Public Council of Governors

Wed 19 January 2022, 17:00 - 18:30

Agenda

17:00 - 17:00
0 min

AGENDA

00 - AGENDA - January 2022 - Public Council of Governors V1.pdf (1 pages)

17:00 - 17:00
0 min

1. Declarations of Interest

Peter Lachecki

17:00 - 17:00
0 min

2. Minutes of the Previous Meeting

Peter Lachecki

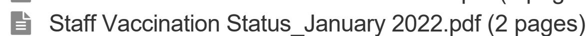
02 - December 2021 - CoG Public Minutes.pdf (6 pages)

17:00 - 17:00
0 min

3. Matters Arising

Peter Lachecki

03 - MATTERS ARISING - COG - Public.pdf (1 pages)


Staff Vaccination Status_January 2022.pdf (2 pages)

17:00 - 17:00
0 min

4. Chair's Update

Peter Lachecki

17:00 - 17:00
0 min

5. Report of the Chief Executive

Deborah Lee

05 - CEO CoG Report_January 2022.pdf (4 pages)

17:00 - 17:00
0 min

6. Youth Engagement Update

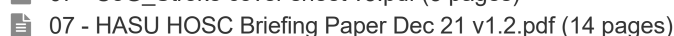
Deborah Lee

17:00 - 17:00
0 min

7. Hyper Acute Stroke Unit (HASU)

Deborah Lee

07 - CoG_Stroke cover sheet v3.pdf (3 pages)


07 - HASU HOSC Briefing Paper Dec 21 v1.2.pdf (14 pages)

17:00 - 17:00
0 min

8. Chairs' Reports from:

8.1. People and Organisational Development Committee

Balvinder Heran

8.1_Chairs report December PODC.pdf (5 pages)

8.2. Finance and Digital Committee

Robert Graves

8.3_Chairs Report F&D_December 2021.pdf (4 pages)

8.3. Quality and Performance Committee

Alison Moon

8.2_Chairs Report QandP_December 2021.pdf (5 pages)

17:00 - 17:00
0 min

9. Governor's Log

Lisa Evans

9.1 - Governors Log Cover Sheet v2.pdf (2 pages)

9.2 - Governors' Log.pdf (1 pages)

17:00 - 17:00
0 min

10. Any Other Business

Peter Lachecki

NHS
Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC AGENDA

Meeting: Council of Governors - Public

Date/Time: Wednesday 19 January 2022 at 17.00

Location: Teams

	Agenda Item	Lead	Purpose	Time	Paper
	Welcome and Apologies	Chair		17.00	
1.	Declarations of Interest	Chair			
	ITEMS FOR DISCUSSION				
2.	Minutes of the Previous Meeting	Chair	Approval		YES
3.	Matters Arising	Chair			
4.	Chair's Update	Chair	Information	17.05	
5.	Report of the Chief Executive	Deborah Lee	Information	17.10	YES
6.	Youth Engagement Update	Deborah Lee	Information	17.25	
7.	Hyper Acute Stroke Unit (HASU)	Deborah Lee	Information	17.40	YES
	REPORTS FROM BOARD COMMITTEES				
8.	Chairs' Reports from: • People & Organisational Development Committee • Finance and Digital Committee • Quality & Performance Committee	 Balvinder Heran Rob Graves Alison Moon	Assurance	17.55	YES
	OTHER ITEMS				
9.	Governor's Log	Lisa Evans	Information	18.25	YES
10.	Any Other Business	Chair			
CLOSE				18.30	

Date of the next meeting: Wednesday 16 March 2022 at 14.30.

DRAFT MINUTES OF THE COUNCIL OF GOVERNORS HELD VIA MICROSOFT TEAMS ON WEDNESDAY 15 DECEMBER 2021 AT 14:00

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

PRESENT:		
Peter Lachecki	PL	Trust Chair (*until item 040/21*)
Alan Thomas	AT	Public Governor, Cheltenham (Lead) *(from 050/21)*
Liz Berragan	LB	Public Governor, Gloucester
Matt Babbage	MB	Appointed Governor, Gloucestershire County Council
Hilary Bowen	HB	Public Governor, Forest of Dean
Geoff Cave	GCa	Public Governor, Tewkesbury
Carolyne Claydon	CC	Staff Governor, Other and Non-Clinical
Graham Coughlin	GCo	Public Governor, Gloucester (from 050/21)
Anne Davies	AD	Public Governor, Cotswold
Mike Ellis	ME	Public Governor, Cheltenham
Colin Greaves	CG	Appointed Governor, Clinical Commissioning Group
Andrea Holder	AH	Public Governor, Tewkesbury
Pat Le Rolland	PLR	Appointed Governor, Age UK Gloucestershire
Sarah Mather	SM	Staff Governor, Nursing and Midwifery
Maggie Powell	MPo	Appointed Governor, Healthwatch
IN ATTENDANCE:		
Lisa Evans	LE	Assistant Trust Secretary
Claire Feehily	CF	Non-Executive Director
Rob Graves	RG	Non-Executive Director
Sim Foreman	SF	Trust Secretary
Balvinder Heran	BH	Non-Executive Director
Deborah Lee	DL	Chief Executive Officer
Rebecca Pritchard	RP	Associate Non-Executive Director
Roy Shubhabrata	RS	Associate Non-Executive Director (from 050/21)
Elaine Warwicker	EWa	Non-Executive Director
APOLOGIES:		
Russell Peek	RPe	Staff Governor, Medical and Dental
Julia Preston	JP	Staff Governor, Nursing and Midwifery
Nick Price	NP	Public Governor, Out of County

045/21 – DECLARATIONS OF INTEREST

There were no declarations of interest

046/21 – MINUTES FROM THE PREVIOUS MEETING

RESOLVED: Minutes APPROVED as an accurate record.

047/21 – MATTERS ARISING

RESOLVED: The Council APPROVED the closed items.

048/21 – CHAIR'S UPDATE

The Chair reported that the January meetings of the Board and Council of Governors would again be held virtually. It was likely that February would be the same. He also reported that this was SF's last meeting of the Council of Governors and thanked him for all that he had done on behalf of the Council and wished him all the best for the future.

RESOLVED: The Council NOTED the update.

049/21 – REPORT OF THE CHIEF EXECUTIVE

DL provided an update report for the Council which was taken as read. Operationally, little had changed since last month's report and the Trust remained extremely busy with activity in Urgent and Emergency Care (UEC) more redolent of peak winter months. The Governors noted that issues around COVID remained emergent with the new variant being found to be highly transmissible and cases doubling in under two days. The impact on individuals with regard to serious illness was still to be understood and the need for people to get vaccinated and boosted was noted.

DL reported a letter had been received from the Government imploring the whole system to work together with the aim of reducing the number of patients whose discharge was delayed by 50%, before Christmas. The positive approach from social care was noted and staff were working hard to ensure discharges into the community by Christmas Eve.

It was noted that the Care Quality Commission (CQC) had ceased inspection activities for the time being. However, the Gloucestershire UEC system had been inspected recently as part of a pilot. DL reported that the visit was welcomed and positive. The Trust was waiting for the full formal report, however the formal letter had been received which mirrored feedback at the visit; positive feedback from patients and families was noted and the new patient experience role was welcomed by the inspectors. There were some areas of the physical environment which needed to be addressed, these were not easy to resolve and inspectors had noted that the Trust was doing the best it could in the circumstances. The Chair was encouraged by the way that DL and Executives had embraced the visit.

An excellent event had been held to launch the Mental Health Strategy, DWC listening events had now concluded and DL had met with Worcester University on the Trust's ambition to achieve University Hospital status. Governors noted that additional capital and non-recurrent revenue had been made available to the regions and the Gloucestershire system had now received confirmation that all bids were successful. The Council noted that around £1million of requests were submitted.

The Governors noted the recent media coverage of the challenges facing colleagues working in our hospitals, and particularly those working in the emergency departments. DL had addressed all staff in her weekly staff update.

There had been a good discussion at the recent Governance and Nominations Committee (GNC) on how the Trust could get young people involved with the Council of Governors. DL was meeting with the youth ambassadors the following day to discuss a way forward and formal changes would be worked through.

The Governors raised a number of questions and SM noted that a media report had found that discharges were being delayed due to a lack of the required equipment. DL reported that the County Council who commissioned the service in question had responded and were addressing the issues raised.

RESOLVED: The Council NOTED the report.

050/21 – GREEN PLAN

DL presented the Green Plan which outlined three objectives; Healthy Environment, Health For All and Embedding Sustainability. The plan had three targets:

- Meet the NHS targets - NHS Net Zero Carbon Footprint of 80% reduction by 2032 and net zero by 2040. NHS Net Zero Carbon Footprint Plus by 2045
- Develop sustainable care models and use digital technologies to benefit our patients with 50% of our follow-up OPD appointments to be virtual by 2025
- Be recognised as a leader in sustainable healthcare and climate change action

DL reported that Gloucestershire Managed Services (GMS) was fully supportive of these aims and the Green Plan was issued as a joint document between both organisations. £13m of external funding had already been secured through the Salix Fund and another £7m had been bid for which would improve the energy efficiency of the Tower Block, along with the aesthetics of the building, through a comprehensive window replacement programme. DL said the goal was to use the period of inevitable disruption to also upgrade bathroom facilities in the Tower Wards. EWa reported that the plan pulled together all the work taking place across the Trust and added that comments were welcome.

