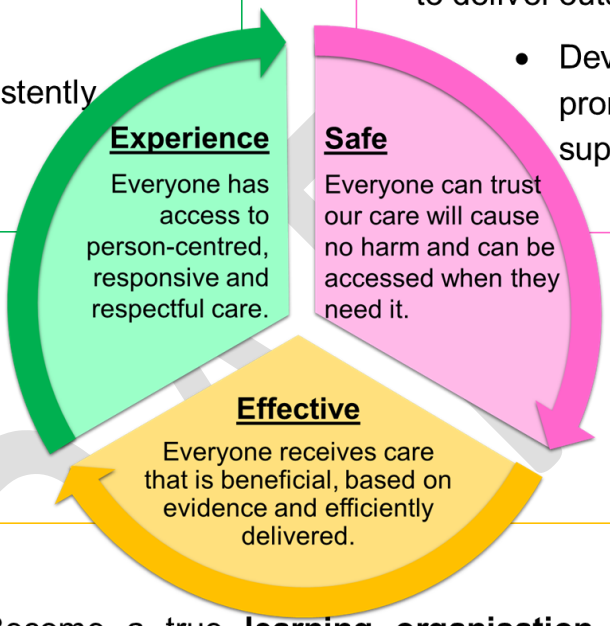
Our three inter-dependent **ambitions,** based on the three pillars of Quality, underpin our strategic goals for the next five years and ensure a focus on high quality health and care**.**

Our six strategic goals have been developed through talking and listening with colleagues, experts by experience and stakeholders; by listening and reviewing feedback from our community and system partners; reviewing our quality indicators; and national improving care programmes.

**Our quality ambitions and strategic goals:**

- Treat people who use our services, their families and carers, and each other with **dignity and respect.**
- Work in partnership to consistently deliver safe and effective **personalised care.**

- **Develop and empower our workforce** to deliver outstanding care.
  - Develop a **just culture** which promotes safety through supporting people to **speak out.**




- Become a true **learning organisation,** with people participation at our core.
- Be an active partner in the One Gloucestershire Integrated Care System, ensuring that **new models of care reflect local needs.**

Each of our strategic goals has several key priorities and objectives that we will achieve as part of a programme of work. The sections below provide more detail about how we will achieve our quality ambitions and strategic goals.

**OUR AMBITION: SAFE**
**Everyone can trust our care will cause no harm and can be accessed when they need it..**

**Our strategic goals:**

- **Develop and empower our workforce** to deliver outstanding care.
- Develop a **just culture** which promotes safety through supporting people to **speak out**

**What works well:** Our staff and services are keen to learn, work with families and experts by experience to improve services.

Rozz McDonald, Mental Health and Learning Disability Education Team Lead, and Kate Allez, Clinical Psychologist are leading the team piloting **'Oliver McGowan Mandatory Training in Learning Disabilities and Autism'** in our Trust.

This training is named after Oliver McGowan, whose death shone a light on the need for health and social care staff to have better training in learning disabilities and autism. It is part of a national commitment to develop a standardised training package.

Launched on 1st April 2021 all of the training is fully co-designed and co-delivered with people with learning disabilities, autistic people with or without a learning disability, family carers and people working within learning disability and autism services. The trial aims to help shape the development of the final training package, which will become mandatory across England in 2022.

Gloucestershire Health and Care NHS Foundation Trust (GHC) is one of four national partners appointed to co-design and co-deliver the training for groups of health and social care staff as part of a national pilot.

**Even better if....**

- Enable our workforce to be happy, confident and competent – introducing civility saves lives programme and supporting our People Strategy.
- Be more open and transparent about incidents, errors or complaints and the actions we take to make changes.
- Establish a 'People Forum' as part of our quality assurance process.

**What we do now that works well and how we can achieve our ambition:**

| How we ensure safe care now... | What we are going to do differently... |
|---|---|
| Governance structures<br>Investigations and learning<br>Freedom to Speak Up Guardian<br>Our values<br>Support and develop our workforce<br>Clinical audits<br>Engage in national Patient Safety Programmes<br>Clinical alerts<br>Datix incident reporting process and review | Increase learning from positive events<br>Increase benchmarking<br>Embed Patient Safety Partners and Specialists<br>Progress the Civility Saves Lives programme<br>Embed Violence Prevention and Reduction Standards |

| Objective | Our measures of success |
|---|---|
| Increase the extent to which we learn from positive events. Develop robust processes to ensure all learning is embedded in practice | - Number of Embedding Learning Events held<br>- Assurances and workstreams delivered by the Learning Assurance Group<br>- Develop a process to share 'Learning on a Page' for compliments, case studies, etc<br>- Develop system to review actions 6 months after the incident/complaint to ensure they remain in place |
| Compare our safety indicators with our previous performance and also with those of similar organisations | - Benchmarking data within governance reports<br>- Active members of national collaboratives<br>- Rapid identification of any outliers, triggering a deep dive and action plan |
| Continue to progress the recommendations within the Patient Safety Strategy (2019) | - Embed Patient Safety Specialists<br>- Embed Patient Safety Partners<br>- Process to effectively support and engage Experts by Experience<br>- Improve our scores on patient safety questions within the Staff Survey, year on year |
| Continue to progress the Civility Saves Lives programme | - Training developed and number of colleagues attending sessions<br>- Colleagues report a culture of psychological safety and a just culture<br>- Reductions in reports of institutional/systemic prejudice and racism<br>- Delivery of Leadership Development Programmes for Creating a Compassionate Culture; Strategies for inclusion; and Creating Psychological Safety. |
| Review our current Freedom to Speak Up Advocate model | - Engagement with colleagues to seek their views on the current model<br>- Adherence to the National Guardian's Office new guidance regarding the development and support of Freedom to Speak Up Champion/Ambassador networks |
| Review and embed Violence Prevention and Reduction Standards to support risk management maximise safe and secure working environments. | - Reduced number of incidents of violence towards staff<br>- Reduced number of incidents of restraints used on patients<br>- Engagement and feedback from people using services and colleagues in risk management and review processes. |

**In the next 12 months we will……**

Deliver **Embedding Learning workshops** following patient safety incidents. A fundamental element will be sharing and learning from experiences and investigations in a compassionate way to develop and improve standards of care. This will be measured through the numbers of post investigation embedding learning workshops delivered and the number of lessons learned bulletins issued.

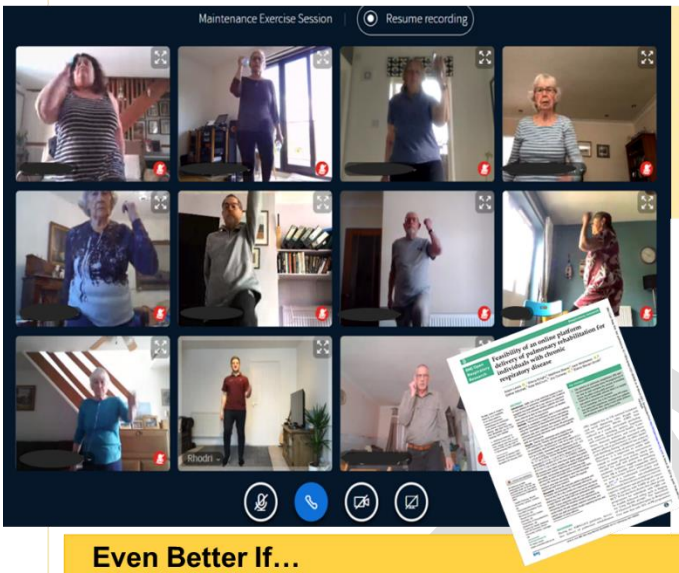
Implementation of the **Civility Saves Lives initiative**, with assurance measured against the co-produced project implementation goals and evaluation over the reporting period.

**OUR AMBITION: EFFECTIVE**
**Everyone receives care that is beneficial, based on evidence and efficiently delivered.**

**Our strategic goals:**

- Become a true **learning organisation,** with people participation at our core.
- Be an active partner in the One Gloucestershire Integrated Care System, ensuring that **new models of care reflect local needs.**

**What's working well**: Colleagues can undertake research and evaluation. GHC's Pulmonary Rehabilitation (PR) team evaluated their on-line programme and published a research paper. Objective evidence of the effectiveness of the approach and feedback from participants encouraged an reassured the team about this new mode of delivery.




"I am really feeling the benefit of taking part in the Wednesday maintenance exercise class held via zoom. I would find it difficult to attend a face to face meeting as I have to rely on public transport so using the link via zoom in my own home. I have talked to the group prior to the class and several find it easier too. I do hope we can continue with zoom classes."

Ester Mitchell (Interim Community manager for Long term Conditions Services) said "SARS-C19 restricted access to face to face pulmonary rehabilitation sessions. So the team undertook to evaluate a rapid service remodelling using the University of Gloucestershire eLearn Moodle platform. Our results indicated that On-line PR improved clinical outcomes and was feasible to deliver. The team are continuing to explore how they can further develop and improve on-line service delivery and incorporate it as part of their service options."

**Even Better If…**

- Ensure our people have the time and resources to contribute to research and evidence based practice.
- More colleagues and people who use our services were trained and confident to use Quality Improvement tools and techniques as part of our approach to improving and evaluating the effectiveness of changes.
- People who use our services had more and different ways to participate in service design and improvement.

**What we do now that works well and how we can achieve our goals:**

| How we ensure effectiveness now... | What we are going to do differently... |
|---|---|
| Many measures of performance and activity | Capture more quality outcome measures |
| Report training compliance against profiles | Increase co-production |
| Supervision and appraisals | Support workforce development and transformation |
| Take part in relevant National Improving Care programmes | Increased use of Quality Improvement methods across services |
| Quality Improvement to learn and develop | Further develop our learning assurance process |

| Objective | Our measures of success |
|---|---|
| **Increase the number of quality outcome measures used across out services, including patient-rated outcome measures** | - Increased number of services capturing quality outcome measures<br>- Quality outcomes measures being used to inform service performance discussions<br>- Increasing reporting of quality outcomes measures within Quality Dashboard |
| **Increase co-production across our organisation** | - Increasing number of co-production events reported, increasing year on year<br>- Training available for our workforce regarding co-production. Number of colleagues who have completed the training will increase year on year<br>- Independent reports from our partners will reflect our increasing partnership working<br>- Launch of our People Participation Strategy and committee |
| **Support the continuous development and transformation of our workforce** | - New training courses developed in response to local needs of our workforce and population<br>- Improved scores on the Staff Survey in relation to effectiveness, support and feeling valued, year on year<br>- Improved sickness and turnover rates, year on year |
| **Continue to be active partners in the One Gloucestershire system** | - Improved population health indicators for the county<br>- Advocate for our communities by recognising unmet need and inequalities; driving innovation to seek solutions<br>- Increasing number of services and pathways demonstrating integrated care |
| **Embed the use of Quality Improvement (QI) methodology across all our service** | - Increasing percentage of colleagues who have completed QI training, year on year<br>- Increasing number of active Quality Improvement projects within the Trust, year on year |
| **Continuously improve our learning assurance processes** | - Embed a reflective discussion approach to ensure compassionate leadership and just culture approaches when learning from serious incidents<br>- A combination of methods in use to ensure effective cascade of learning (learning on a page, safety bulletins, interactive sessions)<br>- Embed a learning culture whereby a safety culture and lessons learnt are part of our business as usual |

**In the next 12 months we will……**

Improve the transition to adult services for children and young people. A specific focus will be placing the young person at the heart of everything we do, ensuring a safe and prompt transfer between services. We aim to achieve this through developing pathways, standardising practice, and reducing delays in care. Fidelity to the care pathways will be evaluated through participation in the NCEPOD study.

**OUR AMBITION: EXPERIENCE**

**Everyone has access to person-centred, responsive and respectful care.**

**Our strategic goals:**

- Treat people who use our services, their families and carers, and each other with **dignity and respect**
- Work in partnership to consistently deliver safe and effective **personalised care**

**What works well: Our staff are committed and passionate about the work they do across all sectors – Childrens', mental health, learning disabilities, hospital and community services.**
In April 2021 BBC Points West featured two people who were receiving end of life care at home delivered by GHC's Community Nursing Services. The presenter said: "families and patients identify this type of care as a gift, a privileged and makes the most difficult time easier to bear."


Lizzie said: **"We won't let people face death alone. When people are told there is nothing more treatment can do it is important people know we can help. People can feel vulnerable and scared at end of life. We support in every way possible – with symptom control, nursing, care, compassion and reassuring family members."**

'C' has terminal cancer and said: **"Its been good in hospital but I'd still rather be at home. At the end of the tunnel there is someone standing up for you"**

'M' a young man and former security guard has a brain tumour and said: **"It makes a difference being at home, close to family and friends"**

**Even better if….**

- Ensure more personalised care approach programmes and resources are integrated into clinical systems;
- Ensure more of our teams have the technology, training and infrastructure to improve mobile working and enabling safe and effective care peoples homes.
- We were clearer about our learning and improvements when care is not as good as it should be or we have made mistakes.
- Ensure more options for different ways people could be involved in improving service delivery.

**What we do now that works well and how we can achieve our goals:**

## How we measure experience now...

Compliments
Friends and Family Tests
Incidents, complaints and concerns
CQC Adult Community Mental Health Survey
Quality visits (NTQ and NEDs)
Staff Survey

## What we are going to do differently...

Improve complaint resolution times
Increase assurances regarding learning from people's experiences, ensuring learning is embedded into practice
Reduce variablity in how we engage with carers
Provide ongoing health and wellbeing support for our colleagues
Establish Expert by Experience quality visits for all of our sites
Increase co-production at every level, in every team

| Objective | Our measures of success |
|---|---|
| Review our complaint handling process for opportunities to provide swifter resolution for people when they raise concerns. | - Earlier resolution of complainants.<br>- Incremental reduction in complaint resolution times until most are resolved within 3 months and only the most complex take up to 6 months to resolve<br>- Support our teams to resolve concerns at the earliest opportunity, through improved processes and training opportunities<br>- Co-produced complaints policy developed and in place |
| Increase opportunities for people to tell us about their experiences of contact with our services | - Incremental increase in compliments and Friends and Family Test responses, quarter on quarter<br>- Additional question within standard Friends and Family Test (FFT) to specifically ask for people's views on their quality of care<br>- Launch of a Carers Friends and Family Test |
| Increase the extent to which care is personalised | - Improved scores on the 'Planning Care' section of the CQC Community Mental Health Survey, year on year<br>- Develop qualitative audit of care plans, to include co-production and personalisation |
| Reduce variability in how well we engage and communicate with carers | - Engage with carers and triangulate feedback with other sources of information and national guidance to co-produce a Trust Carer Strategy<br>- Refresh and relaunch of Carer Aware training for our colleagues<br>- Work towards achieving the third and final star from the national Triangle of Care Scheme |

**In the next 12 months we will……**

Deliver an improved 'Patient and Carer Experience' by developing a GHC Always Events log.

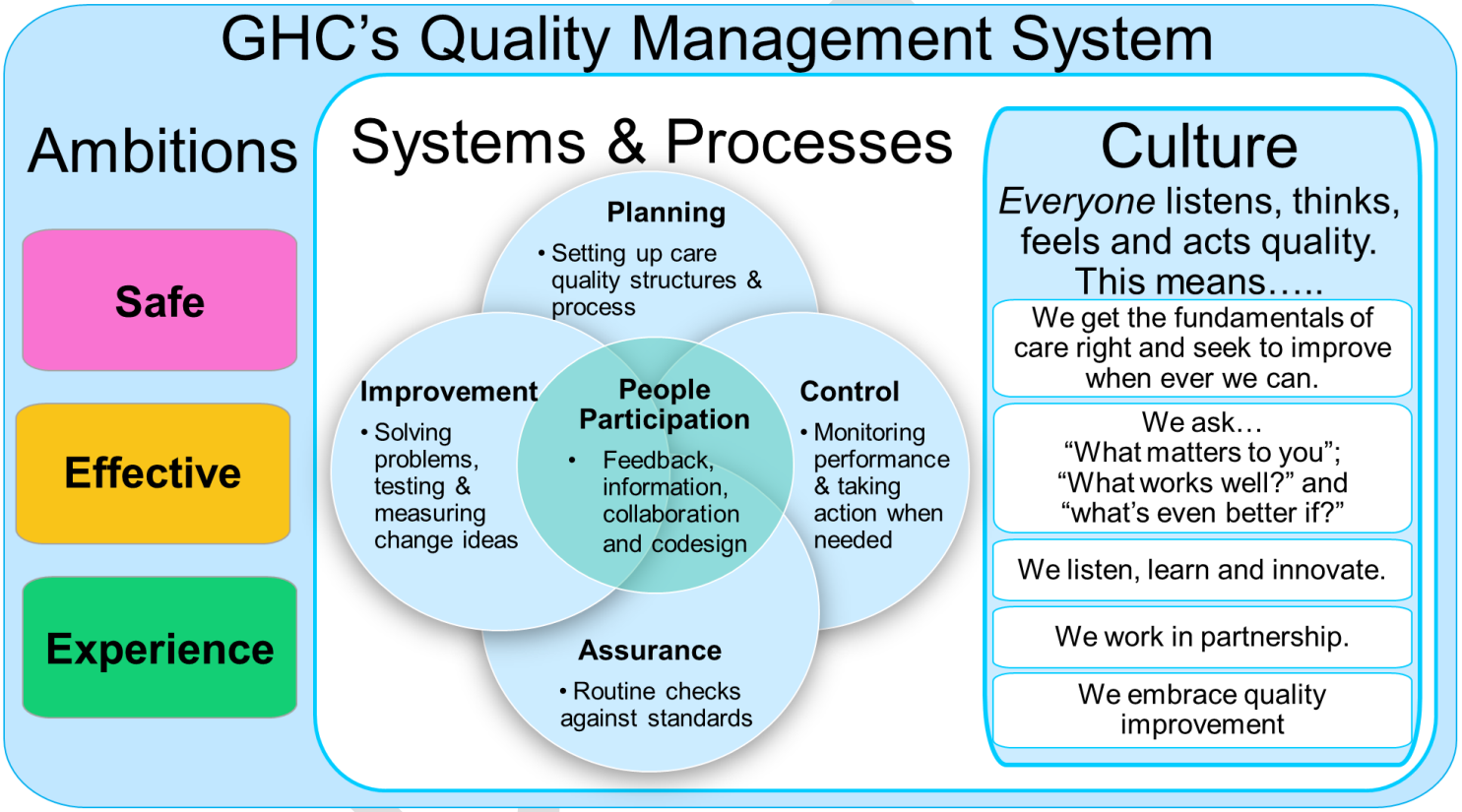
Nobody will wait for longer than 6 months for a final response to a formal complaint. This will be achieved by improving our complaints process and incrementally reducing current response times. Improvement in completion times will be achieved quarter on quarter.

## OUR QUALITY APPROACH TO BECOMING A LEARNING ORGANISATION.

We are developing an approach that we are calling GHC's Quality Management System (QMS). It is based on the concept developed by W. Edward Deming, that continual improvement towards a quality aim provides better services, increases quality, and reduces costs. Our approach is informed by the work of Don Berwick in the context of improving quality in health care services. By continuously striving for quality, understanding what works well and what can be done better, we can achieve our Trust's vision and aims.

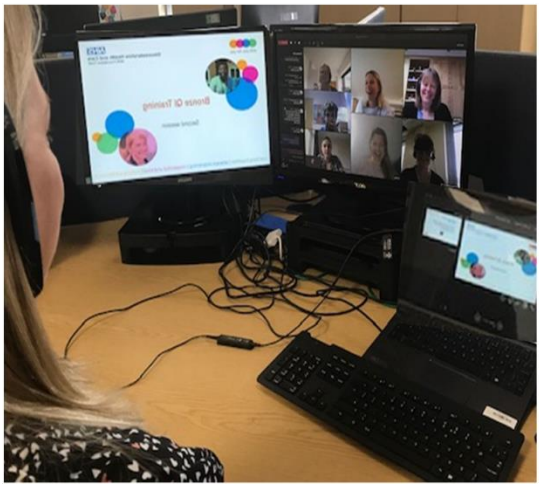
Implementing our QMS requires the development and embedding of processes, practices and a learning culture across the whole organisation. This will take time and commitment to develop.

**GHC's Quality Management System at a glance:**




- We will further develop our Quality Management System to routinely set meaningful targets, monitor, measure and report performance to ensure we provide excellent standards of care and set quality goals to continuously improve the services we provide.
- We will identify and use maturity index tools to help us measure our progress and guide our actions towards becoming a learning organisation.
- We will grow and mature our Quality Improvement (QI) approach as our methodology for solving complex problems, and to provide a consistent approach to testing change ideas and informing our decisions. Developing our new QI Hub is a key enabler and the strategic implementation plan in progress.
- People participation is key – engaging, consulting, co-designing and co-producing with our colleagues, our partners, and the population we serve. We will work with our Partnership and Inclusion team to develop experts by experience roles within our QMS processes, governance structures and improvement projects.

**What's Working Well**: GHC continue to embed a culture of quality and continuous improvement. Despite Covid restrictions colleagues and experts by experience have been busy co-designing Quality Improvement on-line training programmes and developing the QI strategic implementation plan.



Wotton Lawn's Well Woman Wednesday offers ward based health and cervical screening – addressing health inequalities and increasing the likelihood of early detection of cervical cancer by screening for women with serious mental illness. **Angela Willan (Lead Nurse)** said: "QI helped this project progress & develop using Plan-Do-Study-Act cycles. Women on the ward got involved to co-design and co-produce the Well Woman Wednesday project that has now won national awards. Next steps…Men's Health Mondays".

GHC's Wheelchair service put people at the centre of decision making by improving processes to reduce waiting times and increase personalisation. **Jenny Smith (QI manager) said "**A QI approach helped this passionate and highly skilled team shift their thinking from service criticism to continuous improvement. Understanding route causes of problems, unravelling complex systems through mapping and testing changes led to measurable improvement. Not only did people's experience of the service improve by reduced waiting-time; staff satisfaction and personal pride increased."

**Even better if:** QI was everybody's business. **GHC's Claire Lait (Quality Improvement Hub manager)** said "GHC's QI Hub supports improvement projects large and small as the examples show. As a new service we have a lot to do to expand training, resources, expert advice and coaching to all colleagues and experts by experience as well as play a vital role in our systemwide 'Improvers without Boundaries' network. Ensuring improvement is a key focus and has parity over planning, control and assurance in GHC's Quality management system can embed a culture of quality is our ultimate goal."

## What is Quality Improvement?

**"Working together, using methods, tools, data measurement, curiosity and an open mindset to improve healthcare'.**

(GHC QI Hub quote)

A key enabler for the Trust Strategy, Quality Strategy and component of the GHC Quality Management System, the QI Hub was set up in September 2020. The Hubs purpose is to form a more robust QI approach in the organisation and embed QI into our trust culture.

Our QI approach seeks to support the experts – the people who use our services and those that deliver them, to understand the problem identified, find change ideas, test them out, upscale and make them sustainable using reputable, researched tools and proven methodology.

Our QI Hub is new and therefore has a specific QI strategic implementation plan over the next five years. This includes 5 key strategic priorities:

1. Create a dedicated QI hub
2. Create a QI centre of excellence
3. Utilise information and data systems to drive QI
4. Expand our QI community
5. Foster, nurture and embed a culture of continuous improvement.

# HOW WILL WE KNOW WE ARE ACHIEVING OUR AMBITIONS?

## ENABLING, MONITORING AND EVALUATING DELIVERY

Our Quality Strategy sits alongside our annual operating plans – these set out detailed objectives for each year to help us achieve our overall strategy by 2025.

Progression towards delivering our annual objectives will be monitored through our Trust governance structures, inclusive of feedback and collaboration with our stakeholders and will form part of our formal reporting structures. Through regular review, our Trust Board and Council of Governors will ensure our Quality Strategy continues to meet the needs of our organisation

There are a number of ways in which we will measure our progress and adjust our actions as necessary in order to achieve our ambitions. These include external reviews by CQC, feedback from Health Watch and other partners, internal peer review, and also our Quality Management System and quality governance structures.

### Advanced evaluation tools and approaches

To stretch our ambition in our improvement journey we will use advanced evaluations tools and approaches that are evidence based and internationally recognised in the fields of evidencing embedding learning and quality improvement measurement. These include:

- Quality Maturity Index Assessment – *work completed on evaluating our Trust QI approach will help us build a more robust Quality Management System.*
- Embedding Learning Assessment Tool - Kirkpatrick Model: Four Levels of Learning Evaluation[3]. *Currently being utilised in Trust Civility Save Lives programme as part of our post serious incident embedding learning workshops.*

### Care Quality Commission Rating

Gloucestershire Health and Care NHS Foundation Trust was formed in October 2019, following the merger of 2gether NHS Foundation Trust and Gloucestershire Care Services NHS Trust. The CQC rating displayed at the time of writing our strategy is for the combined Gloucestershire Care services and 2gether NHS Foundation Trust completed in 2018. Our new organisation will be inspected and given its own rating in due course.


[3] Kurt, S. "Kirkpatrick Model: Four Levels of Learning Evaluation," in Educational Technology, October 24, 2016. Retrieved from https://educationaltechnology.net/kirkpatrick-model-four-levels-learning-evaluation

## CONCLUSION

Our Quality Strategy sets out Gloucestershire Health and Care NHS Foundation Trusts ambitions and goals for the next five years. We have pledged to place **quality at the heart of everything** we do; for the population that we serve and for our workforce that strives to deliver the best possible care at all times. To achieve this, we set ambitions that focus our activity on quality outcomes:

- **Safety** - providing services that are safe and will not do any harm whilst being open and transparent about any mistakes and ensuring we learn from them.
- **Clinical Effectiveness** - continuously developing our services and learning from best practice, clinical evidence and the latest innovations.
- **Peoples Experience** - providing a friendly and welcoming approach from colleagues who communicate openly and clearly

Our shared ambitions focus our actions so that we can **improve the health and care of people we serve,** people with physical and mental health needs, and learning disabilities; **work better together** to understand peoples needs, lived experience, goals and aspirations**;** and ensure we **meet the needs of local communities**.

Our approach is about **empowering people** and includes **working together** and **continuous improvement** to embed quality initiatives, consistently deliver high quality care and make the changes that matter to people. This will be underpinned by developing our **Quality Management System** that aims to build a culture where everyone **listens, thinks, feels and acts 'quality'**.

We want to be a **learning organisation** that delivers **outstanding care** by working **better together:** this strategy describes how we will meet that challenge.

**We want to take this opportunity to say a heartfelt thank you to everyone who has contributed to shaping our first Quality Strategy. We could not, and would not, have done it without you.**

**THANK YOU!**

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**AGENDA ITEM: 15/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 2021**

**PRESENTED BY:** Angela Potter, Director of Strategy and Partnerships

**AUTHOR:** Peter Hadley, Estates Strategy Manager

**SUBJECT:** **ESTATES STRATEGY 2021-2026**

| | |
|---|---|
| **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 Trust Board the Estates Strategy for final comment and approval.

The Estates Strategy will continue to evolve as a live document as service priorities and working patterns embed and change as a consequence of Covid-19.

**Recommendations and decisions required:**
Trust Board is asked to:

- **Approve** the Estates Strategy subject to any final comments

**Executive summary**

We have 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.

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 strategy 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.

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.

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 Estates over the next 5 years that is flexible, value for money and fit for new ways of working.

**Risks associated with meeting the Trust's values**

The ability to implement strategic Estates decisions while service delivery models and new ways of working evolve and ICS partnerships develop.

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | There is strong alignment with our quality strategy and quality priorities in terms of delivery of outstanding care. The quality of the environment has a significant impact on the theraputic outcomes for people who use our services and on the morale of our colleagues. |
| **Resource Implications** | Alignment with the capital programme however, additional resources are likely to be necessary if we are to achieve our full aspirations |
| **Equality Implications** | None noted |

| **Where has this issue been discussed before?** |
|---|
| . |

| **Appendices:** | N/a |
|---|---|

| **Report authorised by:** | **Title:** |
|---|---|
| Angela Potter | Director of Strategy & Partnerships |

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# Estates Strategy

# 2021 – 2026

# Our Estates Strategy 2021 – 2026

## 1. Introduction

Our **Estates Strategy** for 2021 – 2026 will take us forward on our journey to ensure that we are delivering services in the right locations, from high quality, effective estate.

We formed in 2019 following the merger of two strong, high performing Trusts and this strategy will build on the creativity, passion, drive and expertise shown by our colleagues in the process as well as building on the experiences of our responses to COVID.

This strategy does not sit in isolation but as one of six integrated enabling strategies that underpins the delivery of our overarching strategic aims and the Trust's vision; *Working together to provide outstanding care.*

Our services cover the whole of Gloucestershire and we have produced this strategy to explain how we utilise the estate as an asset and key enabler to deliver outstanding services.

It 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.

Our strategy recognises the importance of providing fit for purpose physical buildings in settings close to our patients' homes. We recognise that the quality of the environment impacts on the quality of the services we provide thus ensure that our services are delivered in fit-for-purpose settings close to our patients' homes is key. This includes occupying our system and public sector partners' buildings, and vice versa where this is functionally and financially viable.

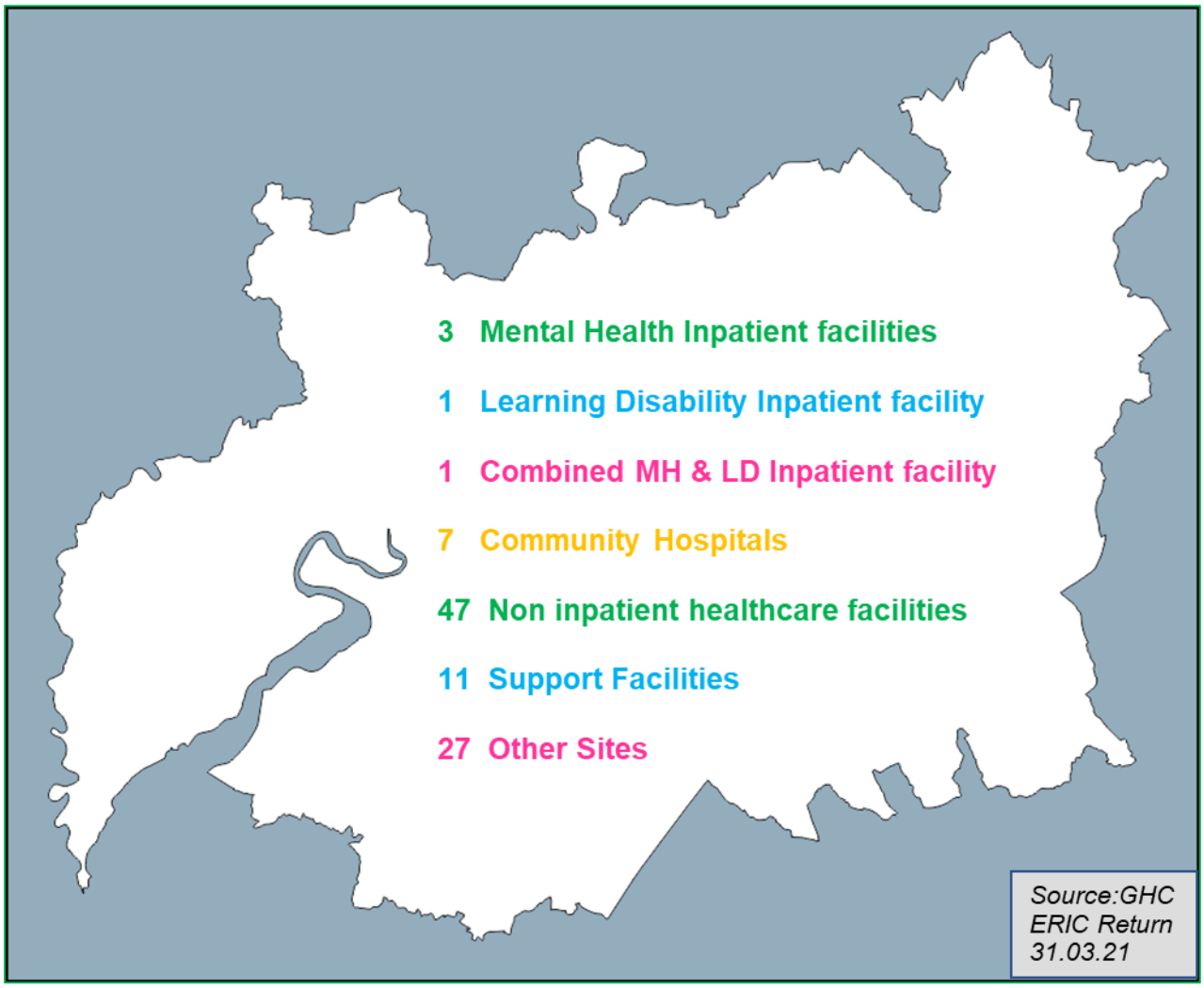
We have co-produced this strategy with our colleagues and by reflecting on what we've been told through a range of engagement events. This strategy is not a static document, as service strategies evolve and develop, so must our estate, but it lays out a roadmap for our ambitious but realistic plans for the next five years.

