GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Public Board of Directors Meeting 12.45, Thursday 12 May 2022 Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital AGENDA				
Ref	**Item**	**Purpose**	**Report type**	**Time**
1	**Chair's Welcome and Introduction**			12.45
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 14 April 2022**	Approval	Enc 1	12.50
5	**Matters arising from Board meeting held on 14 April 2022**	Assurance		
6	**Patient Story** *Suzie Cro, Deputy Director of Quality*	Information	Presentation	12.55
7	**Chief Executive's Briefing** *Mark Pietroni, Interim Chief Executive Officer*	Information	Enc 2	13.30
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Assurance	Enc 3	13.50
9	**Trust Risk Register** *Alex D'Agapeyeff, Interim Medical Director*	Assurance	Enc 4	14.00
10	**Quality Report** *Matt Holdaway, Chief Nurse and Director of Quality, Alex D'Agapeyeff, Interim Medical Director, and Qadar Zada, Chief Operating Officer*	Assurance	Enc 5	14.10
11	**Guardian of Safe Working Hours Report** *Jessica Gunn, Guardian for Safe Working*	Assurance	Enc 6	14.30
Break (14.40-14.50)				
12	**Maternity Reports** *Matt Holdaway, Chief Nurse and Director of Quality* • **Ockenden Gap Analysis**	Assurance	Enc 7	14.50
13	**Finance Report** *Karen Johnson, Director of Finance*	Assurance	Enc 8	15.05
14	**Digital Programme Report** *Mark Hutchinson, Chief Digital and Information Officer*	Assurance	Enc 9	15.20
15	**Use of Trust Seal Report** *Kat Cleverley, Trust Secretary*	Approval	Enc 10	15.30
16	**Assurance Reports:** • **Quality and Performance Committee** *Alison Moon, Non-Executive Director* • **Finance and Digital Committee** *Robert Graves, Non-Executive Director* • **People and Organisational Development Committee** *Balvinder Heran, Non-Executive Director*	Assurance	Enc 11-13	15.35
17	**Any other business**		None	15.40
18	**Questions/Comments from Governors**			
Close by 15.45				

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Trust Board Meeting 14 April 2022, 12.30, Cabinet Suite, Shire Hall			
Chair	Peter Lachecki	PL	Chair
Present	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	Matt Holdaway	MHo	Interim Chief Nurse and Director of Quality
	Karen Johnson	KJ	Director of Finance
	Simon Lanceley	SL	Director of Strategy and Transformation
	Deborah Lee	DL	Chief Executive Officer
	Alison Moon	AM	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Deputy for Safety, Deputy Chief Executive
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director for People
	Roy Shubhabrata	RS	Associate Non-Executive Director
	Qadar Zada	QZ	Chief Operating Officer
Attending	Hillary Bowen	HB	Public Governor
	Shona Duffy	SD	Homeless Specialist Nurse (minute 22/22 only)
	Mike Ellis	ME	Public Governor
	Lisa Evans	LE	Assistant Trust Secretary
	Andrea Holder	AH	Public Governor
	Craig McFarlane	CM	Head of Communications
	Katie Parker-Roberts	KPR	Head of Quality (minute 22/22 only)
	Maggie Powell	MP	Appointed Governor
	Alan Thomas	AT	Public Governor
	Jeremy Marchant	JM	Public Governor
	Jeanette Welsh	JW	Lead for Safeguarding Adults (minute 22/22 only)

Ref	Item
17/22	**Chair's Welcome and Introduction** The Chair welcomed everyone to the meeting.
18/22	**Apologies for absence** Apologies were received from Robert Graves, Elaine Warwicker, and Mark Hutchinson.
19/22	**Declarations of interest** There were no new declarations of interests.
20/22	**Minutes of Board meeting held on 10 March 2022** The minutes were approved as a true and accurate record.
21/22	**Matters arising** None.
22/22	**Staff Story** SD, a Homeless Specialist Nurse attended the meeting with JW, Safeguarding Adults lead to discuss the Trust's approach to safeguarding homeless patients in hospital. SD reported that homeless people had complex needs and a lack of multi-agency working had been noted in the past. Homeless people who

	presented to the Trust were now reviewed by the safeguarding team on admission or following an A&E attendance. SD reported that the team was inexpensive and now worked successfully with other agencies to consider follow-up support and funding. The Board reflected on the presentation and BH asked if there was anything the team was doing because partners were not. SD advised that she did not believe there was any gap in provision. AM congratulated the team on this work and noted that Trust data had generated this improvement across the system, she asked what help the Board could provide to move the work forward even further. JW reported that once a case was identified, the team often needed help to make the solution work, drafting of business cases etc. QZ thanked SD for the work and said that he had learned that not all homeless people wanted a home. SD said that people needed to be empowered to live how they chose to. However, the Board noted that when the Homeless Specialist Nurse post was introduced there were 145 rough sleepers, this had now reduced to 25. DL added that the ICS would bring further opportunities for cross system working.
23/22	**Chief Executive's Briefing** DL reported that it had been five and half years since PL became Trust Chair. PL had navigated the organisation through some very challenging times resulting in its exit from Financial Special Measures, removal of Regulatory Undertakings relating to performance and financial governance and the highlight of achieving a Care Quality Commission Good rating for the first time in the Trust's history. DL reported that operationally, the Trust remained extremely busy with ambulance services reporting increased demand throughout the region. Unfortunately, the inability to discharge patients in a timely way meant that the Trust's Emergency Departments (ED) continued to be congested. Conversations were taking place with Social Care colleagues. DL reported that while the focus on COVID infections had lessened in recent weeks, Gloucestershire continued to experience higher numbers of community COVID cases compared to both national and South West levels. These rates were likely to plateau and begin to decline in the next week or so. Whilst the majority of patients in our hospitals had "incidental" COVID, the operational impact of managing this situation remained very significant and, most notably, staff absences had been at their highest levels for many months. On Wednesday the Trust received an unannounced targeted inspection of its core surgical services and an unannounced inspection of maternity services on 6/7 April by the Care Quality Commission (CQC), the Board noted that seven of the recommendations re maternity services made were already in train. In addition, the CQC would be undertaking a Comprehensive Well-Led Review of the Trust in the coming weeks, including a three-day onsite inspection scheduled to take place from the 3rd to 5th May 2022. The Board noted that the Trust's elective and diagnostic performance remained strong; cancer performance was strong relative to the regional position, but improving 62 cancer waiting performance remained a priority. Other key highlights included: • Preparations for the Trust's first staff awards since 2019 were ongoing • The Trust's Digital Team won *Most Promising Pilot Award* for a digital innovation in the national Leading Health Care Awards, for their work with private partner Polygiest to use artificial intelligence to predict those patients presenting in the Emergency Department at high risk of staying in hospital for more than 21 days • The national Staff Survey results had been published. Not surprisingly, given the challenges of the last year, the survey painted a disappointing picture across the NHS and our Trust was no different. • The Trust would be participating in the National Quarterly Pulse Survey going forward, which would be open to bank staff as well as substantive staff. CF noted that staff across the Trust were describing workloads as punishing, she asked what was being done to ensure their wellbeing. DL reported that team leaders needed good communication with their staff and

	needed to ask the right questions, she added that Executives had meetings with their direct reports and good leadership was key. The 2 wellbeing days which had recently been offered to staff were noted.
24/22	**Trust Risk Register** MP updated the Board on the one risk added to the Trust Risk Register since the last meeting: • **C3682** The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department. Scores: Safety C5 x L4 = 20, Quality C4 x L4 = 16, Statutory C4 x L4 = 16, Reputational C3 x L3 = 9 The Board noted that this risk was due to poor patient flow in the Emergency departments caused by a lack of available beds throughout the hospitals. This was a result of large numbers of Medically Optimised for Discharge (MOFD) patients occupying inpatient beds. It was reported that MOFD had reached a 12-month high, having increased by 16% to an average of 265 patients per day. The pattern of demand had also changed, with higher numbers of mental health patients presenting at EDs in the last 12 months, with approximately 377 patients presenting at our EDs each day. One risk was downgraded from the Trust Risk Register to the Divisional Risk Register. This related to quality of histo-pathology service provision due to functionality issues with TCLE. The risk around harm to patients, staff and visitors from hazardous floor conditions and damaged ceilings as a result of leaks in the roof of the Orchard Centre GRH, Wotton Lodge and Chestnut House was closed as roof repairs were complete. DL reported that the Board would have sight of workforce risks through the Board Assurance Framework. It was noted that there had been good progress on risk, with system partners across the ICS. **RESOLVED:** The Board NOTED the report.
25/22	**Quality and Performance Report** QZ presented the report which summarised the key highlights and exceptions in Trust performance for the February 2022 reporting period. The Board noted that the Gloucestershire system was experiencing exceptional pressure in urgent and emergency care. Very significant ambulance handover delays were creating a risk in the community in relation to response times to Category 2 calls. Prolonged waits in the Emergency Departments (ED) for admission to a hospital bed and to receive prompt treatment were considerable and associated with harm. The Trust was working with system partners to improve quality standards in the EDs and there was wider system focus on patients that no longer required acute hospital care but were unable to be discharged to onward social care. QZ reported that this remained challenging. The Board noted that during February 637 bed days were lost due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways. Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients, and to prevent onward transmissions of COVID-19. QZ welcomed the revised guidance which was expected to limit the impact of COVID. A slight improvement month on month in relation to hospital standardised mortality ratio was noted. An increase in pressure ulcers acquired as in-patient was reported during the winter period. It was reported that February 2022 saw a rate of 7.6 falls per 1,000 bed days; higher than previous months. A high number (10 occurrences) resulted in harm, such as fractures and head injuries. Every fall resulting in moderate harm or worse was reviewed in the weekly Preventing Harm Hub where immediate safety actions and learning were rapidly assessed. Two patients subsequently died and were referred for Serious Incident Investigations. February saw an increase to 33.09% of women experiencing induced labour.