SM asked if there were challenges in getting staff on board, particularly with regard to parking. DL advised that the Trust was trying to ease the burden of parking on site for those who have no option; there were currently 2000 parking spaces across the Trust and 7000 permits, not all those with permits would retain them which would cause disquiet but it was the right approach in her view.

RESOLVED: The Council NOTED the update.

051/21 – CHAIRS' REPORTS

The Chair reported that the GNC had discussed Board Committee Chair's reports the previous evening as part of the governor self-assessment feedback and it was agreed that less time would be given to presentation of the updates, to allow more time for Governor questions in order to hold NEDs to account

People and Organisational Development (OD) Committee (PODC)
BH presented the report from the October 2021 meeting. The Committee received the Staffing Resources report which highlighted issues of concern around agency

spend and hard to recruit posts were discussed. PODC was pleased to note that the Trust was well below the average for time to hire. A presentation was received from medical staffing which noted a 60% expansion of the post graduate medical education programme. There had been good success for getting trainees into vacancies and retaining these staff.

AT asked about staff vaccination levels and DL reported that there was a large number (c10%) who our records indicated were still unvaccinated; one to one conversations were being expedited in light of the looming 31st March deadline for mandatory vaccination. GC asked if refusal was spread across departments; DL advised that figures were broken down by discipline and team with vaccine "hesitancy" seen in all areas but geography had also been identified as an issue. It was AGREED that BH would provide a breakdown of unvaccinated staffing data in her next report. **ACTION BH.**

AT noted resource issues around the Datix upgrade. BH reported that she was assured that discussions were underway and support was in place; regular meetings were taking place to address any concerns around using an out of date system. PLR noted the increase in violence and aggression incidents and asked if PODC was assured that everything was being done to protect staff. BH was assured that actions were in hand and controls were in place.

Finance and Digital Committee

RG presented the reports from the October and November 2021 meetings. RG reported that the Trust's Financial Performance was on plan, agency spend had been considered and an update on capital spend was received. There were concerns around delays to some projects, however the Committee was assured that the programme was being well managed by the finance team. The Digital Programme report was received and this was progressing.

GCa asked about any differences in the activity compared to normal times. It was AGREED that a slide from the Elective Recovery Fund (ERF) presentation would be shared with the Council. **ACTION**

AT noted the good assurance around the implementation of NHS Office 365. RG reported that there was concern previously, however MH had provided a new option to move some users to MS Office 2016; this was lower risk and offered some financial benefits.

Audit and Assurance Committee (AAC)

CF presented the report from the November 2021 meeting. CF reported that the meeting had looked at risk management, including an overview of the risk register and a positive internal audit progress report on the quality of risk management. The external audit report from Deloitte was noted and the audit of GMS and the Charity had taken place.

Estates and Facilities Committee (EFC)

RG presented the report from the November 2021 meeting. EFC had received a positive report from the interim Chair of GMS which provided assurance on progress. Capital expenditure was discussed and reasons for delays were noted. It was noted

that the national cleaning standards had been effectively paused due to the new requirements associated with COVID-19, however DL reported that new standards were coming into effect in April from 2022.

AT raised a question around the acquisition of staff accommodation. RG reported that Trust approval would be needed and requirements would be placed on GMS and the Trust. MP asked if EFC had looked at the strategic site development (SSD) and the impact on patients, visitors and staff including issues around signage and communication. RG confirmed that this was within the remit of EFC and it was AGREED that this would be reported to the next meeting. **ACTION MN**

Quality and Performance Committee (QPC)
AM presented the reports from the October and November 2021 meetings. AM reported that the operational context remained highly challenged in all aspects. It was clear to the Committee how much leadership, focus and hard work was employed in trying to keep patients and colleagues safe, with a positive experience in the most difficult of circumstances. There were system issues around emergency care and the sustained high levels of children and young people presenting with deliberate self-harm were noted where the Trust was an outlier and a report was to be brought back to a future Committee.

Charitable Funds Committee (CFC)
EW reported that this was the first time a report of the CFC had been brought to the Council. EW provided an update on fundraising; the Governors noted that although the pandemic had been hard on many charities, NHS charities had generally been favourably impacted, however it was noted that donations were less than expected in October. A CT gamma scanner appeal was currently taking place.

EW reported that the CFC looked for bids which would provide something over and above core provision. During the pandemic the Charity had provided support for colleagues included boost boxes and meals.

CG noted that the CFC gained assurance in areas where there was no data available; he asked how they did this. EW reported that this could be done through opinion or review and discussion of risks. There was a separate Investment Committee which undertook reviews of risks around investments.

It was AGREED that EW would check that the Charity report was provided to the Council of Governors. **ACTION EW**

RESOLVED: The Council NOTED the assurance reports from the Committee Chairs.

052/21 – GOVERNOR ELECTIONS

SF reported that nominations for Governor vacancies had closed the previous Friday. There had been no nominations received for the Forest of Dean constituency, one nomination for AHP – Juliette Sherrington and one nomination for the Stroud vacancy – Jeremy Marchant. Both candidates were elected uncontested.

The Chair noted that Jeremy Marchant had been a Governor of the Trust previously and it would be good to have him back and to welcome Juliette Sherrington. The lack of any candidate in the Forest of Dean was disappointing.

RESOLVED: The Council NOTED the update.

053/21 – GOVERNANCE AND NOMINATIONS COMMITTEE APPOINTMENTS

SF confirmed the results of the election of members to the Governance and Nominations Committee. The following Governors were elected for 2021/22: GC, SM, PLR and MPo.

- **RESOLVED:** The Council NOTED the election of Geoff Cave, Sarah Mather, Pat Le Rolland and Maggie Powell to the GNC for 2021/22.

054/21 – GOVERNOR'S LOG

SF updated on the themes raised via the Governors' Log since the last full Council meeting.

RESOLVED: The Council NOTED the report for information.

055/21 – ANY OTHER BUSINESS

There was no other business for discussion.

DATE AND TIME OF THE NEXT MEETING

The next meeting of the Council of Governors will take place at 14:30 on Wednesday 19 January 2021 via MS Teams

Signed as a true and accurate record:

Chair
19 December 2021

Council of Governors (Public) – Matters Arising – January 2022

Minute	Action	Owner	Target Date	Update	Status
15 December 2021					
051/21a	**People and OD Committee Update** BH would provide a breakdown of unvaccinated staff in her next PODC report.	**BH**	January	Attached	**COMPLETE**
051/21b	**Finance and Digital Committee Update** A slide from the Elective Recovery Fund (ERF) presentation, which set out activity compared to last year, would be shared with the Council.	**SF**	January	Sent by email to all Governors on 22 December	**COMPLETE**
051/21c	**Estates and Facilities Committee Update** An update on the strategic site development (and the impact on patients, visitors and staff including issues around signage and communication would be reported to the next meeting of E&F and to the workstream.	**SL**	January	On the agenda for the E&F meeting taking place on Thursday 27 January	**PENDING**
051/21d	**Charitable Funds Committee** EW to check that the Charity report was provided to the Council of Governors	**EW**	January	Added to the Governor Portal on Admin Control.	**COMPLETE**

Gloucestershire Hospitals
NHS Foundation Trust

GHTs Staff Vaccination Record Status

Vaccination Deployment Statistics - Trustwide by Division

Division	All Staff	1st Dose Only Recorded	No Dose Recorded	Total Non-compliant	Total Non-compliant as a %
318 Corporate Division	2785	54	208	262	9.4%
318 Covid 19 Division	11	0	2	2	18.2%
318 Diagnostic & Specialty Division	1860	24	70	94	5.1%
318 Gloucestershire Managed Services	842	29	101	130	15.4%
318 Medicine Division	1823	34	114	148	8.1%
318 Non-Division	24	0	0	0	0.0%
318 Surgery Division	2142	31	109	140	6.5%
318 Women & Children Division	912	17	44	61	6.7%
Grand Total	**10399**	**189**	**648**	**837**	**8.0%**

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GHTs Staff Vaccination Record Status

Vaccination Deployment Statistics - Trustwide by Staff Group

Staff Group	All Staff	1st Dose Only Recorded	No Dose Recorded	Total Non-compliant	Total Non-compliant as a %
Add Prof Scientific and Technic	268	2	7	9	3.4%
Additional Clinical Services	2409	66	203	269	11.2%
Administrative and Clerical	1979	30	109	139	7.0%
Allied Health Professionals	579	6	17	23	4.0%
Estates and Ancillary	733	24	95	119	16.2%
Healthcare Scientists	289	2	11	13	4.5%
Medical and Dental	1235	2	83	85	6.9%
Nursing and Midwifery Registered	2902	57	122	179	6.2%
Students	5	0	1	1	20.0%
Grand Total	**10399**	**189**	**648**	**837**	**8.0%**

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COUNCIL OF GOVERNORS – JANUARY 2022
CHIEF EXECUTIVE OFFICER'S REPORT

1. Introduction

1.1 After a short foray into face to face meetings, we continue our meetings in virtual mode in response to the Government's enactment of "Plan B". Whilst disappointing, the safety and wellbeing of all us remains our top priority and the emergence of a new, highly transmissible COVID variant confirms the ongoing need to be both vigilant and cautious. Sadly, we enter 2022 in circumstances that none of us would wish to see but I remain in awe of the dedication and sheer hard work of colleagues throughout the Trust and wider health and care system.