In line with our values we will continue to listen and work in partnership with colleagues as well as patients, stakeholders and communities.

## 2. The GHC Estate – Where are we now?

We operate from over 140 premises which includes 7 Community Hospitals, 2 Mental Health in-patient units and a varied portfolio of clinical and non clinical buildings across the whole of Gloucestershire.

**Figure 1: The GHC Estate**




An analysis of the GHC property portfolio is undertaken in March each year through the NHS Estates Return Information Collection (ERIC). This provides real time estates information allowing organisations to benchmark their performance.

The Trust currently has 49 freehold ownerships totalling 74,300 sq.m. The annual ERIC analysis provides a breakdown of this total owned estate into 'Inpatient Units' and 'Other Reportable Sites' (freehold buildings more than 150 sq.m.) as follows:

**Table 1: GHC Freehold ownerships**

| Estate type | Description | No. of Sites | Gross floor area (Square metres GIA) | Approx total site area (hectares) |
|---|---|---|---|---|
| **Inpatient Units (IPU)** | Mental Health and Learning Disability inpatient units and Community Hospitals | 12 | 47,943 | 21.1 |
| **Other reportable sites (ORS)** | Non inpatient healthcare facilities, support and other sites | 37 | 26.357 | 5.6 |
| *Source: GHC ERIC Return 31.03.21* | **TOTAL** | **49** | **74,300** | **26.7** (66 acres) |

The impact of the COVID-19 pandemic has changed the landscape of delivery across health care services and at the time of writing the strategy, it remains unclear exactly what the long term impact will be on how people want to utilise our physical Estate. It has however, provided a platform for Estates processes, projects and partnerships to be reviewed. We have taken the opportunity to embed technology, adopt more efficient processes and strengthen working with system partners to realise efficiencies.

This work will continue to be key to delivering clear estate development and rationalisation plans and ensuring that over the next 5 years our Estate continues to offer flexible, value for money and fit for purpose accommodation that meets the needs of our new ways of working.

## 3. Our Achievements

Ensuring that good quality, therapeutic environments are in accessible locations and designed to meet the needs of our services now and into the future has been a key priority. Our aspiration to reduce health inequalities and continue to improve accessibility are key strategies for the future. To date, we have achieved:

- Providing the foundation of a fit for purpose Estate
- Supporting strategic service initiatives
- Optimising Asset Holdings
- Revenue savings from moving to lower cost settings
- Disposals to generate capital receipt

**Table 2: Estates & Facilities Achievements 2019-2021**

<table>
<tr><td colspan="4">← Statutory compliance across estate →</td></tr>
<tr><td>Developments, re-purposing and disposals</td><td>Optimising Asset Holdings</td><td>Revenue savings from moves to lower cost sites<br>(to 31.03.21)</td><td>Supporting strategic service initiatives</td></tr>
<tr><td>Enabling Trust response to Covid-19 requirements</td><td>Montpellier upgrade<br>£1.5 million project</td><td rowspan="2">Vacation of GCC sites by GHC ICT staff<br>Total Saving £400,000 per annum</td><td>Stroud AHU Endoscopy & General Liquid Oxygen</td></tr>
<tr><td>Refurbishment for Learning & Development Hub at Invista</td><td>The Maxwell Suite<br>£80,000 upgrade</td><td>Flat refurbishments and decant at Berkeley House</td></tr>
<tr><td>New Forest of Dean Community Hospital (Full Business Case)</td><td>Acorn House (CYPS)<br>£380,000 upgrade</td><td rowspan="2">Vacation of NHSPS sites by GHC colleagues<br>Total Saving £150,000 per annum</td><td>Homeless Healthcare relocation to Rikenel</td></tr>
<tr><td>Holly House & Hatherley Road site disposals (Due to market)</td><td>Backlog maintenance:<br>£2.7 million cleared 2020/21</td><td>Estates & Facilities Hub at Rikenel</td></tr>
<tr><td colspan="4">← Sustainability Improvements →</td></tr>
<tr><td colspan="2">Trust-wide Electric Vehicle charging points<br>18 available (to 31.03.21)</td><td colspan="2">Boiler and generator replacements (6 locations) / LED upgrades (5 locations) and Solar PV installation (2 locations)</td></tr>
</table>

We undertook an extensive condition survey undertaken in 2019. This identifies where we need to invest in strategic sites and where backlog maintenance may prove uneconomic as the older estate is not capable of becoming fit for purpose.

Having identified those parts of our estate that require modernisation, technology upgrades or re-purposing, our Capital Management Group assesses our service needs and prioritises investment in a rolling five year capital plan.

The capital plan is funded through our cash reserves and disposal proceeds from assets identified as surplus to operational requirements. Table 3 below summarises the capital plan for the duration of this strategy with our current priority being the development of a new Community Hospital for the Forest of Dean.

A number of sites, confirmed as surplus by clinicians and commissioners, will be sold over the next 2-3 years, with a process in place to initially offer the asset for acquisition by other public sector partners. The proceeds of these sales are used to fund future capital projects.

The Trust occasionally benefits from individual donations of assets of funds which are also directed to fund our capital plan.

**Table 3: The current GHC capital plan**

| GHC Five Year Estates Capital Plan (£000s) | 2021/22 | 2022/23 | 2023/24 | 2024/25 | 2025/26 | Total |
|---|---|---|---|---|---|---|
| **Developments** | | | | | | |
| Forest of Dean Community Hospital | 3,000 | 16,000 | 3,500 | 0 | 0 | 22,500 |
| LD Assessment & Treatment Unit | 0 | 0 | 2,000 | 0 | 0 | 2,000 |
| Cirencester Campus | 0 | 0 | 5,000 | 0 | 0 | 5,000 |
| Sub-total | 3,000 | 16,000 | 10,500 | 0 | 0 | 29,500 |
| **Land & Buildings** | | | | | | |
| Buildings | 4,737 | 2,500 | 2,500 | 1,000 | 1,000 | 11,737 |
| Backlog Maintenance | 4,431 | 0 | 1,050 | 1,250 | 1,393 | 8,124 |
| Urgent Care | 750 | 0 | 0 | 0 | 0 | 750 |
| Sub-total | 9,918 | 2,500 | 3,550 | 2,250 | 2,393 | 20,611 |
| **Total prior to proceeds / donations** | **12,918** | **18,500** | **14,050** | **2,250** | **2,393** | **50,111** |
| **Disposal proceeds (NBV)** | | | | | | |
| Ambrose House | | -785 | | | | -785 |
| Holly House | | -164 | | | | -164 |
| Hatherley Road | | -400 | | | | -400 |
| Forest of Dean sites | | | -4,454 | | | -4454 |
| **Donations** | | | | | | |
| **Charitable Funds** - Cirencester scheme (Malmesbury) | | | -5,000 | | | -5000 |
| **Total after proceeds / donations** | **12,918** | **17,151** | **4,596** | **2,250** | **2,393** | **39,308** |
| *Note: The above extract excludes IT, Medical Equipment and Unallocated capital from the current GHC five year capital plan* | | | | | | |

In addition to the proposed major capital development in the provision of a new Community Hospital for the Forest of Dean, investment is currently scheduled for the refurbishment of the Minor Injuries and Illness Unit (MIIU) and Jubilee Ward at Stroud General Hospital.

The Trust continues to be a key participant in the One Gloucestershire Estates Board and ICS-wide Estates initiatives.

## 4. Our Challenges

This strategy is not a static document. As service strategies evolve and develop, so must our Estate. In order to meet the Trust's ambitious strategic aims, we must accelerate their transition. Our Estate must adapt and innovate to accommodate future ways of working.

One such recent change has been the speed and agility of change with digital services. The Covid-19 pandemic has altered the expectations of staff and the wider public to one where many interactions are now virtual or online . This, in turn, can alter the way in which we use our buildings.

We will continue to review the way in which we need to use the Estate - embedding greater use of technology may help to support rationalisation of our estate. A strategic estate utilisation project will be a key development piece for us moving forward.

System-wide integration of Estates Strategies is also key to providing agile, technology-enabled accommodation, providing the capacity to address the assessment, diagnosis and treatment backlog and the additional space requirements for COVID-secure environments.

**Our Challenges**

- Limited access to capital – internally sourced cash for capital projects;
- Estates efficiency savings increasingly challenging;
- Large, diverse portfolio – resource implications to manage 140 sites;
- Balancing service accessibility with Estate quality and affordability;
- Net Zero Carbon targets by 2050;
- Changes to International Financial Reporting Standard (IFRS) with leasing now treated as capital spend;
- Backlog maintenance affordability increasingly challenging;
- System-wide capital envelope reduces ability to use cash reserves;
- Community Estate requires expansion with new services and colleagues;
- Housing solutions required with more treatment closer to home;
- Estate needs to be 'Pandemic-ready' for future challenges.

Our Estates Strategy sets out a vision of an efficient, sustainable and clinically fit for purpose estate. This adheres to national NHS Policy for the delivery of the Five Year Forward View and the implementation of new models of care.

## 5. Our ambition – formulation of the Estates Strategy

An Estates Strategy is defined as "A long-term plan for developing and managing the estate in an optimum way in relation to the Trusts service and business needs. On a practical level, the Estates Strategy identifies and manages the risk of compliance with statutory building responsibilities, CQC standards and financial risk from voids, backlog maintenance and capital costs.

Across Gloucestershire we have a shared ICS Estates group and the Trust is a key partner in the One Public estate work. However, there is more work to do here to understand our collective estate utilisation and future aspirations and as one of a number of anchor institutions in the system we recognise the importance of playing a pivotal role in the system wide estate development.

Co-production and collaboration are key to how we will achieve our Trust's strategic aims and estate ambitions. We have completed an analysis of our Estates aims to assess how they support the Trust's overarching strategic aims:

| TRUST STRATEGIC AIMS | ENABLERS | | | | | | ESTATES |
|---|---|---|---|---|---|---|---|
| | QUALITY | PEOPLE | DIGITAL | RESEARCH & INNOVATION | FINANCE | | |
| HIGH QUALITY CARE | | | | | | | High quality, accessible locations. Therapeutic settings. Safe, effective and efficient delivery. |
| BETTER HEALTH | | | | | | | Embedded technology. Partnership with community and system. Integrated, cost-effective services. |
| GREAT PLACE TO WORK | | | | | | | Safe workplace. Welcoming settings and culture. Adoption of new ways of working. |
| SUSTAINABILITY | | | | | | | Reduced carbon footprint. Cost-effective re-purposing of estate. Supply chain realignment. |
| SYSTEM-WIDE INTEGRATION | | | | | | | |

During the development of the Estates Strategy we undertook a series of engagement, co-design and participation events with people who use our services, colleagues and system partners. Our goal was to make sure we understood what Service's aspirations were, what benefits or important outcomes needed to be achieved and what was important to people who use our services.

## 6. Our Estates Vision

"To enable the delivery of outstanding, place-based care by providing high quality settings in the right locations for people".

Improving our patients' health and well-being and the way in which they experience our services, through the effective use of our Estate and facilities is at the core of our strategy. This means that we will ensure that people can access services that are in the right place, for the right person at the right time.

To deliver our vision we have identified six strategic aims that align with the Trust's priorities. Against each of our aims we have identified overarching goals, a number objectives and how we will measure success.

## 7. Our Estates Strategic Aims

**Ensure our Estate provides efficient and effective spaces that are fit for purpose;**

1. **Strengthen Estate integration by working with System Partners;**
2. **Ensure we are making the best use of our Estate;**
3. **Embedding Sustainability models and approaches into our Estate management;**
4. **Maximise innovative property solutions;**
5. **Ensure our Estate supports the health and wellbeing of our people.**

### Estates Strategic Aim 1 - Ensure our Estate provide efficient and effective spaces that are fit for purpose

We will proactively manage our assets and have a clear plan for reducing backlog maintenance. Where assets cannot be cost-effectively maintained or the estate is deemed surplus it will be released, with capital receipts reinvested into the capital programme.

| Ensure our Estates provide efficient and effective spaces that are fit for purpose | |
|---|---|
| **Our goals over the next 5 years are to:** | **Objectives and Actions** |
| • Ensure the physical condition of the Estate is fully compliant with health & safety and business risks;<br>• Improve the utilisation of clinical space and maximise the use of higher quality assets in line with NHSE/I metrics (Carter review);<br>• Reduce operating costs through effective use of robust disposal/reconfiguration asset management and environmental performance improvements;<br>• Support development of accommodation reporting to enable better understanding of the cost and performance of our Estate;<br>• Provide easily accessible care settings that reflect the Trust's aims for high quality and better care. | • Maximise high quality space; disposal of buildings with uneconomic backlog costs<br>• Full analysis of Estate utilisation to inform strategic Estate decisions<br>• Develop integrated portfolio management processes and adopt robust disposal / acquisition processes<br>• Develop cost analysis for individual buildings and services integrated with space utilisation data;<br>• Positive working environments with opportunities for user surveys and feedback;<br>• Work in partnership with stakeholders to ensure our facilities are accessible and welcoming to all and support the wider health inequalities work |
| **Key tasks over the next 12 months** | |
| • Formulate implementation plan with phased delivery of Estates Strategy<br>• Work alongside implementation of other enabling strategies<br>• Continue Estates consolidation process<br>• Embed Estates utilisation survey and develop a Trust-wide roll-out plan<br>• Develop model of Estate cost and performance<br>• | |

## Measures of Success

- Improvements against key measures in the 6 facet survey categories
- Demonstrable improvements from colleague surveys, PLACE, 15 steps
- Continued space utilisation improvements - Non-clinical use < 35% of total and unoccupied/underused < 2.5%
- Continued development of Service line cost analysis.

| Case Study – Pullman Place, Gloucester |
|---|
| Refurbishment of clinical space using a co-design process |



As new and old services integrated and developed, a different solution was needed to ensure people could wait and have appointments in rooms that meet their needs.

An experience led, co-design approach was used with people and partners to ensure the design was aligned with not only building regulations, but the needs of all users of the building.

The clinical needs and operational processes were considered in tandem within the design process.

**Estates Strategic Aim 2 - Strengthen Estate integration by working with System Partners**

Working in partnership with partners to provide a wider foundation of estate assets to enable the delivery of wider system benefits and reduce inequalities. These partnerships will extend beyond the traditional health partnerships and consider how we develop relationships with the local community and third sector to support mutual service delivery objectives but also to maximise opportunities from disposal of surplus sites in order to support the reduction of health inequalities.

| Strengthen Estate integration by working with System Partners | |
|---|---|
| **Our goals over the next 5 years are to:** | **Objectives and Actions** |
| • Integrate system-wide strategic Estate plans into formal and regularly reviewed ICS Strategy;<br><br>• Build strong partnership links with Third Sector providers; | • System wide utilisation and capital project database for efficient management of ICS Estate;<br><br>• Establish working group for integration of thinking and approach with third sector;<br>• Fully utilise Experts by Experience panel for strategic proposals; |

| | |
|---|---|
| • Integrate co-production processes into formulation of Estates strategies and business cases; | |

| Key tasks over the next 12 months |
|---|
| • Pull together individual Provider Estate Strategies in Gloucestershire;<br>• Update Joint ICS Estate Strategy with One Gloucestershire partners;<br>• Prepare Trust-wide enabling strategy summary and timeline;<br>• Establish Third Sector working group for strategy and projects;<br>• Define criteria for assessment of social value for projects;<br>• Identify and participate potential OPE funding. |

## Measures of Success

- Evidence of estate co-production and co-design in service transformation
- Robust ICS estates strategy
- Further co-location and integration of services with partners

**Estates Strategic Aim 3 – Ensure we are making the best use of our Estate**

We wil maximise estate utilisation and work with commissioners and other partners to develop locality based estate plans to ensure we achieve greater co-location and integration with partners.

| Ensure we are making the best use of our Estate | |
|---|---|
| **Our goals over the next 5 years are to:** | **Objectives and Actions** |
| • Estate rationalisation with a focus on better quality estate;<br>• Achieve greater co-location of colleagues and agile co-working;<br>• Ensure development support to embed cultural change with agile working;<br>• Ensure we are getting best value . | • Provide stability for financial modelling and service planning;<br>• Reduce footprint based on space analysis and service needs;<br>• Balance provision of specialist accommodation with local accessibility;<br>• Reduce costs and retain flexibility of occupation; |

| | |
|---|---|
| | • Negotiate lease costs at renewal points (rent review / lease renewal). |

| Key tasks over the next 12 months |
|---|
| • Continuous challenge to the holding of assets and their use;<br>• 'Right Service, Right Estate - set out what services require and where<br>• Ensure site rationalisation /co-location undertaken to promote integrated working rather than to reduce Estate costs;<br>• Consider opportunities from currently under-utilised buildings where leasing to third party, re-purposing or mothballing may allow longer term decisions.<br>• Service delivery will be focused on community settings, either single facilities or a network of local facilities |

## Measures of Success

- Robust programme of lease review and renewals – taking opportunities from break clauses etc. where appropriate
- Space utilisation benchmarks (internal and external)

**Estates Strategic Aim 4 – Embedding Sustainability models and approaches into our Estate management**

Establishing strong links between the Estates Strategy and Green Plan will enable us to improve the environmental management of our estates. We will develop an approach that recognises social and ecological value of our estates.

| **Embedding Sustainability models and approaches into our Estate Management** | |
|---|---|
| **Our goals over the next 5 years are to:** | **Objectives and Actions** |
| • Adopt sustainable construction and asset management processes;<br>• Maximise opportunities for adding social value through the utilisation and development of our estate;<br>• Establish links between nature and preventative healthcare - develop Biodiversity Plan to promote use of natural greenspace; | • Ensure the estate delivers its contribution to the sustainability targets in line with guidance and Green Plan e.g. LED lighting and renewable energy;<br>• Include assessment criteria for sustainability benefits as part of procurement process for estate schemes; |

| | |
|---|---|
| • To understand how can we measure the social value of our estates. | • Expand NHS Forest Programme for creating allotments, dementia gardens, outdoor gyms and green health routes. |

**Key tasks over the next 12 months**

- Establish links with the Sustainability Action Group to support delivery of Net Zero Carbon initiatives;
- Benchmark performance against peers and other NHS providers;
- Support delivery of Trust-wide Biodiversity Plan to enable preventive healthcare and access to green space;
- Consider and develop social value measures for Estates.

## Measures of Success

- Key milestones in Green Plan delivered through improved estate infrastructure.

**Case Study – Sustainability cost saving programme and Trust environmental initiatives**

NHS FOREST
growing forests for health

FOR A GREENER NHS

**NHS allotments for Montpellier Unit**

"The Montpellier unit has given me a lot and this is my way of helping others and repaying the good things they did for me."

Montpellier allotments are on a 0.5 acre site near central Gloucester providing a multifunctional accessible, safe, green space for people who use our services. The allotments enable people to access therapeutic, occupationally focused activity in a safe supportive environment engaging in a range of activities such as horticulture and creative writing.

The allotments have recently secured funding for a co-designed allotment area, creating a new space for people from across the trust who can access the area and expanding the opportunities the allotment can offer.

The allotments are an exciting example of the opportunities for sustainability within healthcare, recognising the value of accessing nature and the impact of environments on people's health and wellbeing.

"I view my role as being particular inspiring to other patients as I have been in their shoes and my volunteering demonstrates to them that there is hope and an alternative path." Kevin Mckenzie Volunteer Patient representative.

**Estates Strategic Aim 5 – Maximise innovative property solutions**

We need to ensure we have a flexible Estate capable of rapid repurposing to meet ongoing service change and transformation. It needs to be able to support new ways of partnership working and enable staff to maximise the use of new technology.

| **Maximise innovative property solutions** | |
|---|---|
| **Our goals over the next 5 years are to:** | **Objectives and Actions** |
| • Ensure the Estate is 'Future pandemic-prepared';<br>• Enable capital investment through Estate rationalisation;<br>• Investigate alternative models of capital investment or partnership working where it is appropriate to do so; | • Digitally enabled Estate for clinical and non-clinical activities;<br>• Opportunity for transformation of Estate through collaborative working;<br>• Consider third party or ICS partner joint ventures;<br>• Support the roll-out of a hybrid working model between home, office and clinical space requirements. |

| **Key tasks over the next 12 months** |
|---|
| • Develop and embed our approach to Space Utilisation and develop a database to inform our estate planning;<br>• Work with ICS partners to assure future pandemic preparedness; |

- Investigate alternative sources of capital investment where appropriate;
- Working with the HR team take forward key aspects from the People Strategy to support different working models for our colleagues

## Measures of Success

- Space utilisation benchmarks (internal and external)
- Embed integrated working and innovation within a robust ICS estates strategy
- Further co-location and integration of services with partners

**Case Study – Estates Challenge of COVID-19 response**

**Repurposing of Edward Jenner Court during first wave of COVID-19**

In response to COVID-19 and to support our essential clinical services, GHC Estates needed to adapt at pace. Our head office became the COVID testing site with a drive through testing pod. The testing pod continues to provide pre-operative testing to ensure people can continue to access essential elective operations and supports testing for colleagues and their families, allowing them quick and easy access to testing.

Adaptation of the building at Edward Jenner Court was integral to the success of this service, ensuring we had everything we needed to run a safe department, despite all the changing guidance.

GHC Estates & Facilities have continued to adapt and re-purpose accommodation as demands for testing services has increased and in support clinical service delivery.

**Estates Strategic Aim 6 – Ensure our Estate supports the health and wellbeing of our people**

| To ensure our Estate supports the health and wellbeing of our people | |
|---|---|
| **Our goals over the next 5 years are to;** | **Objectives and Actions** |
| • Ensure our estate promotes health and wellbeing;<br><br>• To reduce inequalities for our people by providing estates that are accessible and inclusive wherever possible;<br><br>• To enable flexible and adaptable working through integrating estates and digitial delivery. | • Enable people work in safe positive healthy environments that also provide for rest, relaxation and effective team working;<br><br>• Develop an approach to identify and monitor risks to wellbeing within our estates;<br><br>• Create spaces that promote health and wellbeing through partnerships with people, services and partners across the ICS;<br><br>• Work in partnership with diversity networks and people to understand accessibility and inclusion needs; |

| Key tasks over the next 12 months |
|---|
| • Undertake an audit of our key work bases to understand the level of rest facilities and develop a gap analysis and associated action plan<br>• Work in collaboration with people plan<br>• Create/adopt hybrid model of working<br>• Support trust biodiversity plan to enable access to green space<br>• Engage with colleagues to understand how Estates can support their health and wellbeing |

## Measures of success

- Evidence of estate co-production and co-design in service transformation
- Demonstrable improvements from colleague surveys, PLACE, 15 steps
- Reduction in staff absence
- Improved Staff survery results

## 8. How our Estate will change over the next five years

Our Estate Strategy will increasingly focus on local delivery and implementation of changes across the wider system focusing on mechanisms such as population health management to develop targeted iniatives to help reduce health inequalities.

There is now a step-change in collaboration with NHS providers, primary care and local authorities which will accelerate multi-agency service delivery models and multi-occupied buildings. Stakeholder engagement will be integral in the process for assessing and developing our estates proposals moving forward.

**How our Estate will change over the next 5 years?**

- The overall footprint will reduce with the disposal of non-compliant or non-essential buildings or settings;
- Co-location of colleagues will increase, both internal teams and collaborative partners;
- The target is for fewer, higher quality facilities;
- Best practice will continue to be adopted and adapted in the design of space and the management of our Estate;
- Wherever possible, new technologies will be incorporated as part of the Digital strategy to be a fully digital Trust;
- Agile working will undoubtedly reduce the amount of non-clinical space as both colleagues and service users are enabled to interact remotely.

## 9. How do we measure the success of our strategy

During the first year of the strategy we will continue to develop our implementation plan and measures for success. For example, as we continue to roll out our utilisation audits, we will gain a better understanding of how we can utilise and occupy our space differently and therefore set more quantifiable targets with which to measure our progress.

We will share these with Resources Committee for ongoing sign-off as this Strategy evolves.

### Scrutiny and Governance

With a wide and complex strategy over the next 5 years, the Estates function at GHC requires support within the Trust and from across the wider ICS.

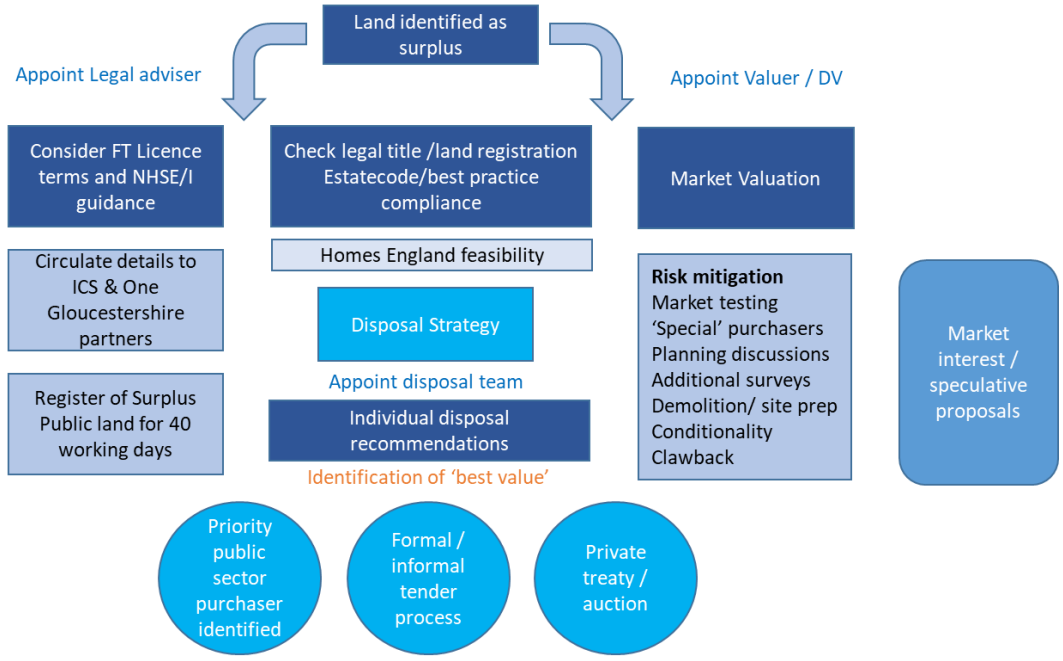
Any Estates proposal will continue to proceed through the existing governance framework of the Capital Management Group and Resources Committee before scrutiny by the Trust Board.

## Case Study – Disposal criteria and recommended process

**In considering whether a building should be identified for disposal, the following criteria should be adopted:**

1. It does not align to clinical locality service delivery strategies;
2. Non compliance with design/space/regulatory and service standards;
3. It is significantly under utilised or vacant;
4. Uneconomic operational costs or backlog maintenance over time;
5. It is is not required by GHC for core business.

GHC adopts the following formal process for disposing of property following a decision to declare the asset surplus to requirements:




## 10. Conclusion

This strategy sets out plans for our Estate at a time when the future level of occupancy of buildings and the adoption of new ways of working remains uncertain.

The Estate will continue to provide the foundation required for a high quality, safe and effective clinical and working environment for our service users, colleagues and partners in Gloucestershire.

We have approved the Full Business Case for the development of a new Community Hospital in the Forest of Dean hospital demonstrating the Trust's commitment to continued investment in our estate and this strategy also acknowledges that where appropriate, we will also rationalise assets that are not fit for purpose or become

surplus to service requirements, adopting a robust assessment and disposal process.

We propose that this Strategy is delivered through an implementation plan where individual processes, projects and partnerships are identified to deliver the Trust's vision and aspirations. Additionally, we recognise that increasingly we need to work with our system partners and maximise the opportunities for Estates collaboration, and partnership working across the public and third sector to deliver excellent care at the heart of our communities.

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**AGENDA ITEM: 16/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 2021**

**PRESENTED BY:** Sandra Betney, Director of Finance / Deputy CEO
**AUTHOR:** Andrew Paterson - Strategic Project Manager

**SUBJECT:** **REFURBISHMENT OF JUBILEE WARD AND MIIU, STROUD GENERAL HOSPITAL**

| | |
|---|---|
| **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 document presents 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.
[

**Recommendations and decisions required**

.
The Trust Board is asked to **approve** the Business Case at a value of approximately £1.5m [£1.964m less League of Friends contribution (c £400k) less applicable VAT reclaim]

**Executive summary**

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.

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.

The preferred option – to proceed with both schemes at the same time, instead of undertaking the work in two separate stages, avoids the need for multiple decants and is more economical.

Taking into account the donation from the Stroud Hospital League of Friends and the allocation in the Trust Capital Plan, the preferred option is affordable.

**Risks associated with meeting the Trust's values**

The refurbishment requires 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 is underway to ensure continuity of service and minimal impact on patient care.

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | The benefits derived from this investment have major quality implications including for patient privacy and dignity, infection control and clinical effectiveness. These are set out in the paper and in Appendix 1. |
| **Resource Implications** | The investment is part of the Trust Capital Plan. There are some transition revenue costs which will be met from non-recurrent underspend. |
| **Equality Implications** | A Quality and Equality Impact Assessment has been completed - this shows that impact on protected characteristics is either neutral or beneficial. |

| **Where has this issue been discussed before?** |
|---|
| A summary paper was discussed at Executive Team meeting on 13th July 2021. |

| **Appendices:** | 1. Strategic Objectives and Benefits for the Refurbishment<br>2. Terms of Reference for Stroud Jubilee Ward and MIIU Refurbishment Project Group<br>3. Refurbishment Project Plan<br>4. Operational Project Plan<br>5. Refurbishment risk matrix<br>6. Operational risk matrix<br>7. Quality and Equality Impact Assessment |
|---|---|

| **Report authorised by:**<br>Sandra Betney | **Title:**<br>Director of Finance / Deputy CEO |
|---|---|

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# Refurbishment of Jubilee Ward and MIIU, Stroud General Hospital

# Business Case July 2021

## Contents

Appendices

1. Strategic Objectives and Benefits for the Refurbishment
2. Terms of Reference for Stroud Jubilee Ward and MIIU Refurbishment Project Group
3. Refurbishment Project Plan
4. Operational Project Plan
5. Refurbishment risk matrix
6. Operational risk matrix
7. Quality and Equality Impact Assessment

## Introduction

This document presents 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.

Stroud General is one of the oldest buildings in the Trust estate. Parts of the current site date back to 1875 and to an extension in 1890. In 2017, Gloucestershire Care Services successfully applied for the building to be included in the Register of Assets of Community Value reflecting the esteem in which the building is held locally.

The old building presents many challenges for delivering modern efficient health care.

Over recent years, there has been considerable investment in bringing facilities at Stroud General to bring facilities up to more modern standards. In addition to the development of the Bowbridge Outpatient unit, improvements have included an extension to the theatre, a refit of endoscopy, new air handling units for theatre and endoscopy, piped oxygen for a part of the building, and some frontage window replacement. In 2018, a major scheme financed jointly by Gloucestershire Care Services and the Stroud Hospital League of Friends, refurbished Cashes Green ward providing additional side rooms and generally improving facilities across the ward.