	The number of cases closed by PALS within 5 days was currently at 73%. Additional staff had been recruited and a review of the service was being undertaken to see how additional support could be brought in for the team. February continued to be a challenging month for the EDs and saw a decrease in performance from 72.57% to 69.25% compared to the previous month and Ambulance handover delays increased. The Trust did not meet the diagnostics standard in February however performance improved on last month from 20.8% to 18.3% this month. For cancer the Trust met 5 of the 9 CWT metrics and exceeded national performance in 8 out of 9 of the CWT metrics. The Trust met the standard for 2 week wait with performance at 93.9%, with breaches attributed to an increased number of referrals, patient choice or COVID self-isolation factors. The 62-day cancer wait standard was not achieved with an unvalidated position of 64.6% For elective care, QZ reported that performance was now tracking at 72% which was a slight improvement on the previous month. The Board noted that staffing remained a challenge but some success in recruitment was noted. RS noted sickness and staff absence levels and asked if there was any correlation between absence and issues with care. MHo reported that although COVID restrictions were being lifted the Trust did not want staff who were unwell at work. Morale and engagement was also an issue and this could impact patient care. MAG asked for a summary of actions coming out of this report. QZ assured the Board that all actions set out in the report were happening. MHo added that a report was being produced which would provide actions and owners; this would be presented to the Board. PL asked if the work being done on falls resulting in harm was making a difference. MHo reported that he would be taking a report to the next Quality and Performance Committee, he added that benchmarking falls was not encouraged; the Trust was looking to eradicate rather than just improve. **RESOLVED:** The Board NOTED the report.
26/22	**Learning From Deaths** MP provided the Board with assurance regarding the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths. Key issues to note: • All deaths in the Trust had a high-level review by the Trust Bereavement Team and the Trust Medical Examiners. • All families communicated with the Bereavement Team and had the opportunity to feedback any comments on the quality of care which were fed back to wards for their learning and onto the End-of-Life Group for learning. The rate of positive feedback had improved consistently and stabilised around 85%. Significant concerns trigger formal Structured Judgment Reviews. • The main learning from Structured Judgment Reviews was through the feedback, reflection and discussion in local clinical meetings at Specialty level. The rate of reviews within 3 months had decreased to 53% from 63% which reflected a significantly busy time for the Trust as we moved into winter last year. Each Division had been asked to review their triggers to ensure sufficient deaths were captured for reviews. • All serious incidents had action plans, based on the identified learning: these were monitored to completion. • Mortality for hospital standardised mortality ratios (HSMR), standardised mortality ratios (SMR) had risen statistically higher than expected, with weekend\weekday mortality also higher than the accepted range. The COVID impact on mortality maintained a complex picture but when COVID was removed from these data the Trust remained within normal variation. o HSMR stood at 108.4 from the previous reported position of 101.4

	○ SMR stood at 106.9 from the previous reported position of 99.4 Summary Hospital-level Mortality Indicator (SHIMI) for period Sept 2020 - Aug 2021 remained in the expected range at 101.32 from 98.13. All deaths were reviewed in the Trust through the Medical Examiner, other triggered deaths were further reviewed through the Trust Structured Judgment Review process, SI investigation and national programmes driving local learning, feedback and system improvement. KJ asked MP if there were any issues causing concern. MP reported that fractured neck of femur had now returned to acceptable levels. Trauma issues were largely due to data collection errors which had generated an action plan and improvements in care. DL added that improvements were made immediately where possible. **RESOLVED:** The Board RECEIVED the report as a briefing and source of assurance that the Trust was continually reviewing and learning from deaths.
27/22	**Journey to Outstanding Report** MHo provided assurance of senior management engagement with wards and departments, and Board visibility. The Board noted that there had been 43 visits completed from April 21 to March 22. The aim had been to increase the rate of bookings to 8 per month depending on the impact of COVID and availability lead directors. Most visits that were cancelled had been re-arranged and were due to work pressures either operational or at department level. Prior to each visit the areas were contacted to check the current position. The main trend noted related to concerns about staffing levels, skills mix including medical and therapy staffing and the delays and process for recruitment and impact of issues arising from the unscheduled care pathway. MHo reported that although there was considerable workload pressure the visits would continue to be planned with a final check on the day to assess the department's workload. PL noted that all precautions were being taken. **RESOLVED:** The Board RECEIVED the report as a source of assurance of leadership visibility and engagement with staff.
28/22	**Finance Report** KJ presented the Financial position of the Trust. Month 11 reported a £133k deficit in month, which was on plan for the month. The Trust had planned to report a small deficit each month for the rest of the year to get to the planned £6k surplus. The Board noted that profiling of these deficits was due to the one-off release of a legal provision in Month 7. For the Year-to-date (YTD) a £138k surplus was reported; this was on plan. Activity delivered 100% of the YTD 19/20 activity levels, and 95% of the February 2020 levels. The Trust was reporting to NHSEI a forecast outturn of £500k surplus for the full year. A significant surplus of around £7m would be delivered mainly in the CCG. 2022/23 planning continued and the Trust was currently working through the system position with partners. The Board noted that at M11, the Trust had goods delivered, works done or services received to the value of £46.4m. The Trust had reported within the M11 NHSIE financial monitoring return a forecast that equalled the funding available of £66.2m. The programme could be divided into four components; System Capital (£24.4m), National Programme (£29m), IFRIC 12 (£0.9m) and Government Grant/Donations (£11.8m).

	The significant challenge to deliver £19.7m capital spend within March had been achieved; KJ reported that the closed position was a £350k overspend; the system would breakeven as Gloucestershire Health and Care (GHC) had underspent. KJ thanked the project team for their work and the Chair acknowledged the huge effort. **RESOLVED**: The Board RECEIVED the contents of the report as a source of assurance that the financial position was understood and under control.
29/22	**Digital Programme Report** SH provided the Board with an update and assurance on the delivery of digital workstreams and projects within GHFT, as well as business as usual functions. New clinical documentation went live on 23rd February 2022, new implementation included the first major drop of doctor's documentation, including clerking, ward round notes and take lists. This had been well received by clinicians. The Board noted that: • AHPs were now also adding clinical notes on EPR. • Additional nursing flowsheets and the tissue donation form went live at the same time. • Office 2016 roll-out continued at pace across the organisation. • 'Tap and go' continued to be rolled out and MP reported that it was already saving clinicians time that could be used for patient care. AM noted frustrations around the Badgernet maternity system and asked how systems were prioritised. MP assured the Board that there was clinical oversight of prioritisation of systems and SH confirmed that Badgernet had now been purchased. It was agreed that a report of the timeline for the introduction of the Badgernet system would be provided to the Finance and Digital Committee. **ACTION** SH reported that the digital team had been shortlisted for digital team of the year. **RESOLVED:** The Board NOTED the report.
30/22	**Committee Assurance Reports** The Board received and noted the following assurance reports for information: • Quality and Performance Committee • Finance and Digital Committee • Audit and Assurance Committee • Estates and Facilities Committee
31/22	**Any other business** CF proposed a vote of thanks to the Chair. **RESOLVED:** The Board agreed unanimously to record a formal vote of thanks to Peter Lachecki, outgoing Chair if the Trust.
32/22	**Questions/Comments from Governors** AT congratulated KJ and the Finance Team for reaching the current financial position. He formally thanked the Chair on behalf of the Council of the Council of Governors.
Close	

Actions/Decisions				
Item	**Action**	**Owner**	**Due Date**	**Update**

Unconfirmed

29/22	**Digital Programme Report** A report of the timeline for the introduction of the Badgernet system would be provided to the Finance and Digital Committee	SH / MH	May	

PUBLIC BOARD – MAY 2022
CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 The news that Deborah Lee, our Chief Executive had a stroke was a shock to us all. Thankfully, she received clot busting treatment (thrombolysis) quickly and made a complete recovery within a few hours. She is currently at home having further tests and taking time to get well. The number and the nature of the messages of support from staff and partners are a testament to the high regard she is held in and the impact she has had on the lives of so many. We continue to send our best wishes to her and her family and look forward to her return in the not-too-distant future.

1.2 As a result, there have been some changes to portfolios in the Executive Team. I am very grateful to Dr Alex D'Agapeyeff, Deputy Medical Director, who has stepped in to my role as Director for Safety and Medical Director, including Responsible Officer and Caldicott Guardian, to release me to focus on covering Deb's role. In the meantime, Matt Holdaway was successfully appointed to the role of Director for Quality and Chief Nurse which he has been covering in an interim capacity – many congratulations; and he will take over the role of Executive Maternity Safety Champion. Deborah Evans started in her new role as Chair on 2 May.

Operational Context

2.1 Operationally, the Trust remains extremely busy. There are some signs that the significant system work in urgent and emergency care is starting to bear fruit; for example, the number of patients who are Medially Optimised for Discharge and no longer require inpatient care has reduced from c280 to c230. However, our Emergency Departments continue to be congested as a result of being unable to flow patients quickly in and out of the ED. This was particularly acute during the two Bank Holiday weekends since our last meeting. Of particular concern is the impact this has on patients conveyed to hospital by ambulance, who are often required to queue outside the hospital pending their transfer into the Department. The first internal Urgent and Emergency Care Improvement Board met on 29 April to ensure that we leave 'no stone unturned' internally to improve the situation for patients and staff.

2.2 Another positive is the reduction of the rate of community transmission of COVID-19 in Gloucestershire, albeit slightly later and from a higher peak than the rest of the UK. This has resulted in a reduction in the number of inpatients who are COVID-19 positive, the majority of whom are admitted with other conditions and their infection with COVID-19 is incidental. The change in community prevalence prompted a revision of the national Infection Prevention and Control guidelines for healthcare settings (but not care homes). This will reduce the impact of COVID-19 on our wards, including visiting restrictions, and increase efficiency in our elective care pathways. Any changes that are implemented locally will be risk assessed to ensure the appropriate balance of safety and risk across all domains.

2.3 The Trust's elective and diagnostic performance remains strong and one of the best in the South West. In spite of the challenging position operationally, the stabilisation of the 52 week-wait position has been maintained at approximately 1700; we remain on track to eliminate waits over 78 weeks this financial year; and we have sustained our position of having no-one waiting over 104 weeks. Cancer performance is strong relative to the regional position but improving 62-day cancer waiting performance remains a huge priority including

the continued work to improve histopathology turnaround times. The Trust is meeting the 2 week-wait standard, the 28-day faster diagnosis standard, and the 31-day new treatment standard.

2.4 The system Operational Plan was submitted on 28 April. The plan sets out our approach to achieving 104.6% of baseline cost-weighted elective activity as part of our recovery plan as well as improvements in urgent and emergency care. There is still a significant financial deficit of £24.2m, of which the Trust's portion is £9.2m. The plan has been submitted to NHSEI and feedback is expected by mid-May.

3 Other Highlights

3.1 The Health and Care Bill received its final reading in Parliament on 26 April and is waiting Royal Assent to pass into legislation. This means that the plans for the Integrated Care System to go live on 1 July will now definitely go ahead. In Gloucestershire these are well developed with the Board Chair and senior officers all appointed. I took part in interviews for some of the clinical lead roles in late April and was very encouraged by the range and depth of the applicants, ensuring a good mix of primary, community and secondary care appointees. We were delighted to host a visit from Matthew Taylor, Chief Executive of NHS Confederation, to the ICS on 4 May. Matthew spent time with our Dermatology team in the Aspen Centre and at Quayside House where colleagues explained the health and social care benefits being delivered through a range of ICS initiatives including: Gloucester Community Building Collective, Matson Project, Tewkesbury Frailty project, Mental Health practitioners in Gloucester City and how our Vaccine programme reduced inequalities.

3.2 Following the unannounced targeted inspection of maternity services, the Trust received another unannounced CQC inspection of core surgical services on 12-13 April. As always, the formal report will be published in due course but the initial feedback described staff as working hard to deliver compassionate care, keen, well-motivated and wanting to improve / advocate for care for their patients. Not surprisingly given the current context there were comments about the difficulties of providing care when there are delays to discharge and 'outliers' on surgical wards. The planned Well-Led Inspection, which was due w/c 3 May, has been postponed due to Deb's illness and will be rescheduled shortly.

3.3 This month we celebrate the fantastic work of our midwives and nurses, as 5 May is International Midwives Day and 12 May is International Day of the Nurse. On both days we are hosting "Festivals of Excellence" as an opportunity to network, connect and celebrate all the improvement work we have continued to do despite the challenges that we have had over this last year. I would like to take this opportunity to thank our midwives and nurses for their hard work and their dedication.

3.4 This month on 18-19 May sees our first Staff Awards since 2019. The shortlist has been published and preparations are being made for what should be two great evenings celebrating the fantastic work everyone has done over the last 3 years.

3.5 Finally, I would like to thank everyone for their support as I have stepped in this new role. The whole team has been amazing and it is thanks to them that things have continued so smoothly.