2. Operational Context

2.1 Operationally, the Trust remains extremely busy with activity in urgent and emergency care more redolent of peak winter months, despite the relatively mild weather and the absence of the usual influenza outbreaks. The number of inpatients with COVID-19 has more than doubled since my last report and is currently at c120. However, anecdotally a large number of these patients are being admitted "with" COVID as opposed to "because" of COVID – unfortunately, not all positive results are analysed for the variant strain, so validated data is not available. Positively, the majority of patients with COVID continue to present with milder symptoms than seen with previous variants, with lower requirements for oxygen; the proportion of COVID positive patients requiring high dependency or critical care is considerably less than in previous waves and the sickest patients remain those who are unvaccinated or those with underlying poor health status. On the 10th January, we closed our COVID area in critical care and any future COVID patients will be cared for in side rooms (unless the clinical picture changes). The benefit of this step is the opening up of capacity for more "green" patients who are typically those that require complex surgery, often for cancer.

2.3 The County's vaccination programme has gathered pace with more than 92.2% of those in Priority Groups 1-9 now boosted and 86% of groups 1-12; this degree of booster coverage is vital given what we believe to be the benefit against Omicron.

2.4 Work continues to fully understand the vaccination status of all staff ahead of the end of March milestone. Based on current data, of our c10,370 employed or hosted staff, 775 are not compliant with the guidance to have had two doses of the vaccine (7.47%); 583 (5.6%) of these staff have no record of any vaccination. An operational delivery and oversight group has been established to ensure as many staff as possible are supported to have the vaccine ahead of the two milestones (first vaccination by 3rd February for unvaccinated staff and 31st March for second dose), to assess the likely impact of the vaccination mandate and to ensure the impact on staffing levels and services is minimised and, where applicable, mitigated in so far as is possible. All staff who have not yet had their first vaccination, or are overdue their second, have been invited to discuss the reasons and the implications for them individually, to ensure their decision is informed by the available evidence and reflects "informed consent". Regrettably, a decision to remain unvaccinated could result in patient facing staff being dismissed. Encouragingly, a number of staff have come forward, following initial contact from the Trust, to say that they are appropriately vaccinated but their record is incomplete or inaccurate.

2.4 The current operational pressures are also being exacerbated by a continuing high number of patients awaiting discharge. At odds with previous years, the numbers of patients awaiting discharge did not reduce significantly in the run up to Christmas and numbers remain in excess of 200, with unusually high numbers also being experienced in community hospital settings. The reasons remain multifactorial but the biggest single constraint continues to be access to social care and in particular domiciliary care although staffing issues and outbreaks in care homes is now impacting on the availability of bedded placements too. The Trust, along with system partners, will be launching a campaign called *There's No Place Like Home* to promote the benefits of family supporting earlier discharge from hospital.

2.5 Reflecting the learning from previous waves of COVID, the Trust reintroduced social distancing practices to some ward areas, where the greatest benefit was perceived to exist. This has resulted in 62 acute beds being removed from wards in order to reduce the risk of patient to patient transmission of COVID. Currently, despite the more transmissible nature of Omicron, nosocomial cases represent around 14% of total inpatient cases compared to more than 30% in previous waves. However, alongside this benefit comes greater operational pressure arising from a reduced bed base including continuing high levels of ambulance handover delays. The risks and benefits of this approach will remain under constant review but currently the aim is to maintain this position to minimise ward outbreaks which, of themselves, lead to a greater loss of beds due to the need to close wards to new admissions.

2.6 In keeping with our Winter Plan, routine operating was paused for a two week period with plans to resume w/c 10th January. All emergency and urgent care (including cancer surgery) has continued. The greatest risk to the recommencement of routine surgery is access to beds and staff, not least if surgical staff need to be redeployed to support urgent and emergency care more widely.

2.7 On a positive note, the focussed efforts of staff in our Emergency Departments and the introduction of a dedicated non-clinical role of Patient Experience Officer, is paying dividends with an upward trend in the Friends and Family Test score, as well as some especially heart-warming compliments from patients and families cared for in the recent weeks. That said, staff in the department continue to work in very challenging circumstances and waiting times for patients are far longer than we would like. The proposed listening events for staff working in urgent and emergency care are underway as part of the Trust's response to the anonymous concerns raised by staff; whilst engagement has been limited, they have provided useful insights into the issues most concerning staff.

3 Key Highlights

3.1 As reported last month, the Care Quality Commission (CQC) undertook a targeted inspection of the Gloucestershire Urgent and Emergency Care (UEC) system during late November and early December, as part of a pilot in which 12 systems nationally were visited as part of a "place" approach to regulation and inspection. However, due to growing operational pressures, all CQC inspection activities were paused before completion of the Gloucestershire inspection. We have been advised that individual reports for those organisations inspected will be issued but at the time of writing, this remains outstanding. Both verbal and early written feedback for our Trust did not raise any major safety concerns, with areas of good practice and opportunities for improvement noted; actions to address the latter are already in hand.

3.2 In the run up to Christmas, the Government announced that the planned April establishment of Integrated Care Systems would be delayed by three months. The primary driver for the delay is to provide sufficient time for the necessary legislation to be considered by both the House of Commons and House of Lords, with opportunity for iteration if required. This has received mixed views given the momentum gathered to date and the continued uncertainty for those individuals who are personally impacted by the change; for others more time to prepare has been welcomed. An assessment of

what this means for *One Gloucestershire* is in hand. The shadow Integrated Care Board (ICB) has a development workshop planned for later this month and this will provide an opportunity to explore next steps and priorities in the context of this revised timeline. Non-executive Director recruitment to the ICB will continue.

3.3 On Christmas Eve, the National Planning Guidance for 2022/23 was published. The guidance recognised that its publication marks two years at the end of January, since the onset of the ongoing pandemic and what has become recognised as the most challenging period of the NHS's 74 year history. The four strategic purposes of the plan remain unchanged, to

- Improve outcomes in population health and healthcare
- Tackle inequalities in outcomes, experience and access
- Enhance productivity and value for money
- Support broader social and economic development

The means through which these strategic aims will be enabled are also set out in the plan and reflect the narrative and priorities from 2021/22. The first of these intentions is widely acknowledged to be the most pressing and yet most difficult to achieve.

- Accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff – this has four distinct components set out which include looking after our people, improving the experience of those with protected characteristics, work differently and grow our workforce for the future.

- Use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies – the focus is on "levelling up" the digital maturity of NHS organisations that lag behind the best with an emphasis on both infrastructure and capability with a core level of digital maturity expected by 2025, alongside a recognition of the risks from cyber insecurity and the contribution the digital agenda can make to achieving the NHS Net Zero Agenda.

- Work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity as the context allows – the emphasis here is largely on elective recovery, delivery of cancer standards, maternity service improvements, improving access to primary care, growing and improving mental health services and services for people with a learning disability and/or autism and transforming the capacity and capability of community services to deliver more care at home to avoid the need for admission to hospital and to ensure more timely discharge from hospital.

- Use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care.

On the latter point, detailed technical guidance on the financial framework for 2022/23 has also been released and is being assessed by the finance team. However, the headlines include retention of a system basis for allocation and management of financial resources including a system and organisational duty to breakeven, a "glide path" from the current system funding envelopes (largely driven by expenditure) to fair shares allocations – timescale unclear but ongoing financial sustainability support for those unable to develop a balanced system plan, increased clarity and certainty over capital allocations with multi-year operational capital allocations and a return to signed contracts between providers and their commissioners albeit with the expectation that this is on "simplified terms".

3.4 Systems are required to develop their response to this guidance to enable a draft submission in mid-March and a final submission by the end of April. These dates will be kept under national review as the operational context unfolds.

3.5 Finally, one of this year's Christmas Day babies is worthy of particular mention with the birth of Hattie Eve-Rose Brown, baby daughter of James Brown, Director of Involvement, Engagement and Communication. Mum, dad and big brother Bailey all doing well!

Deborah Lee
Chief Executive Officer

10th January 2022

Gloucestershire Hospitals
NHS Foundation Trust

COUNCIL OF GOVERNORS, January 2022

REPORT TITLE	
Temporary relocation of the Hyper Acute Stroke Unit (HASU) from GRH to CGH	
AUTHOR(S)	**SPONSOR**
Kate Hellier, Dave Cooper and Clare Stephenson	SIMON LANCELEY, Director of Strategy & Transformation

EXECUTIVE SUMMARY

Purpose:

To update Governors on the proposal to proceed with a temporary service change in response to a workforce risk that is impacting on service delivery. The change would see Hyper Acute Stroke Unit (HASU), TIA clinics and OP clinics move from GRH to CGH from w/c 10th or 17th of January 2022.

Key issues to note:

- Gloucestershire stroke services are already operating under a temporary (emergency) service change. Part of the ICS response to the first wave of COVID-19 involved GHFT Acute Stroke Rehabilitation moving from GRH to CGH and Gloucestershire Health & Care's (GHC) stroke ward at The Vale Community Hospital increasing from 14 to 20 beds. This change is due for review at the end of March 2022.
- This second temporary service change would be implanted in w/c10th or 17th January 2002 and a review of both changes taken at the end of March to determine if the changes are reverted, retained for a further temporary period and/or included in Phase 2 of Fit for The Future and therefore subject to public and staff engagement and consultation.
- Increasing demand pressures in GRH ED are leading to delays in the assessment of stroke patients (requirement to be admitted to stroke ward within 4 hours).
- The service is also carrying an Intolerable Risk associated with workforce shortages, specifically stroke consultants and specialist nurses and therapists.
- A lack of Stroke Consultants is a national issue and neighbouring Trusts are facing similar issues.
- This change would be implemented as a temporary (emergency) service change under the Memorandum of Understanding (MoU) the ICS has in place with Gloucestershire Health Overview and Scrutiny Committee (HOSC).