Jubilee Ward and MIIU occupy the building at the Trinity Road end of the hospital site. This end has missed out on previous remodelling and refurbishment. There were some improvements on Jubilee in 2012 (e.g. to shower rooms), also jointly funded by the League of Friends, but these did not address major issues regarding the configuration of the ward. There has been no significant investment in MIIU.

This business case describes how the proposed scheme:

- Meets the Trust's strategic objectives and addresses the case for change (Strategic Case)
- Is worthwhile and provides value for money (Economic Case)
- Will be procured (Commercial Case)
- Will be affordable (Financial Case)
- Will be implemented (including transitional arrangements) and how it will be evaluated (Management Case).

# 1 Strategic Case

## 1.1 The role of community hospitals in health care in Gloucestershire

The Gloucestershire Integrated Care System Fit for the Future consultation and planning for hospital services in the county has focused attention on the best location for sustainable high-quality hospital services and the need for local services to continue to proactively prevent avoidable admission and to facilitate care pathways that enable people to return home in a timely manner.

This emphasises the role for effectively run community hospitals with community inpatient beds working closely with community-based rehabilitation services to deliver the most efficient use of resources. It also emphasises the need to prevent admission to the main acute hospitals wherever possible and to deal with as much urgent care as is clinically feasible away from the main hospital Emergency Departments.

The community hospitals operated by the Trust in Gloucestershire play an important role in bringing services within easier reach of local populations. Whilst the range of services offered varies between the hospitals, 7 of the hospitals play a role in providing community beds and delivering tier 3 urgent care services through Minor Injury and Illness Units (MIIU).

In addition to inpatient beds and MIIU, Stroud General offers a wide range of services enabling local residents to avoid travel to either Cheltenham or Gloucester:

There are two wards at Stroud General Hospital. Jubilee Ward is a 16-bed ward that works in tandem with Cashes Green Ward (22 beds) to provide both step-down beds facilitating earlier discharge from acute hospitals and step-up care as part of the Trust's response to preventing avoidable acute admission and to maintain care as close as possible to local communities.

Both wards are well utilised although the difficulty in managing infection in the bed bays in Jubilee does lead to a loss of bed days.

In 2019/20 (pre-Covid), Stroud MIIU was the busiest unit within the county in terms of overall attendances.

*Table 1: Attendances at MIIU 2019/20*

| | Attendances | | | |
|---|---|---|---|---|
| **MIIU** | Illness | Injury | Other | **Total** |
| Cirencester Community Hospital | 1165 | 13295 | 2677 | 17,137 |
| Dilke Community Hospital | 1537 | 7836 | 147 | 9,520 |
| Lydney Community Hospital | 581 | 8690 | 75 | 9,346 |
| North Cotswold Community Hospital | 826 | 8071 | 166 | 9,063 |
| Stroud General Hospital | 1053 | 16255 | 181 | 17,489 |
| Tewkesbury Community Hospital | 692 | 6871 | 309 | 7,872 |
| The Vale Community Hospital | 1009 | 5933 | 612 | 7,554 |
| **Grand Total** | 6863 | 66951 | 4167 | **77,981** |

Jubilee Ward is located directly above MIIU at the Trinity Road end of the site. Although there is little clinical link between the two services any work undertaken in either unit will have a significant effect on the operation of the other.

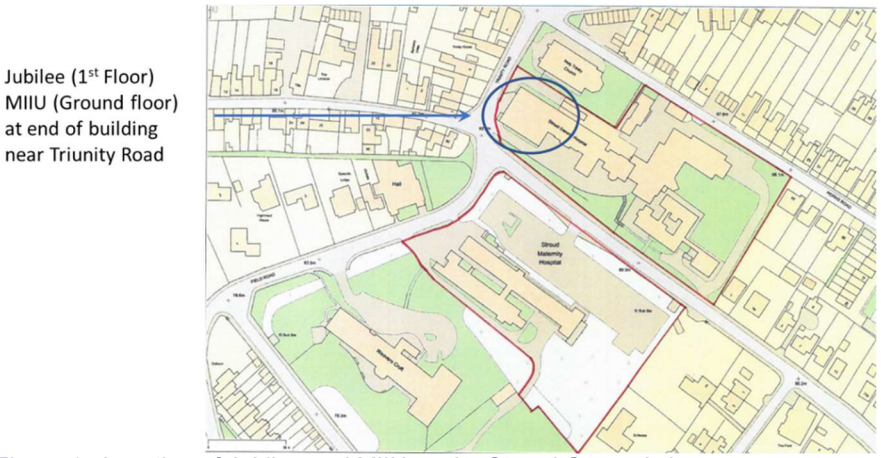



*Figure 1: Location of Jubilee and MIIU on the Stroud General site*

## 1.2 The Case for Change

### 1.2.1 Jubilee Ward

The 16 beds on Jubilee ward are currently configured across 3 bays (2 x 4 beds; 1 x 6 beds) and 2 single side rooms/cubicles. The issues and challenges the ward faces are summarised below.

Key issues include:

- The bed bays (including the 6-bed bay) have a number of physical issues resulting in both clinical and quality risks and compromises:

- There is only one toilet within each bay, with no modern showering facilities. Two additional toilets, the shower and the bath can only be accessed by walking across the general circulation area. This not only seriously compromises patient privacy and dignity, but critically makes it impossible to close off any of the bays for isolation purposes creating a clinical risk.
- The limited number of toilets within easy reach of the beds also makes it difficult to ensure full separation of sexes in the ward as patients may have to leave the bay to use a toilet.
- Handwashing facilities in the bays are limited to just one sink per bay meaning staff have to walk past a number of beds to wash hands between working with different patients.

- The two single bedrooms/cubicles pose significant clinical and health & safety risks to patients and staff:
  - Neither have ensuite facilities so cannot be used to isolate patients, adding to the clinical risk encountered on this ward.
  - They are very small, hindering round-the-bed clinical and other care, nor can they accommodate bariatric patients and equipment.
  - The circulation space and door openings of the side rooms are not big enough to enable a bed to be moved in or out of the single rooms without having to lift the bed which presents unacceptable health and safety risks for both staff and patients.

- There are serious ventilation problems on the ward leading to overheating especially in the summer months. The large windows cannot be opened and there is no other means of controlling the environment within the bays.

- Medical gases and suction are not provided to every bedhead and can only be delivered from stand-alone bottles/units. These take up considerable space and present challenges for safe handling and patient and staff safety.

- Essential ward administrative areas are inadequate and badly located:
  - Staff do not have access to a comfortable place in which to work quietly. The ward office is small and has poor ventilation with no external windows
  - The senior nurse's office is located off the ward which adversely affects productivity and makes supervision difficult.
  - There is no place to meet with patients' family and carers to break bad news or discuss care plans, compromising confidentiality and the patient/family experience.

- Essential support areas are also inappropriately located and sized:

  - A large equipment store occupies a significant space on the ward which could be more appropriately used for clinical care.

- The current patient social room which is also used as a “vintage” memory room is outside the ward area, a short distance down the corridor, and opposite the doors accessing theatres. As such, it can only be used by patients with assistance or under supervision, and consequently is underutilised. Patients with dementia cannot be left without supervision due to the risk of access to stairs and lifts and unlocked doors to Theatre/endoscopy and the Princess Anne Unit.
- The staff changing area is also poorly located being in the clinical ward area. It is small so cannot accommodate staff at shift change.

- Overall, the ward has an outdated and tired appearance, especially when compared with the facilities of Cashes Green Ward (refurbished in 2018).

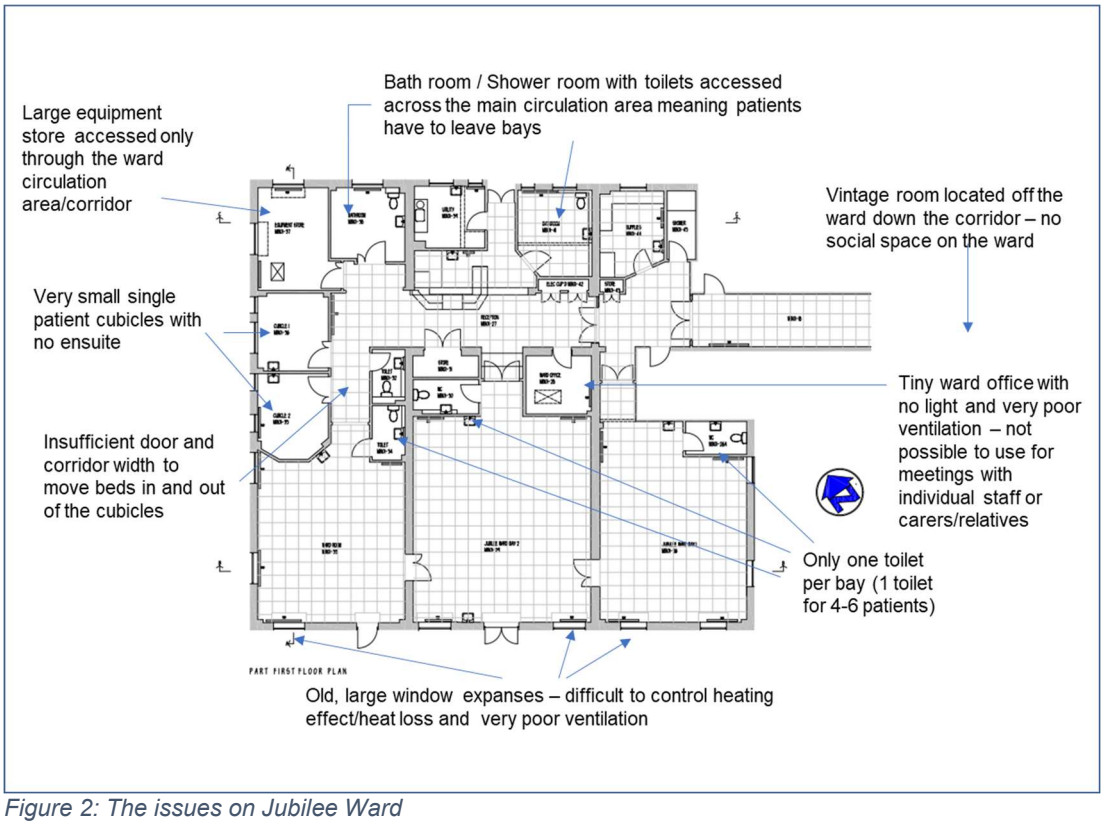



*Figure 2: The issues on Jubilee Ward*

### 1.2.2 MIIU

The MIIU area provides the clinical space for the busiest MIIU service in Gloucestershire and for the local primary care Out of Hours service. The issues and challenges the unit faces are summarised below.

- The area comprises a series of poorly configured clinical spaces, some providing little privacy and dignity. Adjacencies do not enable efficient and effective patient flow and reduce effective use of space. Circulation routes for patients and staff are confusing.

- The **entrance lobby** is small and narrow meaning that both doors will often be open at the same time leading to draughts and heat loss.
- The **reception area** has one access point only to the side of the unit, and has no clear line of sight to the entrance lobby, the waiting area, to the two disabled toilets or other circulation areas that are readily accessible to members of the public entering the building. There can be no overall monitoring or control of patient movements. The reception area is not immediately visible to patients or carers on entering the unit from the street.
- The **waiting area** is the main thoroughfare through the unit, to the outpatients and to other service areas beyond, with no access to natural light.
- The **triage area** is completely separated from the main assessment area. Patients who have been triaged for urgent assessment have then to walk across the waiting area past the front door to the assessment bays.
- The **consulting spaces** (currently used by outpatients and out of hours services) are accessed from a separate narrow corridor on the opposite side of the waiting area from the assessment bays.
- The separate **children's waiting area** is very small and there is no dedicated children's treatment area. With Covid restrictions only one family can use the room at a time.
- The **treatment and consulting areas** are very small with some only around 8 sq m. This is an unacceptable size for clinical use. The **dirty utility room** is very small (4.7 m2). The **eye treatment room** is less than 7 m2 much of which is taken up by the equipment. The size alone makes these rooms inaccessible to many people with disabilities, to bariatric patients and to patients who need to be accompanied. There is no space for undressing.
- The **main assessment area** provides space for 2 curtained bays only with no effective separation, thus confidentiality is breached as conversations can be overheard. Sound can travel from the assessment area to the waiting area. Space is constricted so trolleys are against the wall and can only be accessed from one side.

- There are no showering facilities for patients who may require this before treatment (e.g. those with burns).

- The only space that can be isolated for an infectious patient is the resuscitation room.

- Medical gases and suction are delivered from stand-alone bottles/units. These take up considerable space and present challenges for safe handling and patient and staff safety.

- There is a continual ventilation problem throughout the unit, which is worst in summer months, leading to a lack of fresh air and excessive heat. This makes conditions for both staff and patients oppressive at times. Windows are large expanses with little or no control over light and air.

- There is limited ability to close down clinical areas to public access should this be required in an emergency.

- There is no staff rest area within the unit.

- There is no office for the matron leading the service or space for any staff to work quietly with access to the online system.

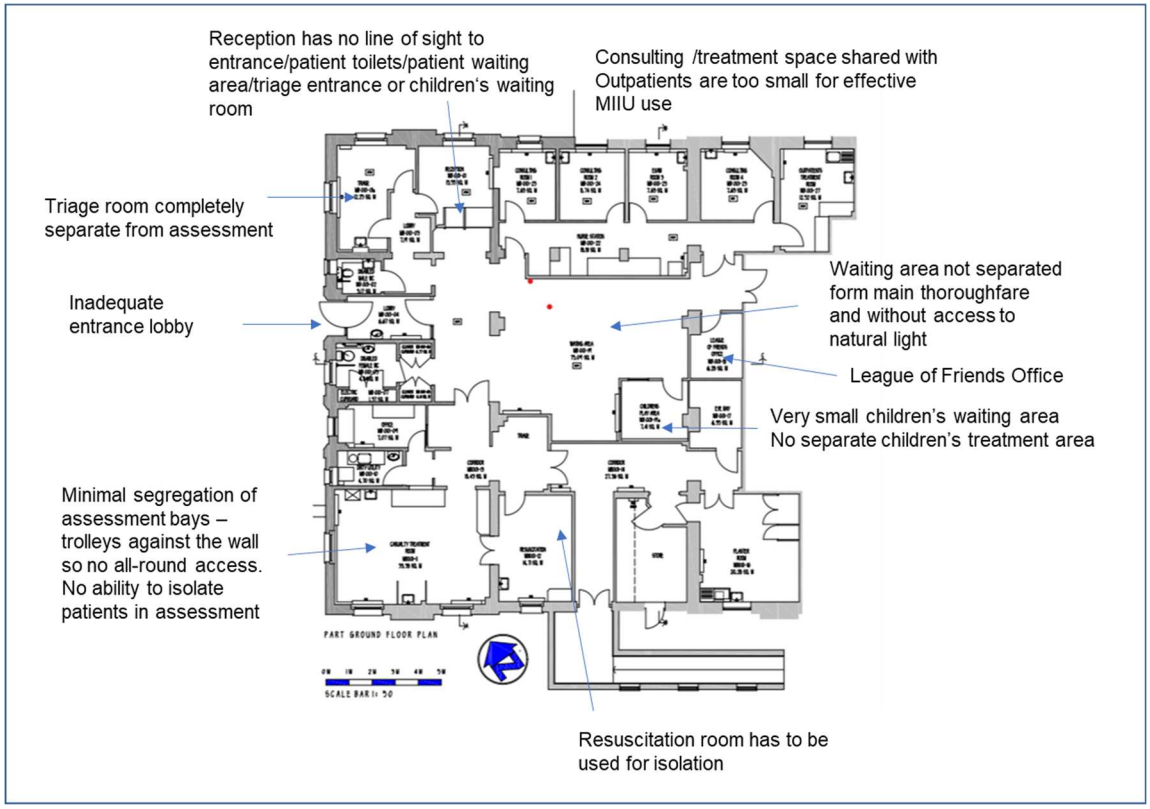



*Figure 3: Issues in MIIU*

## 1.3 Investment objectives and benefits to be achieved

A series of objectives have been agreed which underpin the proposed investment in both Jubilee and MIIU. These are summarised below and set out in detail at Appendix 1 along with the benefits that will be achieved by the completion of the proposed works.

*Table 2: Summary of Investment Objectives and benefits - see Appendix 1 for detail*

| Investment Objective | Benefits |
|---|---|
| 1. To provide clinical facilities that deliver safe and appropriate standards of clinical care | • Improved infection control<br>• Improved clinical standards |
| 2. To provide the best possible conditions for patients | • Improved access to facilities Improved privacy and dignity<br>• Better patient facilities<br>• Provision for those with dementia |
| 3. To provide the most efficient and effective operational configuration | • Improved clinical and service adjacencies<br>• Improved operational control |
| 4. To provide a pleasant and healthy working environment that enables staff and public well being | • Improved ventilation and temperature control<br>• General improvements to the environment<br>• Better staff facilities |

## 1.4 Constraints and dependencies

### 1.4.1 Constraints

- Work on either unit will require closure of both as this will involve substantial physical change – addressing the issues in MIIU requires gutting of most existing partitions and internal walls. Both units require new windows and substantial changes to services, utilities and drainage. This and the installation of piped medical gases necessitates intrusion into both ceilings and floors. In order to facilitate this, services will need to be relocated temporarily.
- It is essential to achieve the changes in a period before the anticipated start of winter pressures in 2021/22 when both MIIU and Jubilee will be important resources for the system and need to be operating at full capacity.
- The refurbishment of Jubilee and MIIU is included in the Trust's capital plan for 2021/22. There is a requirement to complete the investment in this period in order to secure the capital funding.

### 1.4.2 Dependencies

To maintain services during the building works depends on:

- Reinstatement of MIIU at the Vale to help deal with displaced attendances, still closed due to the use of the unit for COVID vaccinations. This is due to become free in August.

- Availability of space locally in Stroud to conduct booked MIIU appointments.
- Reproviding beds at Cirencester Hospital and undertaking minor works to facilitate side room capacity within decant ward.
- A carefully planned programme of running down inpatient admissions in the lead up to decanting in line with experience in previous transitions of service in community hospitals.

## 1.5 Support of Stakeholders

The key local stakeholder is the Stroud Hospital League of Friends. This organisation has played a key role over the years in promoting the need for a hospital in Stroud. They have been supportive of capital developments and are prepared to make a substantial contribution to the works required to bring Jubilee Ward and MIIU up to modern standards.

# 2 Economic Case

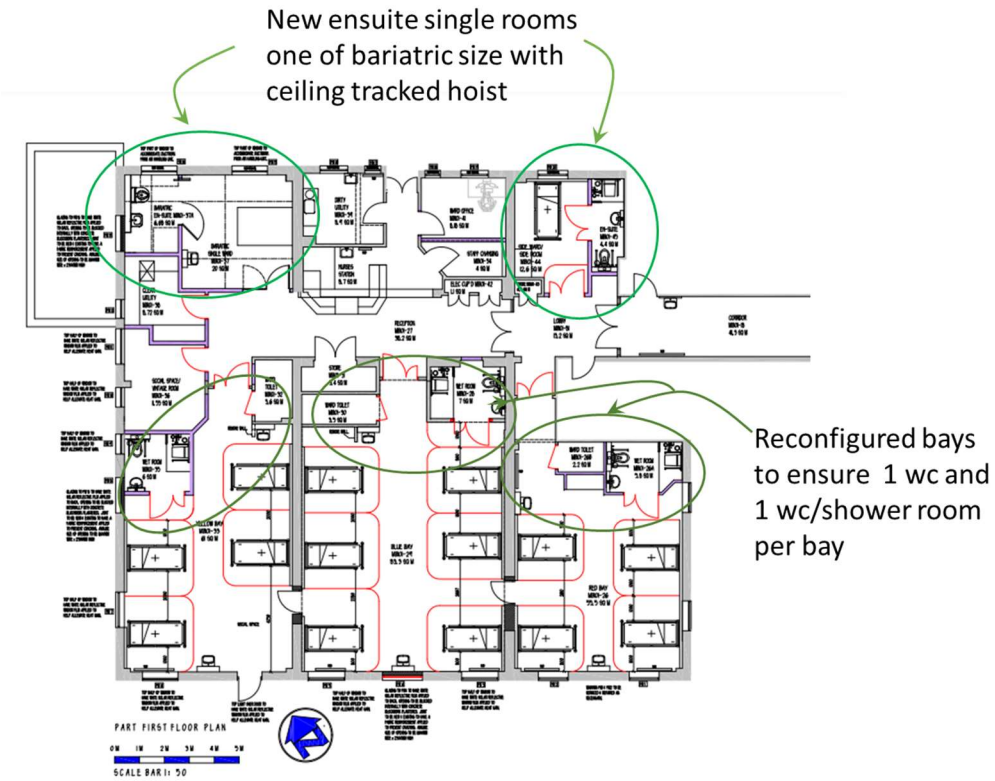
## 2.1 Schemes to address the Investment Objectives

A scheme has been proposed for each of Jubilee and MIIU that addresses the case for change and delivers the benefits listed in Section 1 and detailed at Appendix 1. Both schemes have been designed with the view that this is a one-off opportunity to make a significant difference talking advantage of the closure of the units to make substantial change. They are prudent, no-frill proposals and there is little, if any, scope within either scheme to reduce the specification to save costs. Therefore, they are presented below as whole schemes without a Do Minimum option. Key changes are listed below and annotated on the proposed floor plans.

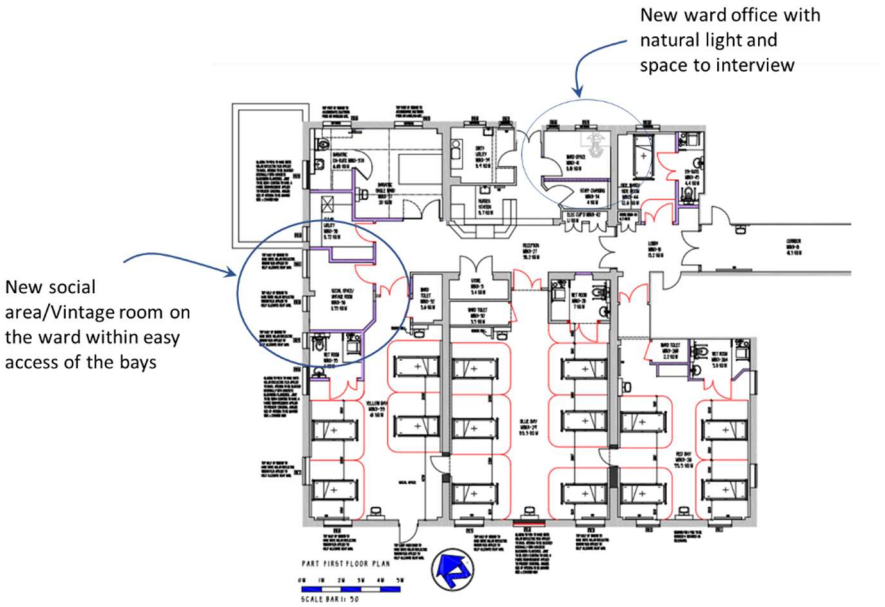
### 2.1.1 Jubilee Ward scheme

Key structural changes include:

- Effective separation of each bay, with each containing a WC and WC/shower room, removing the need for any patient to move outside the bay.
- Ensuite single rooms, one built to bariatric proportions and with a ceiling tracked hoist.



- New social area/vintage room on the ward within easy access of the bays.
- New ward office with natural light and large enough to interview staff or others as required.




In addition, the ward will have:

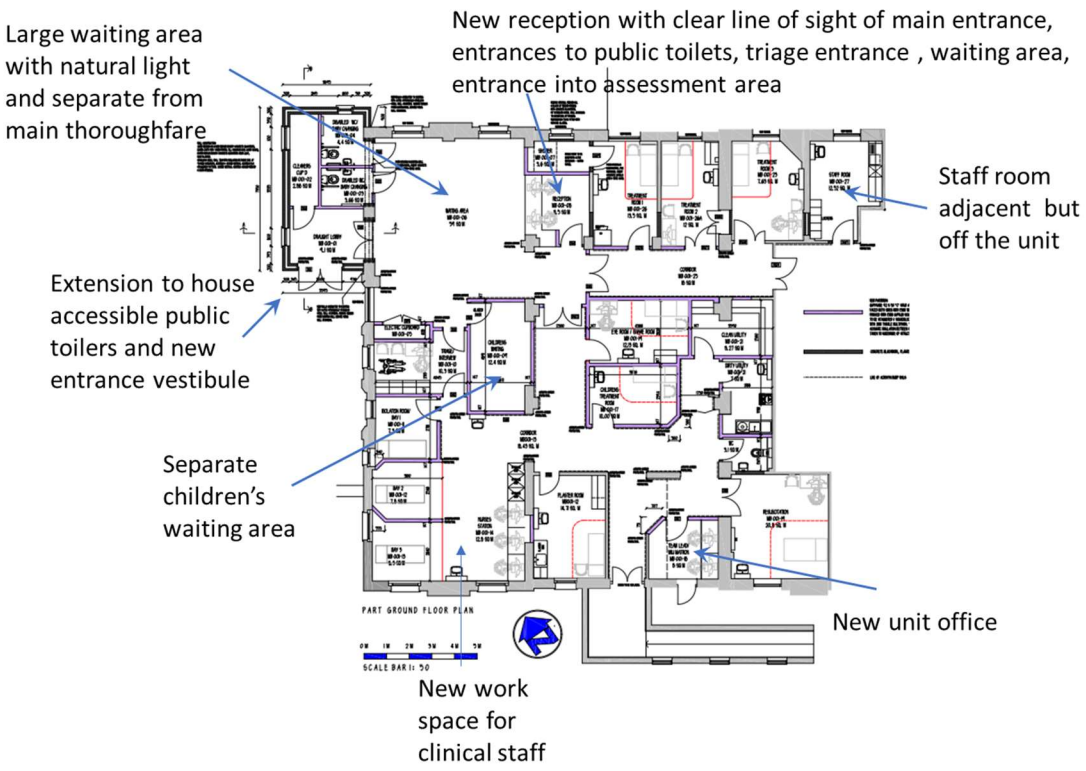
- New air handling and temperature control throughout
- Replacement of windows to address overheating and light issues
- Replacement of sanitary fittings and additional sinks in line with infection control requirements
- Piped medical gases at each bedhead.

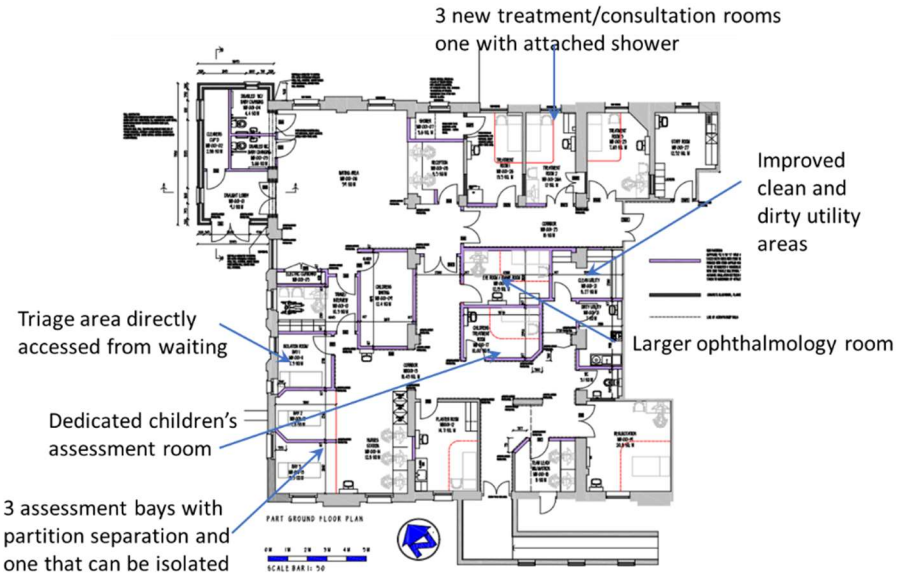
### 2.1.2 MIIU scheme

Key structural changes include:

- Provision of 3 well-appointed treatment/consulting rooms, one with attached shower room
- A triage area linked both to waiting and assessment areas
- Separate assessment bays – one able to be isolated for infection
- Dedicated children's assessment/treatment room.
- Larger ophthalmology room
- Improved clean and dirty utility
- Replacement of resuscitation, plaster rooms
- New entrance and lobby – in an extension also containing new accessible toilets/baby changing areas
- Large waiting area with natural light and separate from main thoroughfare

- A separate children's waiting area
- New reception with clear line of sight of main entrance, entrances to public toilets, triage entrance, waiting area, entrance into assessment area
- Better staff facilities: new work space for clinical staff, new matron's office and new staff room adjacent to the unit.



In addition, the new MIIU unit will have:

- New air handling and temperature control throughout
- Replacement of windows to address overheating and light issues
- Replacement of sanitary fittings and additional sinks in line with infection control requirements
- Piped medical gases in the resuscitation area.

## 2.2 Costed options

As already explained, the schemes have taken the approach that, given the disruption created by any change, this is a one-off opportunity to get things right within the constraints of the building. It therefore makes no sense to pursue a "Do Minimum" option in either scheme.

Four possible options for delivering the schemes have been costed (including VAT):

### Option 1 - Business as Usual (backlog maintenance cost of £0.161m)

Not to proceed with any of the planned changes. Reliance would be made on routine maintenance of the fabric and addressing backlog maintenance but no improvements would be possible.

The Case for Change is strong and given that the Trust has already made a commitment in the Capital Programme, there is little justification in continuing Business as Usual providing that the changes proposed are affordable.

### Option 2 - Refurbish Jubilee Ward only (£1.052m)

This option would deliver the above changes to the ward area only. There would be no improvement to the MIIU below. Both areas would still have to be vacated during the refurbishment as the work on Jubilee would intrude into the MIIU so much that it would not be possible to continue deliver a service.

### Option 3 - Refurbish MIIU only (£1.172m)

This option would deliver the above changes to the MIIU area only. There would be no improvement to the ward above. Both areas would still have to be vacated during the refurbishment as the work on MIIU would intrude into the ward so much that it would not be possible to continue deliver a service.

### Option 4 Proceed with both schemes at the same time (£1.964m)

This would deliver all the benefits for both areas. This will require both areas to be vacated and this would be for a marginally longer period than in Options 2 and 3.

To deliver the scheme in two stages (i.e. undertaking Option 2 and then separately at a later stage, Option 3) would at current prices cost would cost an additional £260k.

Option 4 delivers all the benefits for both areas and financially, with both schemes delivered with a single decant rather than requiring both departments to be disrupted twice.

## 2.3 Other costs

### 2.3.1 Avoided costs (addressing backlog maintenance)

Delivery of the schemes for Jubilee and MIIU will avoid an estimated £141,000 and £22,100 respectively of backlog maintenance programmed for the period 2020 to 2025, including work that has been put on hold pending a decision to proceed with the schemes. See Financial Case for further details.

### 2.3.2 Operating costs

It is not anticipated that there will be any change in costs of clinical and service operations as there will be no change to the scope of services delivered and no changes in staff employed.

The refurbishment gives the opportunity to ensure the most sustainable approach is adopted given the limitations of working with a very old building (see Section 3 .5). Energy savings from new lighting and better insulation will be countered by increased costs from more extensive (although more efficient) air handling and cooling.

### 2.3.3 Transitional costs and double running costs

These would apply for Options 2,3 and 4 as both units would need relocating for the duration, whichever option was chosen. These costs are set out in Section 4, the Financial Case.

### 2.3.4 Equipment costs

The capital costs cited above include Group 1 equipment which includes the air handling, gas supply, bedhead points, all sanitary fittings etc and the tracked ceiling hoist. It is anticipated that existing equipment on the ward and MIIU will be used in the refurbished units and no additional equipment will be required.

### 2.3.5 Income

Since there are no changes in service, no change in income will arise although here may be a reduction of Trust income for the duration of the works as only 13 beds will be made available at Cirencester to replace Jubilee services.