Mark Pietroni
Interim Chief Executive Officer

3 May 2022

April 2022

Board Assurance Framework Summary

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

Board Assurance Framework Summary

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

Archived Risks (score of 6 and below)

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

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**CQC regulations or other quality related regulatory standards are breached**	We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	A range of quality issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance	CN, MD, COO	S3316 M3396E mer C2819N C2669N C1945NT D&S2976 Rad WC3536O bs M2353Di ab D&S3103 Path C3223CO VID C2667NIC C1850NSafe C3034N C3295COOCOVID WC3257Gyn M3682Emer C2628COO C1798COO

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
4X4=16	Risk, control and assurance identification and monitoring processes have highlighted a number of risks to quality and therefore to the strategic objective.	**Dec 2023**	**Dec 2024**	-	A number of quality and workforce plans focused on improved culture would have positive impact on quality.	2019/2020	(green)
		3x4=12	**3x4=12**			2020/2021	(amber)
						2021/2022	(amber)
						2022 Q4	(red)

CONTROLS/MITIGATIONS

- Quality and Performance Committee oversees progress of improvement plans in areas of significant concern highlighted by external reviews, incidents,
- complaints etc.
- Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer)
- Urgent and Emergency Care Board
- Monitoring of performance, access and quality metrics via Quality & Performance Report
- Operational Plan 2022/23
- Quality Strategy and delivery plan
- Risk Management processes
- Quality priorities for 2022/23 (as identified in Quality Account 2021/22)
- QIA processes

GAPS IN CONTROL

- Quality Strategy in need of refresh due to key milestones needing to be reprioritised due to challenges caused by Covid-19 Pandemic and changes in personnel.
- Inability to match recruitment needs due to national and local shortages and the impact on quality of care (links with People and OD Strategy)
- Delay related harm
- Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience
- Quality and Performance Report in need of refresh to enable monitor of key metrics
- NAAS ward accreditation paused.
- Reducing health inequalities programmes of work (Core20 PLUS 5).

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

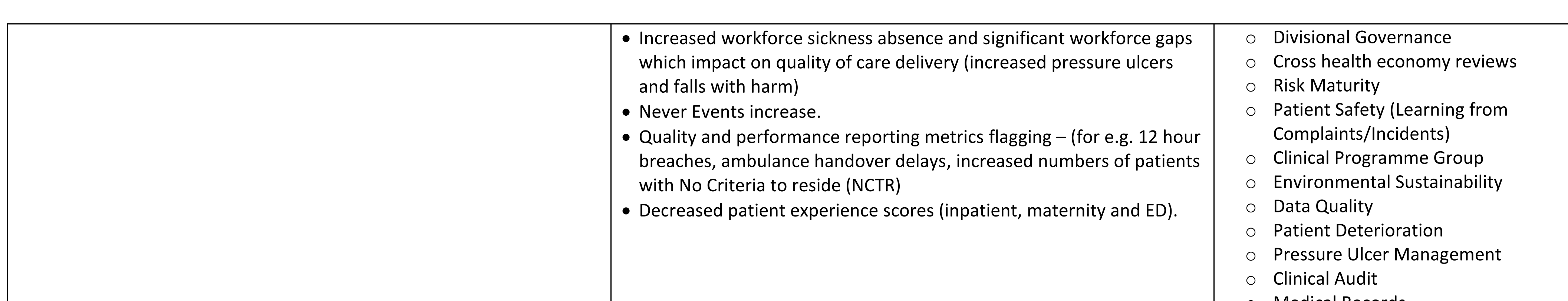
• Improvement programmes • Executive Review process • Internal audit plan adapted to respond to significant quality issues. • J20 Director walkabouts • Trust investment plans prioritised according to risk. • Inspection and review by external bodies (including CQC inspections). • GIRFT review programme. • External reviews of services • Patient Experience Reporting • Learning from deaths reporting • Key issues and Assurance Report (KIAR)	

ACTIONS PLANNED

Action	Lead	Due date	Update
Workforce - Monitoring of impact of workforce challenges on quality and performance	DoQ &CN	Q1 2022/23	- Close monitoring of workforce challenges impact on quality of care via Safer Staffing Report.
Operational Plan - Development of plan in response to NHSE/I planning guidance	COO	Q4 21/22 Q1/2 22/23 Q4 22/23	- Received by Q&P Committee - Agreement of Operational Plan for 2022/23 with external regulators - Delivery of defined planned operational improvements
Quality Strategy and QPR - Review and refresh strategy and delivery plan - Review of metrics within QPR - Define quality priorities for 2022/23 - Development of separate Mental Health Strategy	DoQ &CN	End of Q2 2022/23 21/22 Q4 Q2 22/23	- This work will commence in May 2022 - Work underway - Complete - Draft received by QDG
External reviews of services - Develop action plans in response to recent inspections	DoQ &CN	End of Q1 2022/23	- CQC Medical Care and UEC Care report received action plan being developed. - CQC Maternity focused inspection awaiting report - CQC unannounced core service inspection of surgery awaiting report.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• NHSE/I Regional Maternity Team visit to Maternity Services • Cancer performance • Planned recovery of elective and diagnostic activities in most specialities	• Below average NHS Staff Survey results (metrics for Quality Strategy Delivery). • Operational Plan 2022/23 not fully compliant in all domains (Activity agreed to delivery 104%; however not all quality measures planned to be met; Financial gap identified and not fully mitigated)	• Inspection and review by an external body - CQC pilot ICS inspection Urgent and Emergency Care report. • Internal audit reviews 2022-25: ○ Outpatient Clinic Management ○ MCA and Consent ○ Discharge Processes

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



	• Increased workforce sickness absence and significant workforce gaps which impact on quality of care delivery (increased pressure ulcers and falls with harm) • Never Events increase. • Quality and performance reporting metrics flagging – (for e.g. 12 hour breaches, ambulance handover delays, increased numbers of patients with No Criteria to reside (NCTR) • Decreased patient experience scores (inpatient, maternity and ED).	○ Divisional Governance ○ Cross health economy reviews ○ Risk Maturity ○ Patient Safety (Learning from Complaints/Incidents) ○ Clinical Programme Group ○ Environmental Sustainability ○ Data Quality ○ Patient Deterioration ○ Pressure Ulcer Management ○ Clinical Audit ○ Medical Records ○ Infection Prevention and Control

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Workforce April 2022

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

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

CONTROLS/MITIGATIONS

- Diversity Network with three sub-groups (ethnic minority; LGBTQ+, and disability).
- Compassionate Behaviours Framework
- Compassionate Leadership mandatory training for all leaders and managers
- International recruitment pipeline
- Increased apprenticeships
- Advanced Care and other alternative speciality roles
- Technology enhanced learning and simulation
- Divisional colleague engagement plans
- Proactive Health and Wellbeing interventions
- Formalised workforce Operational Plan submission 2022/2023 to NHSE, integrated with the ICS

GAPS IN CONTROL

- Recruitment processes and practices require transformation
- No formalised marketing and attraction strategy / plan
- Inability to match recruitment needs (due to national and local shortages)
- Staff flight risk post pandemic
- Increased staff sickness absence including the impact of Long Covid related illness
- Pace of operational performance recovery leading to staff burnout
- Full roll out of e-rostering for improved productivity
- Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience

ACTIONS PLANNED

Action	Lead	Due date	Update
Initial scope of e2e transactional recruitment leading to formal transformation change programme	DDfPOD	Commence May 2022	
Development of a marketing and strategy / plan	AD of Resourcing	Commence May 2022	
Delivery of 2022/23 workforce plan including new roles, increased overseas recruitment and robust pipeline plans	DDfPOD	2022-23	
Immediate focussed planning in response to the 2021 Staff Survey outcomes	Head of L&OD/DoP	Commence April 2022	

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

Commencement of formal Workforce Sustainability Programme	DfPOD	2022-23	

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

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

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

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

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee oversees progress of improvement plans in areas of significant concern highlighted by external reviews, incidents, complaints etc. • Internal audit plan adapted to respond to significant quality issues. • Trust investment plans prioritised according to risk.	• Development of larger scale change projects • Regular update of QS and monitoring of goals

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of Programme team to incorporate improvement methodology	SL	March 23	Restructure of programme team completed
Review QS with new Chief Nurse on appointment	MH	March 23	Interviews April
Development of the Just, Learning and Restorative approach	CB	March 23	Initial planning team established

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Progress reported on QS to QPC in October 2021	• Staff survey results	• Update to QPC on QS • Improvement Programme for JL&R approach • Improvement Programme for Staff survey • Internal audit reviews: Workforce Planning; Discharge Processes; Cultural Maturity; Divisional Governance; Cross health economy reviews; Risk Maturity

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

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

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

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

CONTROLS/MITIGATIONS
- Weekly and monthly business cycles in place to monitor/deliver progress against all key KPIs
- Agreed Operational Plan (2022/23) to be in place by Q1/M1
- Substantive Triumvirates in place (or appointed to) for the Operational/Clinical Divisions
- Close working relationships between Operational Divisions and Finance/HR proven in delivery of H2 and other priorities

GAPS IN CONTROL
- Operational Plan 2022/23 not fully compliant in all domains (Activity agreed to delivery 104%; however not all quality measures planned to be met; Financial gap identified and not fully mitigated).

ACTIONS PLANNED

Action	Lead	Due date	Update
Continuation of Operational Plan delivery monitoring (led by BI, Finance and dCOO)	NHL	June 2022	
'Flow' Focussed strategy group planned. Sits with Strategy PMO.	IQ	June 2022	

POSITIVE ASSURANCES
- Elective Recovery Board in place
- Regular 'systemwide' planning meetings in place
- KPI (Cancer performance, diagnostics etc) monitoring meetings are fully established

NEGATIVE ASSURANCES
- Operational Plan 2022/23 not fully compliant and not yet formally agreed

PLANNED ASSURANCE
- Operational Plan 2022/23 to be established to monitor delivery on formal basis from June 2022.
- 'Flow' focussed strategy and delivery group planned June '22
- Internal audit reviews 2022-25:

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

		○ Outpatient Clinic Management ○ Discharge Processes ○ Cultural Maturity ○ Clinical Programme Group ○ Patient Safety: Learning from Complaints/Incidents ○ Patient Deterioration ○ Equalities, Diversity and Inclusion ○ Infection Prevention and Control

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR5	**Poor engagement and involvement with/from patients, colleagues, stakeholders and the public.**	Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services	Insufficient engagement and involvement approach, methodologies or timing.	Colleagues feel 'done to', external stakeholders feel uninformed	Quality and Performance	DoST	

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Board approved Engagement and Involvement Strategy • Quarterly Strategy and Engagement Governors Group • Monthly Team Brief to cascade key messages • Annual Members' Meeting • Friends and Family Test • NHS Staff Survey and NHS Pulse Survey • Quarterly patient experience report to Quality and Performance Committee	• Objective measurement of how well key messages are being cascaded to colleagues.