RECOMMENDATIONS

To note the implementation of the following temporary service changes in the week commencing 10th or 17th January 2022.

- Move the Hyper Acute Stroke Unit, TIA clinics and OP clinics from GRH to CGH, co-locating services with the Acute Stroke Unit at CGH. The stroke beds to be provided on ACUC.
- Implement a stroke direct admission pathway to CGH, by-passing ED.

- Training the acute medical team (ie the acute medical take and ACUC staff) to provide support to the stroke service. .

ACTION/DECISION REQUIRED			
INFORMATION			
IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)			
Outstanding care	☒	Centres of excellence	☐
Compassionate workforce	☒	Financial balance	☐
Quality improvement	☐	Effective estate	☐
Care without boundaries	☐	Digital future	☐
Involved people	☐	Driving research	☐
The primary objective is to maintain a safe and sustainable service			

IMPACT UPON CORPORATE RISKS

Datix Risk Ref: 3706

REGULATORY AND/OR LEGAL IMPLICATIONS

Change will be implemented under the MOU in place between Gloucestershire ICS and Gloucestershire HOSC.
Should evidence show there would be sustainable patient and staff benefits of the temporary change becoming permanent, this would be secured through the Fit for The Future programme and subject to required level of public and staff engagement and consultation.

SUSTAINABILITY IMPACT

The temporary re-location of HASU from GRH to CGH will impact some patient and carer travel times; either positively (for patients in the east of the county) or negatively (for patients in the west).
An initial analysis of the impact of moving ASU to CGH has shown the there is a relatively even distribution of patients admitted to the GHNHSFT stroke service from the east and the west of the county.
Full travel analysis will be completed as part of the work-up of long-term options.

EQUALITY IMPACT

A full Integrated Impact Assessment would be developed if this temporary change is to be considered in the long-term.
Details of a previous impact assessment are included in the MoU

PATIENT IMPACT

Change in the admission pathway from GRH to CGH. Patients with a stroke/query stroke will be assessed and admitted in CGH rather than GRH.

RESOURCE IMPLICATIONS			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐
Other	☐		

ACTION/DECISION REQUIRED

N/A

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES								
Audit & Assurance Committee	☐	MM/YY	People & OD Committee	☐	MM/YY	Trust Leadership Team	☐	12/21
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	☐	MM/YY	Other (specify below)	☐	MM/YY
Finance & Digital Committee	☐	MM/YY	Remuneration Committee	☐	MM/YY	Other?		

OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS
Supported by TLT

Briefing paper on Hyper Acute Stroke Unit
Temporary Service change
Health Overview and Scrutiny Committee

Document Control

Responsible Director:	Ellen Rule, Director of Transformation and Service Redesign
Status:	V 1.2

Version	**Date**	**Author/ Reviewer**	**Comments**
1.0	23/12/2021	Micky Griffith	V 1.0 draft developed for review
1.1	23/12/2021	BP & SL	Incorporate amendments
1.2	23/12/2021	ER	Incorporate amendments

Document Distribution:

Forum/Audience	Date	Doc	Comments
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1. Purpose of the Document

This paper for the Gloucestershire Health Overview and Scrutiny Committee (HOSC) provides information on the temporary relocation of Gloucestershire Hospitals NHS Foundation Trust's (GHNHSFT) Hyper Acute Stroke Unit (HASU), Transient Ischaemic Attack (TIA) clinics and Outpatient (OP) clinics from Gloucestershire Royal Hospital (GRH) to Cheltenham General Hospital (CGH); co-locating services with the Acute Stroke Unit (ASU) at CGH and the HASU stroke beds to be provided on the Acute Care Unit (ACUC). The change will be implemented as a Temporary Service Change under the Memorandum of Understanding (MOU) in place between Gloucestershire Integrated Care System (ICS) and Gloucestershire HOSC.

2. Context

Two elements of Gloucestershire stroke services are already operating under a temporary (emergency) service change. Part of the ICS response to the first wave of COVID-19 involved GHNHSFT Acute Stroke Rehabilitation moving from GRH to CGH and Gloucestershire Health & Care's (GHC) stroke ward at The Vale Community Hospital increasing from 14 to 20 beds. These two changes are due for review at the end of March 2022.

Further information on this can be found in Annex 1.

3. Case for Change

The third change to stroke services is necessary as part of the ICS response to increasing winter pressures (emergency attendances and admissions), Stroke Consultant and Stroke Specialist Nurse workforce challenges and in preparation for an anticipated increase in hospital attendances and admissions related to the Omicron variant of COVID-19. Collectively, these elements are impacting the ability to consistently deliver a high-quality stroke service

Increasing demand pressures in GRH Emergency Department (ED) can lead to delays in stroke patients being seen by the correct team impacting the ability to meet national standards for stroke care, for example time to CT scan carrying out thrombolysis and admission to a dedicated stroke ward within 4 hours.

The service is also carrying an Intolerable Risk associated with workforce shortages. Due to a number of planned and unplanned changes, from January 2022 the stroke senior decision making team will consist of a Stroke Consultant, an Associate Specialist and a locum consultant, to provide medical cover for stroke wards and outpatient clinics across both sites. In addition, the stroke specialist nurse team is down to one member of staff and the Speech and Language Therapists (SALT) team is reduced to two members of staff.

Nationally there is a shortage of stroke doctors. The Trust has attempted to recruit to these posts substantively, but this has been difficult as, across the country, Trusts are chasing a limited workforce pool.

4. Temporary Service Change - Hyper Acute Stroke Unit (HASU)

Gloucestershire Hospitals NHS Foundation Trust's (GHNHSFT) Hyper Acute Stroke Unit (HASU), Transient Ischaemic Attack (TIA) clinics and Outpatient (OP) clinics will move from Gloucestershire Royal Hospital (GRH) to Cheltenham General Hospital (CGH); co-locating services with the Acute Stroke Unit at CGH and with the HASU stroke beds to be provided on ACUC.

This second temporary service change will be implemented w/c 10th January 2022 and will be reviewed at the end of March 2022 to determine if the changes are reverted or retained for a further temporary period. Should evidence show there would be sustainable patient and staff benefits of the temporary change becoming permanent, this would be secured through the Fit for The Future programme and subject to required level of public and staff involvement.

The previous Temporary Service Changes (Acute Stroke Rehabilitation moving from GRH to CGH and stroke beds at The Vale Community Hospital) are part of the stroke pathway review and will also to be updated in March 2022.

This move will be enabled by implementing a stroke direct admission pathway to CGH, therefore by-passing ED. There will also be training for the acute medical team (i.e. the acute medical take and ACUC staff), to provide support to the stroke service.

The Trust has discussed the proposal with the national Getting It Right First Time (GIRFT) clinical lead for stroke services and has been advised that a similar model is currently being used at East Kent Hospitals with direct admissions to a planned care site. Feedback on the proposed model has been positive and supportive.

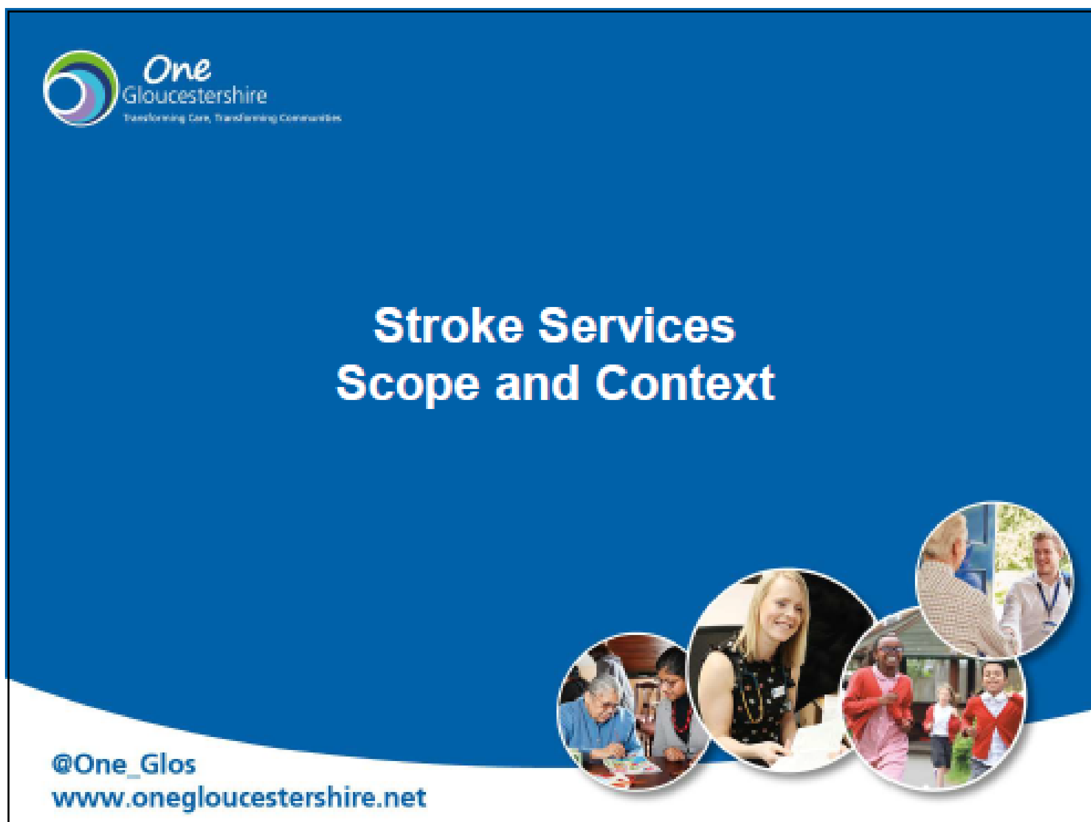
This change will be implemented as a temporary (emergency) service change under the Memorandum of Understanding (MoU) the ICS has in place with Gloucestershire Health Overview and Scrutiny Committee (HOSC).