The Stroud Hospital League of Friends have indicated a preparedness to contribute significantly to the capital required. At this stage, the contribution is assumed to be £400,000 for Option 4 i.e. the two schemes undertaken at the same time. The contribution to the other Options has not been discussed.

## 2.4 Costing of benefits

As seen in Section 1, delivering the scheme for Jubilee and MIIU will result in substantial improvements in terms of:

- Safe and appropriate standards of care
- Best possible conditions for patients
- Effective and efficient clinical configuration
- A pleasant and healthy working environment

It is difficult to attribute a cost to these benefits in a meaningful way:

- There will be no change to overall clinical activity although the number of bed days lost due to infection could decrease.
- MIIU capacity is most affected by surges in demand and staffing numbers and skills. The new MIIU will not change the staff structure so that although the better use of space in MIIU will increase its ability to hold more patients, it is not believed that the number of hours in which MIIU may have to close to new patients will be greatly affected.

## 2.5 Conclusion on preferred option

### Option 4 Proceed with both schemes at the same time £1.964m

This would deliver all the benefits for both areas. As in the other options, this will require both areas to be vacated.

Option 4 deliver all the benefits for both areas and financially, this results in a cost reduction of approximately £260k compared with doing the two schemes I n separate stages. In addition. both schemes are delivered with a single decant rather than requiring both departments to be disrupted twice.

As such the recommended way forward is a combined refurbishment of both Stroud MIIU and Jubilee Ward.

# 3 Commercial Case

## 3.1 The Design team

In the period up to procurement, the Trust Capital Delivery Manager has been supported by external specialists to enable a full technical design for each scheme to be developed to provide a detailed specification for tendering.

External specialists and advisers for RIBA stages 1-4 were as follows:

| Function | Specialist firm |
|---|---|
| Project Management | Gleeds |
| Architects | Anderson Architecture |
| Quantity Surveyors | Adam Fletcher & Partners |
| Structural Engineers | Waterman Group |
| Mechanical and Engineering | Service Design Solutions |

## 3.2 Tender process

Following detailed work by the design team, working with end users in both units, the proposed schemes were costed by the Quantity Surveyors to produce a Pre-tender Estimate to function as a benchmark against tendered prices. The original intention was to test the Pre-tender Estimates in a conventional competitive tender exercise in June/July 2021.

Delays in the design stage have been caused by the complexity of working with an old building with a number of unknowns. This has reduced the time available for a conventional tendering exercise if the project is to meet the deadlines for returning both the ward and MIIU to operations before the expected upsurge in winter pressures.

An alternative approach to use the South West Procurement Alliance framework has therefore been adopted. The framework enables the Trust to engage with contractors who have already passed quality and price criteria. This has the key advantage of shortening the procurement process. The Trust has approached Speller Metcalfe on the framework to tender for the work.

The tender period is no running until the second week of August enabling the Trust to come to a decision to be made in the week commencing 16 August.

## 3.3 Type of contract

An Intermediate JCT contract will be used in order to facilitate liaison and control of deliverables.

## 3.4 Stroud Hospital League of Friends

The investment is dependent on an anticipated donation from the Stroud Hospital League of Friends.

Discussions are underway to ensure that the donation is used in areas which can maximise the VAT reclaim that the League may be entitled to.

This will require separate contract for the work that will be undertaken on behalf of the League of Friends.

## 3.5 Planning permission

A planning application *for a proposed single storey extension to provide new entrance lobby together with associated external ventilation plant and alterations to windows* was submitted to the planning authority (Stroud District Council) on 13 January 2021, receiving permission on 5 March 2021. This was the only planning permission required.

## 3.6 Sustainability

Refurbishment provides the opportunity for complete refitting of lighting and the replacement of large window expanses that can both excessive heat loss in winter and heat gain sin summer leading to current problems with the war d and MIIU environment. The two existing air handling units are extremely inefficient and will be replaced.

Savings created e.g. through the use of LED lighting throughout will be offset by the increased energy costs of the new air handling and cooling system.

The system has been specified to be as energy efficient as practical and specifies the use of PIR in toilets etc, and individual room control.

The air handling in MIIU will be shut down when the unit is not in use.

All energy using systems in Jubilee and MIIU will be linked to the hospital's building management system for monitoring and control

# 4 Financial Case

## 4.1 Capital costs and funding.

Refurbishment of Jubilee and MIIU is part of the Trust Capital Programme for 2021/22 for which an allowance of £1.5m has been made.

The pre-tender estimate for the preferred option is £1.964m before any VAT reclaim. Once a price has been agreed with the contractor, the Trust will engage its tax advisers, Liaison Financial, to examine all elements for potential VAT reclaim. Allowing for the anticipated contribution of £400,000 from the Stroud Hospital League of Friends and VAT reclaim, the preferred option remains affordable.

### 4.1.1 Capital cost by element

*Table 3: Breakdown of capital costs*

| Element | Net Cost | Vat | Gross |
|---|---|---|---|
| RIBA Stage 1 - 7 Fees | £135,151 | £27,030 | £162,181 |
| Building works | £1,463,365 | £292,673 | £1,756,038 |
| **Total** | **£1,636,709** | **£319,703** | **£1,964,051** |

### 4.1.2 Avoided cost (Backlog maintenance)

The refurbishment of both units will address all internal backlog maintenance requirements that have been identified in the Oakleaf 6-facet survey. These have been costed at £163,000, so this call on the backlog maintenance allowances in the Trust Capital Plan will be avoided. Details of the identified maintenance requirements that will be subsumed by the two schemes are set out below:

*Table 4: Backlog maintenance identified for Jubilee and MIIU*

| Unit | Description | Cost | Year | Comments |
|---|---|---|---|---|
| Jubilee | Floor | £46,000 | 2020 | Vinyl sheet flooring: Worn and aged to Bed bays require replacement. |
| Jubilee | Sanitary Fittings | £6,000 | 2020 | Wash hand basin: Aged and not to modern standards. |
| Jubilee | Fixed Units | £15,000 | 2021 | Clinical storage: Showing signs of age and wear and requires replacement within the maintenance schedule. |

| Unit | Description | Cost | Year | Comments |
|---|---|---|---|---|
| Jubilee | Sanitary Fittings | £6,000 | 2021 | Patient WC to Wet Room: Showing signs of age and require refurbishment within the maintenance schedule. |
| Jubilee | Sanitary Fittings | £30,000 | 2021 | Patient WC and Wet Room to Bed bay: Requires refurbishment within the maintenance schedule. |
| Jubilee | Decorations | £23,000 | 2021 | Redecoration required as part of a regular maintenance schedule. |
| Jubilee | Fixed Units | £15,000 | 2023 | Nurse station: Requires refurbishment within the maintenance schedule. |
| Subtotal for Jubilee | | £141,000 | | |
| MIIU | Fixed Units | £6,000 | 2020 | Clinical units to Treatment Rooms: Are considered aged and require replacement. |
| MIIU | Decorations | £9,000 | 2020 | Redecoration required as part of a regular maintenance schedule. |
| MIIU | Floor | £5,000 | 2023 | Vinyl sheet flooring: Sections are aged and worn flooring with replacement required within the maintenance schedule. |
| MIIIU | Sanitary Fittings | £2,100 | 2025 | Patient WCs: long term refurbishment expected to be required within the maintenance schedule. |
| Subtotal for MIIU | | £22,100 | | |
| **Total for Jubilee and MIIU** | | **£163,100** | | |

## 4.2 Other project related costs

### 4.2.1 Capital

Minor works are required to enable space at Cirencester to be used again as part of Thames Ward, creating two side rooms and increasing decant capacity from 13 to 15. A sum of £60k+VAT has been agreed by the Capital Management Group so that this work can proceed and be completed to facilitate the transfer of services towards the end of August.

### 4.2.2 Revenue costs

The Refurbishment Project Group have concluded that:

- Any patient transport for the few remaining patients moving from Jubilee to Cirencester and on return to Stroud will be covered by existing arrangements with SW Ambulance NHS Trust.
- There are unlikely to be additional costs for medical cover or agency costs resulting from the temporary change in location.
- Storage in the interim period will be found within Trust premises and not incur cost.

The following costs have been identified:

- Shuttle bus transport for staff from Stroud to Cirencester - £41k for the period of relocation
- Removal costs from Stroud to Cirencester and on return - £12k .

These will be funded from non-recurrent underspend.

### 4.2.3 Other costs

*Table 5: Capital cost elements*

| Element | Per annum | How funded |
|---|---|---|
| Additional capital charges at 3.5% | £68,741 (year 1) | Included in Trust Financial plans |
| Depreciation over the life of the asset (straight line depreciation over 35 years) | £56,115 | Included in Trust Financial plans |

## 4.3 Potential contribution from League of Friends

Discussions are at an advanced stage with the Stroud Hospital League of Friends who are greatly supportive of the refurbishment and who wish to make a substantial donation of up to £400,000 to the final costs.

## 4.4 Conclusion of affordability

Taking into account the contribution of £400,000 from the Stroud Hospital League of Friends, Option 4 is affordable in terms of the Trust Capital Programme.

# 5 Management Case

## 5.1 Project governance arrangements, roles and responsibilities

A small Programme Board will oversee the delivery of the programme of work required to complete the refurbishment (RIBA stages 5-7). This Board will be chaired by the Trust Associate Director of Estates, Facilities & Medical Equipment and will comprise a Trust Capital Delivery Manager and a Deputy Chief Operating Officer to represent service interests.

The Capital Delivery Manager will liaise with the contractor on a day to day basis. The contractor will maintain the construction project plan and the construction risk register. The Capital Delivery Manger will oversee the management of the contract and change control, escalating issues as required.

The operational arrangements (decanting, interim provision and re-establishing services in Jubilee Ward and MIIU on completion of the building works) will be overseen by the *Stroud Jubilee Ward and MIIU Refurbishment Project Group* (Terms of reference at Appendix 2). This Project Group has been meeting for over two months and is an operational oversight group that reports to the Chief Operating Officer. The Group is chaired by a Deputy Chief Operating Officer. The Associate Director of Estates, the Capital Delivery Manager, the Deputy Service Director of Community Hospitals and the Service Director Urgent Care and Specialty Services are members of the Group along with key service leads for Jubilee Ward and MIIU.

## 5.2 Transition arrangements, contingency and business continuity

### Jubilee Ward services

The Trust will be re-providing at least 13 beds within Cirencester Hospital by utilising Thames and Churn Wards; these wards will be renamed Preston Ward for reporting purposes. A detailed bed management plan is being prepared to reduce the number of patients occupying beds in Jubilee ward over the two weeks prior to the ward closure so that a reduced number of patients will actually be transferred. Once Preston Ward is operational, bed numbers will be increased over a week up to operating capacity.

GHC have previous experience of this process having undertaken similar ward decants for refurbishment in the past few years. Staff working on Jubilee Ward will transfer with the patients and work from Preston Ward in Cirencester for the duration. The Trust will provide transport between the two sites and shift patterns will be amended as required to ensure travel times and shift handovers are included. The Trust has

embarked on staff engagement sessions to ensure that all staff are kept fully informed and have the opportunity to raise any concerns they have.

### Stroud MIIU

The Operational plan to manage the temporary closure of the MIIU at Stroud focuses on developing the role of telephone triage. Approximately 20% of the GHC MIIU activity is now delivered through pre-booked appointments following telephone triage with patients choosing to call their local unit. However, In Stroud only 5% of activity is in booked appointments. The MIIU closure provides an excellent opportunity to further develop and implement the 'Talk before you Walk' initiative and increase this pre-booked rate in line with other areas, supporting the National direction of travel for booked appointments. This would also support post Stroud refurbishment MIIU activity and flow. Provision will be made for some booked appointments in rooms in Stroud Maternity Hospital, temporarily vacated by Children's and Young People's Services. Appointments will also be offered at MIIUs at the Vale (Dursley) and at Cirencester. Stroud MIIU staff will be distributed between the three MIIUs in line with anticipated demand.

## 5.3 Project plan

In order to ensure that both MIIU and Jubilee are operational for the main winter pressure period from January 2022 onwards, it is essential that the procurement and construction time table and the associated operational plans are adhered to.

Key dates are:

- Decant of existing services in the weekend of 21st and 22nd August 2021.
- Contractor Mobilisation 23rd August
- Contractor Programme 14-16 weeks aiming to complete before Christmas 2021.

The construction project plan is included at Appendix 3.
The operational project plan is included at Appendix 4.

## 5.4 Project risks, mitigation and management

The Programme Board is responsible for the monitoring and management of the risks associated with the refurbishment. A risk matrix is included at Appendix 5. Key risks include:

- The current volatile market for materials leading to unstable and high prices and availability

- The availability of labour to carry out construction due to increased demand on the construction industry
- The extent of asbestos containing materials is unknown (survey will be undertaken as soon as practically possible following the engagement of the contractor).

The Project Group is responsible for the management and monitoring of operational risks leading up to the decant, the interim period of service relocation and the return of services to Stroud. A risk matrix is included at Appendix 6. Key risks include:

- Further waves of COVID and social distancing requirements affect movements of staff and
- The reduction in beds (in the temporary move to Cirencester and the rundown of inpatient numbers in the lead up to decanting, places additional strains of the system.
- Moving some work to Cirencester places pressure on services that have to remain at other parts of the hospital in Stroud (e.g. therapy).

All risks are identified and managed according to the Trust Risk Management Policy and are reviewed regularly for mitigation and scoring.

## 5.5 Benefits realisation

There are three types of benefit that will be realised:

- Benefits that will be realised through the agreed design and the satisfactory completion of the refurbishment – these will have been achieved in December 2021/January 2022 when the refurbished units are commissioned.
- Benefits enabled by the building but requiring specific action to fully realise. Realisation will be over the initial operating period January to April 2022 – for example the use of the single rooms in Jubilee to the best effect and achieving the consistent segregation of sexes on the ward. Realising these benefits is the responsibility of the Deputy Service Director of Community Hospitals and the Service Director Urgent Care and Specialty Services.
- Benefits as perceived by patients and staff using the building (these will be assessed by the end of the initial operational phase (January to April 2022 and again in the period June to September 2022). Assessing these benefits will be the responsibility of the Deputy Service Director of Community Hospitals and the Service Director Urgent Care and Specialty Services.

## 5.6 Public and staff engagement

The Trust Communications Manager has worked closely with service leads to agree a stakeholder map identifying leads for various elements of communications required across a range of groups and stakeholders.

Internal engagement around the moves began on July 15 and there has been on-site engagement with Trust staff, as well as colleagues from systems partners working in X-ray, theatre, ultrasound and outpatient clinics. Prior to that service leads and staff within both units had an opportunity to discuss the proposed schemes and comment on evolving plans.

Engagement with patients, families and carers is being led by Stroud Hospital Matron with support the communications team.

Communication with neighbours to the Stroud site is being planned by Trust communications and Partnerships and Inclusion Teams.

System-wide communications to ensure public awareness and appropriate signposting to alternative services (especially around the closure of Stroud MIIU) are being developed with the Communications teams at GHC, GHFT and the CCG

## 5.7 Post project evaluation

The Trust is committed to evaluating both the project processes and the success of the investment created through this project.

***The Project Implementation Review*** will be undertaken within two months of the commissioning of the units and the transfer of services back to Stroud in order to capture the lessons learnt. The process will be a combined exercise by the Programme Board and the Project Group.

Areas of focus will include:

- Effectiveness of the project structure.
- Effectiveness of service planning, the anticipation of issues and the ability to take action where required.
- Any unforeseen impact on other services.

***A Post-Evaluation Review (PER)*** for reviewing how well the service is running and delivering its anticipated benefits will take place after the initial operational period and will link with the benefits realisation monitoring described above.

## 5.8 Equality Impact Assessment

A Quality and Equality Impact Assessment has been completed and submitted to the Trust's Improving Care Group. This QIA EIA is attached at Appendix 7.

## Conclusion

This business case has shown a pressing case for change for both Jubilee Ward and the MIIU at Stroud General Hospital and how the proposed schemes deliver the investment objectives that will result in the substantial benefits identified for patients, staff and service operations.

The preferred option – to proceed with both schemes at the same time, instead of undertaking the work in two separate stages, avoids the need for multiple decants and is more economical.

Taking into account the donation from the Stroud Hospital League of Friends and the allocation in the Trust Capital Plan, the preferred option is affordable.

This Business Case is therefore commended to the Trust Board for approval to enable work to progress and the schemes to be completed in time to meet anticipated winter pressures.

## Appendix 1: Strategic objectives and benefits for the refurbishment

A series of objectives have been agreed which underpin the proposed investment in both Jubilee and MIIU. These are set out in detail below along with the benefits that will be achieved by the completion of the proposed works.

### Investment objective 1

| **1. *To provide clinical facilities that deliver safe and appropriate standards of clinical care*** |
|---|

| **BENEFITS: Improved infection control** | |
|---|---|
| **Jubilee Ward** | **MIIU** |
| Full compliance to infection control measures by<br>○ enabling the isolation of each bay<br>○ providing adequate toilet and showering facilities on each bay<br>○ ceasing the movement of patients outside their bay area.<br>○ Improved handwashing facilities that comply with standards. | The ability to isolate infectious patients in a segregated assessment bay without closing down the resuscitation room (as is current practice). |
| Re-providing 2 single rooms with ensuite facilities to enable effective isolation of suspected or actual infectious patients. This will also reduce the need to transfer patients to Cashes Green ward which involves moving patients across the hospital. | |
| **BENEFITS: Improved clinical standards** | |
| **Jubilee Ward** | **MIIU** |
| Medical gases and suction at each bedhead in the bays and single rooms | Greatly improved space standards in modern assessment/consulting and treatment rooms that are fit-for-purpose potentially expanding the range of treatment that can be offered. |
| Ability to cater for a bariatric patient increasing the opportunity to transfer such patients from acute hospitals. | Patient showering facility to improve treatments of burns patients. |
| | Sufficient space to allow access to assessment trolleys from all sides. |

Appendix 1: Strategic objectives and benefits for the refurbishment

## Investment objective 2

***2. To provide the best possible conditions for patients***

| **BENEFITS: Improved access to facilities** | |
|---|---|
| **Jubilee Ward** | **MIIU** |
| Improved and convenient access to toilets and to modern shower/wet rooms which patients prefer to baths. 2 toilets will be provided for each bay. Facilities with full disabled access. | Improved patient toilets with baby changing facilities in both male and female toilets. |
| **BENEFITS: Improved privacy and dignity** | |
| **Jubilee Ward** | **MIIU** |
| Improved privacy and dignity by removing the need to walk across the general circulation area, thus ensuring more effective sex segregation. | Improved privacy and dignity in the separation of assessment spaces in individual bays, reducing the risk of sound travel and conversations being overheard. Removing the travel of sound from assessment area to waiting area |
| 2 single rooms that could be used for patients who particularly need their own space eg those at end of life | |
| **BENEFITS: Better patient facilities** | |
| **Jubilee Ward** | **MIIU** |
| A new social area /vintage room as an integral part of the ward which can provide:<br>• Better access for patients and their families<br>• Opportunities for patients to have time away from distractions<br>• Another space to have difficult conversations with patients and their relatives away from the other patient | Greatly improved waiting area for both adults and children in a separate children's waiting room, with waiting areas set apart from general circulation and with access to natural light. |
| **BENEFITS: Provision for those with dementia** | |
| **Jubilee Ward** | **MIIU** |
| Better provision for patients with dementia through the reduction of the need for movement within the ward. The use of colour etc in the new fabric and easier access to the vintage room.<br>Ability to allow patients walking with purpose to access vintage room without need for close observation (if appropriate) therefore reducing stress and anxiety to patient. | Better provision for patients with dementia through the better configuration of the rooms, a clearer patient flow and through the use of new colours in the fabric etc. |

Appendix 1: Strategic objectives and benefits for the refurbishment

## Investment objective 3

***3. To provide the most efficient and effective operational configuration***

| **BENEFITS: Improved clinical and service adjacencies** | |
|---|---|
| **Jubilee Ward** | **MIIU** |
| Less need to spend time supervising the movement of patients within the ward and in the social area | Ensuring triage is adjacent to the assessment area reducing unnecessary patient movement and helping to maintain flow. |
| | A clear route to and from assessment and to treatment rooms |
| | A short journey from children's waiting to the dedicated children's treatment room. |
| **BENEFITS: Improved operational control** | |
| **Jubilee Ward** | **MIIU** |
| The ability to manage effectively areas of the ward for both sex separation and infection control. | Excellent line of sight from the reception area to entrance lobby, waiting area, public toilet entrances, triage area and entrance to children's waiting area |
| A reasonably sized office on the ward enabling greater senior nurse presence and improved communication with staff and patients/carers. | Much better separation of circulation space from waiting space. |
| Sufficient space in the circulation area and appropriately sized door openings to enable beds to be moved easily in and out of all bed areas | The ability to lock down areas within the unit in the event of an emergency in order to protect and contain. |
| Reduced disruption and infection transmission risk caused by movement of large equipment as the store will be relocated off the ward. | |
| More efficient circulation for both patients and staff reducing wastage of time. | Clearer, less confusing routes through MIIU. |

Appendix 1: Strategic objectives and benefits for the refurbishment

## Investment Objective 4

| ***4. To provide a pleasant and healthy working environment that enables staff and public well being*** | |
|---|---|
| **BENEFITS: Improved ventilation and temperature control** | |
| **Jubilee Ward** | **MIIU** |
| New ventilation system and new windows with control for each area ending the extreme temperature and poor circulation that currently affect the ward. | New ventilation system and new windows with control for each area ending the extreme temperature and poor circulation that currently affect the unit. |
| **BENEFITS: General improvements to the environment** | |
| **Jubilee Ward** | **MIIU** |
| General refurbishment of walls and floors and all fittings including new colours to assist those with dementia. | General refurbishment of walls and floors and all fittings including new colours to assist those with dementia. |
| **BENEFITS: Better staff facilities** | |
| **Jubilee Ward** | **MIIU** |
| A properly sized ward office where interviews can be held. | Better provision of staff changing and other facilities where staff can take a break way from patient care. |
| Better provision of staff changing and other facilities where staff can take a break way from patient care. | A dedicated office where interviews can be held and where staff can work quietly and where the unit Matron can be based |

# Appendix 2: Stroud Jubilee Ward and MIIU Refurbishment Project Group

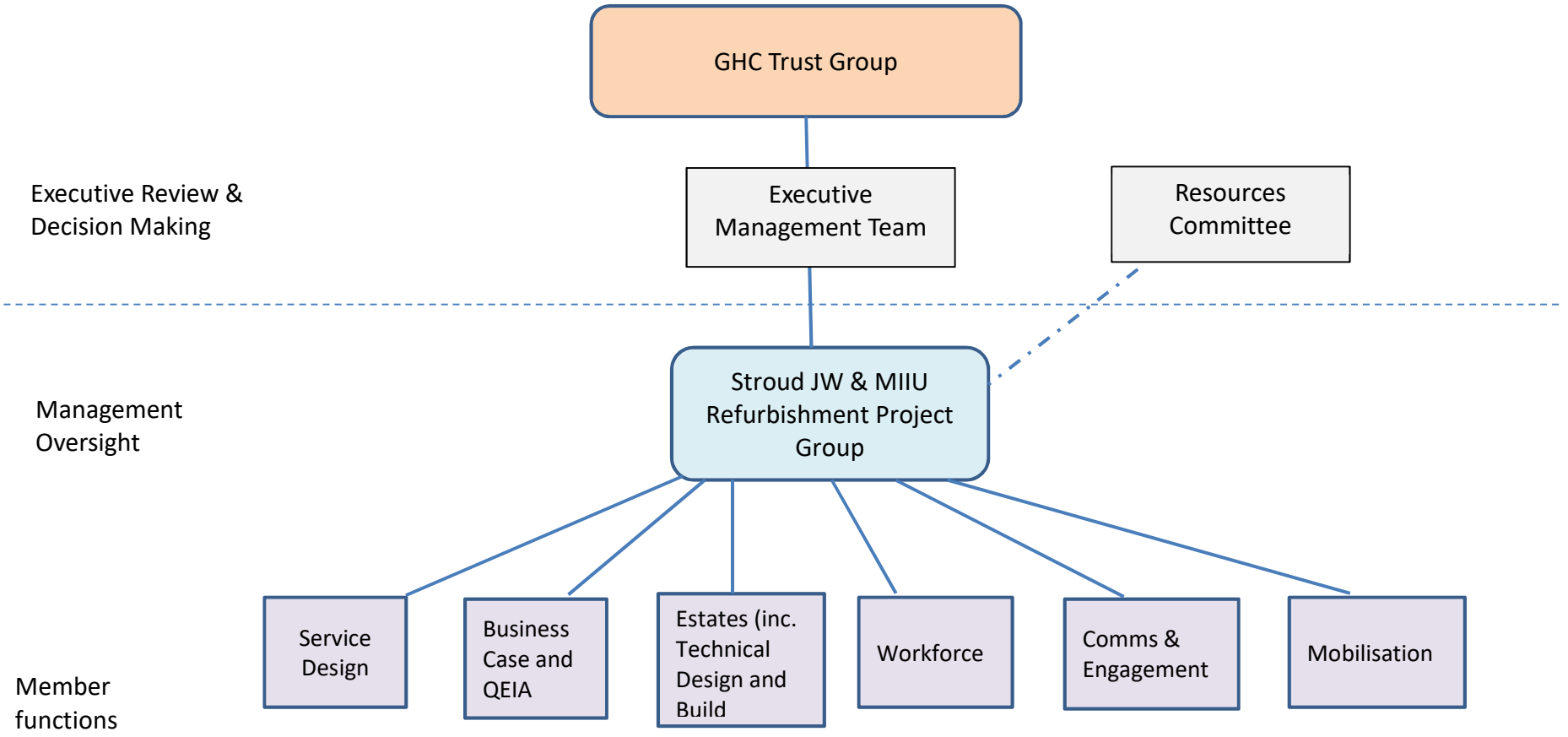
## TERMS OF REFERENCE

| 1. | **Purpose** |
|---|---|
| | The Jubilee Ward and MIIU Stroud Refurbishment Project Group is responsible for the management and operational delivery of the programme of work required to facilitate the refurbishment of Jubilee Ward and the MIIU in Stroud General Hospital.<br><br>This includes the relocation of the MIIU, the inpatient ward and redeployment of staff as identified, as well as contributing to the business plan development, finalisation of the estates design plans and timelines in order to manage and respond to the expectations of key stakeholders. |
| **2.** | **Membership** |
| | The core membership consists of:<br>• Deputy COO - Margaret Dalziel *(Chair)*<br>• Deputy Service Director of Community Hospitals *(co-chair)* - Juliette Richardson<br>• Associate Director of Estates, Facilities & Medical Equipment – Kevin Adams<br>• Service Director for Urgent Care – Helen Mee<br>• Communications Manager – Matt Blackman<br>• Matron, Stroud General Hospital – Liz Lovett<br>• Matron, Cirencester and Fairford Hospitals – Linda Edwards<br>• MIIU Lead – Lee Iddles<br>• HR Advisor – Keri Barrow<br>• Capital Estates Manager – Gavin Rowcraft<br>• Project Manager – Fiona Smith<br>• Facilities Lead – Amy Bennett<br><br>Other attendees, as required:<br>• Jubilee Ward Senior Sister – Sarah Gazzard<br>• Business Intelligence - Ashley Jones<br>• Clinical Systems – Amanda Linley<br>• Service Director Hospitals – Julie Goodenough<br>• Finance – Melissa Skelton<br>• MIIU Team Lead - Ali Hicks<br>• Facilities Lead, Cirencester – Di Foster<br>• Strategic Project Manager – Andrew Paterson |
| **3.** | **Quorum** |
| | To be quorate the following must be in attendance: Chair or Co-Chair, one Matron or Senior Sister, one MIIU representative and one Estates/Capital representative. |

| | |
|---|---|
| | |
| **4.** | **Reporting Arrangements and Relationships** |
| | The Jubilee and MIIU Stroud refurbishment project group is an operational oversight group that reports to the Chief Operating Officer, aligned to the Business Case that reports to Director of Finance.<br><br>It monitors the refurbishment programme of work and receives updates on progress from the Estates Capital team.<br><br>Verbal reports are provided fortnightly by the Chair to the COO.<br><br>Execs received presentation on scheme and will receive Full Business Case at the end of July.<br><br>The project is regularly reviewed at the Transformation Hub who receive updates by exception. |
| **5.** | **Powers** |
| | The Project Group has delegated responsibility from the Executives to oversee, facilitate and manage this project, alongside the responsibilities delegated to Associate Director of Estates, Facilities & Medical Equipment to submit a Full Business Case and implementation plan to the Trust Group. |
| **6.** | **Roles and Responsibilities** |
| | The Project Group will be responsible for:<br>• Ensuring that operational services are involved in the design of the refurbishment of Jubilee Ward and the MIIU<br>• Ensuring that all operational services impacted in Stroud are kept fully informed on progress of the refurbishment.<br>• Establishing and maintaining an action log, a risk and issue register and to escalate any concerns and risks through the agreed reporting route.<br>• Contributing to the development of a robust Full Business Case for approval by Gloucestershire Health and Care Foundation NHS Trust (GHC) Trust Board<br>• Ensuring that appropriate and timely communications are provided to all stakeholders both internally and externally.<br>• Holding staff engagement sessions ensuring that staff are kept fully informed at all times and have the opportunity to raise concerns and also that Staffside is kept fully informed.<br>• Preparing a mobilisation plan to illustrate transition into the implementation of the project.<br>• Preparing the benefits realisation documentation for handover to operational teams at the end of the project<br>• Collating and maintaining any revenue finance costs associated with this refurbishment<br>• Monitoring the delivery of the project within agreed timescales, budget and quality. |

| | |
|---|---|
| | |
| **7.** | **Frequency and Review of Meetings** |
| **7.1** | The Jubilee and Stroud MIIU Project Group will have regular weekly meetings with support from the Transformation Hub during the set-up and transition phase of this project.<br><br>During the implementation phase meetings will be fortnightly and under regular review. |
| | |

# Stroud Jubilee Ward and MIIU Refurbishment Governance



**0517 01 Jubilee Ward and MIIU**
**INDICATIVE PROGRAMME**

| Version-04 | 17/08/2020 | 24/08/2020 | 31/08/2020 | 07/09/2020 | 07/06/2021 | 14/06/2021 | 21/06/2021 | 28/06/2021 | 05/07/2021 | 12/07/2021 | 19/07/2021 | 26/07/2021 | 02/08/2021 | 09/08/2021 | 16/08/2021 | 23/08/2021 | 30/08/2021 | 06/09/2021 | 13/09/2021 | 20/09/2021 | 27/09/2021 | 04/10/2021 | 11/10/2021 | 18/10/2021 | 25/10/2021 | 01/11/2021 | 08/11/2021 | 15/11/2021 | 22/11/2021 | 29/11/2021 | 06/12/2021 | 13/12/2021 | 20/12/2021 | 27/12/2021 | 03/01/2022 | 10/01/2022 | 17/01/2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Project Wk. | 1 | 2 | 3 | 4 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 |
| | RIBA STAGE 1- 2 | | | | | | | | | | | | | | Ward & premises decant - indicative programme | | RIBA STAGE 5 | | | | | | | | | | | | | | | | Christmas | Christmas | RIBA STAGE 6 | | |
| **Business Case Submission** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Design Freeze 15/06** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **M&E / Structural drawings update** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CDM 2015: Prepare PCI | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| QS - Prepare PTE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Design team review of technical pack prior to issue | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Technical design pack issued to Trust for GHCT team review | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **GATEWAY 2: GHCT Technical Proposal Review** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Technical Design Pack issued to Trust Procurement to Tender | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tender Pack Issued - Tender period assumed 6 weeks at this stage) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Tender Return: TARs, Contractor recommendations for appointment | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **GATEWAY 3: Trust consideration and contractor appointment/Award Contract** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CONTRACTOR APPOINTED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RIBA STAGE 5** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| CDM 2015: F10 Notification | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Contractor lead-in/mobilisation period (say 3 weeks) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Pre Start Meeting | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Construction Phase (say 14-16 weeks) TBC | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| RIBA STAGE 5 COMPLETED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **RIBA STAGE 6** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PROJECT COMPLETED PC/Handover - Rectification Period Commences) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