ACTIONS PLANNED

Action	Lead	Due date	Update
Incorporate lessons learned from FFTF phase 1 into phase 2 engagement and consultation programme	DoST	May 2022	FFTF Phase 2 engagement to run in May and June 2022
Continue to develop Team Brief to improve cascade processes	DEI&C	From Jan 2022	Team Brief now launched and feedback being incorporated
New Communication & Engagement metrics report	DEI&C	May 2022	New report in development with regular reporting to S&T Delivery Group. Reporting to P&OD Committee to be established

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Approach and feedback from the Consultation Institute on Fit for the Future engagement and consultation programme • Progress demonstrated in 2021/22 Engagement & Involvement Annual Review • Level of engagement and involvement from Governors • Inclusion of patient and staff stories at Trust Board including bi-annual learning report	• Engagement score from 2021 NHS staff survey saw 0.3 point reduction on 2020 score (6.6 from 6.9) and is now below national average of 6.8	Internal audit reviews 2022-25: • Cultural Maturity • Outpatient Clinic Management • Patient Safety: Learning from Complaints/Incidents • Equalities, Diversity and Inclusion • Staff Engagement • Recruitment and Retention

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

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

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

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Service Development Group peer review business cases	• Finance strategy in draft and needs completing

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

• Programme Delivery Group for financial sustainability • ICS one savings programme to share ideas, resources and drive consistency • Monthly monitoring of the financial position • Controls around temporary staffing • Driving productivity through transformation programmes i.e., theatres and OP	• Clear line of accountability • Robust benefits identification, delivery and tracking across major projects • No accountability framework

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of the financial sustainability team reporting within the strategy and transformation portfolio	DOF/ DOS	Feb 22	This team has now moved across, training and development ongoing. Vacancies being filled by a combination of permanent and interim staff to get the governance and reporting in place by Mar 22. Detailed plans around deliverability of the financial sustainability programme will be in first draft by end of April.
Robust benefits identification, delivery and tracking across major projects	DOF/ DOS	Jun 22	Capacity now in place to develop the process, format and framework around how we capture the benefits. This will be tested during the financial year and where necessary adapted to ensure the process is robust and effective.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Achieved key annual financial targets in 2020-21. • Achieved key annual financial targets in 2021-22. • Continued the monitoring of financial sustainability during the pandemic. • ERF monies being generated by Trust. • Improved and co-ordinated system working. • External Audit VFM report, Sept 21.	• Moderate/Limited assurance rating from internal auditor on key financial controls and payroll 2020-21. • Temporary staff spend consistently above target. • Planned Trust and System underlying deficit moving into 22/23 a significant concern. • Continuing under-delivery of recurring efficiency programme. • ERF tightening of trajectories has impacted upon the system and H2 outlook doesn't look positive • Lack of benefit realisation on schemes that should be delivering financial improvement; no real consequences of financial deviation, no review on whether to continue to stop a project if overspending	Internal Audits planned 2022-25: • Cross health economy reviews • Shared Services reviews • Risk Maturity • Data Quality • Budgetary Control • Charitable Funds • Payroll Overpayments NHSE/I scrutiny of Trust/system finances. ICS accountability and assurance on system wide transformational changes.

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR8: Failure to develop estate — April 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR8	**Failure to develop our estate which will affect access to services and our environmental impact.**	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact	• Capital constraints • Age and inefficiency of buildings & infrastructure • Limited shared use of estate across ICS	Access, financial and environmental impact of continuing to operate services from older building stock and infrastructure	Estates and Facilities	DoST	

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY
		Aug 2022	Jan 2023	-		
4x4=16	£72m backlog maintenance (2021) of which £41m is critical infrastructure. Capital constraints and reliance on national capital to fund significant estate developments.	**4x3=12**	**4x3=12**		No route to securing additional significant capital in 2022-23 to address estates risks and infrastructure.	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Estates Strategy – Phase1 approved by Board • Estates Strategy – Phase 2 approved by E&F Committee, to Board in June 22 • Strategic Site Development Programme (SSDP) rated as BREAM 'good' and in construction phase • Public Sector Decarbonisation Scheme (PSDS) £13M funding secured in 2021/22 • Board approved Green Plan, that has received national recognition • Green Plan governance structure with Executive Lead, including: Green Champions, Green Council, Climate Emergency Leadership Group into E&F Committee • ICS Estates Development plan defined for 2022/23	• Maturity of ICS Estates Group impacting on pace of shared use of ICS estate • ICS Estates Strategy that reflects organisational estate strategies • Lack of alternative routes to capital other than NHSE/I

ACTIONS PLANNED

Action	Lead	Due date	Update
ICS Estates Strategy	ICS DoF	Q3 22/23	
Oversight of Green Plan	DST	2022/23	DoST nominated Executive Lead from April 2022
Further PSDS applications	GMS	Q4 2023	
Targeted Investment Fund (TIF) bid for 5th Ortho theatre	DST	June 2022	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

• SSD Programme progressing to plan • Trust ability to respond to and secure ad-hoc capital funding in-year from NHSE&I and grants • Declaration of Climate Emergency in 2020 • Big Green conversations • Move of Dermatology off-site to Aspen Centre (GP surgery) • 22/23 TIF bid – 5th Orthopaedic theatre at CGH • Vital energy contract performance – reducing emissions and returning power to national grid	• Scale of estates backlog at £72m of which £41m is rated as Critical Infrastructure Risk • Electrical infrastructure capacity constraints • Age of estate at GRH and CGH • Unsuccessful in PSDS bid in 2022/23 • ICS CDEL limits constrain level of capital investment and prevents the Trust using cash to address estates backlog at the scale required • Access to significant capital – New Hospital Programme funding is committed to 2025 and GHFT is not part of that programme	Internal audit reviews 2023-2025: • Environmental Sustainability • Estates Management

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR9	**Inability to access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings.**	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact	• Capital constraints • Age and inefficiency of buildings & infrastructure • List of equipment at >10 years • Scale of backlog maintenance @ £72M	Unable to address backlog and critical infrastructure risks and/or replace equipment within lifecycle impacting on service delivery, patient and staff experience	Estates and Facilities	DST	

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY
		Aug 2022	Jan 2023	-		
4x4=16	Trust capital programme is c£24M per year of which the £8M allocated to estates is not at the scale required to address the £72M backlog or £41M Critical Infrastructure risk. £8M is also allocated to medical equipment	4x3=12	4x3=12		• ICS CDEL limits constrain level of capital investment and prevents the Trust using cash to address estates backlog and risks at the scale required • Access to significant capital – New Hospital Programme funding is committed to 2025 and GHFT is not part of that programme • Managed Equipment Service (MES) procurement on hold as business case did not demonstrate value for money and impact of IFRS16 was unknown in 21/22.	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Strategic Site Development Programme (SSDP) secured £39.5M of external funding to deliver Phase 1 of Estates Strategy by Summer 2023 • £13M secured through Public Sector Decarbonisation Scheme in 2021/22 • Good track record of securing ad-hoc capital for estate and equipment schemes: £14.6M in 20/21; £5.4M in 21/22 • Ensure all external bids for capital include element to address backlog maintenance risks in development areas • Charitable funded	• Strategy to explore and secure alternative routes to capital and infrastructure investment • Lack of a CDEL prioritisation process within the ICS that recognises the level of risk being carried by each organisation • Lack of clarity on scale of national funding and application route for New Hospital Programme post 2025

ACTIONS PLANNED

Action	Lead	Due date	Update
Review MES business case	DoF/ DST	Q1 22/23	
Targeted Investment Fund (TIF) bid for 5th Ortho theatre	DST	June 2022	Business case in production
Review scope and priorities of ICS Estates Strategy Group	DST	Q1 22/23	

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

• Develop shortlist of business cases to address estate priorities in readiness for NHSE&I calls for capital	DST	Q1/Q2 22/23	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Trust ability to respond to and secure ad-hoc capital funding in-year from NHSE&I and grants • Trust ability to secure grant funding e.g. PSDS • Regular engagement with local MPs to make case for investment • PFI is being maintained to 'Condition B' in line with contract	• Unsuccessful in PSDS bid in 2022/23 • £3M allocated to critical risks in 22/23 leaves significant and high risks unmitigated	Internal audit reviews 2023-25: • Environmental Sustainability • Estates Management

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

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

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

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

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

ACTIONS PLANNED

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

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

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

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

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

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

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

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

ACTIONS PLANNED

Action	Lead	Due date	Update

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

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

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

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

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

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

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

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

	become the growth limiting areas						

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

ACTIONS PLANNED

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

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

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

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

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

Report to Board of Directors			
Agenda item:	9	Enclosure Number:	4
Date	12 May 2022		
Title	Trust Risk Register		
Author /Sponsoring Director/Presenter	Lee Troake, Head of Risk, Health and Safety Alex D'Agapeyeff, Interim Medical Director and Director of Safety		

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

Summary of Report

Purpose

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

One risk was added to the TRR and one risk was closed at Risk Management Group on 4 May 2022.

Key issues to note

NEW RISK ADDED TO TRUST RISK REGISTER (TRR)

- **C2715** - The risk to quality of care of patients remaining in recovery when they require ward-based care

Scores: Quality C3 x L5 = 15, Workforce C3 x L3 = 9, Safety C2 x L3 = 6

Risk Cause: Lack of inpatient beds leading to patients who require ward-based care remaining in Recovery where the appropriate facilities for their inpatient care are not available.

RISK SCORE REDUCED FOR TRR RISK

- None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

- None

PROPOSED CLOSURES OF RISKS ON THE TRR

- **M3396Emer –** The risk to patient safety relating to poorer outcomes and potential harm

throughout their hospital stay as a result of spending longer than 8 hours in ED **Reason for closure:** Risk closed as is covered by M3396 already on the Trust Risk Register

Recommendation

The Board is asked to note the report.

Enclosures

- Trust Risk Register

Risk Register Layout (with Actions)