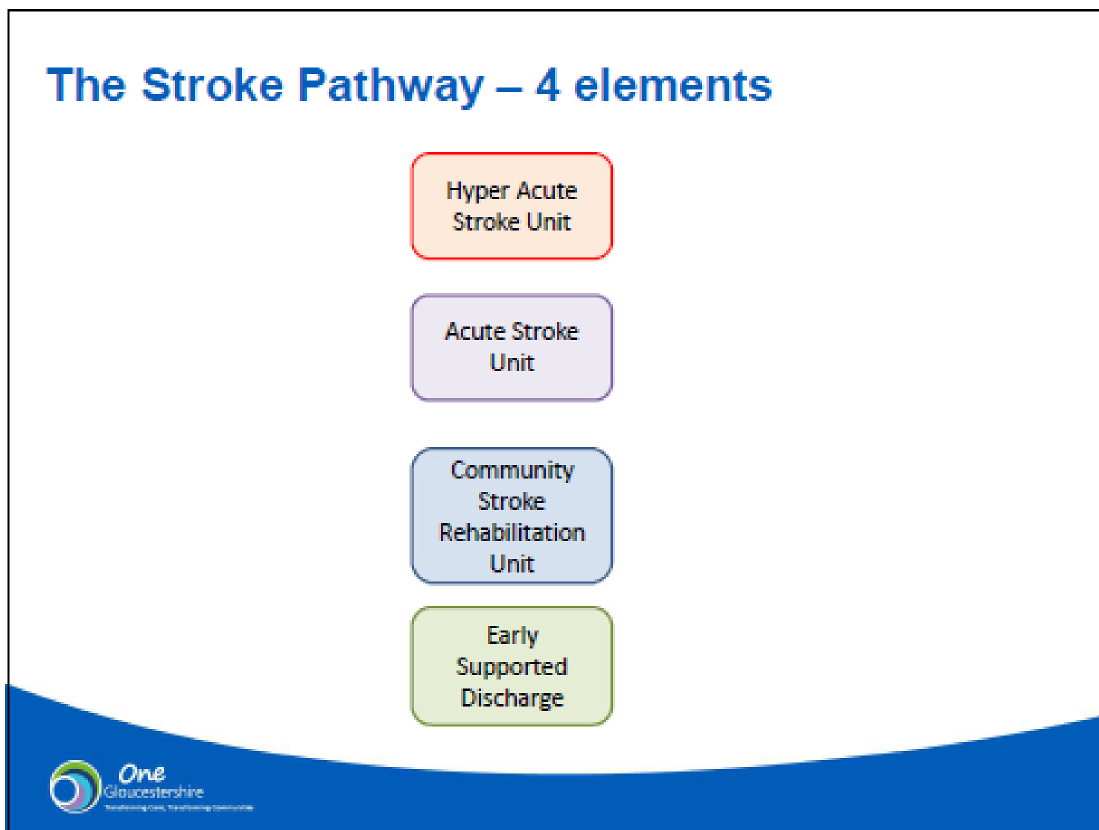
Memorandum of Understanding (MoU) Pro-forma is provided in Annex 2.

5. Conclusion

HOSC are requested to note the temporary relocation of HASU from GRH to CGH and, in accordance with the MOU protocols, further updates will be provided on the impact of this in due course.

Annex 1: Stroke Services: scope and context





The Stroke Pathway – HASU

Hyper Acute Stroke Unit

Acute Stroke Unit

Community Stroke Rehabilitation Unit

Early Supported Discharge

- Suspected stroke and TIA patients
- Patients assessed if suitable for thrombolysis and thrombectomy)
- 850 patients per year
- Length of Stay (< 3 days)
- Transferred to Acute Stroke Unit (50%) or usual place of residence
- Gloucestershire Hospitals NHS FT
- Currently located at Gloucestershire Royal Hospital

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The Stroke Pathway – ASU

Hyper Acute Stroke Unit

Acute Stroke Unit

Community Stroke Rehabilitation Unit

Early Supported Discharge

- Stroke Rehabilitation
- 500 patients per year
- Length of Stay (Median average 12 days)
- Transferred to Community Stroke Rehabilitation or usual place of residence
- Gloucestershire Hospitals NHS FT
- Pre-COVID 19 located at Gloucestershire Royal Hospital
- Currently located at Cheltenham General Hospital

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The Stroke Pathway – Community Rehabilitation

Hyper Acute Stroke Unit

Acute Stroke Unit

Community Stroke Rehabilitation Unit

Early Supported Discharge

- Stroke Rehabilitation
- 200 patients per year
- LoS (Median average 34 days)
- Discharged to usual place of residence (74%), new Care Home (16%) or specialist unit (1%)
- Gloucestershire Health & Care NHS FT
- Located at The Vale Community Hospital
- Pre-COVID 19 capacity = 14 beds
- Current (temporary) capacity = 20 beds

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The Stroke Pathway – Early Supported Discharge

Hyper Acute Stroke Unit

Acute Stroke Unit

Community Stroke Rehabilitation Unit

Early Supported Discharge

- A therapy led outreach community 'step down' service delivered at usual place of residence
- Up to 6 weeks
- 474 patients per year
- Supporting improved flow from acute and rehabilitation stroke unit beds
- Gloucestershire Health & Care NHS FT

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Stroke Pathway Service Review 2021/22

Hyper Acute Stroke Unit

Acute Stroke Unit

Community Stroke Rehabilitation Unit

Early Supported Discharge

- To maintain and enhance outcomes for patients as measured by SSNAP* performance
- To determine the optimal number of beds across the pathway (including at The Vale)
- To determine the preferred location of Acute Stroke Unit (CGH or GRH)
- Longer term preferred staffing models for each element of the pathway
- Opportunity presented by enhancing the Early Supported Discharge service
- To update in March 2022 including temporary changes

* Sentinel Stroke National Audit Programme https://www.strokeaudit.org/About-SSNAP.aspx

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Third Stroke Service Temporary Change

Relocation of HASU from GRH to CGH

Hyper Acute Stroke Unit

- The change is necessary as part of the Integrated Care System (ICS) response to increasing winter pressures (emergency attendances and admissions) and Stroke Consultant and Stroke Specialist Nurse workforce shortages.
- Move the HASU from GRH to beds within the Acute Care Unit at CGH
- Centralise stroke inpatient beds onto one site at CGH
- Implement in Jan 2022 as an emergency (temporary) service change in line with the agreed MOU

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Annex 2: Memorandum of Understanding (MoU) Pro-forma
Consideration of a temporary (emergency) service change:
Hyper Acute Stroke Unit

Name of NHS Trust/ Name of NHS Commissioning Organisation

Gloucestershire Clinical Commissioning Group (CCG)

Gloucestershire Hospitals NHS Foundation Trust (GHNHSFT)

Lead Manager and contact details

Simon Lanceley, Director of Strategy & Transformation, GHNHSFT

Dave Cooper, General Manager for Care of the Elderly, Neurology and Stroke, GHNHSFT

Details of the current service

This paper focuses on the proposal to move the Hyper Acute Stroke Unit (HASU) element of the acute hospital stroke service temporarily to Cheltenham General Hospital.

The change is necessary as part of the Integrated Care System (ICS) response to increasing winter pressures (emergency attendances and admissions), Stroke Consultant and Stroke Specialist Nurse workforce challenges and in preparation for an anticipated increase in hospital attendances and admissions related to the Omicron variant of COVID-19. Collectively, these elements are impacting the ability to consistently deliver a high-quality stroke service.

This change would be implemented as an emergency (temporary) service change in line with the agreed MOU and is in addition to the existing emergency (temporary) service change that resulted in the Acute Stroke Unit (ASU) moving to Cheltenham General as part of the ICS response to the first wave of COVID-19.

The HASU is currently located on a shared ward with Cardiology on the Gloucestershire Royal Hospital (GRH) site. The majority of stroke patients are admitted directly to HASU for up to 3 days. After this period, patients who require ongoing inpatient care are transferred to the ASU, which is currently on Woodmancote ward at Cheltenham General Hospital (CGH) site.

	Hyper Acute Stroke Unit (HASU)	Acute Stroke Unit (ASU)
Current temporary service model	8 beds that can be flexed up to 12 beds shared ward with Cardiology at GRH	32 beds on Woodmancote ward at CGH.