RIBA STAGE 2 (Concept Design) Completed

Todays Date

# Jubilee Ward and Stroud MIIU Refurbishment Programme - Project Plan

**May 2021 to December 2021**

**Last updated: 19 July 2021**
**Last updated by: Fiona Smith**
**Version No: 004**
**Exec Sponsor: Hilary Shand / SRO:Margaret Dalziel**
**Project Lead: Fiona Smith**

**Dashboard:**

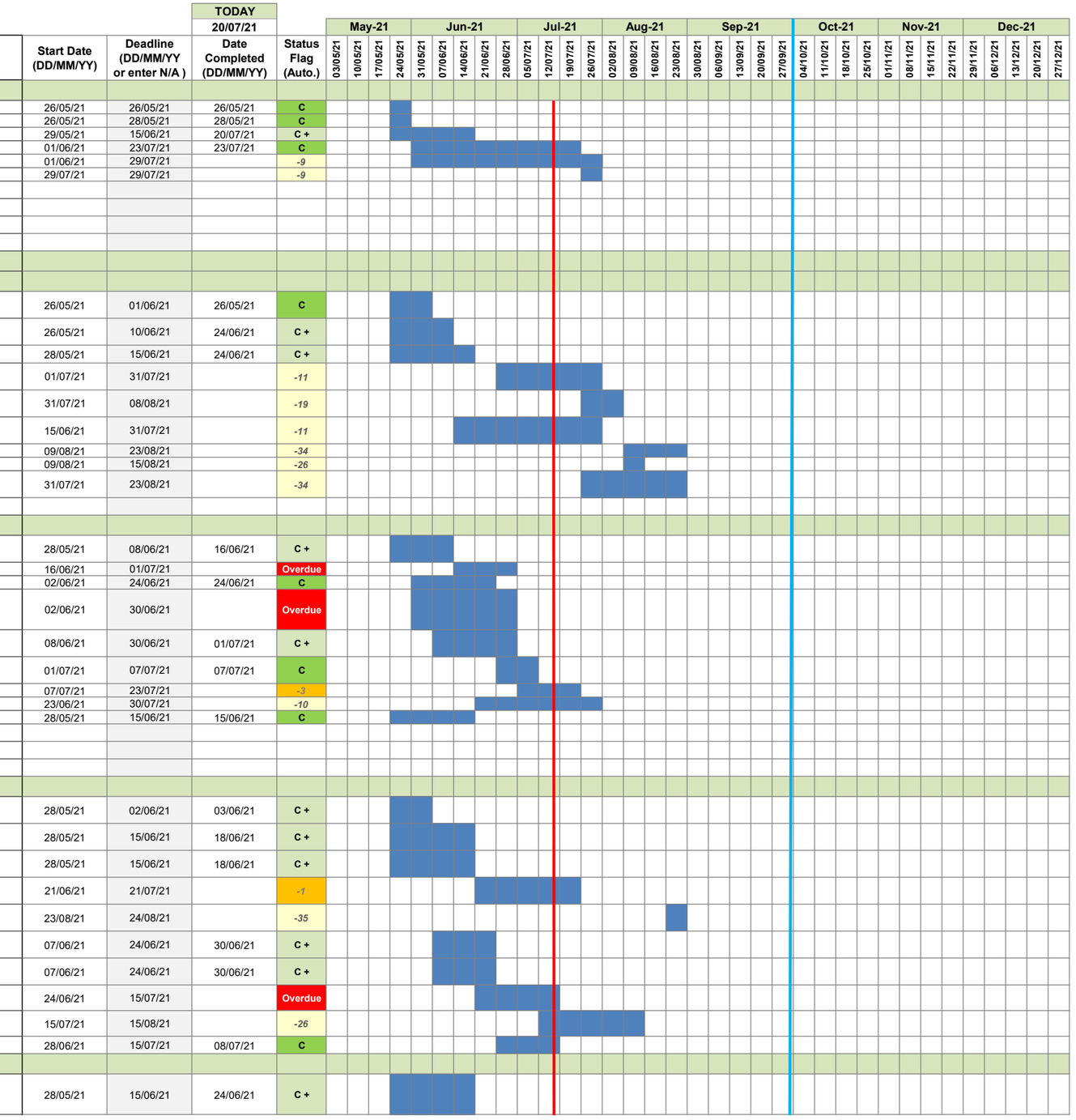
| | |
|---|---|
| Total Tasks | 63 |
| Total Tasks with a Deadline | 63 |
| Tasks Completed | 28 |
| Tasks Outstanding | 35 |
| Tasks due within 7 days | 5 |
| Tasks due today | 1 |
| Tasks Overdue (Immediate action needed) | 5 |

**Key / Notes:**

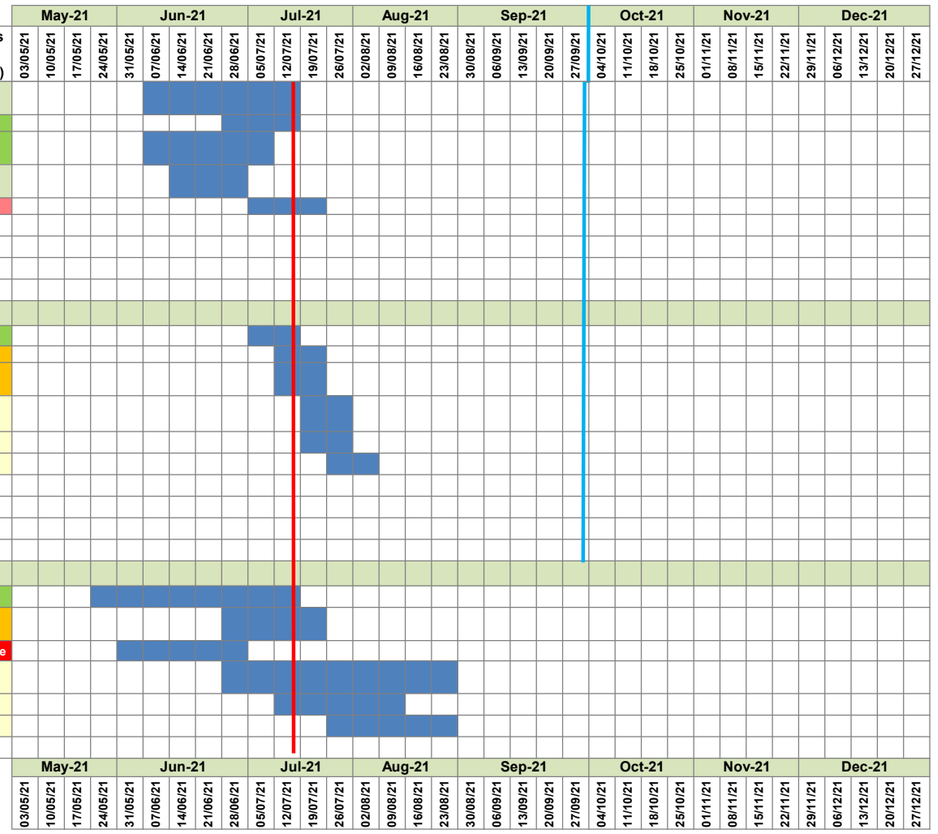
**Planned timescale** *(maps against dates for start & finish automatically)*
**Checkpoint** *(Copy & Paste to required date)*
**Project Milestone to be delivered** *(Copy & Paste to required date)*
**Current point in time** *(Drag to reflect 'current' date)*
**'Go Live' / Day 1** *(Drag to reflect 'go live' / Day 1 date)*

**Note:** For additional rows, ensure you copy the entire 'Work Stream' and / or 'task' rows from existing plan & then 'insert copied cells' (rows) into the spreadsheet
**Note:** Date headings (**in row 16**) start on a Monday
**Note:** You only need to enter the first date in the heading range (**in Cell 'H16'**)

| ID | | Milestones / Tasks | Responsible Person | Notes / Comments | Start Date (DD/MM/YY) | Deadline (DD/MM/YY or enter N/A ) | Date Completed (DD/MM/YY) | Status Flag (Auto.) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | TODAY → | 20/07/21 |
| **1. Governance** | | | | | | | | |
| 1.1 | | Agree membership of Project Group and meetings schedule | Margaret Dalziel | | 26/05/21 | 26/05/21 | 26/05/21 | C |
| 1.2 | | ToR drafted and project documentation agreed | Fiona Smith | | 26/05/21 | 28/05/21 | 28/05/21 | C |
| 1.3 | | ToR agreed and signed off by project group | Margaret Dalziel | | 29/05/21 | 15/06/21 | 20/07/21 | C + |
| 1.4 | | Business Case submitted to Capital Management Group | Andrew Paterson | | 01/06/21 | 23/07/21 | 23/07/21 | C |
| 1.5 | | Business Case submitted to Trust Board | Andrew Paterson | | 01/06/21 | 29/07/21 | | -9 |
| 1.5 | | Board decision on agreed way forward | Hilary Shand | | 29/07/21 | 29/07/21 | | -9 |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| **2. Estates Work Stream - see refurbishment project plan** | | | | | | | | |
| **3. Jubilee Ward - Closure and re-location** | | | | | | | | |
| 3.1 | | Clarify bed numbers and confirm location for re-provision of beds | Margaret Dalziel | | 26/05/21 | 01/06/21 | 26/05/21 | C |
| 3.2 | | Scope impacts of ward closure on other areas of SGH i.e. theatre to inform Comms plan | Liz Lovett | | 26/05/21 | 10/06/21 | 24/06/21 | C + |
| 3.3 | | Agree name with BI for receiving ward in Cirencester | Liz Lovett | | 28/05/21 | 15/06/21 | 24/06/21 | C + |
| 3.4 | | Prepare bed flow management plan to reduce from 16 beds to 13 prior to move | Liz Lovett | | 01/07/21 | 31/07/21 | | -11 |
| 3.5 | | Advise CCG/GHFT and gain agreement to bed reduction and bed flow plan | Hilary Shand / Margaret Dalziel | | 31/07/21 | 08/08/21 | | -19 |
| 3.6 | | Comms/engagement with partners impacted i.e. GHFT/Inhealth | Julie Goodenough | | 15/06/21 | 31/07/21 | | -11 |
| 3.7 | | Commence reduction to agreed bed numbers for move | Liz Lovett | | 09/08/21 | 23/08/21 | | -34 |
| 3.8 | | Patient transfer booked | Liz Lovett | | 09/08/21 | 15/08/21 | | -26 |
| 3.9 | | Equipment reviewed for transfer and for storage and labelled appropriately | Liz Lovett | | 31/07/21 | 23/08/21 | | -34 |
| 3.10 | | | | | | | | |
| **4. Minor Injuries Unit** | | | | | | | | |
| 4.1 | | Capture occupancy of all rooms impacted by the refurbishment in MIIU | Fiona Smith | | 28/05/21 | 08/06/21 | 16/06/21 | C + |
| 4.2 | | Engage with OOHs re options for temporary relocation | Liz Lovett | | 16/06/21 | 01/07/21 | | Overdue |
| 4.3 | | Review impact on adajacent activity: x-ray and ultrasound | Lee Iddles | | 02/06/21 | 24/06/21 | 24/06/21 | C |
| 4.4 | | Prepare Comms, to include social media campaign and posters to increase take up of MIIU booked appts vs walk ins and agreeing criteria for 'booked appts' | Lee Iddles / Kate Nelmes | | 02/06/21 | 30/06/21 | | Overdue |
| 4.5 | | Consider options for alternative space in SGH for MIIU booked appts and recommend preferred option | Lee Iddles | | 08/06/21 | 30/06/21 | 01/07/21 | C + |
| 4.6 | | Identify any issues and remedial work required with preferred option | Lee Iddles | | 01/07/21 | 07/07/21 | 07/07/21 | C |
| 4.7 | | Space confirmed for MIIU booked appointments | Lee Iddles | | 07/07/21 | 23/07/21 | | -3 |
| 4.8 | | Equipment review and transfer or storage identified | Lee Iddles | | 23/06/21 | 30/07/21 | | -10 |
| 4.9 | | Staff redeployment plan to be worked up | Lee Iddles | | 28/05/21 | 15/06/21 | 15/06/21 | C |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| **5. Cirencester Hospital** | | | | | | | | |
| 5.1 | | Agree bed allocation in Cirencester between Thames and Churn | Linda Edwards | | 28/05/21 | 02/06/21 | 03/06/21 | C + |
| 5.2 | | Review storage provision and agree additional space if required | Linda Edwards | | 28/05/21 | 15/06/21 | 18/06/21 | C + |
| 5.3 | | Review impact on any services currently using Thames, Churn and HMP | Linda Edwards | | 28/05/21 | 15/06/21 | 18/06/21 | C + |
| 5.4 | | Agree any staffing support available for SGH i.e. therapy/facilities/portering | Linda Edwards | | 21/06/21 | 21/07/21 | | -1 |
| 5.5 | | Cirencester staff to undertake walkabout/induction for SGH staff transferring | Linda Edwards | | 23/08/21 | 24/08/21 | | -35 |
| 5.6 | | Options for lack of isolation beds to be agreed | Linda Edwards/Liz Lovett | | 07/06/21 | 24/06/21 | 30/06/21 | C + |
| 5.7 | | Preferred option agreed and actions identified to enable | Linda Edwards/Liz Lovett | | 07/06/21 | 24/06/21 | 30/06/21 | C + |
| 5.8 | | Estates to agree costs to enable solution to work | Kevin Adams | | 24/06/21 | 15/07/21 | | Overdue |
| 5.9 | | Estates work to be undertaken | Kevin Adams | | 15/07/21 | 15/08/21 | | -26 |
| 5.10 | | Confirm medical cover for additional beds | Liz Lovett | | 28/06/21 | 15/07/21 | 08/07/21 | C |
| **6. Workforce** | | | | | | | | |
| 6.1 | | Confirm and provide list of all staff impacted by closure of Ward and re-location and staff from MIIU requiring redeployment | Liz Lovett / Lee Iddles | | 28/05/21 | 15/06/21 | 24/06/21 | C + |



| ID | | Milestones / Tasks | Responsible Person | Notes / Comments | Start Date (DD/MM/YY) | Deadline (DD/MM/YY or enter N/A ) | TODAY 20/07/21 Date Completed (DD/MM/YY) | Status Flag (Auto.) |
|---|---|---|---|---|---|---|---|---|
| 6.2 | | Hold engagement / Q&A session with all impacted staff and HR | Margaret Dalziel | | 08/06/21 | 14/07/21 | 15/07/21 | C + |
| 6.3 | | Agree amended staffing levels and shift changes | Liz Lovett | | 01/07/21 | 15/07/21 | 08/07/21 | C |
| 6.4 | | Staff travel plans to be agreed, i.e requirement for shuttle bus | Liz Lovett | | 08/06/21 | 05/07/21 | 05/07/21 | C |
| 6.5 | | Inform Staffside of planned changes and invite to staff engagement sessions | Margaret Dalziel | | 15/06/21 | 30/06/21 | 07/07/21 | C + |
| 6.6 | | Obtain shuttle bus quotes from procurement | Fiona Smith | | 05/07/21 | 20/07/21 | | 0 |
| 6.7 | | | | | | | | |
| **6.8** | | | | | | | | |
| **6.9** | | | | | | | | |
| **6.10** | | | | | | | | |
| **7. MIIU Temporary Solution - Stroud Maternity** | | | | | | | | |
| 7.1 | | Engagement with Children's Services in Stroud Maternity | Helen Mee | | 07/07/21 | 15/07/21 | 15/07/21 | C |
| 7.2 | | Look for alternative space for Children's services | Fiona Smith | | 16/07/21 | 23/07/21 | | -3 |
| 7.3 | | Confirm and plan for any work required to make identified space usable | Kevin Adams | | 16/07/21 | 23/07/21 | | -3 |
| 7.4 | | Space confirmed at Stroud Maternity for MIIU booked appointments | Lee Iddles | | 23/07/21 | 29/07/21 | | -9 |
| 7.5 | | Alternative space for Children's identified and agreed | Jo Ritter | | 23/07/21 | 30/07/21 | | -10 |
| 7.6 | | Comms to all staff impacted | Jo Ritter | | 30/07/21 | 02/08/21 | | -13 |
| 7.7 | | | | | | | | |
| 7.8 | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| **7. Comms and Engagement** | | | | | | | | |
| 7.1 | | Share plans with staff | Liz Lovett | | 26/05/21 | 15/07/21 | 08/07/21 | C |
| 7.2 | | Hold internal engagement workshops /Q&A with all staff impacted | Margaret Dalziel | | 28/06/21 | 21/07/21 | | -1 |
| 7.3 | | Undertake stakeholder mapping and prepare Comms plan | Matt Blackman | | 01/06/21 | 30/06/21 | | Overdue |
| 7.4 | | External engagement with system partners / Councillors / CCG etc. | Matt Blackman | | 01/07/21 | 23/08/21 | | -34 |
| 7.5 | | Comms to local service users | Matt Blackman | | 15/07/21 | 15/08/21 | | -26 |
| 7.6 | | Comms / letters to patients | Matt Blackman | | 01/08/21 | 23/08/21 | | -34 |
| 7.7 | | | | | | | | |



# 01 Jubilee Ward and MIIU Risk & Issue Register

gleeds

| Risk Register | | | | | Assessment | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Ref | Date Identified | Risk | Risk Impact | Risk Type (Programme/ Cost) | Probability (1-10)% | Severity (1-10) | Risk Rating (1-100) | Proposals / Actions to Mitigate | Owner / Action By | Status Open / Closed | Date Closed |
| 3 | 29 Jan 21 | Project Affordability - pre-tender - pre-tender estimates exceed the Trust budget cost | Project is delayed allowing for re-design and value engineering and or the project is withdrawn.<br>Additional fees required as consultants undertake additional work. | Cost | 8 | 8 | 64 | Project was to be competitively tendered to ensure value for money achieved. Now following framework route.<br>Scrutiny of Contractor costs to ensure value for money | Trust | Open | |
| 24 | 22 Jun 21 | Increased Construction costs due to increased material costs (Covid/Brexit/availability), | Increased Project Costs | Cost | 8 | 8 | 64 | Choose competitive tender route. Scrutiny of Contactor costs | Trust | Open | |
| 25 | 22 Jun 21 | Availability of labour / resources to carry out construction due to increased demand on the construction industry | Increased Project Costs / delay | Programme/ Cost | 7 | 7 | 49 | Ensure programme is robust and refelcts availability of resources. Extra assurances from supply chain | Contractor | Open | |
| 11 | 15 Oct 20 | Asbestos -ACMs noted in management survey: Unknown location and condition above ceiling or floor within floor voids. ACMs may also be present within electrical apparatus, plant equipment etc and cold water services. | Ongoing risk to health. | Cost | 6 | 7 | 42 | The building is operational and is expected to remain so until end of winter 2021. Trusts to consider phasing / decant and surveys works to be programmed accordingly.<br>Trust have decided to award the Intrusive R&D inspection/surveys to the Contractor once in place | Trust | Open | |
| 1 | 23 Oct 20 | User Group input - inability of stakeholders to devote sufficient time to adequately support the project. Reliance of staff resilience and goodwill whilst doing the 'day job' | Delays in the design whilst allowing for user group input and review on proposals | Programme | 5 | 8 | 40 | Provide as appropriate the opportunity for users to be included in DTM's and or additional forums to review proposals and project reviews of plans where plans can be presented by the design team and seek confirmation from all groups at sign off | Trust | Closed | |
| 2 | 15 Oct 20 | Stakeholder Engagement - engagement with end users/stakeholders is fragmented and does not provide for the input from all parties; designs are not fully bought into by all stakeholder groups | Delays in providing for the re review of design information pre tender and costly changes post tender. | Programme | 5 | 8 | 40 | Input from wider user groups and Trust stakeholders is being managed and channelled by Gavin as Estate Lead for the project - emails / signatory list of sign off from the defined user groups for each Gateway is sought and note Gateways in place to fix the design to allow progress to continue to the next stage. | Trust | Closed | |
| 13 | 15 Oct 20 | Structural Support -Reconfiguration of internal space requires removal of internal walls, which may be load bearing. | Change of proposed internal layout to accommodate load bearing walls.<br>Incorporation of structural lintels to support ceiling/roof structure over.<br>Increased construction costs. | Cost | 5 | 8 | 40 | 03/12/2020 > Watermans have attended a site visit with Gleeds and Trust to assess investigations required both for internal alterations and external extension. Feedback to be given early December and arrangements for intrusive surveys etc. made.<br>> Structural layout plans issued and previous reports made available; layouts to be issued to Watermans once frozen and as part of design team review of the developing design | Designer | Open | |
| 10 | 15 Oct 20 | Covid-19 -Lockdown- Second or subsequent waves of infection, national/localised lockdown. | Extended programme.<br>Increased project, contractor, and professional team costs to complete project. Delayed project delivery. Affects on supply chain/materials, labour force.<br>Key Stakeholder engagement/decision making could be delayed. | Programme | 6 | 6 | 36 | Monitor national/local guidance - Restrictions.<br>Regular contact with client and project team to mitigate risks.<br>Client/Team/Contractor etc to ensure they have a mitigation and business continuity plan in place. | Trust / Contractor / Design Team | Open | |
| 6 | 15 Oct 20 | Changes in Estate Operations -for Jubilee and MIIU Jubilee Ward and minor injuries unit can not be made available for the purposes of carrying out intrusive works and/ or the commencement of construction | Programmes delays to reflect the new phasing and project start with cost increase and or abortive costs to consider | | 4 | 9 | 36 | Trust to continue to inform the project team on operational plans and draft phasing occupation plans accordingly. Project to be tendered in this financial year with a break in the programme for decant. Contractor to assume Qu2 2021 start on site for the proposes of pricing? | Trust | Open | |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 12 | 23 Oct 20 | Covid -19 -impact on methods of working -The social distancing measure specifically the 2m distancing rule has impacts on activities on site | Reduction in productivity elongating programmes with additional prelims, hop, and causing risk to programme delivery | Programme | 5 | 7 | **35** | Discuss impact and working methodologies with Speller Metcalfe during ECI and ensure tender returns reflect patterns of working; make provision accordingly in pre tender estimates | Trust | Open | |
| 7 | 23 Oct 20 | Gaps in Design - poorly coordinated design | Gaps in design leading to inaccuracies in costs estimates and/or costly contractor provisional sums / escalated costs to deal with gaps in design detail | Programme | 4 | 8 | **32** | Procurement approach is for the production of fully designed technical design solutions at RIBA Stage 4 for Tender. Programme to allow sufficient time for design team reviews. | Trust | Open | |
| 23 | 15 Feb 21 | Results from the Site Investigation surveys means changes to the Design Team pack | Delays in design impacting on overall programme as target dates. Additional fees required as consultants undertake additional work. | Programme / Cost | 5 | 6 | **30** | Design unknowns are being mitigated as far as possible using reasonable assumptions to enable the project to be tendered | Design Team / Trust | Open | |
| 5 | 15 Oct 20 | Delays in release of information to the design team- Record drawing information for the building and building services are not available and or are made available in good time to inform the developing design | Delays in design production impacting on overall programme as target dates and Trust gateways are missed. Additional fees required as consultants undertake additional survey work as required to inform the developing design proposals. | Programme/ Cost | 5 | 5 | **25** | Consultant team meeting with Trust maintenance teams to build knowledge and understanding of building and building systems held 23/10/2020; useful information gathering; SDS advising on next steps and information needs to progress<br><br>Design unknowns are being mitigated as far as possible using reasonable assumptions to enable the project to be tendered | Trust | Open | |
| 22 | 29 Jan 21 | Jubilee Ward is being used for COVID patients, preventing access by the design team for intrusive surveys. | It is unknown when the ward will be safely available again. This creates a drag on the programme and completion of the technical design packages of unknown duration. | Programme | 4 | 6 | **24** | Design Team are mitigating this by making assumptions and considering worse-case scenario's in order to produce a design package that can be traditionally tendered and costed with investigative surveys undertaken when possible to finalise technical design / firm up costs (if that stage is reached). | Trust | Closed | |
| 14 | 15 Oct 20 | Working in an operational setting | Noise and dust from works impacting NHS staff & patients<br>Safety concerns for NHS staff & patients | | 4 | 6 | **24** | The Ward and MIIU will be fully decanted - Trust to confirm the operation of any remaining Services on the site and work to be scheduled with due regard to any continued operations on site to reduce noise & impact. | Trust | Open | |
| 19 | 03 Dec 20 | Decision on positioning of AHU unit. | May have planning permission / fire escape route / maintenance considerations. | Programme | 4 | 5 | **20** | Intrusive surveys are being organised and Design Team are to advise on statutory consents / fire etc. | Design Team / Trust | Closed | |
| 16 | 15 Oct 20 | Damage to property | Damage to an existing structure not associated with the project during delivery and other activities | | 3 | 5 | **15** | Site compound to be setup by contractor, contractor to provide localised protection to buildings/structure. Construction traffic routes, agreed. Contractor to develop and mitigate risks as part of their CDM CPP. | Contractor | Open | |
| 17 | 03 Dec 20 | Additional design challenges / elements discovered during intrusive investigations. | Delivery of design elements. | Programme | 5 | 3 | **15** | This is being mitigated by organising investigative surveys, arranged with guidance of Design Team and for Structural and M&E investigations, now before further development of design. | Design Team / Trust | Open | |
| 15 | 15 Oct 20 | Site access issues | Patient/public safety to internal/external areas. | | 4 | 3 | **12** | Access routes, site compound to be agreed with Trust prior to works commencing. Loss of some car parking spaces likely. Trust to provide alternative provision. | Contractor | Open | |
| 21 | 24 Nov 20 | Party Wall etc Act 1996: Agreeing works with adjoining owner: Historic church building/wall may be affected during construction works (Foundation Design) | Adjoining Buildings (vibration) Dispute arises under the Act. | Programme/ Cost | 3 | 3 | **9** | Undertake Site Appraisal: Appoint Party Wall Surveyor: Engage with adjoining Owner: Programme duration allows sufficient time to serve notices if required to serve and subsequently prepare Award in advance of construction works | Trust | Open | |

**Risk Register - Operational Risks for the Transition and Implementation of the Jubilee Ward and Stroud MIIU project**

Last updated: 19 July 2021

| Ref | Date opened | Raised by | Title / Theme | Description | Controls / Mitigations in place | Gaps in controls | Initial Risk | | | Risk Owner | Progress (Action Plan Summary) | Current Risk | | | Review Date | Next Review Date | Open/Closed | Date Closed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Likelihood | Consequence | Risk Score* (Auto Fill) | | | Likelihood | Consequence | Risk Score* (Auto Fill) | | | | |
| 1 | 27-May-21 | Fiona Smith | Infection Control | There is an IP&C risk with no isolation beds on Thames Ward/Churn Ward if an infection breaks out resulting in the ward being closed to new patients | Discussion with IP&C and a SOP to be agreed and signed by JT and communicated to all staff and On Call Managers. | | 3 | 4 | 12 | Liz Lovett/Linda Edwards | Estates actively looking to converting flat to create 2 side rooms | 2 | 4 | 8 | 08/07/2021 | 20/07/2021 | Open | |
| 2 | 27-May-21 | Fiona Smith | Operational | There is a risk that theatre lists and/or x-ray activity will be disrupted due to noise from the contractors resulting in theatre lists and x-ray appointments being cancelled | Regular contact with Contractor is kept to a minimum during key hours. Good communication with GHFT service leads to ensure they are kept informed of major demolition works and other very noisy activity on site so they can plan accordingly. | | 4 | 3 | 12 | Liz Lovett | Informed Sarah Bayliss at GHFT. Room 1 which is adjacent to the MIIU area is not as well used as the main room which has digital x-ray. | 2 | 3 | 6 | 30/06/2021 | 20/07/2021 | Open | |
| 3 | 27-May-01 | Lee Iddles | MIIU/ ED | There is a risk that very sick patients will walk in to SGH MIIU when it is closed resulting in an increased risk of delayed response to emergency care plus, risk of not being found if attending the main hospital MIIu and collapsing. | Good communication to the public that Stroud MIIU is closed to walkins , call NHS111 or 999 if emergency. Good comms around telephone triage for MIIU and booked appointments only. Strict criteria for booked appointments to be developed. | Public choice and learned behaviours mean patients may continue to walk in. | 3 | 4 | 12 | Lee Iddles | A review of Stroud Maternity for suitability and available space taken place. There are suitable rooms. Helen to contact Mel and Jo in CYP regarding the use of these rooms before Estates carry out any work required. Additional risk of crossing the car park if SM used, uneven surface in car park and poor lighting. Comms going out to improve the use of booked appointments. | 3 | 4 | 12 | 30/06/2021 | 20/07/2021 | Open | |
| 4 | 27-May-21 | Fiona Smith | Contingency | There is a risk that the work programme may take longer than the 14-16 weeks allowed resulting in a delay in reopening SGH MIIU and the beds on Jubilee Ward resulting in pressures across urgent care and beds during winter pressures. | | | 4 | 3 | 12 | Margaret Dalziel | Clear project plans and timelines with regular review and updates on each element of the programme<br>Keep all partners in the loop<br>Plan contingencies for bed base<br>Project Group agreed that MIIU was the priority area to hand over to BAU first. | 3 | 3 | 9 | 06/07/2021 | 20/07/2021 | Open | |
| 5 | 07-Jun-21 | Margaret Dalziel | Financial | There is a risk that there is insufficient revenue to cover all potential project costs i.e. removals, storage, shuttle bus etc. resulting in cost pressures within the directorate | Consider using charitable funds. | | 2 | 3 | 6 | Juliette Richardson /Kevin Adams | Costs being collated. As this project is early in the financial year there may be additional capital funding available, Kevin to review funding once pre-tender estimates are returned. Potential for NR funding to be used. | 2 | 2 | 4 | 30/06/2021 | 20/07/2021 | Open | |
| 6 | 08-Jun-21 | Liz Lovett | Workforce | There is a risk that there will be reduction of therapy cover on the Ward due to therapists having to cover both SGH and Thames in Cirencester plus due to vacancies and maternity leave resulting in increased length of stay and the need to rationalise patient dependency when admitting patients. There is also a risk to therapy staff well being. | To use locum therapists on Thames, they could support other Cirencester wards too. Remaining therapist could divide time across both hospital wards but this will limit the amount of therapy she can deliver. Ongoing recruitment to take place. | Ability to not accept high therapy needs or complex patients but this would go against GHC's admission criteria | 4 | 4 | 16 | Liz Lovett | Currently no bank/locums available. Bank team chasing as urgent.<br>Currently reviewing 3 options:<br>1. over recruit into establishment (preferred option)<br>2. look at different cohorts of patients for admission<br>3. use Band 3 rehab technicians with qualified staff oversight | 4 | 3 | 12 | 06/07/2021 | 20/07/2021 | Open | |

| Ref | Date opened | Raised by | Title / Theme | Description | Controls / Mitigations in place | Gaps in controls | Initial Risk | | | Risk Owner | Progress (Action Plan Summary) | Current Risk | | | Review Date | Next Review Date | Open/Closed | Date Closed |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | Likelihood | Consequence | Risk Score* (Auto Fill) | | | Likelihood | Consequence | Risk Score* (Auto Fill) | | | | |
| 7 | 08-Jun-21 | Liz Lovett | Operational | There is a risk that a further Covid surge may impact on travel from SGH to Cirencester resulting in transport company or staff being concerned re safety of transport especially if Covid positive in hospital. | Transport to be able to accommodate staff with social distancing, Clear information for transport company and ward staff on IP&C guidance and reassurance will be needed. Staff would have to travel by themselves which would lead to increased need for parking spaces and travel expenses. | | 2 | 3 | 6 | Marion Johnson | Travel requirements being captured. | 2 | 3 | 6 | 30/06/2021 | 20/07/2021 | Open | |
| 8 | 05-Jul-21 | Liz Lovett | Operational | There is a risk that emergency call bells in Theatre and Endoscopy will not be heard by staff in Cashes Green Ward | Urgent request to Estates to install emergency call bell in Cashes Green. Use the Mitel phones to be explored. | | 3 | 3 | 9 | Liz Lovett | | 3 | 3 | 9 | 08/07/2021 | 20/07/2021 | Open | |
| 9 | 08-Jul-21 | Margaret Dalziel | MIIU capacity | There is a risk that MIIU are not able to secure any temporary space in Stroud for booked appointments resulting in a lack of UC capacity in Stroud and pressure elsewhere in the system | Looking to secure clinic rooms in Stroud Maternity that are currently occupied by Children's Services. Helen meeting with CYP to progress this | | 3 | 4 | 12 | Helen Mee | Meeting held 19 July with Urgent Care and CYP. CYP will move some of their clinical activity to SGH Outpatients. There is still a requirement to resolve storage and the use of a group room. Space still to be found for the IMMS service through September - December. Activity being mapped. | 2 | 4 | 8 | 19/07/2021 | 20/07/2021 | Open | |
| 10 | 08-Jul-21 | Helen Mee | MIII Operational | There is a risk that the DOS will book inappropriate patients i.e. lower limb injuries to booked appointments in Stroud resulting in patients having to be either taken across the car park to x-ray by porters or redirected to other sites. | Clear and regular communication with the DOS. | | 3 | 3 | 9 | | | 3 | 3 | 9 | 08/07/2021 | 20/07/2021 | Open | |