ID	Ref	Date opened	Specialty / Service Line	Inherent Risk	Operational Lead for Risk	Cause	Effect	Impact	Title of Strategic Group	Title of Assurance Committee / Board	Date Risk to be reviewed by	Highest Scoring Domain	Consequence	Likelihood	Current	Target	Controls in place	Gaps in controls	Assurances / Monitoring	Action / Mitigation	Responsibility ('To')	Progress	Due date	Done date	Closed date
2353	M2353Diab	07/07/2016	Diabetology	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	Macklin, Susan	Lack of fully funded Inpatient Diabetic Nursing Service leading to an increased risk of diabetic and insulin related incidents (actual & potential).	A limited (reactive) nursing service can only be offered to inpatients with diabetes who have e-referred and may have experienced episodes of hypoglycaemia, hyperglycaemia, DKA, HHS, and other diabetes management queries. Some of which is due to lack of education and support in diabetes management, which impacts length of stay, poor patient experience and actual harm.	Inpatients with diabetes receiving sub-optimal care resulting in; poorer clinical outcomes, longer lengths of stay, higher rates of complications & increased mortality. Inability to provide a proactive service to prevent patient harm and increase patient safety. Poor patient experience.	Divisional Board - Medical, Quality Delivery Group, People and OD Delivery Group	Trust Leadership Team, Quality and Performance Committee, People and OD Committee	01/05/2022	Safety	Moderate (3)	Likely - Weekly (4)	8 -12 High risk	4 - 6 Moderate risk	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.77wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. 3)1.0wte DISN commenced March 2021, funded by CCG for 12 month and a further one in June 2021 . 4) 0.77 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding 5) 3 WTE 12 month fixed term dedicated inpatients diabetes nurses NHSE funded - 3rd due to start 11/21	1) Provision of dedicated funded DISN team in relation to the bed base of GHT 2) Demand and capacity model of DISN team. 3) Business case submitted for further resource as informed by demand and capacity model. 4) 1.0wte due Nov 2021 - delayed due to difficulties in recruiting	HR statistics, Patient experience, NADIA results, NADIA Harms audit report, GIRFT recommendations, NICE Guidance 17(2015)Type1 diabetes in adults (QS 6)	Business case draft 2 to be submitted	Smith, Tom	Draft 2 if in-patient business case (Diabetes) under construction. Submit to SD mid Oct 2018 for review	28/02/2019	27/08/2020	
																				Business case to be submitted	Millard, Tom	[06/01/2022 09:45:01 Mary Barnes] Business case submitted in Novemebr [19/07/2021 08:09:11 Verity Jowett] (Email from Tom Millard) I discussed this diabetes business case (ID 5734) with Zoe and Laura on Tuesday. We agreed that it doesn't need doing now, because we are in the process of collating evidence for the benefits of the new fixed term band 6 DSNs, for example in terms of length of stay, in hospital DKA, insulin prescribing errors etc... We agreed that it will become a key business case later in the year, when we'll need to apply for longer term funding for those roles, but that can be done only when we have the evidence. Business case put on hold due to Covid-19 pandemic and extended due date but will review...	30/11/2021	06/01/2022	
																				Demand and Capacity model for diabetes	Greenway, Laura	[01/02/2022 15:49:58 Laura Greenway] business case submitted awaiting outcome	31/01/2022	01/02/2022	
																				Liaise with Steve Hams to raise this diabetes risk onto TRR	Hitchman, Gavin	Paper completed on the Diabetes risk that takes through more detail that the risk register. Shared with Chief Nurse but he is now on AL. Shared with Medical Director & Deputy Chief Nurse to ask for sponsorship. Chief Nurse is back Monday 5th October and will reply.	05/10/2020	25/09/2020	
																				New Elearning module in progress	Greenway, Laura	[01/02/2022 15:50:37 Laura Greenway] now in use - to monitor feedback and effectiveness of this	01/05/2022		
																				to complete bimonthly audit into inpatient care for diabetes	Greenway, Laura	[01/02/2022 15:51:09 Laura Greenway] completed for CGH in Dec - showed positive results. To do GRH	01/05/2022		
3257	WC3257Gyn	12/06/2020	Gynaecology	The risk of not having a dedicated gynaecology bed base staffed by gynaecology nurses to keep women safe from avoidable harm and to provide the right care and treatment.	Hutchinson, Becky	Loss of gynaecology ward due to Covid 19 -temporary reduced bed base within surgical division, women being accommodated on various wards throughout the Gloucester Royal site, staffed by general nurses. Dedicated 24 hour telephone advise line has had to be withdrawn	Women not receiving specialised nursing care Patients seen in Gynae outpatients who require an inpatient bed remaining after the facility closes at 5pm Nursing roving team not covering 24 hour period to support patients in different ward environments	- Poor quality care for women - Gynae nurses having to work beyond hours to support care of patients in outpatients as no appropriate setting for women to be admitted to. - staff burn out increase in nursing bank costs to support this - Failure of appropriate post-operative care/observations resulting in delayed return to theatre and potentially not recognising post-operative complications endangering life. - Women with potentially complex needs undergoing Gynae operations or admissions being cared for in mixed sex units therefore not meeting RCOG standard of care - Unable to provide emergency telephone advice to women who are suspected of ectopic pregnancy or who are undergoing a miscarriage, out-of-hours - Women with heavy pv bleeding and abdominal pain following misoprostol pre-operatively in an inappropriate setting- out-patient area or treatment room - Women attending for miscarriage management and termination of pregnancy being accommodated in outpatient setting prior to surgery and are not allocated a bed resulting in discharge from theatre recovery without inpatient facilities. - Lack of privacy and dignity - Partners not always able to be accommodated to remain with women - Women who are having miscarriage in inappropriate environment +/- inexperienced staff potentially affecting patient experience also potential lack of privacy and dignity due to sharing bathroom/toilet - Potential failure of recognising appropriate medical intervention required for women who collapse during miscarriage - Women who are having procedures for miscarriages or termination for abnormality being discharged from theatre recovery - Lack of clinical expertise to advise and counsel women regarding consent for cremation of fetal products potentially causing more emotional distress. - Potential failure to recognise early warning signs for women with gynae' problems i.e. ectopic pregnancy -potential to fail to act on ruptured ectopic - Inappropriate bladder care post-operatively resulting in short or long term complications and damage due to either lack of bladder drainage, premature removal of catheter or unnecessary catheterisation - Delayed discharge for women with hyperemesis due to insufficient treatment/rehydration during in-patient stay - Follow up appointments not made for patients when discharged from in-patient setting resulting in lack of timely review of patients/further assessment/investigations - Unable to meet NHS England principle of 'Right care, right skills, right place, right time' - Not meeting standard of quality care for RCOG standard 46 - Difficult to provide gynae	Quality Delivery Group, Divisional Board - W & C	Quality and Performance Committee, Trust Board, Trust Leadership Team	31/05/2022	Quality	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	1 - 3 Low risk	•Specialist gynae nurses to support in-patient care and nursing staff regardless of patient location during daytime shift •Training provided to 2b staff •Written guidance provided to 2b staff •Set up of emergency gynae assessment unit in out-patient setting- to improve flow through ED •Women attending for SMOM and genetic abnormality STOP pre-operatively seen in GOPD in order to provide emotional support and complete necessary documentation while 2b not available- staff beginning their shift early to facilitate this •Helpline for early pregnancy patients provided during EPA office hours •Women with hyperemesis admitted to maternity ward if there is capacity •Women who are having medical management of miscarriage given a choice of being admitted to Delivery suite if capacity allows and if patient in agreement •Checklist completed for theatre/2b/ED for completion of documents and consent forms for pregnancy loss/sensitive disposal •Patients who are stable and suitable to be transferred to SAU while awaiting an in-patient bed from GOPD after 17:00hr with gynae nursing support •Emergency contact details of gynaecology staff provided to SAU •Nurses from within gynaecology division staying after their contracted hours to stay with patients after 17:00hrs if no suitable bed to be transferred to- until such times that this can happen •Trial without catheter (TWOC)for post-operative patients taking place in GOPD • ANPs to carry bleep in roving nurse absent during clinical hours to provide advice to inpatient staff	•Unable to meet quality standards of care as per RCOG, CQC framework and NICE guidance •No regular planned STOP list •No gynaecology nursing support/care for patients 24hrs/7 days a week •No nurse with specific gynaecology training(RCOG standard 48 /49 on each each shift –CQC) •Frequently no suitable location for patients from emergency gynae' assessment unit to be admitted into after 5pm •No suitable environment to give misoprostol prior to planned SMOMs or STOP, particularly if multiple patients •Lack of beds resulting in women having SMOMs and STOP's discharged from theatre recovery with no toilet facilities/privacy •Lack of side rooms/appropriate setting for women who are miscarrying requiring admission. RCOG quality standard 46 women should have provision of side rooms •No helpline for women who have attended early pregnancy assessment clinic outside of office hours (NICE guidance 126) • SAU frequently do not have capacity after 5pm therefore patients have to be returned to ED if long wait for bed •lack of gynae nursing support out of hours or if gynae roving nurse off sick	•Retrospective audit of care given to hyperemesis patients as per guidance, further prospective audit planned •Gynaecology dashboard monitored and discussed within division monthly •Monitoring of Datix at monthly risk and gynae governance meetings •Monitoring of complaints and risks within division Monitoring the patient location of where gynaecology inpatients are accommodated	Write a business case to ensure correct staffing	Hutchinson, Becky	[10/12/2021 12:49:00 Becky Hutchinson] roving nurse provided 7 days a week during daytime shift. current discussions around securing a specific area for gynaecology but no clear plan. Staffing unable to be reviewed until permanent area secured for gynaecology in patients [11/02/2021 11:35:32 Becky Hutchinson] several discussions over the last few months with Vivien Mortimore, Carole Webster and Steve Hams about staffing for gynaecology in-patients. Staff approached on 9a if would be interested in supporting current model of care-minimal staff response. gynae nurses still currently working with medical division. currently updating the risk on the register to reflect current situation	12/10/2020	10/12/2020	
																				write an action plan for changes to 2b to support gynaecology in-patients	Hutchinson, Becky	[07/12/2021 16:48:23 Becky Hutchinson] 7/12 further training arranged with the ward 2b staff due to change in staffing [19/02/2021 12:53:01 Becky Hutchinson] training sessions to 2b staff increased written guidance provided and updated Aishling invited to risk management meetings for gynae changes made to day room to create a treatment type room due to Covid and influx of other specialities and uncertainty of long-term plan for gynae no further works requested	31/01/2021	19/02/2021	
																				to rind suitable location for gynaecology in-patient service	Hernandez, Judith	[09/09/2021 12:04:14 Jossette Jones] Action reoppened [28/05/2021 10:20:21 Becky Hutchinson] gynaecology currently located with 9a. 6-7 beds although some patients on 5th floor despite 7 beds not filled with gynae on 9a. nursing staff returned to 9a with the exception of 1.9 WTE still roving until end of September. meeting to be organised with medical and surgical division to discuss long term plan for gynae.	26/11/2021	28/05/2021	
																				Identify suitable bed base with correct capacity both short and long term	Holdaway, Matt	[07/04/2022 17:14:10 Lee Troake] [07/04/2022 17:13:52 Lee Troake] bed base identified on 2a and works in scope for preparing this area for gynae patients [07/12/2021 16:52:02 Becky Hutchinson] ongoing crisis with beds throughout hospital therefore no possibility for change in short term plan in the next 6-8 weeks. gynae strategy being developed for long term plan and goals [07/04/2022 17:13:52 Lee Troake] bed base identified on 2a and works in scope for preparing this area for gynae patients [07/12/2021 16:52:02 Becky Hutchinson] ongoing crisis with beds throughout hospital therefore no possibility for change in short term plan in the next 6-8 weeks. gynae strategy being developed for long term plan and goals	31/03/2022	07/04/2022	