Details of the proposed change to service

Proposal: To move the HASU from GRH to CGH. This move will centralise all acute stroke beds onto one site at CGH. A stroke consultation service will be provided on the GRH site, to manage inpatient referrals from other specialties.

Proposed patient pathway:

- SWASFT/GP call via CINAPSIS
- The patient is accepted by the stroke team
- The patient arrives at CGH and is taken directly for a CT scan (no contact with the Emergency Department at CGH)
- The patient is swabbed for COVID 19.
- If negative the patient is admitted to a bed on ACUC.
- If positive the patient is admitted to Knightsbridge ward.
- All patients requiring specialist stroke care (COVID and non COVID) will be managed at CGH, similar to the oncology pathway.

If patients require ongoing inpatient care, following their stay on HASU, they will be transferred to the Acute Stroke Unit, also at CGH. There will be an agreed protocol with South West Ambulance Services Foundation Trust (SWASFT) to take all stroke/query stroke patients direct to CGH.

Any patient arriving at GRH would be assessed in GRH ED. Experience of other centres that operate this proposed model suggests that these numbers are likely to be low and their symptoms are likely to be mild – and rarely would need intervention i.e. thrombolysis or thrombectomy. If required, patients would be transferred to CGH for admission or referred to the Trans Ischaemic Attack (TIA) Clinic.

The Trust has discussed the proposal with the national Getting It Right First Time (GIRFT) clinical lead for stroke services and has been advised that a similar model is currently being used at East Kent Hospitals with direct admissions to a planned care site. Feedback on the proposed model has been positive and supportive.

It is also proposed to transfer TIA clinic and stroke outpatient clinics to CGH.

<u>The benefits of this proposal include:</u>

- Reduced pressure in GRH ED and GRH cardiology ward/medical bed base in anticipation of increased COVID-19 (Omicron) attendances and admissions from January 2022
- Direct patient pathway to acute medical/stroke team avoiding ED – reducing pressure in GRH and CGH ED
- Same site for HASU and ASU – benefits for staff covering all stroke areas (stroke doctors, nurses and therapists).
- Stroke Consultants/Associate Specialists on same site, so more able to cross cover each other.
- Faster training of on-call medical take team, ACUC nurses by Stroke team.
- Better training of stroke ward juniors
- TIA clinic could be run from Ambulatory Emergency Care Unit (AEC) at CGH – enabling faster access to specialist opinion, ability to train acute medical juniors in stroke.
- Reduced pressure on GRH CT/MRI.

<u>The following options were considered and discounted:</u>

Do nothing – this would not address the immediate staffing challenge of a reduced workforce – one stroke Consultant, an Associate Specialist and a locum consultant - covering HASU and Acute Stroke Rehabilitation across two sites. Further deterioration in the time to review by a senior clinician in ED departments for stroke patients.

Move ASU back to GRH: This would enable stroke services to be provided on one site, but this would return 32 beds to the GRH site, displacing another service (with no spare capacity available) and further increasing the level of bed occupancy at GRH.

Timescales involved
To undertake the transfer of HASU to CGH in the week commencing 10th January 2022 for a period of no less than 3 months and will be reviewed at the end of March 2022 to determine if the changes are reverted or retained for a further temporary period. Should evidence show there would be sustainable patient and staff benefits of the temporary change becoming permanent, this would be secured through the Fit for The Future programme and subject to required level of public and staff involvement. Please note that the previous Temporary Service Changes (Acute Stroke Rehabilitation moving from GRH to CGH and stroke beds at The Vale Community Hospital) are part of the stroke pathway review and will also to be updated in March 2022.
What is the reason for the proposed service change?
Emergency Care Demand: GRH and CGH Emergency Departments (EDs) are facing increasing demand due to delayed presentations from the pandemic, continued COVID 19 demand, difficulties in patients accessing other services and the normal increase over winter. This can lead to delays in stroke patients being seen by the correct team impacting the ability to meet national standards for stroke care, for example time to CT scan carrying out thrombolysis and admission to a dedicated stroke ward within 4 hours. In addition, a combination of planned and unplanned staff changes means the number of stroke medical and nursing staff will substantially reduce. This position will make it difficult to provide safe and sustainable staffing levels on stroke wards at GRH and CGH and to continue to provide outpatient services on both sites. ***Workforce:*** Due to a number of planned and unplanned changes, from January 2022 the stroke senior decision-making team will consist of a Stroke Consultant, an Associate Specialist and a locum consultant, to provide medical cover for stroke wards and outpatient clinics across both sites. In addition, the stroke specialist nurse team is down to one member of staff and the Speech and Language Therapists (SALT) team is reduced to two members of staff. Nationally there is a shortage of stroke doctors. The Trust has attempted to recruit to these posts substantively, but this has been difficult as, across the country, Trusts are chasing a limited workforce pool. Strenuous efforts have also been made to backfill these posts, including locum/off framework agency staff. Despite these efforts it has proved difficult to cover these vacancies in sufficient time. The Trust is hopeful that it can recruit an additional locum Stroke Consultant in January 2022. Given the above position the Trust has identified the stroke staffing levels as an intolerable risk (number *ID 3706)* and has been exploring options to reconfigure the service to make the best use of available staff. Centralising stroke services onto one site will help mitigate this risk.
Has any consultation or engagement/ involvement taken place to date?
There has been engagement with staff involved in the delivery of stroke services and with those staff who will be impacted by the proposed changes. There have also been ongoing discussions with SWASFT to design the proposed pathway.

Given the pace of the proposed service change there will not be sufficient time for public engagement to be conducted at the point of instigation of these temporary changes. This is in line with accepted practice when change is required as an 'emergency' response to an intolerable risk. We will continue to work through the Stroke Task and Finish Group to develop a longer-term proposal for Stroke care in Gloucestershire and this will include engagement with patients and stakeholders.	
Expected impact of change and what is being done to address this	
Changes in accessibility (i.e. transport issues/ opening hours etc)	The temporary re-location of HASU from GRH to CGH will impact some patient and carer travel times; either positively (for patients in the east of the county) or negatively (for patients in the west). An initial analysis of the impact of moving ASU to CGH has shown the there is a relatively even distribution of patients admitted to the stroke service from the east and the west of the county. Full travel analysis will be completed by the Stroke Task and Finish Group as part of the work-up of long-term options.
Patients/ carers affected (demographic assumptions that have been made)	A full Integrated Impact Assessment would be developed if this temporary change is to be considered in the long-term option. Previous impact assessment has identified the following that would need to be considered: **Age** The age of an individual combined with additional factors including other 'protected characteristics' may affect their health and social care needs. Individuals may also experience discrimination and inequalities because of their age. Analysis of previous stroke patients has identified that 60% are >75 years, 20% are 65-74 years and 20% 18-64 years. **Gender** There is no conclusive evidence to suggest that access to and experience of acute hospital care differs solely on the basis of a person's gender. Analysis of previous stroke patients has identified that 53% are male and 47% female. **Race / Ethnicity** Studies of secondary care usage have found that ethnicity is a significant predictor of acute hospital admission. The district with the highest proportion of ethnic diversity is Gloucester city meaning that a geographical distribution of services away from GRH might have a greater impact on these communities. **Disability** Forest of Dean is the only district locally that exceeds the national average in terms of the proportion of residents living with a disability. People with disabilities may have an increased risk of developing secondary conditions that are more likely to result in the need for acute care. This geographical clustering means that geographical

	changes to where services are delivered may have a disproportionate impact on those with disabilities in terms of access. A travel impact assessment will be needed to fully assess this impact. Providing services from a planned care site, with a shorter overall length of stay, may well benefit those with disabilities as they may be more affected by such factors than the general population.
Changes in methods of delivery (venue / practitioner)	Emergency patient pathway will change from GRH to CGH. There will be a direct admit pathway to HASU. via: a) Emergency Department presentation b) Outpatients via attendance at a TIA clinic c) From an inpatient ward where a patient has suffered a stroke that was not predicted and therefore the patient is not already under active stroke inpatient treatment. Care will be delivered through the stroke specialist medical and nursing team supported by the acute medical physicians (via the acute medical take) and ACUC team. The following essential support services have adjusted work patterns to provide cover, ensuring minimal service disruption as a result of the temporary service move: • Physical Therapy • Cognitive Therapy • Psychological Support • Dietitian • Speech & Language Therapy • Radiology • Vascular Laboratory
Impact upon other service delivery	Whilst the temporary service change remains in place, support services, such as those noted above, will continue to adjust work patterns in order to facilitate patient support at CGH. Other services such as health records, portering, catering and pharmacy would not be affected as these are all currently provided across both Cheltenham and Gloucester sites. Experience will be monitored using Friends and Family Test patient survey.
Wider implications	It is not envisaged that there will be any negative implications on the wider community or health economy whilst the temporary service change remains in place.
Equality/ Inequality issues	A full Integrated Impact Assessment would be developed if this temporary change is to be considered in the long-term option. Previous impact assessment has identified the following that would need to be considered: **Deprivation**