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Date: 23/06/2021

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|---|---|
| **Scheme Name:** | Redesign and refurbishment of the MIIU and Jubilee Inpatient Ward at Stroud General Hospital |

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|---|---|
| **Scheme Overview:** | The scheme proposed is the redesign and refurbishment of the Minor Injuries and Illness Unit and Jubilee Inpatient Ward, at Stroud General Hospital. The redesign and refurbishment of Jubilee Inpatient Ward will firstly ensure compliance with infection, prevention and control standards, by creating two en-suite siderooms, toilet and showering facilities in each bay, improve handwashing facilities and allow isolation of each bay, if infection is detected. It will also address inequalities, because one of the the en-suite side rooms witll be spacious and kitted out with overhead tracking, allowing the ward to meet the needs of bariatric patients. There will be improved provison of care for patients with dementia, through the creation of a Vintage Room/social area within the ward, that can be better accessed by patients and their relatives allowing inproved visiblity to staff for the purpose of observation and promote independence , when appropriate. It is also expected that the refurbishment of both departments will improve the experience of patients and staff morale, thus ensuring overall complaince stipulated by the Care Quality Commission. The scheme will also have a positive impact on patient flow throughout the system..The MIIU and Inpatient Ward will temporarily close. MIIU activity will be diverted to Cirencester and The Vale MIIU. Jubilee Ward will temporarily redeploy to Cirencester Hospital, Thames Ward/Churn Suite at Cirencester Hospital, The scheme is estimated to take 12 weeks. |

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|---|---|---|
| **Director Lead:** | Name: Hilary Shand/Margaert Dalziel | Role: Acting COO and Interim DCOO |
| **Completed By (Work Stream Lead):** | Name: Juliette Richardson | Role: Deputy Service Director - Community Hospitals |

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| **Specific Quality Indicator(s):** | |
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*Please complete all fields highlighted:*

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# Quality Impact Assessment (QIA)

| *Patient Safety* | Details | Impact | Score |
|---|---|---|---|
| **Please record the impact / risks** of making this change on Patient Safety | **Jubilee IMPACT 1. IP&C**-a) Two single rooms with en-suite facilities, to enable isolation of patients with suspected or known infections, without the need to use commodes that need to be taken in and out of the room, or the requirement to transfer patients across the floor, via the surgical unit, to Cashes Green Ward. b) Toilets and shower/wet rooms in each bay, will stop the movement of patients outside of their bay area. c) The redesign will enable isolation of each bay area, if required. d) Improved hand washing facilities in each bay to aid compliance. e) Two toilets in each bay will promote continence and reduce the risk of urinary infection, through improved access. **2. Improved provision of care for patients with dementia**-a) The creation of a Vintage Room/social area within the ward will be more readily accessible for patients and their relatives. The room will create a calming environment and aid reminiscence, or aid as a distraction technique; the current room is situated off the ward. This should reduce the risk of distress and or agitation; this may result in a reduction in falls. **3.** The redesign of the ward will support patient flow, hence improve patient safety. **RISKS**- 1. There may not be sufficient space to safely move around the patient on a bariatric bed in the lift nearest Jubilee Ward, if they need to go for an x-ray. **2.** During the temporary move to Cirencester, there is an IP&C risk as there are no isolation beds on Thames/Churn Ward and if an infection breaks out, nosocomial infection may occur. Also if the ward closes due to infection this will result in the ward being closed to new patients, which will impact on patient flow. **3.** Ward medical cover will be split over both SGH and Cirencester sites; currently it is 10 hours a day; 5 hours per ward, but if a patient deteriorates on the adjacent ward the Dr will attend. **4**. Minimum staffing levels may not be met, if staff cannot independently travel to Cirencester. 5. Noise disruption may affect clinicians concentration in the Theatres.<br><br>**MIIU Impact 1.** The layout of the new waiting room will ensure that children and adults are able to wait safely in separate areas with oversight from the central triage room . The Triage room /waiting room is positioned so in case of escalation full lockdown of the unit and safety of staff and patients can be maintained . **2**.clinical rooms are overseen by the central nursing station ensuring consistent monitoring of unwell patients **3.** Clinical cubicles with doors enable isolation of patients with suspected infections and individual hand washing sinks in each room reduce cross contamination. **RISKS**- 1.There may continue not be sufficient waiting space during Covid to maintain social distancing when the department is busy. 2. The unit will need to move to Stroud Maternity to provide booked appointments only- there is a risk that patients will still walk into the main hospital or walking to the maternity unit with significant injury/ illness.. 3.During the temporary location there is a long walk to x-ray over a poor surface carpark, there is a risk of further injury. | 3 | 6 |
| **Please record the mitigations** to be put in place to address the risks / impacts identified | **Jubilee Ward:** | **Probability** | |
| | **Jubilee.** The purchase of a bariatric chair and trolley will reduce the risk of not being able to move around the patient safely in the lift nearest to Jubilee Ward. 2. The conversion of the "flat" on Thames Ward would create two isolation rooms for infectious patients or patients could be moved to Windrush or Coln. 3. Planned rotas, so that there is cover on both sites, 5 hours a day. If there is a rapidly deteriorating patient, Cirencester medical cover will attend, if able to do so. SGH Staff will receive an induction in Cirencester, so they are aware of process to call for help.<br>4. Hiring of a shuttle bus.<br>**MIIU**- 1. Patients will be assessed and asked to wait outside if the department is busy , this is also reduced by being booked appointments only .2.good communication of the relocation and booked appointments only of the MIIU will reduce the risk. 3 estates to improve car park surface and improve lighting for when it's dark, signage to be in place directing patients to x-ray. | 2 | |

| *Clinical Effectiveness* | Details | Impact | |
|---|---|---|---|
| **Please record the impact / risks** of making this change on Clinical Effectiveness | **IMPACT 1. Improved Clinical Standards and Reduced Inequalities-** a) Piped medical gases and suction at each bed head; improved responsiveness. b) One of the single rooms will be spacious, allowing for the provision of care to bariatric patients, with over head tracking fitted, also improving compliance with moving and handling. The size of the room will also facilitate improved rehabilitation through the use of specialised equipment that will fit in the room. c) Toilets and ensuite in each bay, improving mobility as patients will be able to walk to toilet more freely, instead of walking to the bathroom, promote continence by walking to the toilet, improved patient exp instead of using a commode, improve independence and dignity and privacy.<br>**2. Improved Privacy and Dignity**- a) Toilets and shower/wet rooms in each bay will reduce the need for a commode at the bed side and remove the need to travel across the general circulation area, ensuring more effective same sex segregation. b) En suite side rooms for patients who need their own particular space, such as those at end of life. This will also afford privacy for their relatives. **3. Leadership-** A reasonably sized office on the ward will enable greater Senior Nurse visibility. 4. The Vintage room/social space will enable independence, as patients without cognitive impairment may not always have to have a member of staff in the room. **RISKS 1.** There is a risk that there will be reduction of therapy cover on the ward due to therapists having to cover both SGH and Thames in Cirencester plus due to vacancies and maternity leave resulting in increased length of stay and the need to rationalise patient dependency when admitting patients. There is also a risk that the ward will not be able to accept patients with high therapy or complex needs or complex patients, which would go against GHC's admission criteria There is also a risk to therapy staff well being. **2.** There is a risk that theatre lists and/or x-ray activity will be disrupted due to noise from the contractors, resulting in theatre lists and x-ray appointments being cancelled. There is a risk of possible disruption and potential dust ingress in theatres at Stroud while the building work is being completed . **3**. There is a risk that Cirencester will lose storage temporarily, when Jubilee decants. This could mean that timely access to equipment may be delayed.<br>**MIIU-** 1. Improved clinical standards- Spacious, purpose built MIIU cubicles with ease to work around, purpose built Resus ensuring best care can be delivered . Improved working environment for both patients and staff . 2. Privacy and Dignity, cubicles with walls and separate rooms will ensure privacy and dignity are maintained . Purpose built children's room will also ensure a positive experience for children in the unit. 3 Leadership - an office will allow the team lead and Matron to work in the unit , staff meetings can be held with confidential surroundings. 4. Staff breaks - there will be a separate break room where staff can take a break on site and not be disturbed by patients of staff trying to access the office or drug cupboards. RISKS. There will be a reduction in service during the refurb due to booked appointments only . | 2 | **Score** 6 |
| **Please record the mitigations** to be put in place to address the risks / impacts identified | | **Probability** | |
| | **1.**To use locum therapists on Thames; they could support other Cirencester wards too. Remaining therapist could divide time across both hospital wards but this will limit the amount of therapy she can deliver. Ongoing recruitment to take place. **2.** Good communication with contractors to identify when they will be carrying out the noisy demolition work may aid the planning of lists when they will do their noisy demolition work, will minimise disruption doing it all at once. Good communication with GHFT service leads to ensure they are kept informed of major demolition works and other very noisy activity on site, so they can plan accordingly. 3. Cirencester equipment will be moved to the Healthy Market Place. | 3 | |

| *Patient Experience* | Details | Impact | |
|---|---|---|---|
| **Please record the impact / risks** of making this change on Patient Experience | **Jubilee IMPACT** 1. En-suite side rooms will improve privacy and dignity for patients and their relatives, particularly at end of life. Likewise, the toilets and shower/wet rooms in each bay will afford improved privacy and dignity; patients will not need to walk across the general circulation area of the ward and this limits same sex breach interactions. 2. The patient experience will be enhanced through a modernised and aesthetically improved environment 3. A new ventilation system and windows will control temperature and air circulation. 4. A bespoke Vintage Room/social room will provide better provision for patients and their relatives. RISKS 1. Well being of patients if relatives cannot travel to Cirencester. 2. Patients may not receive their planned surgical intervention in a timely manner when demolition work occurs. 3. Patients and clinicians may complain about the impact of being unable to access services at SGH and complain about the noise caused by demolition work. 4. Increased traffic to Cirencester may cause congestion on access roads and car parking. 5. Security risk at SGH, as the main entrance doors to the Hospital will need to remain open over the weekend for access to x-ray.<br><br>**MIIU-** activity to the redeployed MIIU at Stroud Maternity, may outweigh capacity, thus resulting in patients being re-directed to other MIIUs. | 3 | **Score** 6 |
| **Please record the mitigations** to be put in place to address the risks / impacts identified | **Proposed Mitigation** | **Probability** | |
| | **1.** Letters to patients and their relatives about the planed move, to include bus route timetable**. 2 and 3.** GHC Communications and Management team will work closely with system partners to ensure a coordinated communication plan is in place to support and communicate consistent messages about the planned refurbishment timetable. Communication and signage to direct direct people to x-ray from Trinity Entrance and support people navigate to the correct area at the correct time. **4.** | | |

| | | |
|---|---|---|
| | Signage for car parking **5.** Ward doors are locked and bell/key pad entry only.<br>**MIIU-** clear criteria for patients appropriate to MIIU Stroud to be agreed , telephone triage and NHS111 to be informed of criteria, other patients to be redirected to other MIIU sites. | 2 |

**Consideration has been given to the safeguarding of adults and children**
(Add comments if required) ☑

**The impact on equalities has been assessed in line with policy**
(To view EIA click button below) ☑

View EIA

| | |
|---|---|
| Maximum Risk Score | 6 |

EIA Residual Risk Score: 9

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| | Does the Policy, Strategy or other process contain statements, conditions or requirements that could impact on any protected group more than another? | Impact (Drop down) | Impact Score (Autofill) | 1. Please state why the impact may be postive or negative.<br>2. Show mitigation for negative impact or benefits in Section 2. | Outline the adjustments identified.<br>How they will eliminate or minimise the potential adverse impact.<br>OR<br>Outline the benefits that will result from the change | Residual Risk (Probability) (Drop down) |
|---|---|---|---|---|---|---|
| 1 | Age? | Neutral | 0 | | | 1 |
| 2 | Gender? | Neutral | 0 | | | 1 |
| 3 | Disability? | Benefit | 1 | Bariatric patients. Patients with cogitive issues, such as dementia. | | 1 |
| 4 | Race or Ethnicity? | Neutral | 0 | | | 1 |
| 5 | Religion or Belief? | Neutral | 0 | | | 1 |
| 6 | Sexual Orientation? | Benefit | 1 | The en-suite side rooms and dedicated toilets and shower/wet rooms per bay will eliminate the need to enter the general circulation area | | 1 |
| 7 | Gender Reassignment? | Neutral | 0 | | | 1 |
| 8 | Pregnancy or Maternity? | Neutral | 0 | | | 1 |
| 9 | Marriage or Civil Partnership? | Neutral | 0 | | | 1 |
| | Impact Total Score: | | 2 | | Residual Risk Total Score: | 9 |

| | |
|---|---|
| Adverse | -1 |
| Neutral | 0 |
| Benefit | 1 |

| PROBABILITY | Score |
|---|---|
| Rare | 1 |
| Unlikely | 2 |
| Possible | 3 |
| Likely | 4 |
| Almost certain | 5 |

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**AGENDA ITEM: 17/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 2021**

**PRESENTED BY:** Sandra Betney, Director of Finance and Deputy CEO

**AUTHOR:** Kyra Boon, Capital Delivery Manager

**SUBJECT:** **SOUTHGATE MOORINGS REFURBISHMENT**

| | |
|---|---|
| **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:**

- Provide a business justification and establish costs for the refurbishment of the ground floor of Southgate Moorings.
- To request Board approval for this scheme to progress

**Recommendations and decisions required**

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.

The Trust Board is asked to:

- Agree to the investment of a total project cost of £1,127,026
- Acknowledge that this will be investing a significant sum in a leased building with 12 years remaining of a 15-year lease agreement.
- Note the current status of the building industry supply chain and its impact on the availability of materials; timescales; and costs of building schemes.

**Executive summary**

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.

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.

**Risks associated with meeting the Trust's values**

This project is centred around improving the patient and staff experience **(Making a Difference),** as well as ensuring compliance with ventilation requirements **(Always Improving)**

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | This project ensures that the ground floor is on par with the remainder of the building. |
| **Resource Implications** | Capital allocation would need to be agreed as feasible. |
| **Equality Implications** | This project ensures that service users have inclusive access throughout the ground floor. |

| **Where has this issue been discussed before?** |
|---|
| Capital Management Group – April 2021 and 21st July 2021 |

| **Appendices:** | Page 14 - Appendix A - Outline floor plan<br>Page 15 - Appendix B - Backlog maintenance list |
|---|---|

| **Report authorised by:**<br>Sandra Betney | **Title:**<br>Director of Finance |
|---|---|

**SOUTHGATE MOORINGS REFURBISHMENT**

## 1.0 STRATEGIC CASE

### 1.1 Purpose

This business case refers to Southgate Moorings, Kimbrose Way, Gloucester.

GHC have a 15-year lease on the whole building, from 27th June 2018, with 12 years left to run.

This project proposes a refurbishment of the ground floor which is predominantly used by the community dental service, with two clinical rooms and an office used by the Lymphoedema service. The community dental service provides specialist care to a wide range of service users with additional needs. The 1st and 2nd floor were refurbished for other services in 2018.

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.

### 1.2 Approvals

The Capital Management Group (CMG) have supported the referral of this paper onto Board given the value of over £1million.

### 1.3 Background/case of need

The ground floor was refurbished in 2008/9 to accommodate the dental service, so the fixtures and fittings and building services are now dated and end of life. The floor layout has grown organically and is not efficient for staff to work in. The mechanical ventilation system is old and requires replacing to ensure it is compliant with the latest Health Technical Memorandum (HTM 03-01). The functional space does not accommodate bariatric patients easily, nor patients in electric wheelchairs. The reception is not welcoming to patients with additional needs. The foul drainage system is not efficient which results in a malodorous smell filtering through parts of the building

#### 1.3.1 Ventilation

As part of the survey work to underpin the design a report was commissioned on the current ventilation system and found it required a significant upgrade to meet the requirements under HTM 03-01 Specialised Ventilation for Healthcare premises. The original cost plan assumed the current system could be adapted but the survey showed this is not the case. The dental surgeries and clinic rooms require 10 air changes per hour, with the 4 surgeries and recovery room that undertake anaesthetic treatments requiring 15 air changes per hour. The proposal to remedy this is to provide an external air handling unit.

## 1.4 Project aims

The project aims were agreed by the operational project team as:

- Improvement of patient and staff experience
- Efficient location of dental surgeries to improve clinical service/practice
- Improved accessibility and use of services for patients
- Compliance with Infection Control standard
- Comply with current Health Building Notes (HBNs) and Health Technical Memorandum (HTMs)
- Improve sustainability to assist in meeting our obligations under the Climate Change Act

## 1.5 Main benefits

### 1.5.1 Benefits

| *Aim/benefits* | *Measure benefits* |
|---|---|
| Improvement of patient and staff experience and well being | • Pre and post survey to patients to measure their experience.<br>• Pre and post survey to staff to measure their experience. |
| Efficient location and refurbishment of dental surgeries to improve clinical service/practice | • Part of surveys above |
| Improve accessibility and use of services for patients | • Part of surveys above |
| Compliance with Infection Control standards | • 100% compliance |
| Meet all current HBNs and HTMs * | • 100% compliance. This project ensures that the actions from the Infection Control June 21 audit are complete.<br>• Reduce backlog maintenance schedule to low risk |
| Improve sustainability to assist in meeting Trust targets. | • Savings of £1,647 p.a. in utility costs, and £277 in maintenance.<br>• Savings of 5,466 kg C02 p.a. |
| Improve Health and Safety | • Monitor Datix incidents |

1.6 **Main Risks**

1.6.1 Inability to provide dental service for service users with additional needs. Investment would be needed to provide alternative accommodation or cease provision.

1.6.2 Future service disruption for any users of the floor whilst backlog maintenance is being undertaken.

1.6.3 Loss of staff morale as environment not comparable with the other two floors of the premises, nor other dental facilities.

1.6.4 Loss of reputation with Commissioners

1.6.5 The design of the premises is not inclusive (poorly designed reception, narrow doorways, small rooms)

1.7 **Trust Strategic Aims**

The Trust Strategic Aims that are met by the refurbishment are:

| Aims | How it is proposed they are met: |
|---|---|
| High Quality Care | Facilities that are fit for 2021 with inclusive design |
| Great Place to Work | Improved functional layouts, refurbished staff room and drainage system. |
| Sustainability | Using low energy technology wherever possible. |

1.8 **Summary of Strategic Case**

Without the full investment in the ground floor facility, the Trust risks a loss of dental service, of operational reputation and staff morale. Progression of this is therefore seen as in line with Trust strategic objectives.

## 2.0 ECONOMIC CASE

2.1 **Option 1** - Business as usual.

'Do nothing' is not an option. The current clinical and treatment rooms fail to deliver the required air changes per hour. To address the air changes only will cost in the region of £0.5 million once site set up, builders work in connection with the services and design costs are factored in. This option would not address any of the other aims and would still be disruptive to the service and require a decant.

2.2 **Option 2** – Refurbishment (preferred option)

The recommended option, whilst addressing the air change compliance, would be to take the opportunity to undertake all of the work and capture all of the benefits.

### 2.2.1 Scope of works

The outline approved plan is shown in **Appendix A**

| Aim | How this option meets the objectives |
|---|---|
| Improvement of patient and staff experience | <u>Patient</u><br>• Wider entrance to waiting area<br>• New flooring, lighting and redecoration to all patient facing areas<br>• New reception desk that is at a lower, more welcoming height, (security is provided by the depth of the worktop, some higher areas, panic button and two escape doors).<br>• Improving the acoustics where there are problems<br>• Improving patient dignity by adding a bariatric toilet, widening doorways and ensuring door + half where required, ensuring rooms have sufficient space for wheelchairs to turn<br><br><u>Staff</u><br>• Refurbished staff welfare room<br>• Air conditioning in clinical rooms (8 in total)<br>• Improving the acoustics where there are problems<br>• Eliminating the sewerage smell that is present in most of the floor |
| Efficient location and refurbishment of dental surgeries to improve clinical service/practice | • Relocating the main staff office to behind reception, freeing up space for a larger 6th surgery with the others<br>• Relocating all surgeries together |
| Improve accessibility and use of services for patients | • Only two of the dental surgeries have a door plus half, this will ensure that all 8 clinical rooms plus the OPG room and any corridors have wider doorways<br>• Addition of a bariatric WC facility |
| Compliance with Infection Control | • Addition of a dirty utility for the non-dental clinical rooms<br>• Removal of carpet and replacement with vinyl<br>• 100% compliance with Infection Control June 21 audit |
| Meet all current HBNs and HTMs * | • This is an opportunity to address backlog maintenance and the full extent of items replaced are at **Appendix B**. £65,000. They include distribution boards, flooring, doors, kitchen units. |

| Aim | How this option meets the objectives |
|---|---|
| | • The ventilation will meet the HTM_03-01– recommended air-change rates |
| Improve sustainability to assist in meeting Trust targets. | • Installing LED lighting throughout.<br>• Adding a new bike shelter to encourage cycling to work |
| Improve Health and Safety | • Creating a fenced waste compound to prevent rough sleepers and the public using the area for waste and as a urinal.<br>• Installing an access-controlled gate to prevent the general public using the car park as a pedestrian short cut<br>• Full drainage review and elimination of waste odours |

* Health Building Note 11-01 – Facilities for Primary and Community Care Services, Health Technical Memorandum 01-05 decontamination in primary care dental practices (2013), Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises, Health Technical Memorandum 07-07 Sustainable health and social care buildings: Planning, design, construction and refurbishment, Health Technical Memorandum 08-01: Acoustics

### 2.3 Summary of Economic Case

The preferred option (2.2):

- Ensures safety with compliance with HTM 03-01 with the provision of a new AHU
- Improves patient journey, dignity and general experience
- Improves staff morale, wellbeing and operational working
- Meets inclusive design requirements
- Ensures 100% compliance with infection control
- Addresses 65k backlog maintenance for a number of years which would disrupt service if operational.
- Supports the sustainability agenda
- Improves security and safety

On this basis the preferred option is deemed value for money.

## 3.0 COMMERCIAL CASE

### 3.1 Procurement route

The project is currently being developed with the contractor Speller Metcalfe with Gleeds as the main designer, maintaining design liability. The proposal is that Speller Metcalfe will be appointed from the South West Procurement Alliance (SWPA) framework. Spellers bid has been evaluated by Gleed's QS and those costs are included under 4.1.

### 3.2 Construction phase

The services will move to alternative clinics whilst the work is being undertaken, to facilitate a quicker project and a lower price. It is likely that the site compound will take up a considerable amount of the parking spaces and the first and second floor staff will be impacted accordingly. An alternative option has been found and included within the commissioning costs.

### 3.3 Permissions

Landlord permissions have been agreed for the internal work but not for the additional AHU requirement, this is currently being sought. This is not anticipated to be a problem. There will be legal fees for the agreed licenses which are included in the costs.

Planning permissions will need to be sought for the air handling units on the outside of the building as this building is located in a conservation area. Pre-application advice has been sought on the preferred location and approval verbally given by a Planning Officer, in order to minimise the risk of rejection. Next steps are a full planning application average length 8 weeks. The Trust could then proceed at a low risk to maintain the programme. Planning permission is already granted for the external works for the waste compound and cycle shelter.

### 3.4 Decommissioning and commissioning

The area will need to be cleared completely in order for the contractors to undertake the work, this includes a number of specialist suppliers to remove and store expensive imaging and decontamination equipment. The remainder will be removed into storage. Costs for this have been included in the table below.

### 3.5 Summary of Commercial Case

Speller Metcalfe have put a viable cost in for this work and are interested and resourced to undertake the project. On this basis the project is deliverable.

## 4.0 FINANCIAL CASE

Earlier this month CMG, in response to the cost pressures experienced by this scheme and others, redistributed the 21/22 capital programme and allocated the full project cost. In doing so CMG deferred some backlog maintenance activity to 23/24. No high or significant risk items have been deferred as a result of this reallocation.

### 4.1 Capital costs

The table below is based on the preferred option and costs from Speller Metcalfe.

| Element | £ | |
|---|---|---|
| Works cost | £ | **698,255.52** |
| Contractor prelims | £ | 51,872.60 |
| Contractor profit at 5% | £ | 37,804.94 |
| *Sub total* | £ | 787,933.06 |
| Risk allowance at 5% | £ | 34,912.78 |
| *Sub total* | £ | 822,845.84 |
| VAT at 20% | £ | 164,569.17 |
| *Sub total* | £ | 987,415.00 |
| Less VAT reclaim @ 20% | £ | 32,913.83 |
| ***Build costs including applicable VAT*** | **£** | **954,501.17** |
| Design/legal fees /surveys | £ | 136,525.00 |
| Plus commissioning costs | £ | 36,000.00 |
| **Total project cost** | **£** | **1,127,026.17** |
| Less spend in 20-21 | £ | 74,000.00 |
| **Total for 21-22** | **£** | **1,053,026.17** |

## 4.2 Revenue

| Element | Per annum | How funded |
|---|---|---|
| Heat/light/power/maintenance and additional cleaning | £500 for air conditioning maintenance<br><br>£1,000 for new filters/maintenance of AHU<br><br>£5,132 for the additional cleaning<br><br>Total £6,632 | Will be met from the current estates and facilities budget |
| Capital charges at 3.5% | £37,802 in year one<br>£1,644 in year 12 | |
| Depreciation over the life of the asset (12 years) | £93,919 per annum | |
| **Total revenue** | £138,353 (in year 1)<br>£102,194 (in year 12)<br>£1,443,285 (whole project cost with interest) | |

### 4.3 Cash flow 21/22

Indicatively, if approved, the project would be spent as follows;

| April | May | June | July | Aug | Sep | Oct | Nov | Dec | Total |
|---|---|---|---|---|---|---|---|---|---|
| £ 4,000 | £ 2,000 | £ 8,000 | £ 14,000 | £ 14,200 | £ 252,825 | £ 252,825 | £ 252,825 | £ 252,325 | £ 1,053,001 |

### 4.4 VAT treatment

Internal Vat advice is that this project will be banded as Major Alterations and will have a 20% of applicable VAT reclaim.

### 4.5 Project cost increase rationale

At concept design stage an indicative budget of £750,000 was set. Whilst there has bene some additional scope in relation to backlog and air handling, increases otherwise are broadly due to the economic climate as highlighted under 5.6. The preferred option represents the fundamentals required to deliver the benefits outlined.

### 4.6 Summary of Financial Case

On the basis of the above and the work undertaken by CMG the project is considered affordable.

## 5.0 PROJECT MANAGEMENT CASE

### 5.1 Professional advice

Gleeds Building Surveying Ltd have been appointed via the SWPA framework to manage the project and have professional liability for any other professionals.

### 5.2 Project Group

A project group meets at least monthly and have been involved with design sign off and reviewing plans. Members include Operational staff, Radiation Protection Advisor, Infection Control, Fire Safety Manager, Local Security Management Specialist and Estates and Facilities colleagues.

### 5.3 Project Board

The Project Board are available to resolve any issues and comprise:

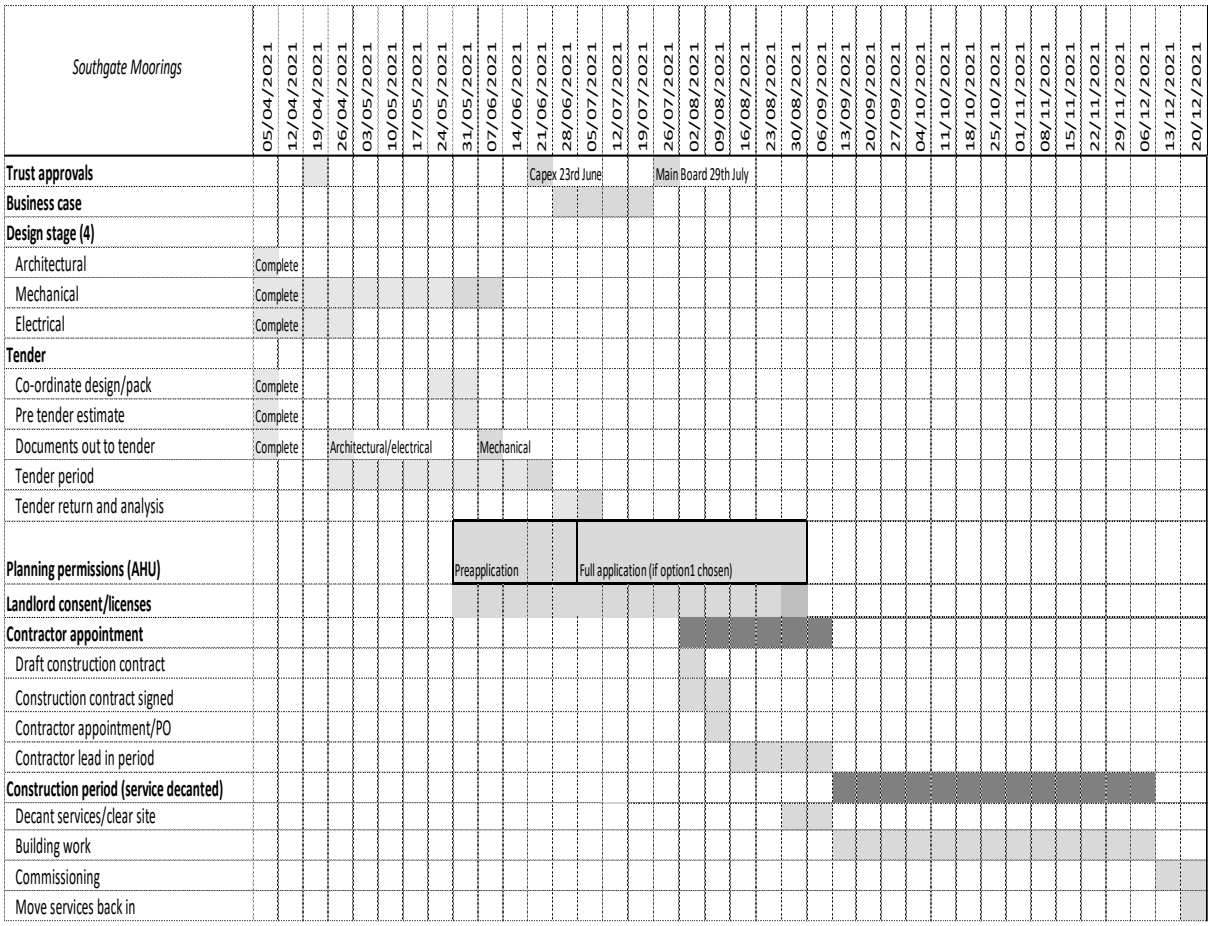
- Associate Director of Estates and Facilities
- Deputy Service Director for Urgent Care and Specialty Services
- Deputy Director of Adult Community Services

The Project Board will be responsible for managing to the agreed budget including the spend of the risk allocation. Any issues likely to take the spend over the agreed budget will require further authorisation, and will initially be escalated to CMG.