									nursing care to patients in a timely manner in different locations with minimal Gynae nursing support available - Unable to provide 24hr helpline for patients seen within early pregnancy assessment clinic (as												Work with site team to cohort gynaecology patients to identified bed base	Hutchinson, Becky	[08/12/2021 15:19:40 Becky Hutchinson] Becky Hughes regularly reminding site team to cohort gynae patients on 2b. Frequently visible during site meetings.	31/12/2021	10/12/2021
2404	D&S2404CHaem		02/12/2016	Clinical Haematology	Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Johny, Asha	Increased workload with no subsequent increase in resource to support service provision. Lack of trained haematology consultants to fill vacancies. 4 consultants left the service in 2021, one taking early retirement and 2 leaving the service due to unsustainable workload demand. One newly recruited consultant in 2021 planning to resign (now resigned). Vacancy factor of 30% for consultant staff, with additional sickness to cover.	Lack of capacity to meet demand, working over and above full capacity Delayed diagnosis and treatment on 2WW pathway Failure to meet 2WW and 62 day targets Unsafe staff levels to manage workload Time off with stress for both medical and nursing staff Shortage of review slots in both OP and day unit to facilitate early discharge or follow up post discharge Cost of locum £211,000 per annum WLI clinics Missed/delayed cancer diagnoses with litigation risk Consultant staff are unable to	Significant patient safety risk as waiting list of both new and follow up patients is over 16 months. Missed relapse and opportunity for early intervention Avoidable death due to delayed treatment Toxicity due to inadequate monitoring Loss of income for the Trust due to lack of OP capacity Reduced health and wellbeing, stress and anxiety. Poor job satisfaction and very low morale (documented in external review) Lack of capacity to meet demand has led to delayed cancer diagnosis, missed relapse of cancer and lack of monitoring to intervene early.	Divisional Board - D & S, Quality Delivery Group, People and OD Delivery Group	Quality and Performance Committee, People and OD Committee	07/06/2022	Safety	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 - Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place. Update August 2021- No locums available (agency or NHS) for over 3 months Urgent and chemotherapy	Ongoing transferral of 20% patients to ensure urgent chemo patients can be seen, leaving patients at risk. 30% vacancy factor at consultant level, with additional sickness. Staff are at risk of burn out and further resignation likely. No paid SPA time or payment for additional roles/management Trust does not offer the same recruitment package as other Trusts and therefore recurrent failure to recruit from outside the area.	Monitored via the specialty sickness and staffing report	Develop Business case to meet capacity demand	Iles, Tracy	Case agreed after last TLT	15/03/2017	15/03/2017
																						succession planning for consultant retirement	Johny, Asha	New consultant appointed	15/11/2019	22/09/2020
																						Raise with divison to bring recruitment incentive requirements to PODOG	Johny, Asha	[07/04/2022 18:22:20 Asha Johny] Advertised with incentive, recruited to one post, consultant due to start July 2022	31/12/2021	07/04/2022
																						Develop a business case for non-medical prescriber to help with clinics	Johny, Asha	[07/04/2022 18:22:50 Asha Johny] in progress. Intolerable risk process has allocated additional funding, case to be developed	31/12/2021	07/04/2022
																						Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Johny, Asha	[07/04/2022 18:23:21 Asha Johny] Explored with Bristol, no current ability to assist with this	31/12/2021	07/04/2022
2669	C2669N		06/02/2018	All Specialties, All Ward Areas	The risk of harm to patients as a result of falls	Bradley, Craig	Patients falling during in-patient episodes due to lack of / inadequate assessment and controls and not receiving adequate post-falls management.	Fall resulting in harm to a patient	Patient suffering a moderate or serious injury Increase in complaints Increase in claims Increase in coroner reviews Increased patient length of stay Increased workload for staff Increased stress for staff Decreased patient experience Decrease in patients quality of life Increase in health concerns, possible disability for patient	Divisional Board - Corporate / DOG, Quality Delivery Group	Quality and Performance Committee, Trust Leadership Team	29/04/2022	Safety	Major (4)	Possible - Monthly (3)	8 -12 High risk	4 - 6 Moderate risk	1. Falls prevention assessments on EPR 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6. Falls prevention champions on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	Non-completion of falls prevention assessment including lying and standing blood pressure not being completed or recorded Non-completion of actions in the Trust Falls action plan Incorrect RN:HCA ratios, use of temporary staff Difficulty attending local falls meetings due to operational pressures	Action plan monitoring Falls dashboard National Falls Audit Divisional Reports/dashboards	Discussion with Matrons on 2 ward to trial process	Monro, Andrew	Limited availability of staff to attend ward when notified Process when attending is to check that all documentation has been completed.	07/07/2017	07/07/2017
																						Develop and implement falls training package for registered nurses	Bradley, Craig	Falls training package in place. Ongoing mitigation.	31/01/2020	27/02/2020
																						develop and implement training package for HCAs	Jordan, Nadine	[24/05/2021 09:02:45 Lee Troake] Training now in progress Nadine has worked with high risk areas such as AMU Training postponed due to Covid-19 To be rearranged	31/03/2021	24/05/2021
																						#Little things matter campaign	Bradley, Craig	Update to Falls Group by Matron Matt Little was that this campaign has ended, to be presented at SNMC	28/02/2019	22/02/2019
																						Discussion with matrons on 2 wards to trial process	Bradley, Craig	Process now well underway across all divisions	29/03/2019	22/01/2020
																						Review 12 hr standard for completion of risk assessment	Jordan, Nadine	Policy amended August 2020	30/07/2020	26/08/2020
																						Alter falls policy to reflect use of hoverjack for retrieval from floor	Jordan, Nadine	Falls policy updated and action cards written to reflect the use of appropriate equipment to retrieve a patient off floor	30/07/2020	26/08/2020
																						review location and availability of hoverjacks	Jordan, Nadine	Hoverjacks purchased and distributed around both sites. GRH locations AMU, CCU/HASU, 3b (covering 2nd and 3rd floor), 4a (covering 4th and 5th floor), 6b (covering 6th and 7th floor), 9b (covering 8th and 9th floor), 1 remaining in the equipment library CGH locations Ryeworth (covering Ryeworth and Guiting), Woodmancote (covering Woodmancote and Knightsbridge), Bibury (covering Bibury and Snowshill), Prescott (covering Prescott, Rendcombe, Lilleybrook, Kemerton and Chedworth), Alstone (covering Alstone, Dixton and Hazelton), 1 remaining in the equipment library They are all labelled with where they are all located and for whose use, also logged with the equipment library.	18/01/2021	05/01/2021
																						Set up register of ward training for falls	Jordan, Nadine	on going -register taken at each training session	31/03/2020	06/05/2020
																						Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR	Potente, Leanne	[21/07/2021 08:22:07 Carol Cooper] Nadine Jordan has emailed the ward regarding completion of EPR following Leanne leaving trust prior to completing action	30/04/2021	21/07/2021
																						Discuss flow sheet for bed rails on EPR at documentation group	Bradley, Craig	[08/06/2021 09:53:39 Craig Bradley] Complete - now live on EPR	30/04/2021	08/06/2021
																						W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell	Bradley, Craig	[25/03/2022 16:07:52 Craig Bradley]	30/09/2021	25/03/2022
																						Review use of slipper socks with N Jordan	Bradley, Craig	[25/03/2022 16:07:56 Craig Bradley]	29/10/2021	25/03/2022
																						SIM training to use hoverjack on 7a	Jordan, Nadine	[25/03/2022 16:08:03 Craig Bradley] [30/09/2021 11:22:15 Carol Cooper] Transferred over from W139167 July 2021 On hold due to pandemic. All wards now have access to Hoverjack, located on alternate floors in Tower Block [30/09/2021 11:22:15 Carol Cooper] Transferred over from W139167 July 2021 On hold due to pandemic. All wards now have access to Hoverjack, located on alternate floors in Tower Block	30/11/2021	25/03/2022
																						Following presentation of W168912 N Jordan to attend ward to review completion of falls documentation and required management of patient following assessment by staff	Jordan, Nadine	[16/02/2022 07:49:58 Nadine Jordan] Ward had education session on completion of falls documentation	28/02/2022	16/02/2022
																						Following presenntation of W171436 to PHH N Jordan to forward information to purchase slippers for patients in ED	Jordan, Nadine	[20/01/2022 07:31:56 Nadine Jordan] Email sent to Heather Pearce and Debra Ritsperis with the information around slippers	31/01/2022	13/01/2022
																						W165353 Nadine Jordan to review with 9a x-ray identifying # and communication of #	Jordan, Nadine	[16/02/2022 07:47:36 Nadine Jordan] Confirmed #- presented at Preventing Harm Hub	02/03/2022	16/02/2022
2895	F2895		05/03/2019	Trust Management Team	There is a risk the Trust is unable to generate and/or borrow sufficient capital to cover its capital programme (estates backlog value @2021 £72M of which £43M is critical infrastructure), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and	Lanceley, Simon	Inability to generate and borrow sufficient capital	Failure of critical equipment and/or buildings	Risk that patients and staff are exposed to service interruptions	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Finance and Digital Committee	GMS Board, Trust Leadership Team	08/06/2022	Environmental	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	8 -12 High risk	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI;	1. Restriction/availability of sufficient capital funding to resolve maintenance backlog; 2. Trust to undertake a comprehensive physical condition and/or targeted asset lifecycle survey to determine the current cost level of backlog maintenance to the retained estate;	Reporting and monitoring through E&F Committee and Contract meeting	1. Prioritisation of capital managed through the intolerable risks process for 2019/20	Johnson, Karen	19/20 complete	30/04/2020	25/09/2020
																						escalation to NHSI and system	Johnson, Karen	[12/03/2021 14:51:10 Lee Troake] escalated to NHSI and system	30/04/2020	12/03/2021
																						To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Johnson, Karen	[18/03/2022 13:53:14 Johanna Bogle] complete	31/03/2022	18/03/2022