	Gloucester city has the highest proportion of its population living in the most deprived areas **<u>Homelessness</u>** On average 2.37 per 1000 households are homeless in Gloucestershire with highest levels in Cheltenham and Gloucester city. **<u>Substance Misuse</u>** The age standardised hospital admissions due to substance misuse in Gloucestershire is among the lowest in the South West region at 38 per 100,000 persons; lower than both regional and national rates; however mortality rates suggest that the district of Gloucester City has the highest rates of deaths due to substance misuse, significantly higher than county and national averages. **<u>Mental Health</u>** The prevalence of mental health disease within the GP practice registered population within Gloucestershire is among the lowest in the South West region at 0.8%; significantly lower than both regional and national averages GHFT admission data demonstrates that more people attend GRH than CGH with mental health related issues. The specialist stroke rehabilitation service at the Vale is a county wide service and is open to the whole population based on clinical need. The remaining community hospitals will all continue to offer general rehabilitation for all residents across the county
Name of person completing this pro-forma	David Cooper - General Manager – Care of the Elderly, Neurology, Stroke Kate Hellier – Clinical Lead for Stroke Services Clare Stephenson – Strategy and Transformation Programme Manager
Date proforma completed	December 2021
Outcome (HOSC Comments)	

REPORT TO TRUST BOARD – DECEMBER 2021

From the People & Organisation Development Committee Chair – Balvinder Heran, Non-Executive Director

This report describes the business conducted at the People and Organisational Development Committee on 14TH December 2021 indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Agenda Item	Report/Key Points	Challenges	Assurance	Residual Issues / gaps in controls or assurance
Chairs introduction - Future of NHS HR OD Briefing Pack	Summary of national 'Futures' Report presented outlining the vision for HR and OD 2030 presented.	Committee struck by analysis that HR and OD functions were digitally immature in the NHS and required investment.	Committee received report and assured that some immediate actions required were delivered - Board level oversight of EDI, people metrics and a Board level Director of People	Updates on progress and any actions for Trust to consider to be on forward plan
Board Assurance Framework	New principle risk agreed - compassionate workforce; PR02.5 The Trust fails to develop and maintain a compassionate culture which supports the ambition to deliver 'Best care for each other'. One rating amended (reduced) relating to PR5.5 and Stakeholder engagement.	Committee confirmed acceptance of new risk and amended rating		BAF to remain on the work-plan for the committee
Risk Register	New risk added **C3696 P&OD: *Proposed highest scoring domain- workforce and statutory (9): C3 x L3***: *risk of staff members refusing to receive the covid-19 vaccine in*	What was the staff response to the mandation?	The Trust continues to encourage staff to get vaccinated and will seek to redeploy these individuals and if this fails dismissal is last option.	Future update on the risk to be provided as further guidance and assessment of impact received

	accordance with the government mandate; leading to increased staff turnover, redeployment challenges and impacting on staff morale.	Can staff work for other providers? Datix – has IT liaised with the Datix project team regarding the delivery of the programme	Not for patient facing services if the person will be deployed for the provision of a regulated activity The CIO and Director of Safety have met to consider the risks of programme slippage.	Committee to receive regular updates on progress with this critical upgrade
ICS Update	Organisational Update - ICB Board development commencing - System leadership development funding received - Additional cohorts of FLOURISH are in place - EDI Chair networking and development commenced - Resourcing role for System advertised	What are the challenges to system working? How can NEDs assist in improving ICS working?	Appropriate resources and commitment of time/capacity. There are few System roles across the People agenda. Offer an independent view of working arrangements, what is prioritised, what is invested in.	ICS to remain on the agenda as a standing item.
Presentation from the Surgical Division – Staff Engagement	Presentation on engagement received. Themes included: - Leadership visibility - Listening events - Embedding EDI in staff engagement sessions and added to meeting agendas - Focussed work on theatres - Collaboration with service lines and staff co design and delivery	Committee were pleased by the range of engagement initiatives How can the Division measure success? How are metrics such as appraisals being met?	Quarterly reviews provide a structure to describe achievements and impact of interventions. The new (trial) appraisal pack makes the achievement of appraisal conversations more achievable. The Divisional Tri remain focussed on this	Committee to receive a future update on progress within the Division. Committee noted link between health inequalities/deprivation and staff demographics

	- Quality boards - Positive action in recruitment and promotion		metric	
Freedom to Speak Up update	July – September saw 32 referrals - an increase on previous quarter and year by c30% More concerns on patient safety (1/3) 6 issues made anonymously - a significant decline.	Do the team collect the demographics of those who speak up A Freedom to Speak Up guardian stepped down (GMS) was there any issues/reasons given? Given press and complaints external to the organisation, is there an opportunity to promote the function more in the Trust? Face to face walkabouts won't necessarily meet the needs of those working unusual hours? How else can you catch people Could those that raise concerns act as champions? What is behind the reporting that some people would not use the service again	People are asked to declare their protected characteristics Reason given was work/life balance given that the Freedom to Speak up Role is an add on and sometimes operationally difficult to manage The service is promoted regularly through promotional material, on-boarding presence, walkabouts, attending meetings, seeking colleague referrals. Some colleagues do not feel the service meets their expectations such as resolving an issue in a certain way and with the outcome they desire.	Committee will see demographic data in the next report. Next report to offer further reflections on why colleagues might not use the Freedom to Speak up service again and actions to improve take up
Equality	EDI Steering Group is monitoring	Committee were supportive	EDI strategy will review	Future EDI Strategy will

Diversity and Inclusion Action Plan update	the EDI action plan. There are 13 objectives, 7 are closed, 4 near completion and 2 have not progressed such as setting up an ICS Inclusion hub. Next steps will be to devise an EDI strategy which will include the EDI objectives and future ambitions as defined under the Best Care for each other	of the creation of the EDI strategy in 2022. Committee sought assurance that the strategy would include learning from the pandemic Are the areas not well progressed such as improving Comms to EM Staff to be included in the EDI Strategy?	COVID learning and include objectives not yet progressed	be tabled
Staff Health and Wellbeing update	Half year report - Hub less in demand compared to the COVID pandemic year. - Over 20 people in the peer support network - TRIM has been launched and 50 people have been trained as practitioners - Access to EAP is consistent - The Psychology team is fully established - Compassionate team workshop is being launched	Could we see an increase in demand with winter months? Does the hub have surge capacity to cope?	2020 hub has flexed to bring in additional support to manage any surge. Team is larger and more resilient Demand for psychological services are growing especially for teams New system well-being line is in place with qualified psychologists who act as additional support	Next report - April 2022

Health and Safety Objectives	Good progress on SHARPS and slips and trips Less progress on workplace inspections due to capacity issues. Violence and aggression has risen 30% in the last twelve months.	Can themes for violence and aggression with actions be provided in the next report? The abuse of staff should not be tolerated and NEDs remain supportive of thinking about what the Trust needs to do to tackle this	Violence and aggression incidents reviewed weekly and a sanctions group has commenced. Patients with capacity are written to and consideration is being given to flagging on a patients record any incidents and engaging with the police to take forward prosecutions	Future report to provide detail on violence and aggression
	More manual handling incidents have been recorded in the half-year.	Why is the manual handling target set at 50% training?	This target was set during the pandemic and reflected the ability to conduct face to face training. Training is also provided by the lead manual handling practitioner at ward level. Attending face to face training is prioritised for those without prior experience in role and for those without passported skills from other organisations	

Board note/matter for escalation: None

Balvinder Heran
Chair of People and OD Committee, 15 December 2021

NHS
Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – January 2022

From: The Finance and Digital Committee Chair – Rob Graves, Non-Executive Director

This report describes the business conducted at the Finance and Digital Committee held on 23rd December 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Digital and EPR Programme Report	Updates and assurance on Digital workstreams. Highlighted: - Successful introduction of ED optimisations - Upgrade to Sunrise EPR version 20 processed Nov 30th - ePMA project preparation progressing to conclusion of first stage - NEW documentation for nurse and doctors in EPR for February availability	TCLE implementation not referenced in highlights – have the operational issues been resolved?	Significant progress made via the task and finish group - residual issues arising the extremely old legacy system that was being replaced	
Digital Risk Register	Full review of the risk register which currently holds 61 risks. Controls and mitigations in place. Discussion about fallout from incidents in partner organisations	Will the data centre refurbishment programme be delivered on time given that the report refers to some issues?	Completion by year end expected with no significant concerns.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Integrated Care System Update – Digital	Update on system-wide activity	What is the status of the ICS Digital Strategy?	Good engagement from system partners with the HIMSS Continuity of Care Assessment initiative. While some barriers to full collaboration remain progress is being made.	
Financial Performance Report	Summary of the month 8 and year to date financial position covering revenue, costs and the balance sheet position. Year to date the Trust has a £0.5 million surplus which is on plan. The Trust is projecting to meet its break-even year end plan. Significant discussion of the challenges and opportunities arising between levels of funding in 21/22 and 22/23.	What is the appropriate level to set for supplementary spending on low value equipment? Is there a clear understanding of the statutory requirements concerning asbestos?	Assuring discussion on the analysis of opportunities in 21/22 and agreement on the approach to small item expenditure. Asbestos locations are known and documented – the proposed expenditure is to address the most significant issues on an accelerated timetable	
Capital Programme Report	The year's capital programme has increase to £67.2 million incorporating latest supplementary allocations. Year to date spending at £27.3 million is £11.2 million behind plan. Discussion covering the risk of not completing projects and potential mitigation.	Project specific questions and summary challenge on the viability of meeting the target.	Comprehensive analysis of project spending plans, projects risking missing their timing and potential mitigations.	Continuing concern about the total year spend
Financial Sustainability	Verbal update advised that the year's outturn is projected at £7.0 million which is £1	When will the committee see the detailed review?	February meeting	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	million above plan. Description of work in progress to link the programme with the quality improvement agenda			
Renal Haemodialysis Procurement Process	Detailed presentation covering the assumptions and proposed approach to the re-rendering of the Trust's Renal Haemodialysis service		The Committee was assured of the robustness of the approach and supported the 6 recommendations to progress the project	
Approval of various reserved matters for GMS	GMs management presented 2 proposals requiring Trust approval under the schedule of Reserved Matters: - Engagement of interim staff - Placement of the Sterile Linen	What is the basis for the proposed term of the Linen contract?	Committee assured that appropriate governance is applied to the Reserved Matters	Contract term to be reviewed with Procurement
Update on Salix project	Interim report on the progress of the capital projects associated with grants under the Public Sector Decarbonisation scheme. Most projects elements progressing on the revises and agreed timetable (completion by March '22). Contractual difficulty with one element of the programme - mitigation described	Will the current situation result in forfeit of a proportion of the grant?	Plans being prepared to prevent loss of funding	Updates to continue
Integrated Care System Update -	Verbal update on the positive progress towards new		Assurance that the Directors of Finance	Formal update planned for January meeting.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Finance	governance processes.		system will be meeting to discuss contract management.	