## 5.4 Programme

Proposed key dates are:

- Start on site mid-September
- Estimated completion before Christmas
- Estimated build programme 13 weeks




## 5.5 Risks of project delivery

| Risk | Likelihood | Impact | Mitigation | Owner |
|---|---|---|---|---|
| Planning permission - Non-approval of air handling unit (AHU) location | Low | Medium | Pre-application advice sought. Alternative options are available. | Project Manager |
| Programme delay if preferred location of AHU not approved | Medium | Low | Likely delay 1 month, still achievable in financial year though | Project Manager |
| Contractor insolvency | Low | Low | Speller Metcalfe are a large and | Project Manager |

| Risk | Likelihood | Impact | Mitigation | Owner |
|---|---|---|---|---|
| | | | reliable contractor | |
| Supply chain issues causing programme delay See 5.6 below | High | Low | Clause in contract to mitigate financial loss. | Project Manager |
| Landlord consent | Low | High | Dialogue opened already and no issues envisaged. | Project Manager |

### 5.6 Cost and Supply Risk

The British building industry is in the midst of a supply crisis. The Construction Leadership Council recently warned that cement, electrical components, timber, steel and paints are all in short supply due to unprecedented levels of demand that are set to continue. As a result, it has been necessary for many building contractors to delay projects and others have been forced to close down altogether.

With demand globally increasing and the UK importing many of its raw materials, lead times for orders are lengthening while prices are increasing. The industry is witnessing price rises of between 10-15% across the board with timber seeing between 50-80% increase and 30-50% increase on cement. Steel joists are more expensive because iron ore has gone up by more than 80%

The supply shortages stem from a number of factors including:

- Warmer winter affecting timber production in Scandinavia
- Sharp rise in shipping costs due to COVID-19 and Brexit related issues also leading to delays at ports
- The increase in domestic activity seeing a sharp rise in home improvement projects

### 5.7 Summary of Project Management Case

On the basis that the issues above have been factored into planning and noting the risks highlighted there is confidence that this project is deliverable.

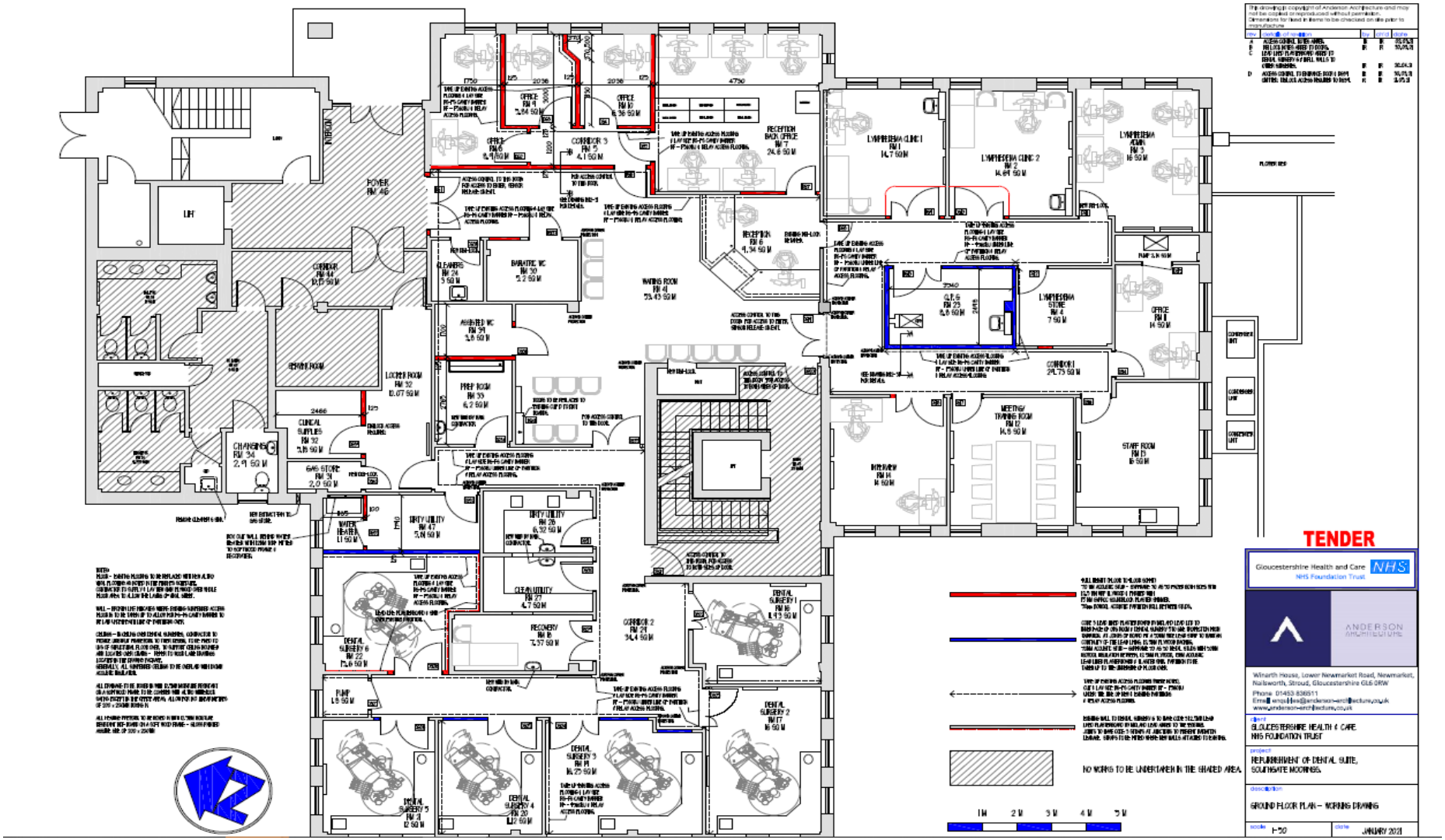
## 6.0 SUMMARY

The Trust Board is asked to:

- **Agree** to the investment of a total project cost of £1,127,026

- **Acknowledge** that this will be investing a significant sum in a leased building with 12 years remaining of a 15-year lease agreement.
- **Note** the current status of the building industry supply chain and its impact on the availability of materials; timescales; and costs of building schemes.

## Appendix A – **Outline plan**



## Appendix B – Backlog maintenance schedule

| Site Name | Block No. | Block Name | Zone Name | Summary | Description | Type | Condition | Rem Life Years | Oakleaf Cost | Adjusted cost | Year | Comments | Remedial Action | Consequence | Likelihood | Risk Score | Risk Rank |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor | C - Building - Internal Fabric | 07 - Internal Doors | Building | C | 0 | £150.00 | £150.00 | 2020 | Timber entrance door: Operation is poor. | Cost allows for repair. | 3 | 5 | 15 | SIGNIFICANT |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor - Reception Electrical Cupboard | R - Engineering - Electrical | 03 - Distribution Boards | M&E | C | 0 | £2,500.00 | £3,750.00 | 2020 | MEM distribution board is beyond expected lifecycle. | Cost allows for replacement. | 3 | 4 | 12 | SIGNIFICANT |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor - Reception Electrical Cupboard | R - Engineering - Electrical | 03 - Distribution Boards | M&E | C | 0 | £2,500.00 | £3,750.00 | 2020 | MEM distribution board is beyond expected lifecycle. | Cost allows for replacement. | 3 | 4 | 12 | SIGNIFICANT |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor | C - Building - Internal Fabric | 03 - Floor | Building | C | 0 | £6,000.00 | £6,000.00 | 2020 | Vinyl sheet floor: Is aged and marked. | Cost allows for like for like replacement of the existing floor finish. | 2 | 5 | 10 | MODERATE |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor | C - Building - Internal Fabric | 05 - Fixed Units | Building | C | 0 | £5,000.00 | £5,000.00 | 2020 | Kitchen units: Allow to upgrade. | Cost allows to upgrade conforming to modern standards. | 2 | 5 | 10 | MODERATE |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor | C - Building - Internal Fabric | 01 - Decorations | Building | C | 0 | £22,000.00 | £22,000.00 | 2020 | Redecoration is required as part of a regular maintenance schedule. | Cost allows for two coats of emulsion and includes gloss work. | 1 | 5 | 5 | LOW |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor | C - Building - Internal Fabric | 03 - Floor | Building | C | 0 | £4,000.00 | £4,000.00 | 2020 | Carpet: Is marked and worn. | Cost allows for like for like replacement of the existing floor finish. | 1 | 5 | 5 | LOW |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor | C - Building - Internal Fabric | 06 - Sanitary Fittings | Building | B | 1 | £10,000.00 | £10,000.00 | 2021 | Male/female WC's: Although well maintained, are considered dated. | Cost allows to upgrade conforming to modern standards. | 2 | 4 | 8 | MODERATE |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor | K - Engineering - Vent & Cooling | 02 - Controls | M&E | B | 5 | £500.00 | £500.00 | 2025 | Air Force Vent Products control panel coming towards the end of its life expectancy. | Cost allows for replacement. | 3 | 3 | 9 | MODERATE |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor | M - Engineering - Hot/Cold Water | 08 - Expansion Vessels | M&E | B | 3 | £200.00 | £200.00 | 2023 | Boss expansion vessel coming towards the end of its life expectancy. | Cost allows for replacement. | 3 | 3 | 9 | MODERATE |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor - Reception Electrical Cupboard | R - Engineering - Electrical | 03 - Distribution Boards | M&E | B | 5 | £2,500.00 | £3,750.00 | 2025 | MEM distribution board is coming towards the end of its life expectancy. | Cost allows for replacement. | 3 | 3 | 9 | MODERATE |
| Southgate Moorings | 001 | Main Building | 00 - Ground Floor | C - Building - Internal Fabric | 05 - Fixed Units | Building | B | 4 | £6,000.00 | £6,000.00 | 2024 | Clinical units: Are showing signs of age. | Cost allows to upgrade conforming to modern standards. | 2 | 3 | 6 | LOW |

with you, for you

NHS
Gloucestershire Health and Care
NHS Foundation Trust

**AGENDA ITEM: 18/**0721

**REPORT TO:** **TRUST BOARD PUBLIC SESSION – 29 July 2021**

**PRESENTED BY:** Marcia Gallagher, Chair of the Audit and Assurance Committee

**AUTHOR:** Lavinia Rowsell – Head of Corporate Governance and Trust

**SUBJECT:** **AUDIT AND ASSURANCE ANNUAL REPORT 1 April 2020 – 31 March 2021**

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

**The purpose of this report is to**

Receive the annual report of the Audit and Assurance Committee for 2020/2021.

**Recommendations and decisions required**

The Board is asked to note the Committee's Annual Report 2020/21.

**Executive summary**

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*."

The attached report provides 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 provides 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 have 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.

| **Risks associated with meeting the Trust's values** |
|---|
| Failure to identify and mitigate corporate and strategic risks may adversely affect the Trust's strategic goals of engagement, quality and sustainability. |

| **Corporate considerations** | |
|---|---|
| **Quality Implications** | Effective management of risk provides assurance that patient services are being delivered safely. |
| **Resource Implications** | None other than those identified in the report. |
| **Equality Implications** | None other than those identified in the report. |

| **Where has this issue been discussed before?** |
|---|
| N/A |

| **Report authorised by:** | **Title:** |
|---|---|
| Marcia Gallagher | Non-Executive Director |

Gloucestershire Health and Care NHS Foundation Trust

# Audit and Assurance Committee Annual Report

## 1st April 2020 – 31 March 2021

## 1.0 INTRODUCTION

1.1 The Audit and Assurance Committee was established in its current form under Board delegation from 1 October 2019 in line with the governance arrangements agreed and set in place from the date of the merger of the Trust with Gloucestershire Care Services NHS Trust. Its terms of reference are informed by good practice and Audit and Assurance Committee guidance within the NHS sector and other sectors.

1.2 All Non-Executive Directors are members of the Committee, with the exception of the Trust Chair with four NEDs as core members. This membership enables the Committee to triangulate information and assurance received at other Board Committees, each of which is chaired by a member of the Audit and Assurance Committee.

1.3 A number of officers are in regular attendance in accordance with the Committee's Terms of Reference. These include the Director of Finance (or a delegated alternate), the Head of Governance and Trust Secretary (or a delegated alternate), Internal and External Auditors, and the Local Counter Fraud Specialist. Other Directors and Managers attended at the request of the Committee, for example where further information is required on follow up actions following issues being raised through an Internal Audit. After each meeting of the Committee, the Audit and Assurance Committee Chair provides a summary report of the Committee's deliberations and decisions to the next Board meeting.

1.4 The Committee met 5 times during the period 1 April 2020 to 31 March 2021, and has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the Trust's business through self-assessment and review, and by requesting assurances from Trust Officers. Each meeting was quorate.

1.5 Attendance by members at the Committee during the period was as follows:

| **Members*** | 28/05/20 | 17/06/20 | 06/08/20 | 05/11/20 | 11/02/21 |
|---|---|---|---|---|---|
| Marcia Gallagher (Chair) | Y | Y | Y | Y | Y |
| Graham Russell | Y | Y | Y | Y | Y |
| Maria Bond | Y | Y | Y | N | Y |
| Steve Brittan | Y | Y | Y | Y | Y |

**There are four core members of the Committee but all Non-Executive Directors (excluding the Board Chair) are invited to attend and can count towards the quorum.*

All members receive papers and have the opportunity to raise any concerns with the Chair even where they do not attend.

1.6 The following were in attendance at the Committee during the period with their attendance dependent on issues to be discussed.

- Director of Finance
- Deputy Director of Finance
- Other Directors as required
- Head of Counter Fraud and/or Team members (receives papers and can raise any concerns with the Chair or Director of Finance if not attending.)
- Members of the Trust Secretariat
- Internal Audit
- External Audit
- Members of the Management Team for specific items

## 2.0 PRINCIPAL REVIEW AREAS

2.1 This annual report is divided into five sections, reflecting the five key duties of the Committee as set out in its terms of reference.

### 2.2 Governance, Risk Management and Internal Control

2.3 The Committee has reviewed relevant disclosure statements, in particular the Annual Governance Statement together with the Head of Internal Audit Opinion, external audit opinion and other appropriate independent assurances.

2.4 The Head of Internal Audit Opinion was based on the audit work carried out during the year in line with the plan approved by the Committee, and also had regard to the Trust's Board Assurance Framework, Risk Register, and other control mechanisms. This opinion contributed to the Committee's assessment of the effectiveness of the Trust's system of internal control, and to the completion of its Annual Governance Statement.

2.5 The Committee reviewed the Corporate Risk Register and the Board Assurance Framework at regular intervals in order to provide challenge and receive assurance that strategic and corporate risks are being adequately monitored. The Board Assurance Framework has been reviewed in year to align with the Trust's new strategic framework.

2.6 The Committee reviewed both the draft and final versions of the Annual Governance Statement which set out the systems and processes for internal control and formed part of the Trust's 2020/21 Annual Report.

2.7 Compliance reports on governance processes including the Register of Directors' Interests, and the Register of Gifts and Hospitality are reviewed annually.

2.8 The Chairs of all Gloucestershire Trusts' Audit and Assurance Committees are able to meet to discuss governance issues around Integrated Care Systems and other issues of mutual interest. It was agreed that in order to a greater understanding on issues facing partner organisations within the system, Audit Committee Chairs may attend each other's meetings as observers.

2.9 The Committee has reviewed the completeness of the risk management system and the extent to which it is embedded within the organisation. An Internal Audit on risk management was conducted in year and was rated as 'low risk'. The Committee acknowledges the progress made in year and believes that while adequate systems for risk management are in place, continued management focus is required to ensure that risk management continues to be embedded within the Trust.

**2.10 Internal Audit**

2.11 In completing its work, the Committee places considerable reliance on the work of the Internal Auditors. Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. During the year the Committee reviewed and approved the internal audit plan for 2020/21 and considered the findings of internal audit in relation to work on the following issues:

| | **Report Rating** |
|---|---|
| Corporate and Quality Governance | Low |
| Risk Management | Low |
| Information Governance (DSP toolkit) | TBC |
| Performance Management/ Data Quality | Medium |
| System Working (advisory) | Advisory |
| Consultant Job Planning | High |
| Supplier Data Transfer | High |
| Financial Governance | Low |
| Financial Systems (Accounts Payable) | TBC |
| HR | High |
| Cyber Security (advisory) | Advisory |
| IT Problem Solving | Medium |
| ESR (Payroll) | Medium |
| Multi-site COVID | Medium |

2.12 Over the year, a number of audits have been included at the request of management including Supplier Data Transfer, ESR (payroll) and IT problem solving. Where audits were rated as high risk, the responsible Director was invited to attend the meeting to discuss the findings and planned response. On each occasion the Committee sought assurance that measures had been put in place to ensure that the recommendations were to be taken forward with timeliness. Of the three high risk rated reports, the Internal Auditors were satisfied that the Trust has action plans in place to address the risks.

2.13 The audits produced a total of 34 findings. There were 11 low, 18 medium and 4 high risk-rated findings and 1 advisory finding. In respect of each of these findings the Committee sought and received assurance on the mitigating actions being taken, following up outstanding actions as necessary and referring issues to other Committees as appropriate in order for progress with action plans to be monitored.

2.14 During the year, and in line with government guidelines, the majority of the Internal Audit programme has continued to be undertaken remotely.

2.15 The Committee has been pleased to note during the period continued good performance in terms of the timely completion of management actions arising from Internal Audit Reviews. Tracking of IA recommendations is reviewed at each meeting.

**2.16 External Audit**

- The Committee received and noted the final audit in respect of the 2020/21 Annual Report Financial Accounts.
- The Committee reviewed and agreed the external audit plan for 2020/21.
- The Committee reviewed and commented on the reports prepared by external audit which have kept the Committee apprised of progress against the External Audit Plan.

**2.17 Private Meeting with the Auditors**

2.18 Committee Members met privately with internal and external auditors during the period. No concerns were raised by either auditor, and both gave positive feedback about the reputation of the Trust and the working relationships that had been established.

**2.19 Other Assurance Functions**

2.20 The Committee has reviewed the findings of other significant assurance functions where appropriate, and has considered any governance implications for the Trust.

2.21 The Committee received regular Counter Fraud updates, and received the Counter Fraud Annual Report for 2020/21 and the Counter Fraud work plan for 2021/22. The Trust has maintained compliance with the Standards for Providers throughout the year through the delivery of proactive and reactive work in accordance with the approved workplan. The agreed planned total of 200 days of counter fraud activity was delivered during 2020/21 across the 4 generic areas of Counter Fraud activity as defined by the NHS Counter Fraud Authority (NHS CFA); Strategic Governance, Inform and Involve, Prevent and Deter and Hold to Account.

2.22 During the year, proactive local reviews have included a review of Estates and the appointment of professional consultants, the use of purchase cards, and an Association of British Pharmaceutical Industries data set review.

2.23 The NHS CFA requires all NHS providers to sustain their compliance with the standards for countering fraud, bribery and corruption. The new standards for the year were implemented in January 2021. For 2020/2021, the Annual Self Review Tool (SRT) (the mechanism used to annual report compliance against the standards) has been replaced by the Counter Fraud Functional Standard Return (CFFSR). Despite all activity for the year being devised and undertaken in accordance with the previous standards, the CFFSR must be based on the new standards which have a greater level as specificity. This will result in an increase in red and amber ratings for the Trust in certain areas. The NHS CFA has acknowledged that this will be a base line measurement only, and there will be an increase in red and amber ratings. The counter fraud workplan for 2021/2022 identifies the work required for the Trust to meet the new requirements.

**2.24 Management**

2.25 The Committee has challenged the assurance process when appropriate, and has requested and received assurance from Trust management and various other sources both internally and externally throughout the year.

2.26 The Committee works to an annual plan of scheduled agenda topics. In setting this annual plan, the Committee considers items currently on the Risk Register, items of current interest, and items raised by the auditors and the Executive Team. In addition the Committee follows up risk items previously identified to ensure that it remains informed of progress against previously agreed actions. A rolling programme of actions is maintained and monitored accordingly for all Committee meetings.

**2.27 Compliance Reporting**

2.28 The Committee received Losses and Special Payments reports at various points through the year, as required by the Trust's Standing Financial Instructions. The Committee sought assurance in each case as to the processes in place to recover these amounts, and prevent recurrence.

2.29 The Committee has regular reports at meetings on waivers over £25k applied in the preceding period. This reporting includes nil returns.

2.30 The Committee reviewed the 2020/21 financial statements and annual report at the May 2020 meeting prior to recommending the final accounts for Accounting Officer signature, in line with authority delegated by the Board.

2.31 The Committee was pleased to note the external audit report which indicated that an unqualified audit opinion was to be given to the accounts, and that the

auditors had not identified any significant weaknesses in systems of accounting and financial control.

## 3.0 OTHER MATTERS

3.1 The Committee formally reviewed its effectiveness during the year. Its format and operation has been informed by best practice and no issues have been identified to date.

3.2 The Committee compiled an Annual Report on its activities which will be considered by the Board.

3.3 The Committee reviewed its terms of reference during the year with minor amendments approved by the Board.

## 4.0 CONCLUSION

4.1 The Committee's primary contribution to the achievement of the Trust's strategic objectives is to ensure that Governance, Control, Risk Management and Audit systems are sound, reliable, and robust. The work of the Committee in the last financial year, and the triangulation of information and assurance received both at the Audit and Assurance Committee and at other Committees chaired by members of the Audit and Assurance Committee, have enabled the Audit and Assurance Committee to conclude that the Trust's systems are in the main sound, reliable and robust.

**Marcia Gallagher**
Chair, Audit and Assurance Committee
May 2021

**GLOUCESTERSHIRE HEALTH AND CARE NHS FOUNDATION TRUST**

**COUNCIL OF GOVERNORS MEETING**

Wednesday, 12 May 2021
Held via Microsoft Teams

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| | | | |
|---|---|---|---|
| **PRESENT**: | Ingrid Barker (Chair) | Nic Matthews | Sarah Nicholson |
| | Katie Clark | Jo Smith | Mervyn Dawe |
| | Chris Witham | Graham Hewitt | Tracey Thomas |
| | Ruth McShane | June Hennell | Anneka Newman |
| | Laura Bailey | Karen Bennett | Alison Feher |
| | Kizzy Kukreja | Katherine Stratton | |

**IN ATTENDANCE:** Graham Russell, Non-Executive Director/Deputy Chair
Marcia Gallagher, Non-Executive Director
Maria Bond, Non-Executive Director
Steve Brittan, Non-Executive Director
Sumita Hutchison, Non-Executive Director
Jan Marriott, Non-Executive Director
Paul Roberts, Chief Executive
Neil Savage, Director of HR & OD
Lavinia Rowsell, Head of Corporate Governance & Trust Secretary
Anna Hilditch, Assistant Trust Secretary
Gillian Steels, Trust Secretary Advisor
Kate Nelmes, Head of Communications
Sandra Betney, Director of Finance (From Item 18)
John Trevains, Director of Nursing, Therapies and Quality (Item 12)

## 1. WELCOMES AND APOLOGIES

1.1 Apologies were received from Brian Robinson, Anne Roberts, Dan Brookes, Juanita Paris, Said Hansdot, Jenny Hincks and Julie Clatworthy. Apologies were also received from Steve Alvis, Non-Executive Director.

1.2 Ingrid Barker welcomed everyone to the meeting. It was noted that this would be Alison Feher's last Council meeting as she would be standing down as a Staff Governor on 31 May 2021. Ingrid Barker led the Council in expressing thanks to Alison for her contribution over the last 3 years.

1.3 Since the last meeting of the Council, it was noted that Dawn Rooke, Public Governor for the Forest had tendered her resignation. Following a recent Governor election, the Council noted that a new Public Governor for Tewkesbury had been appointed to replace Josephine Smith when her final term ended on 14 July. An election was still underway for the Health & Social Care Professions staff group, with the results being known on 31 May 2021.

## 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 10 March 2021 were agreed as a correct record, subject to a small addition at 6.10 to state that Governors had also expressed their concerns regarding the proposed 1% national pay uplift for NHS staff.

## 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.

4.2 Mervyn Dawe informed the Council that he was liaising with James Wright about the production of a report for Governors offering assurance around Out of Area placements. It was planned that a full report would be presented to the Council at its next formal meeting.

## 5. MEETING EVALUATION AND FEEDBACK

5.1 The Council received the collated evaluation and feedback received from the previous meeting in March. Ingrid Barker thanked Governor colleagues for their helpful and valuable feedback, advising that all feedback would be reviewed, and the learning taken on board for future meetings.

## 6. CHAIR'S REPORT

6.1 The Council received the Chair's Activity Report. It was noted that this report had been written and presented to the Trust Board at their 31 March meeting and was presented to the Council for information and reference. This report and its content were noted.

## 7. CHIEF EXECUTIVE'S REPORT

7.1 Paul Roberts, Chief Executive presented a verbal report to the Council.

7.2 The Council noted that this continued to be a very busy time operationally. There had been a huge reduction in Covid infection rates and the number of Covid patients in the system had also reduced. GHC currently had no Covid inpatients however community beds continued to care for those in recovery.

7.3 GHC had now lifted its strong visiting restrictions with hospitals operating under Covid Secure Environment regulations.

7.4 GHC runs 96 services, and all services were now back up and running fully with a few high-profile exceptions, including the Vale MIIU which would re-open in the summer. Innovation and the use of technology had come to the fore during the pandemic and the Trust would continue some of this practice going forward, looking at a blended approach of face-to-face and digital solutions.

7.5 GHC had been very involved in the mass vaccination programme, with the Trust's focus being on frontline staff and supporting the Primary Care Networks (PCN) to vaccinate patients. GHC had also focused on the homeless, the travelling community and ethnic minorities as it was important to ensure equitable access to all communities. Mervyn Dawe said it was good to see the work being carried out to ensure that vaccinations were promoted and made available to all communities and asked whether there were any specific groups that had been identified where more work was needed to promote the vaccinations. Paul Roberts said that a number of communities had been identified and the Trust and its partners were working closely with community and faith leaders to get specific communications out, as well as setting up roving vaccination clinics to make access available to as many people as possible. There had also been a lower uptake of the vaccine from younger people.

7.6 Paul Roberts advised that the Trust was currently finalising its Business Plans for 2021/22. He said that there was good investment in mental health services this year, and a key focus on frailty and complex care at home services. The Council noted that staffing and the ability to recruit qualified staff remained a real challenge. There had been Inpatient and Community nursing shortages before Covid hit, and the Trust had been able to adapt with different working models during Covid, but there was a real need to review the staffing models as demand for services was increasing. Neil Savage advised that the Trust was in discussion with system partners to look at developing system wide recruitment programmes.

7.7 The Council was informed that the Trust Strategy had now been officially launched and Governor colleagues were thanked for their input during the development of this.

## 8. MEMBERSHIP UPDATE REPORT

8.1 The purpose of this report was to provide an update on Trust membership, including progress with the Membership & Engagement Strategy action plan.

8.2 The Trust's Membership & Engagement Strategy was approved at the March Council of Governors meeting. This was subsequently approved by the Trust Board at their meeting on 31 March. The associated action plan is progressing well, and this will be monitored and reviewed by the Governors Membership & Engagement Committee, the next meeting of which will take place on 23 June.

8.3 The Council received an overview of Public membership statistics, which included a breakdown by constituency, ethnicity, disability and age profile. As of 6 May 2021, the Trust had 5926 Public members, of which 4971 were in Gloucestershire. The last membership report received by the Council in November reported the total number of Public members at 6096, of which 5110 were in Gloucestershire. This represents an overall reduction in Public members of 170.

8.4 Work to develop and increase the functionality of the Trust's in-house membership database has taken place, and as of 1 March 2021 it is now possible to accurately see how many Public members join and how many leave the Trust each month. A record is also kept of those members leaving the Trust to get an understanding about the reasons why people no longer wish to remain as a Trust member.

8.5 Laura Bailey noted that there was a much higher percentage of woman signed up as public members than men. Anna Hilditch advised that this had always been the case, however, the Membership & Engagement Strategy had identified this as a key focus point so further work would be taking place to review this and to encourage more men to join as members.

## 9. FEEDBACK FROM GOVERNOR PRE-MEETING

9.1 The Council received a summary of the key items discussed at the earlier pre-meeting, which included:

- Discussed the new Public Governor/NED/Strategy and Partnership Team pairings and the need to consider how links with the staff Governors could be developed
- Provided feedback and comment on the first draft of the Governor Dashboard
- Discussed the Holding to Account presentations and how to get the most out of these sessions, noting that the information provided to Governors in advance did not provide enough detail to form effective questions and challenge in advance.
- Asked that consideration be given to providing Governors, particularly Public Governors with ID badges and Trust email addresses for correspondence.

9.2 Ingrid Barker said that she really welcomed the feedback around the HTA process, agreeing that this was an important element of the Governor role which would evolve over time. It was agreed that action would be carried out to provide ID badges for Trust Governors and the suggestion of Trust email addresses would be explored further. **ACTION**

## 10. REPORT FROM THE NOMINATIONS AND REMUNERATION COMMITTEE

10.1 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 28 April. He provided strong assurance to the Council that the Committee ensured best practice that was in line with national guidance.

10.2 The Committee received a report setting out a recommendation for the reappointment of Jan Marriott whose first term of office would come to an end on 30 September 2021. As set out in the Trust's Standing Orders, Jan was eligible to be re-appointed for a further 3-year term. In considering its decision, the Nominations and Remuneration Committee received a review of Jan's experience, performance and attendance during 2020/21. It was noted that Jan had received a positive appraisal and had a very good attendance record at Trust Board and Committee meetings. The Committee considered this report and was happy to recommend to the Council of Governors that Jan Marriott be reappointed for a period of 3 years, beginning on 1 October 2021. **The Council of Governors approved this recommendation.**

10.3 At the February meeting of the Nominations and Remuneration Committee a report was presented setting out the process and timeline for both the Chair and Non-Executive Director appraisals for 2020/21. It was proposed that these processes would both be carried out during March/April, with the outcome being

reported to the April meeting of the Nominations and Remuneration Committee. The Committee noted at the previous meeting that NHS England/Improvement (NHSEI) had advised that they would be issuing revised guidance, specifically related to the Trust Chair appraisal process. It was therefore proposed that the process for seeking multisource feedback from external stakeholders and partner organisations would be paused until this new guidance was received. Despite this delay, the Committee supported the decision for the Trust to proceed with its internal systems for seeking feedback, self-assessment and objective setting. The revised guidance was received on Friday 9th April. This was reviewed, and no fundamental changes to the appraisal process were identified. A decision was made that the Trust would proceed with seeking external feedback as part of the Chair's appraisal. Considering this delay, it was agreed as sensible that the outcome of both the Chair and the NED appraisal processes be delayed until the June meeting of the Nominations and Remuneration Committee to allow sufficient time to receive and evaluate this valuable external feedback. The Committee had supported this proposal.

10.4 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.

10.5 The Health and Social Care Act requires that Trusts ensure that all Executive and Non-Executive Director positions are filled by people that meet the requirements of the Fit and Proper Persons Regulations. In line with the legislation, an annual process for monitoring and reviewing the ongoing fitness of existing directors to ensure that they remain fit for their role, had been undertaken. All Directors have been asked to complete a FPPT self-declaration and annual conflicts of interest return. In addition, the Trust Secretariat has checked the insolvency register and register of disqualified Directors. The declarations register was presented to the Committee for information. It was noted that there were no issues to be brought to the attention of the Committee following the checks.

10.6 The Nominations and Remuneration Committee received an update on progress and current timelines for the recruitment for a Non-Executive Director. The Committee received an update on potential candidate numbers and contacts made so far. The Committee also received the updated recruitment timeframe, noting that it was proposed to have a preferred candidate identified for approval by 14th July Council of Governors meeting.