2613	M2613Card	29/11/2017	Cardiology	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Mills, Joseph	Ageing profile of Cardiac lab Room 1; 14 years old,Room 3 currently 11 years old. Both are outside the recommend RCR 7 years guidance for replacement, notice served by GE on maintenance contract for Room 1 to expire December 2020.	Prolonged down time resulting in deteriorating RTT, delayed treatment times and potential patient harm. Negative impact on patient flow and length of stay due to down time and conflicting of scheduling with elective work.	Harm to patients due to excessive exposure to radiation. Delay in treatment due to increased down time and Primary PCI roll out of 24/7 services in-line with Trust strategic vision. Impact on in-patients and elective patients resulting in an increased length of stay and potential harm due to lack of procedural functionality. Inability to recruit and retain sufficiently trained staff without	Capital Control Group, Centre of Excellence Delivery Group, Divisional Board - Medical	Service Review Meetings	31/05/2022	Safety	Major (4)	Possible - Monthly (3)	8 -12 High risk	4 - 6 Moderate risk	Modular lab in place from Feb 2021 Maintenance was extended until April 2021 to cover repairs Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	Lab 1 – maintenance extended until April 21 but with no promise to be able to source parts or fix, so pretty precarious situation if it breaks Mobile lab delivered in Dec 2020 to CGH, issue with access, had to employ company to build a link corridor, finished and ready to use from 15/2/21, we moved lab 1 to mobile unit on Wednesday 17/2/21 after 2 days of training	Radiation protection monitoring of dosages monthly (TLD's staff monitoring badges) within the lab. Annual equipment service (completed on weekends to prevent a loss of activity). Reporting of image quality concerns to GE and radiation protection team.	This has been worked up at part of STP replace bid.	Brockie, Nicola	MES bid is on-going, review meetings monthly.	21/01/2019	07/12/2018
																				Submission of cardiac cath lab case	Olivant, Evelyn		11/03/2020	04/03/2020
																				Procure Mobile cath lab	Mills, Joseph	Mobile lab procured, contract agreed, meeting set up	01/12/2020	03/12/2020
																				Project manager to resolve concerns regarding other departments phasing of moves to enable works to start	Hewish, Tom		31/03/2021	11/06/2021
2517	D&S2517Path	15/05/2017	Pathology	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Lewis, Jonathan	Temperature control across the Pathology laboratories is inadequate affecting Histopathology, Mortuary and Stores, Microbiology, but especially Clinical Chemistry and Haematology and Transfusion. Air conditioning systems at Cheltenham are not adequate for purpose nor are cooling systems in Gloucester. This used to be a problem only in summer but is now all year with temperatures uniformly over 25oC in Chemistry and over 30oC reached in parts of the Chemistry laboratory in winter.	Ambient air temperatures are not maintained within acceptable ranges for analyses and storage of reagents Air temperature outside the standard 20-25oC range is not suitable for reagents and analysers. Room temperatures frequently reach level of 30oC and above during the summer months, causing problems for the mortuary body store and for lab areas. Over summer of 2019 temperatures reached 34oC in Chemistry in Gloucester, noting that a temperature of 35oC results in complete shut down of all analytical equipment in the laboratory (Datix W112541 and W112544).	Potential for loss of ability to process Pathology, especially Clinical Chemistry samples on one side of the county, leading to delayed turnaround times, inability to support A&E waiting times, and various urgent clinical pathways thus affecting patient safety. Temporary withdrawal of part of the repertoire of tests across all laboratories (as equipment failure noted across all disciplines at times of elevated ambient temperature). Risk of reporting incorrect results. Prolonged turnaround times due to transporting tests off site, reorganising the location of reagents to preserve stability (£100k of reagent in use at any one time in Chemistry alone, similar in other labs). Frequent recalibration of equipment where the calibration is temperature sensitive and thus increased cost of additional calibration material and loss of staff time with potential quality impacts	Divisional Board - D & S		31/05/2022	Statutory	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	Air conditioning installed in some laboratory (although not adequate). Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis. Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	The current ventilation systems do not perform adequately when the external air temperature rises. Temporary air conditioning units do not provide sufficient cooling. The air conditioning units blow cold air onto sensitive equipment which results in fluctuations in operating temperature that requires recalibration. The AC needs to move or we need deflectors to divert the air flow. As yet, there is no agreed timetable to complete the works ahead of the warmer weather in spring 2022 in GRH. High risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab may also be affected; resulting in a total loss of service The ventilation systems in other areas are inadequate for full control. If work has to be transferred to Bristol this will compromise their capacity and adversely affect turnaround times for laboratory services (affecting patient safety	Daily temperature monitoring of max an min temperatures. Alarms when temperatures exceed limits. Air conditioning equipment downtime log to record breakdowns	Review performance and advise on improvement	Hull, Terry	[28/10/2021 17:57:14 Terry Hull] Works underway to CGH Pathology. Completion 12/22 GRH under assessment Work scheduled in 2020/20 Capital	31/03/2022	
																				Review service schedule	Hull, Terry	[28/10/2021 17:58:39 Terry Hull] Works scheduled in 2020/20. Capital Temperature control works underway to CGH Pathology, completion expected 12/22 Works scheduled in 2020/20. Capital	31/03/2021	28/10/2021
																				A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed	Walsh, Anthony	Risk assessment has been completed and reviewed.	28/09/2018	19/11/2019
																				A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Walsh, Anthony	Draft Business Case developed but not required since the risk and mitigating actions had already been accepted and funding set aside.	31/12/2019	02/03/2020
1850	C1850NSafe	16/01/2014	All Ward Areas, Emergency Department	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour whilst on the ward. the The risk of a prolonged inpatient stay whilst awaiting an Adolescent Mental Health (Tier 4) facility or foster care placement.	Freebrey, Clare	Admitting and providing care for children and young people with significant mental health needs to a non-mental health inpatient environment. Children and young people are admitted in crisis for assessment and essential medical care, but stay longer than required because the determined discharge destination of choice is a Tier 4 bed.	Delayed treatment for their mental health condition or emotional dysregulation. There is significant risk of these patients further harming themselves or other patients, staff and visitors as the resources available to monitor and manage these patients effectively in an acute Trust is limited. There are no on-site specialist facilities or clinical expertise in adolescent mental health	Potential deterioration in presenting condition Child not receiving effective /safe care for their condition in an appropriate, safe and secure environment Additional agency RMN's are employed to support the child, but these staff are of inconsistent quality and availability when needed. Financial implications of employing additional staff with adolescent mental health expertise to monitor and supervise. Reduced availability of staff to	Divisional Board - Corporate / DOG, Divisional Board - W & C, Quality Delivery Group, Safeguarding Strategic Group	Quality and Performance Committee, Trust Board, Trust Leadership Team	24/05/2022	Safety	Moderate (3)	Likely - Weekly (4)	8 -12 High risk	4 - 6 Moderate risk	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC and commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff after difficult incidents	Additional nursing staff for Children's Centre to provide enhanced nursing care to these children. Additional finance to cover cost of RMNs	Datix V&A/Sanctions Group reviewing all incidents and applying sanctions following MDT meetings	Develop Intensive Intervention programme	Mortimore, Vivien	Work cintinues to improve the pathway for children with no health needs. This action sits with GHAC and the commissioners to progress.	01/04/2020	14/04/2020
																				Escalation of risk to Mental Health County Partnership	Arnold, Maggie	Completed, Commissioners have invested in increased services due to be implemented and monitored by the End of March 2017	29/04/2016	29/04/2016
																				Escaled to CCG	Freebrey, Clare	Meeting held and it was agreed that they would raise this and allocated a designated social worker to work with the ward to avoid issue trying to contact different social workers for each child.	31/07/2020	24/07/2020
2976	D&S2976Rad	09/07/2019	Breast, Breast Screening Service, Imaging	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Chatzakis, Georgios	Shortage of Radiology Breast specialty Doctors	Inability to see patients within defined targets. Additional workload to other members of staff.	Breaching Screening targets and 62 day cancer targets. Stress levels increased. Sickness levels possibly may rise. Due to reduction - cancellation of clinics is occurring - The following data for the period 01.04.21 – 31.10.21 which is only a snapshot but gives an indication of numbers: Reduced No's in Screening Assessment Clinics due to staffing: 6 clinics Cancelled Screening Assessment Clinics: 16 Clinics Reduced to one imager in Symptomatic Clinic: 28 Clinics. Due to reduction - cancellation of clinics is occuring	Quality Delivery Group, Screening Performance Committee, Trust Health and Safety Committee	People and OD Committee, Quality and Performance Committee	29/04/2022	Quality	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	Additional clinics covered by current staff. Have reduced screening numbers identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are similar.	Working through process to replace staff who have retired. 1 Member of staff who plans to retire in approx. 12 months Member of staff can go off sick with no replacement in post to cover work including MDT National shortage of breast radiologist Current other radiologist who undertake some Breast work are unable to work additional PA for breast Is breast radiology reporting going to be centralised as unable to outsource this. 2 WTE Gap in consultants as require 3.7 WTE establishment with actually only 1.7 WTE currently covered	Monitoring targets and breaches Backlog MDT attendance	meeting with HR to progress replacement of staff in Breast screening	Holland, Alex	[01/04/2021 17:26:36 Alex Holland] Meetings have taken place. Med staffing & Locums exploring options via ID medical. Enhanced package also to be offered to substantive role as now hard to fill vacancy	02/09/2019	01/04/2021
																				Arrange meeting to discuss with Lead Executive	Biston, Cathryn	[02/12/2021 13:10:58 Mary Barnes] Risk discussed at RMG with executives and accepted as Trust Risk [28/10/2021 12:02:12 Joanne Harvey] There is a meeting to discuss additional information required for this risk the week of the 2ist of November - It will then be forwarded to the exec sponsor [30/09/2021 14:55:34 Mary Barnes] risk reviewed. Risk to be reviewed by GC and JH before ensuring meeting with executive by November RMG	30/11/2021	01/12/2021
																				Develop escalation process for when Breast Radiologist is not available to provide service	Chatzakis, Georgios	[06/10/2021 11:11:29 Georgios Chatzakis] When the only FT Breast Radiologist is not available to provide service, eg. annual leave, sickness,other part time colleagues stepping in if possible and if not possible clinics are cancelled/reduced.	01/02/2022	
																				Discuss the possible set up of national reporting center	Holland, Alex	[05/04/2022 13:17:50 Heather Nicolson] Discussed but not agreed, due to the impact on patient experience and continuity of care to remain local	25/02/2022	05/04/2022
																				widen recruitment net to include head hunter agencies using Trust agreed supplier listlist	Holland, Alex	[05/04/2022 13:16:55 Heather Nicolson] use of partnership locum agency	25/02/2022	05/04/2022
3611	IT3611CYBER	16/09/2021	All Specialties	The risk of unauthorised and malicious access to the GHT and ICS network via an unpatched application (Office 2010) that is out of support and in wide use across the Trust.	Turner, Thelma	Office 2010 is an outdated version of the Microsoft Office suite. Now over 10 years old it is end of life and no longer supported by Microsoft.	As the product is out of support Microsoft is no longer developing fixes for any vulnerability found within the Office 2010 suite. As a result it no longer receives security updates. This results in the trust losing a vital layer of our defence in depth approach to cyber security	Office 2010 is vulnerable to cyber threats that might arrive as document attachments. As the application is in use across the organisation by approximately 8,500 users any successful malicious access would have widespread impact. Alongside our clinical systems, GHFT relies heavily on the Microsoft Office 2010 suite of products which includes Outlook, Excel and Word for day to day information management. It would only take one malicious attachment to be opened on a vulnerable device to start a potentially catastrophic chain reaction.	Digital Care Delivery Group, Information Governance and Health Records Group	Finance and Digital Committee	30/05/2022	Business	Catastrophic (5)	Unlikely - Annually (2)	8 -12 High risk	4 - 6 Moderate risk	Defence in depth approach; In addition to application security which is the gap to which this risk relates, NHSmail is protected by layered security solutions which aim to remove threats before the email is delivered. SBS blocks access to malicious sites MDE prevents malicious activity on devices, complimented by Sophos Central with InterceptX. Users are not permitted to install applications and we have limited numbers of privileged accounts.	Additional comms about email attachment security Updated plan for moving Trust use off Office 2010. Project to migrate to Office 365 has been on hold following risks identified in initial plan. No longer a gap as project approach has been adjusted to using Office 2016 as an interim step to moving to office 365.	The N365 (now 2016) project is monitored via monthly reports to Digital Care Delivery Group DCDG	Project approach	Atherton, Andy	[03/02/2022 15:17:30 Thelma Turner] Revised approach agreed to use 2016 as an interim step in the move away from office 2010	07/12/2021	01/12/2021
1798	C1798COO	09/07/2014	All Specialties	The risk of delayed follow up care due outpatient capacity constraints all specialities.	Zada, Qadar	A large backlog of patients following pandemic.	The list of follow up grew with limited risk stratification for booking patients according to the outcome of the previous appointment / clinical recommendation over an appropriate time frame. There is a significant capacity issue to processing the review of the numbers and limited capacity to undertake risk stratification of the patients on a follow up list.	Patients wait for extended periods of time without follow up review and / or we do not discharge patients in a timely manner back to primary care. This can result in a poor patient experience, a detrimental affect on their recovery or long term management and delayed diagnosis or treatment leading to avoidable harm.	Divisional Board - Corporate / DOG, Out Patient Board, Quality Delivery Group	Quality and Performance Committee, Trust Leadership Team	07/06/2022	Quality	Moderate (3)	Almost certain - Daily (5)	15 - 25 Extreme risk	4 - 6 Moderate risk	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the	Review at weekly Check and Challenge PTL meeting, with a focus that has demonstrated significant improvement. Focus continues of clearing the longest waiting patients. Some very specific speciality areas require additional capacity to see patients. Raised at Tri to Tri and Divisional Boards (Surgery; Medicine; W&C & D&S)	Performance manage the specialties through the PTL Individual specialty recovery plans & delivery against these plans underway and reviewed weekly (aggregate no's at Check and Challenge) and through Divisional Tri reviews.	1. Revise systems for reviewing patients waiting over time	Elyan, Sean		20/01/2017	20/01/2017
																				2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan	Taylor-Drewe, Felicity	Assurance and tracking in place through weekly check and challenge (with progress update) and through Divisional Boards and Planned Care Delivery Group	11/01/2018	01/03/2019
																				3. Additional provision for capacity in key speciliities to support f/u clearance of backlog	Taylor-Drewe, Felicity	additional funding for APS for ENT review and for Ophthalmology approx. 1,000 attendances	28/03/2019	29/03/2019
																				To resolve outstanding areas of concern	Hardy-Lofaro, Neil	[07/04/2022 11:30:47 Lee Troake] action unclear	31/10/2021	07/04/2022