Rob Graves
Chair of Finance and Digital Committee
6th January 2022

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – January 2021

From the Quality and Performance Committee – Alison Moon, Non-Executive Director

This report describes the business conducted at the Quality and Performance Committee held on 22 December 2021, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Quality and Performance Report including current situation with COVID/omicron, infection prevention and control and winter plan. All delivery group reports taken as read. Emerging risk with SWAST and risks to timely transfers to hospitals of women in labour.	Significant challenges remain operationally, approx. 210 people medically optimised for discharge, winter plan previously foresaw challenges in January/February without omicron being present, impact of which unknown at time of meeting. Divisional plans in place, risk of large % staff absence, contingency planning underway. Wider system actions noted. Infection prevention and control issues with bed days lost through COVID, norovirus and C Diff. More work underway re prescribing, cleanliness and PPE. Increase in hospital acquired pressure ulcers reported, validation of data	How will the transmissibility of omicron impact the bed base?	Set number of socially distanced beds reduced to 156 due to lessons learnt from first wave, although noting each COVID surge had been different. Learning from London will be key, noting staff absence a key risk.	
		Has the NHSE/I letter to systems re discharge before Christmas had any impact?	Confirmed the letter had enabled work at pace but flow of patients remained very challenging. Further NHSE/I directive expected for system.	
		Global email states that inpatient COVID testing not happening as planned, has there been an improvement?	Advised too early to know if reminder to all staff has had an impact, will report next month to committee.	
		Noting the description of actual harms and the risk of high % staff absence, is	Medical Director confident of data capture. Assurance given of a plan if high %	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	requested. Updates on cancer and planned care positions shared.	there confidence in accurate data reporting?	absences, some duties/task would be reviewed, although assurance given that meetings to monitor harm and safety would not be stepped down. Executive discussions ongoing recognising the need to be more explicit for staff to support difficult care decisions which may need to be made. Work in progress being led by Chief Nurse.	
		In planned care, clarification sought on comparisons of the Trust prioritisation codes with other trusts.	Active work described in this area, part of reporting to committee.	
		From previous meeting, how is the planned communications with families and carers of children progressing?	Different way of working described, reviewing how children could still be seen if adult carer unwell.	
		Ophthalmology does not appear to be included in the communications work described. Question on the over	Dedicated team of co-ordinators in place who provide an enhanced offer.	
		700 people waiting over 52 weeks, what specialties and what is driving it?	Newly formed elective recovery board focus on this and raising profile of	Detailed paper to committee in February.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		High rates of patient cancellation noted e.g. ENT, what being done to address?	health inequalities.	
		In cancer report, what are the reasons for delay in qualifying patients' harm reviews being undertaken.	Update to be provided at next committee meeting.	
		From maternity update, current pressures for SWAST across the region noted, example of overall pressures on the NHS.	Local communications with patients, all patients with booked delivery had been contacted at time of meeting.	
Serious Incident Report, including never events.	Details of two x further never events verbally reported after report written. Incident reporting from ED noted to have doubled since last reporting period, complaints overall increasing, themes of waiting and delays in care. New senior appointment to PALs team positive.		Initial findings of the further never events described. Numbers of never events a continued concern, detailed plan for improvement for further review at committee. Informed a personal letter sent from the Medical Director to all staff.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Leadership response to anonymous letter (ED) – verbal update.	Verbal update from Chief Executive. Two of four planned listening events had been held with Trust Chair in attendance.		Assurance given to committee that no high levels of corroboration to contents of letter found and staff encouraged to report incidents (as seen in serious incident report) Further work needed on ensuring closing of loop when concerns are raised through incident reporting.	Written report and response to January Committee
Patient Experience Report Quarter 2	Report noted, some encouraging data emerging from improving FFT in ED setting. New patient experience role in ED seen to be making a positive impact.	How will this role link into quarterly reports and will there be any wider learning across the Trust?	Assurance received on the positive impact of this role and focus of leadership team to drive improvement in this area. Early success of the role has resulted in additional funding for second role. Main learning to date, role being non-clinical does not get into the detail of treatment and care so can focus on the experience aspects.	Will be included in quarterly reports from Q3 onwards.
Hyper Acute Stroke Unit-Temporary Service Change	Report on stroke services and reduction in substantive stroke consultants. Proposal to move hyper-acute stroke unit to Cheltenham General. Improvements described, improvement in pathway, (including time to scan)	Is the reason for staff leaving known and what are staff views on the proposal?	Different reasons for leaving known and some roles difficult to recruit into. Range of views from colleagues re the proposal, mainly supportive and positive, although some concerns re workload.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	release of beds at Glos Royal. Previously presented informally to HOSC, no major issues raised.	Previous temporary changes had seen staff not feel included or informed. Is this process as good as it can be?	Felt to be better, noted some concerns expected but felt to be an open and transparent process	
Safer Nurse Staffing Report	Briefing of Trust response to NHSE/I letter on nurse staffing over winter period. Report outlines compliance with requirements and current gaps/areas for development.	What level of confidence that line managers doing regular check-ins on staff well-being?	Chief Nurse felt it to be a high priority, conversations on shift by shift basis observed. Important agenda item at senior leadership level.	Written update to committee in January, with copy of NHSE/I letter and Trust response.
		Are there any concerns on achieving compliance on the three areas?	Confidence given that all will be achieved end Dec/early January	

Alison Moon
Chair of Quality and Performance Committee
28 December 2021

COUNCIL OF GOVERNORS – JANUARY 2022

REPORT TITLE			
Governors' Log Report			
AUTHOR(S)		**SPONSOR**	
Becky Smith, Corporate Governance Administrator		Lisa Evans, Assistant Trust Secretary	
EXECUTIVE SUMMARY			
Purpose To update the Council of Governors on the themes raised via the Governors' Log since the last full Council of Governors meeting on 15 December 2021. Key issues to note The Governor's Log is now available to view at any time within the Governor Resource Centre on Admin Control.			
RECOMMENDATIONS			
The Council of Governors is asked to NOTE the report for INFORMATION.			
ACTION/DECISION REQUIRED			
INFORMATION			
IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)			
Outstanding care	☐	Centres of excellence	☐
Compassionate workforce	☐	Financial balance	☐
Quality improvement	☐	Effective estate	☐
Care without boundaries	☐	Digital future	☐
Involved people	☒	Driving research	☐
IMPACT UPON CORPORATE RISKS			
There are no related Corporate Risks.			
REGULATORY AND/OR LEGAL IMPLICATIONS			
There are no related legal implications.			
SUSTAINABILITY IMPACT			
Governors provide an important role acting as a critical friend to the Trust in raising and highlighting instances where sustainability at the Trust could be improved.			
EQUALITY IMPACT			
Governors provide an important role acting as a critical friend to the Trust in raising and highlighting issues around equality and diversity.			
PATIENT IMPACT			
Governors provide an important role acting as a critical friend to the Trust in raising and highlighting instances where quality and patient care is not as it should be.			

RESOURCE IMPLICATIONS			
Finance	☐	Information Management & Technology	☐
Human Resources	☐	Buildings	☐
Other	☐		

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES								
Audit & Assurance Committee	☐	MM/YY	People & OD Committee	☐	MM/YY	Trust Leadership Team	☐	MM/YY
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	☐	MM/YY	Other (specify below)	☐	MM/YY
Finance & Digital Committee	☐	MM/YY	Remuneration Committee	☐	MM/YY	Other?		
OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS								
Not applicable								

NHS
Gloucestershire Hospitals
NHS Foundation Trust

REF	01/22	STATUS	OPEN		
SUBMITTED	03/01/2022	DEADLINE	18/01/2022	RESPONDED	
GOVERNOR	Maggie Powell				
LEAD	Qadar Zada/Alex D'Agapeyeff				
THEME	Biopsy Result Wait Times				
QUESTION					
I understand that in early December, patients were being told that biopsy results were taking 6-8 weeks. Is this still the case? What is being done to address what seems to me, as a lay person, to be a worryingly long delay? How is it impacting on clinical decisions regarding the need for treatment?					
ANSWER					