## 11. NON-EXECUTIVE DIRECTOR PORTFOLIOS

11.1 The purpose of this report was to provide the Council with an annual update on the key roles and responsibilities of the Non-Executive Directors, including chairing arrangements, statutory roles and locality focus. This item was for information.

11.2 Ingrid Barker advised that a review of the Trust's governance structure was taking place and it was likely that a number of changes would be made to the NED portfolios in light of this, in particular around Committee membership and chairing. Once this process was complete an updated portfolio would be recirculated to Governors for information.

## 12. HOLDING TO ACCOUNT SESSION

12.1 The Council received a HTA presentation from Maria Bond, NED and Chair of the Quality Committee. The presentation provided Governors with an overview of the purpose of the Committee, the key ways of working, those things that had worked well and a summary of the areas where development was underway.

12.2 The Quality Committee look at three areas which are nationally mandated: Patient Experience, Patient Safety and Patient Outcomes.

12.3 Maria Bond informed the Governors that a recent meeting of the Audit & Assurance Committee received the Internal Audit Plan for 2021/22 and it was agreed that stronger links were needed with the Quality Committee around clinical audits. The receipt of the annual Clinical Audit plan has now been built into the Audit Committee schedule, once received and signed off at Quality.

12.4 Pressure ulcers has been a long-standing issue for the Trust and the Quality Committee requested a "deep dive" to be able to gain better assurance on the work taking place to address this. A detailed analysis was presented to the Committee with real data and provided a real understanding of the issues and the specific areas where GHC could improve. Discussions also took place about how we can work as a wider system.

12.5 There had been a dip in the performance of complaints and the timeliness of responses to complainants. Assurance was sought on this. A number of team members had been redeployed during Covid and since returning to the team performance had improved. However, the Quality Committee requested more granularity to be able to review the underlying performance.

12.6 The Quality Committee receive the Quality Dashboard at each of its meetings. This is a dynamic document and during Covid, specific Covid measures and monitoring indicators were added to include PPE and vaccination rates. Work was now underway to streamline this data into business as usual reporting. The Quality Dashboard includes data on services with agreed key performance indicators (KPIs); however, it also maintains a focus on those areas without KPIs to ensure nothing is overlooked. A key focus area is identified for presentation at each meeting.

12.7 Maria Bond said that the Trust was performing well overall in its Friends and Family Test (FFT) results which was excellent. However, she was interested in drilling down into this performance to look at whether there were any areas that were not performing as well and whether any improvements were needed. Further analysis of the FFT results has now been provided for the Committee. Maria said that it was very important to not simply accept the information presented at the Committee and that asking for further analysis to seek greater assurance was key.

12.8 It was noted that an Expert by Experience attended each meeting of the Quality Committee, and this was an excellent opportunity to get feedback and to ensure that the focus was on what matters to the patients. The Committee focused on outcome measures – people may receive an appointment within a specified timeframe, but it was important to focus on the outcome of those appointments.

12.9 The Committee receives a Clinical presentation at every meeting. These presentations take time out to look at those areas of the Trust and specific services that were performing well, but more importantly also focussed on areas requiring more attention.

12.10 Maria Bond closed her presentation by expressing her thanks to June Hennell and Josephine Smith for their attendance and participation as Governor observers at the Quality Committee up to April 2021.

12.11 Graham Hewitt said that it was good to hear that the Committee maintained a focus on all services, regardless of KPIs. He also welcomed knowing that the Committee had sought additional assurance on the feedback received from services to help identify areas requiring more focus.

12.12 Graham Hewitt asked whether there had been any key changes in clinical practice due to Covid. John Trevains, Director of Nursing, Therapies and Quality advised that it had been vital to continue quality monitoring processes during Covid and noted that only 1 Quality Committee had been cancelled during the year. The increased use of virtual appointments and consultations had been great, however, consideration about the increased risks around safeguarding needed to be managed, for example health visiting services where it was not possible to fully see or assess the home environment. It was noted that health visiting and children's services teams were using a mix of appointment types to limit this risk, but these were important considerations when looking at the use of digital going forwards. The Trust's digital appointments platform "Attend Anywhere" did enable instant feedback from patients which had been a helpful development. The Trust would be introducing associated quality measures alongside any new clinical practice.

12.13 Chris Witham thanked Maria for her presentation which had been informative and had offered good assurance around blind spots and the level of scrutiny. He said that the Quality Committee could often receive some excellent "good news stories" and asked whether there were any links through to the Trust's Communications Team to publicise these. Maria Bond advised that there was a section at the end of the agenda which acted as a checklist for referring items to other committees, Governors or the Trust Board and agreed that it would be helpful to include a referral to Communications. The Trust did need to get better at recognising and celebrating the good news stories. **ACTION**

## 13. STAFF SURVEY RESULTS 2020

13.1 Neil Savage, Director of HR&OD was in attendance to present the key results and findings from the 2020 Staff Survey to the Council.

13.2 This was Gloucestershire Health and Care NHS Foundation Trust's first ever single Staff Survey feedback report, covering data gathered from colleagues during Quarter 3 of 2020/21. It was important to note that the 2020 Survey came at a time when colleagues, the organisation and the wider NHS was significantly impacted by Covid.

13.3 Neil Savage said that the results presented a performance that the Trust should be proud of given the context of the post-merger period and the pandemic, with many post-merger organisations having historically suffered a notable reduction in staff ratings.

13.4 The Council received the key headlines which included:

- Significantly improved response rate – 46.3%.
- 80% of ratings improved or remained unchanged
- Of the Ten Themes - 7 improved, two were unchanged, and one worsened
- Highest improvement rating is an 11% increase (colleagues reporting that they do not "come to work when feeling unwell in the last 3 months"), with a number of other statistically significant improvements in the order of 5%, 6%, 7%, 8% and 10%
- 10% improvement on colleagues agreeing the Trust takes positive action on Health and Well-being
- Colleagues agreeing senior managers act on staff feedback is up 8%
- 71% of colleagues would recommend the Trust as a place to work
- 79.5% of colleagues would recommend the Trust to provide care
- Largest reduced rating is 'During the last 12 months have you felt unwell as a result of work-related stress?' which is up by 3%
- All the other reduced scores are in the low 1-2% reduced rating range
- The highest % of improved scores/stayed the same are in the line manager and health and wellbeing sections
- The highest % of the reduced scores are in the Your Job section

13.5 It was noted that the survey results had been discussed widely throughout the Trust and the draft staff survey results action plan had been developed and presented to the Executive Team. A dedicated session for Board members to review and discuss the Staff Survey results would be taking place later in the month.

13.6 Ruth McShane noted that the response rate from Gloucestershire CCG had been very high and asked whether the Trust had discussed the reasons for this for potential learning. Neil Savage informed the Council that this was the first year that the CCG had taken part in the staff survey. They had far fewer members of staff and these were largely office based. However, he said that GHC was considering a hybrid survey for future years, with colleagues having the ability to complete the survey online or via a paper copy as it was acknowledged that front line clinical staff did not spend as much time at their computers as office-based colleagues.

13.7 Given the limited time available at the meeting, it was suggested that a small working group meeting would be helpful for Governors to discuss the results in more detail. This was supported and a date would be sought and circulated. **ACTION**

## 14. CHANGE TO TRUST CONSTITUTION

14.1 As part of the recent Review and Refresh work, the Council of Governors supported the proposals around changes to the composition of the Council, in

particular with regard to the reduction in Staff Governor positions. The revised composition and subsequent change to the constitution was approved at the November Council of Governors meeting.

14.2 The Medical, Dental and Nursing staff constituency reduced from 4 posts to 3 and this took effect from 1 January 2021. There is a provision within our constitution which states that of the 3 seats within the Medical, Dental & Nursing staff class – 1 must be reserved for a nurse, 1 for a doctor and 1 for a doctor or dentist. This specific provision about reserved seats was not updated at the time to accurately reflect the revised composition and meant that the Trust could only ever have 1 nurse representative on the Council. A small amendment to the constitution was therefore suggested, to ensure that one of the 3 seats was open to all staff within that constituency to apply.

14.3 Mervyn Dawe advised that the Nominations and Remuneration Committee had received this report at their previous meeting on 28 April and had supported this revision, for onward presentation to the Council for approval.

14.4 The Council approved the revision to the Constitution and noted that the equivalent paper to this one would also be considered by the Trust Board at its meeting on 27 May 2021.

## 15. COUNCIL OF GOVERNOR ANNUAL WORK PLAN

15.1 The Council received and noted the annual work plan for the Council of Governors, which was presented to the Council for information.

## 16. GOVERNOR ANNUAL DECLARATIONS

16.1 The Council of Governors received and noted the 2020/21 Annual Governor declarations, for information and record. This included declarations of interest, Fit and Proper Person Test and confirmation of compliance with the Governors Code of Conduct.

## 17. PROVIDER LICENCE DECLARATIONS

17.1 The provider licence requires the Board to make a series of annual declarations to confirm the Trust's compliance with the licence conditions, and also to confirm that the Trust has and intends to keep in place systems and processes to implement appropriate standards of corporate governance. The individual declarations comprise:

- Corporate Governance Statement
- Governor Training declaration
- Systems for Compliance with Licence Conditions declaration

17.2 The Board must sign off its self-certification on systems for compliance with the licence by 31 May and must publish this declaration by 30 June. In addition, the Board makes these declarations 'having regard to the views of Governors'. The Council of Governors should express its views in the context of its statutory duty to hold the Non-Executive Directors to account for the performance of the Board,

therefore basing its views on the robustness of the Board's own assurance process in coming to a decision.

17.3 This report sought to provide evidence of that assurance process to Governors and Governors were invited to comment on the declaration process to allow the Board to take account of Governors' views when making these declarations.

17.4 The Council of Governors received this report and supported the submission of the declarations, as set out.

## 18. APPOINTMENT OF EXTERNAL AUDITORS - TIMELINE

18.1 Sandra Betney, Director of Finance was in attendance to present the Governors with the background and proposed timeline for the appointment of the Trust's external auditors.

18.2 KPMG were appointed as the Trust's external auditor by the 2gether Council of Governors. The contract from 1 April 2017 covered three audits and two extension options were enacted. The current contract ends on 31 March 2022 (covering the 2021/22 audit of accounts).

18.3 The Council of Governors will work with the Director of Finance and members of the Audit and Assurance Committee to undertake the appointment process, with the final decision on the appointment being made by the Council of Governors.

18.4 Sandra Betney advised that it is good practice to go through a process for the appointment of the external auditor every 3-5 years. This is usually a competitive process which includes seeking quotes from interested audit firms, assessing the quality of the work that they will perform and agreeing the price they will charge for delivering the services. It was noted that although the Auditors would start from 1st April 2022 the Trust would need to allow time for handover from the current auditors.

18.5 The proposed timeline was presented to the Council:

- Agree specification - July 2021
- Market Exploration - October 2021
- Decision to tender - November 2021 (Council)
- Issue Tender - December 2021
- Evaluation - January 2022
- Decision plus stand still - February 2022
- Contract commences - 1st April 2022

18.6 The Council discussed some of the current market considerations, noting the lack of external auditor firms available. This was recognised nationally. Sandra Betney advised that the barrier to entry into the market was very high for local firms, who simply did not have the resources to go through tender processes.

18.7 Mervyn Dawe noted that he had participated in the previous appointment and provided assurance to the Council that this had been a very thorough process.

18.8 The Council noted the content of the presentation, and the proposed timeline. The next report scheduled for the Council of Governors would be in November when the decision would be made whether or not to tender for the services. In the meantime, Governors were encouraged to contact Sandra Betney directly with any further questions or queries.

## 19. GOVERNOR ACTIVITY UPDATES

19.1 Governors provided verbal updates on their activities over the past months.

19.2 Ruth McShane said that she had recently met with the Greater England Governor at Gloucestershire Hospital's Trust which had been a very helpful networking opportunity.

19.3 Chris Witham advised that he had had an excellent meeting with Annie Nightingale in the Trust's Communications Team around digital services and accessibility. He had also asked the Director of HR&OD about EU Settled Status and said that the response received demonstrated some exemplary practice within GHC.

## 20. ANY OTHER BUSINESS

20.1 June Hennell reported on problems people were experiencing accessing services. She asked whether the Trust ensured that GPs were up to date with the services available and understood the current position with waiting lists as there was a concern that GPs were not referring people as they thought there were long wait times. Ingrid Barker advised that the CCG were the leads for Primary Care (GPs) but this was a very important issue and it was therefore vital to ensure that these comments were fed back to them. **ACTION**

## 21. DATE OF NEXT MEETING

21.1 The next meeting would take place on Wednesday, 14 July 2021 at 5.00pm.

**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 | **ID badges**<br>**Complete**<br>Now printed and awaiting distribution.<br><br>**Email addresses**<br>**Progressing**<br>Approval now received for the setting up of GHC email addresses for Public Governors. New user forms to be completed. |
| 12.13 | Section at the end of Quality Committee agendas to be included for referring items to the Communications Team for onward publicising | Anna Hilditch | **Complete** |
| 13.7 | A small working group meeting would be set up for Governors to discuss the results of the Staff Survey in more detail with the Director of HR&OD | Anna Hilditch | **Complete**<br>Session took place on 9 June |
| 20.1 | Concerns raised about people accessing services and communication with GPs to be referred to colleagues at the CCG | | **Complete**<br>Concerns raised with Director of Primary Care and Locality Development for consideration |

**AGENDA ITEM: 20/**0721

# AUDIT AND ASSURANCE COMMITTEE SUMMARY REPORT

## DATE OF MEETING 26 May 2021

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| **COMMITTEE GOVERNANCE** | • Committee Chair – Marcia Gallagher, Non-Executive Director<br>• Attendance (membership) – 100%<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### INTERNAL AUDIT ANNUAL REPORT 2020/21 DRAFT

The Committee **received** the final draft Internal Audit Report for 2020/21 which provided a summary of the work undertaken by Internal Audit and included the Head of Internal Audit opinion for the year.

The Head of Internal Audit opinion received was; *Generally satisfactorily with some improvements required.*

### FINAL ACCOUNTS AND CERTIFICATES

The Committee received the Final Accounts and Certificates for 2020/2021 for Gloucestershire Health and Care NHS Foundation Trust. The Director of Finance confirmed that there had been no significant changes to the accounts since their consideration at the last meeting of the Committee. It was noted that there may be some minor amendments as the audit was finalised.

The Committee **approved** the 2020/2021 Annual Accounts for Gloucestershire Health and Care NHS Foundation Trust on behalf of the Board. The Committee **approved** the signing of:

- The Statutory Accounts (including the statement of financial position and foreword to the accounts).
- TAC Summarisation Schedule Certificate (NHS Improvement's Accounts) (TACs)
- Letter of Representation.

The Committee formally thanked Sandra Betney and the Finance Team for their work in producing the Accounts and for a successful outcome.

### ANNUAL REPORT 2020/21

The Committee received the Annual Report 2020/21 for Gloucestershire Health and Care NHS Foundation Trust. All comments received at the previous meeting had been considered and incorporated within the report. It had been subject to External Audit and no issues remained outstanding from this process.

Following consideration, the Committee:

- **Approved** the signing off of the Report and Accounts by the Chief Executive and Finance Director
- **Approved** the submission of the Report and Accounts to NHSE/I
- **Approved** the Annual Report and Accounts to be submitted to be laid before parliament

### EXTERNAL AUDIT REVIEW OF THE ANNUAL REPORT AND ACCOUNTS 2019/20

The Committee received the External Audit year-end report for 2020/2021. The External Auditors presented their report, and confirmed that their provisional audit conclusion was an unqualified audit opinion. It was reported that no uncorrected audit misstatements had been identified.

The External Auditors thanked the Finance Team for their assistance during the audit acknowledging the challenges introduced by Covid-19 and continuing to work from two finance ledgers. The new finance system would introduce efficiency in the process and support greater team working.

The Committee **noted** the report.

**EXTERNAL AUDIT – VALUE FOR MONEY RISK ASSESSMENT 20219/20**

The Committee received the Value for Money (VFM) Risk Assessment for 2020/21, providing the outcomes of the External Audit value for money risk assessment procedures under the new VFM responsibilities for 2020/21. It was reported no significant risks had been identified and a clean audit opinion was given.

The Committee **noted** the report.

**OTHER ITEMS RECEIVED BY THE COMMITTEE**

The Committee **considered** the evidence presented in the Considerations prior to the approvals of the Accounts and Risk of Material Misstatements report and declared it was satisfied with the reliability of the Annual Accounts and the Letter of Representation.

The Committee **considered** the Committee's Annual report 2020/21 and **endorsed** it for presentation to the Trust Board subject to minor amendments.

The Committee **commented** on the Internal Audit Plan and **approved** the plan of work for 2021/22.

**ACTIONS REQUIRED BY THE BOARD**

The Board is asked to:

- **Note** the contents of this summary.

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| **DATE OF NEXT MEETING** | 12 August 2021 |

**AGENDA ITEM: 22/**0721

# CHARITABLE FUNDS COMMITTEE SUMMARY REPORT

## DATE OF MEETING 9 June 2021

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| **COMMITTEE GOVERNANCE** | • Committee Chair – Sumita Hutchison, Non-Executive Director<br>• Attendance (membership) – 66%<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### FINANCE REPORT

The Committee received the Finance Report for the Trust's charities which reported the funds balance at 31st March 2021 had increased from £284k to £406k, an increase of £122k.
The Committee was informed that the increase in funding was largely due to funds received from NHS Charities Together and reported a total of £169k had been received to date from the charity.
The Committee **noted** the report.

### BIDS AND UPDATES ON PROGRESING BIDS

The Committee received the report on Bids and Updates on Progressing Bids which provided an overview of the bids which had been completed and were in progress for the Trust as of 31st March 2021.

The Committee **reviewed** the current position of the funds and **noted** the overspend on the NHS Charities Fund.

### MONTPELLIER ALLOTMENT PROPOSALS

The Committee **noted** the current request for funding from the South West Provider Collaborative and that a decision was yet to be received regarding this. The Committee would be updated in due course.

### VOLUNTEER SERVICE SUPPORT

The Committee received the charitable funding bid to support the Volunteer Service and the Director of HR and OD informed the Committee the bid sought to support the Volunteer Services across the Trust for 2021/2022 by providing catering and travel expenses; covid testing and full uniform. The bid totaled £13,000.

The Committee was informed the Volunteer Services had in the past been funded through Charitable Funds. It was reported that discussions were taking place with the Director of Finance and Chief Executive Officer about whether this could be funded from core funding going forward. This would need to be considered further and a decision made by the Trust Board.
The Committee agreed to ring fence £13k funding, given how important volunteering is to the Trust, allocating 50% of the required funding now to enable certainty to the service and allow work to progress. A paper on the future funding arrangements for the volunteer services would be prepared for consideration at a forthcoming meeting of the Trust Board by the HR Director.

### NHS CHARITIES TOGETHER

The Committee received the NHS Charities Together report which provided the Committee with an overview of the expenditure against the grant funds the Trust had received from the NHS Charities Together in response to the Covid-19 pandemic. This funding had mainly been used to support Health and Well Being initiatives in the Trust. The Committee was informed that detailed Pulse Surveys would be run from July which would provide feedback on the impact of the health and wellbeing offer funded

by charitable funds as there would be a specific questions on this. A further discussion would take with the Executive Team and Board regarding ongoing funding for staff health and wellbeing.

The Committee **noted** the ongoing expenditure and progress against the NHS Charities Together allocations.

**DEVELOPING A CHARITABLE FUNDS STRATEGY – PROGRESS REPORT**

The Committee received an update on Developing a Charitable Funds Strategy for the Trust and the proposed next steps in developing a future direction for Charitable Funds activities. The Committee endorsed the proposal to seek external support for developing the strategy.

**OTHER ITEMS RECEIVED BY THE COMMITEE**

- The Committee **received** the Log of Approvals made Outside of the Committee.
- The Committee **received** a verbal update on Brockenborough.
- The Committee **received** and **noted** the League of Friends update.

**ACTIONS REQUIRED BY THE BOARD**

The Board is asked to:

- **Note** the contents of this summary.
- **Discuss** the funding of the Volunteer Service Support.

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| **DATE OF NEXT MEETING** | 10 September 2021 |

# RESOURCES COMMITTEE SUMMARY REPORT

## DATE OF MEETING 24 June 2021

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| **COMMITTEE GOVERNANCE** | • Committee Chair – Graham Russell, Non-Executive Director<br>• Attendance (membership) – 100%<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### FINANCE REPORT – MONTH 2

The Committee received the Finance Report for month 2 which provided an update on the Trust's financial position. The Director of Finance highlighted the Trust was only managing to the H1 plan (Gloucestershire ICS had been given an overall H1 funding envelope that it collectively would have to manage for the first six months of 21/22). The H2 position had not yet been agreed for the Trust or the System.

The Committee noted that the capital expenditure to date was running behind plan. This was due to a number of factors which included asbestos issues and prolonged tenders amongst other works. The Committee was assured this was being closely monitored.

The Director of Finance informed the Committee of an issue which had been discussed at the Capital Management Group [the previous day] concerning emerging pressures on the capital programme. The pressures were due to a delay in supplies and also a delay to works starting as an impact of difficulties in obtaining materials. It was reported an increase in price of up to 80% for some items which were required in building works. i.e. steel and concrete. This was recognised as a national position and it was unknown when or if the prices would reduce.

The Committee was informed that discussions had been held in regards to three of the Trust schemes which were underway; in which the materials had not yet been fully purchased. The three schemes affected were:

- Montpellier scheme
- Wotton Lawn ligature work (concerning windows and doors)
- Southgate Moorings scheme

The Committee noted it was likely to see the impact across the whole of the capital programme.
The Committee noted schemes and projects were being re-prioritised to ensure delivery of pressures.

### PERFORMANCE REPORT – MONTH 2

The Committee received the Performance Report for month 2 which provided a high-level view of the key performance indicators in exception across the Trust. It was reported that there were no new indicators which had not been seen in the previous 12 months. There were 9 indicators in exception for Mental Health and Learning Disability Services and 10 indicators in exception in Physical Community Health Services.

It was highlighted that the Trust wide indictor for sickness absence was compliant in the month of May, performing at 3.94% against the 4% target. This was the first time that GHC as a merged Trust had achieved this target which was excellent news.

The Committee **noted** the aligned Performance Dashboard Report for May 2021/22.
The Committee **acknowledged** the ongoing impact of the pandemic on operational performance.

The Committee **noted** the report as a **significant level of assurance** that our contract and regulatory performance measures are being met or that appropriate service recovery action plans are being developed to address areas requiring improvement - in line with the pandemic response & operational planning.

## SARC AND SOE TENDER PARTNERSHIP APPROACH

The Committee received the SARC (Sexual Assault and Referral Centre) and SOE (Sexual Offences Examiner) tender. The Trust had responded to the tender and discussions would soon commence regarding the partnership approach. The Committee supported the tender process, noting that this presented a good partnership approach.

## 2020 STAFF SURVEY PROGRESS UPDATE AND PULSE SURVEY RESULT SUMMARY

The Committee received the 2020 Staff Survey Progress update and Pulse Survey Result Summary. The report showed an increase of 3.1% of staff feeling overworked or that their workload was too high. This indicated staff were feeling fatigued. It was also highlighted that 29.3% of staff supported more frequent team huddles and virtual check-ins. This was an increase of 11.4% from the previous wave.

The Committee **noted** the progress with taking forward the Staff Survey action plan.
The Committee **noted** the results of the most recent Staff PULSE survey on health and well-being and that the Health and Wellbeing Hub were considering the next actions to take forward with Executive and Communications support.
The Committee was **assured** that the Trust was continuing to engage with colleagues and progress actions identified as an output of the 2020 Staff Survey results.

## OTHER ITEMS RECEIVED BY THE COMMITTEE

The Committee **noted** the final Our People Strategy and **noted** the launch plan.
The Committee **noted** and **commented** on the draft Estates Strategy.
The Committee **noted** the Working Well – Occupational Health Annual Assurance Report.

## 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.

## ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.
- **Note** the Chair's Action taken outside of the meeting to approve the submission of the Premises Assurance Model Assessment

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| **DATE OF NEXT MEETING** | 26 August 2021 |

**AGENDA ITEM: 24/**0721

# QUALITY COMMITTEE SUMMARY REPORT

## DATE OF MEETING 01 July 2021

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| **COMMITTEE GOVERNANCE** | • Committee Chair – Maria Bond, Non-Executive Director<br>• Attendance (membership) – 71%<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### QUALITY DASHBOARD REPORT

The Committee received the Quality Dashboard and was informed that there had been an increase from 7% to 9% of "moderate" and upwards safety issues. The issues related to Wotton Lawn and it was noted that some issues had been retrospectively reported as part of the covid system.
The Committee was assured that there had been no new inpatient Covid deaths or inpatient Covid cases.
The Director of Nursing, Therapies and Quality reported that there had been 2 cases of Clostridium Difficile Infections (C Diff) and it was noted the safety thermometer data remained paused.
It was reported the Trust had been successful in recruiting the first District Nursing direct entry international recruit and the Trust would be the first Trust within the Pilot sites to achieve this. The Committee also noted that 32 RGNs had now been appointed which was excellent news.
In response to concern raised relating to the significant surge in demand for inpatient beds (in the month of May) with increased levels of patient acuity and dependency which had resulted in a shortage of bed availability; the Director of Nursing, Therapies and Quality assured the Committee he was leading the task and finish group, which would be looking to develop the admission and discharge pathways to ensure these were running smoothly, and working with partner organisations to look at the processes in place. Community processes and delays to hospital transportation were also being reviewed. The Committee agreed the Trust Board should be sighted on this issue.

The Committee **received, noted** and **discussed** the May 2021 Quality Dashboard.

### CLINICAL INCIDENTS AND ALERTS

The Committee received the Clinical Incidents and Alerts report and was asked to note
the increase in incidents reported specifically relating to inpatient care at Wotton Lawn and the Director of Nursing, Therapies and Quality provided assurance that all Trust incidents were reviewed by the Safety team.
The Committee was informed that two incidents had occurred of patients having positive MRSA results on Coln Ward, Cirencester Hospital. One patient was not able to be determined if they had contracted MRSA whilst out of the ward, therefore an investigation was not required. The other positive patient had not had swabs taken on admission and therefore could also not be determined if contracted on the ward. The Committee was informed learning was identified reminding staff to take MRSA swabs upon admission.
The Committee was informed of the occurrence of a sudden unexpected death of a 68-year-old inpatient detained under the Mental Health Act on Greyfriars PICU. The incident was not declared as a SIRI due to awaiting the Cause of Death from HMCO. It was reported the decision would be reconsidered if the post-mortem notes issues of significance. At this point, further investigation will be passed to colleagues in Mortality Review to feed into LeDeR.

The Committee **noted**:
The actions taken in respect of clinical incidents reported and escalated for investigation
The learning and change made following a clinical incident.

The clinical alert received by the trust and actions outstanding.

## LEARNING FROM DEATHS

The Committee received the Learning from Deaths – quarter 4 report which provided information about the mortality review process and outcomes found during 2020/21.

It was 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

The Committee was informed 42 case record mortality reviews and 14 comprehensive investigations had been carried out (by 8 April 2021) in relation to the 829 deaths. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 16 in the first quarter
- 21 in the second quarter
- 14 in the third quarter
- 5 in the fourth quarter

The Medical Director assured the Committee that at the time of the report being written (30 April 2021) none of the deaths were judged likely to have been due to problems in the care provided by the Trust.
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. The Medical Director thanked John Trevains, Director of Nursing, Therapies and Quality for the support that he provided to both families during the investigation and praised his vast levels of compassion and understanding.

The Committee **noted** the contents of the Learning from Deaths Report covering 2020/21.

## OTHER ITEMS RECEIVED BY THE COMMITTEE

- A Volunteer Patient Experience Representative presentation was **received** by the Committee.
- The Committee **received** the Patient safety and Experience Report.
- The Committee **received** a verbal update on Medical Staffing.
- The Committee **noted** the contents of the Quality Assurance Group Summary Report.
- The Committee **received** and **discussed** the Quality Strategy and noted it would be received by the Trust Board on 29 July, and would then be formatted and finalised by the Communications Team.

## ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.
- **Note** the issue raised relating to the significant surge in demand for inpatient beds

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| **DATE OF NEXT MEETING** | 02 September 2021 |

**AGENDA ITEM: 25/**0721

# MENTAL HEALTH LEGISLATION SCRUTINY COMMITTEE SUMMARY REPORT

## DATE OF MEETING 21 July 2021

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| **COMMITTEE GOVERNANCE** | • Committee Chair – Jan Marriott, Non-Executive Director<br>• Quorate – Yes |

## KEY POINTS TO DRAW TO THE BOARD'S ATTENTION

### UPDATE ON THE CONSULTATION ON REFORMS TO THE MHA WHITE PAPER

The Government had now published its response to the Consultation on Reforms to the MHA. The Trust submitted its response to the consultation, incorporating comments and feedback received at the April Committee meeting. It was noted that a Task and Finish Group would be established to look in more detail at how the reforms would be implemented and to carry out a scoping exercise of the key workstreams including legislative and procedural changes, care planning and workforce. The Task and Finish Group will have to identify the considerable additional resources required in order to implement the recommended changes in response to the reforms of the MHA; in particular the changes to tribunals but balanced against the planned increase in resources to provide better 24/7 community support for people which may reduce the need for inpatient beds by preventing/and or better supporting people in crisis.

There was no certainty yet about the future of the Mental Health Act Managers but the Committee recognised that it would not wish to lose the skills the group have if the White Paper dissolves the role in favour of only Tribunals.

Following discussion, it was agreed the Committee would receive presentations on the new Complex Needs (predominantly personality disorders) Service pilot and Transforming Community MH Services. The presentations would be received at the next MHLS Committee meeting 20th October.

The Committee agreed that there was a need to have senior operational representation at its meetings and the Chief Operating Officer (or a senior level deputy) would be asked to attend all future MHLS Committee meetings. The Chair of the Interagency Monitoring Group would also be invited to attend future meetings.

### MHA ACTIVITY 2012 – 21

The Committee received the MHA Activity report which provided information on MHA Activity and trends from 2012 – 2021.

It was reported that the predominant themes confirmed within the report had previously been considered by the Committee; The themes were as follows:

- an upwards trend in the use of some sections of the MHA, especially sections 2 and 3
- an upwards trend of direct admissions on section, with a corresponding downwards trend of detentions after informal admission
- disproportionately higher use of the MHA with people of ethnic minority background, including CTOs.

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

## AMHP UPDATE

The Committee was informed of the increasing pressure and demand for inpatient beds locally and nationally, both in terms of the number of people being admitted on section and the acuity of patients. The increase in referrals received between midnight and 8am was highlighted. This showed an increase from the 28 (Quarter 1 2020/21) to 57 (Quarter 1 2021/22). The Committee was informed that the increase would continue to be monitored, along with the impact on colleagues – particularly AMHPs and Crisis teams who were having to carry significant risks as a result of there being no beds available. It was suggested that this might be a key risk to refer to the Risk Register. The committee felt that it was vital that messages from the Board and senior leadership team are routinely shared with colleagues re-enforcing that the potential risks faced due to the service pressures are shared and owned collectively.

It was suggested that many of the referrals received between the hours of midnight – 8am were due to a person being in distress but were not necessarily mental health related. It was agreed that this would be analysed further, and an update provided back at the next MHLS Committee meeting. The Committee also asked that further consideration be given to how the lack of inpatient beds could potentially influence and impact the choices of the mental health assessments carried out.

## OTHER ITEMS RECEIVED BY THE COMMITTEE

- The Committee received the SCT Concerns of Family policy
- The Committee received the Audit of timings of Hearings.
- The Committee received and noted the review of DOLs Applications

## ACTIONS REQUIRED BY THE BOARD

The Board is asked to:

- **Note** the contents of this summary.

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| **DATE OF NEXT MEETING** | 20 October 2021 |