2819	C2819N	06/11/2018	All Specialties, All Ward Areas	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	King, Ben	The inconsistent use NEWS2 in terms of frequency of observation, failure to identify and escalate the deteriorating patient.	Poor clinical decision making which could lead to patient harm.	Leading to failure to recognise the deteriorating patient which may cause serious harm to patients through treatment delays	Digital Care Board, Divisional Board - Corporate / DOG, Quality Delivery Group	Quality and Performance Committee, Trust Leadership Team	25/04/2022	Safety	Major (4)	Possible - Monthly (3)	8 -12 High risk	4 - 6 Moderate risk	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and Resuscitation Study Days o Ward Based Simulation o Acute Care Response Team Feedback to Ward teams o Following up DCC discharges on wards • Use of 2222 calls – these calls are now primarily for deteriorating patients rather than for cardiac arrest patients • Any staff member can refer patients to ACRT 24/7 regardless of the NEWS2 score for that patient • ACRT are able to escalate to any department / specialist clinical team directly • ACRT (depending on seniority and experience) are able to respond and carry out many tasks traditionally undertaken by doctors o ACRT can identify when patient management has apparently been suboptimal and feedback directly to senior clinicians	Implementation of a system of electronic Vital Signs would allow: Patients deteriorating to be identified more quickly There would be less chance of signs of deterioration going undetected Teams across the network could identify deteriorating patients in different areas Planning for workforce for the future as electronic obs would give clear picture of acuity of GHT patients Consideration being given to allowing patients / relatives permission to contact ACRT directly - currently the service is not sufficiently robust to introduce this but it needs to be considered	Recording Ongoing audit of in-patient ward performance • 5 patients per ward, every month • Face to face feedback to ward teams • Results circulated monthly to matrons and ward managers Monitoring Nursing Metrics NAAS component Recognition On-going audit of completed NEWS2 charts which should identify when need for escalation is recognised Reporting • Facility for Acute Care Response Team (ACRT)to identify suboptimal escalation (though currently some referrals directly to medical teams and do not come through the ACRT) Responding • ACRT able to identify when there has been an inadequate response to patient deterioration identified by NEWS2	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams	King, Ben	Introduction of Electronic Vital Signs (including Electronic Neuro Observations) on 17th March 2020. Generating lists for the medical staff and Acute care Response Team but the wards are still escalating deteriorating patients via the bleep system. The lists generated are of patients with NEWS2 scores of 1-4, 5-6 and 7 and over. Not introduced to the following areas that remain on paper based charts: Paediatrics, Maternity, ED, Recovery and DCC Staff are able to indicate on the system that help with deteriorating patients has been sought however sometimes, in this the early stages, evidence of who contacted who can be difficult to find. EPR team remain very much involved with the process and are addressing some of the 'snags' as they are identified.	31/12/2019	14/04/2020
																				Development of an Improvement Programme	King, Ben	Electronic Observations introduced in March 2020. Snags in system being identified, staff assimilating to its use. Now beginning the process of using information gathered and stored for analysis. Discussions ongoing as to how to make best use of the available data.	30/09/2019	06/05/2020
2424	S2424Th	16/01/2017	Theatres	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Matthews, Alexandra	Ventilation in theatre 1-10 at GRH and 3,4,5, phoenix and eye theatre at CGH are >10 years old. HTML new guidance has been issued - currently failing standards Risk of complete failure of ventilation system and/or inability to obtain parts	Failure of ventilation which would result in a loss of theatre activity Ventilation working at suboptimal levels	Loss of all activity in theatre for period of time required to fix problem. Financial impact of loss of activity Potential significant delays in management of patients awaiting surgery and impact on waiting list targets Cross infection risks for patients and staff with resultant increasing length of stay, cost of treating infection and sickness and absence of staff (refer to manufacturers selling points)	Divisional Board - Surgery, Estates and Facilities Committee	Quality and Performance Committee, Trust Leadership Team	03/06/2022	Business	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	Verification data demonstrates that failing to meet new HTML standards (add any issues with external contractor response)	Annual Verification of ventilation by approved person of all theatres. Surgical Site Infection data and Root cause analysis of surgical site infection Maintenance reports and details of break down	Write risk assesment	Chikwanha, Andrew	Action no longer relevant	30/03/2020	24/04/2020
																				Update business case for Theatre refurb programme	Matthews, Alexandra	Cathryn Biston to produce a new report on current state of all theatres for March 2017 as original is outdated by 10 years.	27/02/2017	27/02/2017
																				Agree enhanced checking and verification of Theatre ventilation and engineering.	Wells, John	monthly ventilation meetings to review all reports that come through estates and agree actions	27/02/2017	21/12/2017
																				meet with Luke Harris to handover risk	Chikwanha, Andrew		30/04/2018	15/06/2018
																				implement quarterly theatre ventilation meetings with estates	Tyers, Candice	Meetings now rescheduled with estates	30/06/2020	03/08/2020
																				gather finance data associated with loss of theatre activity to calculate financial risk	Bevan, Michelle		29/05/2020	19/05/2020
																				investigate business risks associated with closure of theatres to install new ventilation	Bevan, Michelle		29/05/2020	19/05/2020
																				review performance data against HTML standards with Estates and implications for safety and statutory risk	Bevan, Michelle	New standards are for theatres with specific dimensions. Theatres do not meet these dimensions therefore working off old standards. Plan in refurbishment to enlarge theatres	29/05/2020	19/05/2020
																				calculate finance as percente of budget	Matthews, Alexandra		29/05/2020	03/08/2020
																				Creation of an age profile of theatres ventilation list	Tyers, Candice	[05/01/2021 14:59:53 Candice Tyers] Completed and attached in progress documents on risk.	05/01/2021	05/01/2021
																				Action plan for replacement of all obsolete ventilation systems in theatres	Tyers, Candice	[08/03/2021 10:55:03 Candice Tyers] GMS have plan available with theatres 3 & 4commencing 21/22 [05/01/2021 15:06:31 Candice Tyers] Theatre has all the detail of the obsolete theatres and are creating a rolling replacement plan which will need capital support to action.	24/02/2021	08/03/2021
																				Five Year Theatre Replacement/Refurbishment Plan	Hull, Terry		30/06/2021	
																				arrange replacement valve and acurator for air handling unit TH1	Hill, Niki		31/03/2022	
3084	C3084	21/11/2019	All Specialties, All Ward Areas	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Troake, Lee	Currently using an outdated version of DATIX which has functionality issues for example: -inability to integrate with new applications, poor integration between clinical systems , HR systems and business data -no analytics module, lack of basic automation/does not detect data discrepancies (i.e. score calculating etc) -Poor audit trail in risk register module - no version control of	Unable to confidently compile accurate data to support compliance, quality and safety improvement and assurance. Manual processes have to be used to cleanse, extract and manipulate data, increasing the risk of human error and different reporting mechanisms across the Trust. Lack of good governance around risk, safety and document control.	Decision making and objective setting is influenced by risk data that lacks integrity. This may result in resources being misaligned to the risks. There may be missed opportunities or failure to address risks at early stage or mismanagement of risk exposing patients, visitors and staff. There is also an impact on productivity due to increased workloads / processing time required. This in turn increases	Divisional Board - Corporate / DOG, Finance and Digital Committee, Trust Health and Safety Committee	Finance and Digital Committee, Quality and Performance Committee, Trust Leadership Team	07/05/2022	Quality	Moderate (3)	Almost certain - Daily (5)	15 - 25 Extreme risk	4 - 6 Moderate risk	Governance process Reporting structure Patient safety and H&S advisors monitoring the system daily Monthly performance reports on new, overdue risks, partially completed risks, uncontrolled risks and overdue actions etc Risk Assessments, inspections and audits held by local departments Risk Management Framework in place	Lack of modern functional risk management software Lack of modern document control software for policies, procedures, risk assessments, safe systems of work, permits etc. Lack of central control of risk assessments, audits, inspections etc. - not visible to organisation Unable to electronically link an incident investigation to a claim - records and investigations	Corporate Risk Manager reporting to RMG, PODC and Audit and Assurance Committee Reports to H&S Committee and divisional H&S meetings	Prepare a business case for upgrade / replacement of DATIX	Collins, Victoria	[12/03/2021 15:51:06 Lee Troake] business case was provided along with quotes to Dan Corfield. Have moved due date as action owner is unable to complete the business case as DATIX have not responded to our queries on the new system. Further meeting with DATIX on 26 November 2020	15/02/2021	12/03/2021
																				Arrange demonstration of DATIX and Ulysis	Collins, Victoria	Demo arranged for January 23	31/12/2019	10/12/2019
2628	C2628COO	29/12/2017	Breast, Cardiology, Clinical Haematology, Clinical Immunology/Allergy, Dermatology, Ear, Nose and Throat, Gastroenterology, General Surgery, Gynaecology, Lower GI, Neurology, Ophthalmology, Oromaxillo facial, Outpatients, Paediatrics, Respiratory, Rheumatology, Trauma and Orthopaedics, Upper GI, Urology, Vascular	The risk of poor patient experience & outcomes resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards and the impact of Covid-19 in 2020/21.	Zada, Qadar	During C-19 the approach has been to treat in Clinical Urgency order and to review patients who were booked as new patients and those with a pathway under review. Whilst services have been reinstated as part of recovery, each service has a significant backlog which means patients are not managed within 18 weeks.	Failure to offer appointments in a timely manner, poor patient experience and potential risk of deterioration.	Intervention by Regulator Impact on Patient Experience. Potential patient harm. Impact on Trust Reputation. Failure to meet the National Performance Standards for RTT.	Divisional Board - Corporate / DOG, Planned Care Delivery Group	Quality and Performance Committee, Trust Leadership Team	07/06/2022	Statutory	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	Monitoring by clinical urgency and prioritisation is in place Additional capacity is being sought for each specialty Weekly review of PTL by the COO Monthly oversight by Improvement Board, led by CEO	Don't have sufficient capacity to reduce the backlog from the pandemic at a sufficient pace. Reduced available of the Independent Sector. High levels of medically optimised for discharge patients occupying bed base.	PTLs developed provides opportunity for daily monitoring by specialities. The numbers over wait bands and at patient level are reviewed weekly for each service line by the Deputy COO. AD for Elective Access attend Trak Recovery meetings. Support from Business Intelligence to work together to support the reduction in DQ errors, in particular specific teams for DQ03 and DQ12. Intolerable risk request for	1.RTT and TrakCare plans monitored through the delivery and assurance structures	Taylor-Drewe, Felicity	Speciality delivery plan in progress	28/03/2019	31/01/2019
																				Formally review the Bed modelling and scenarios proposed as part of H2 submission.	Hardy-Lofaro, Neil	[15/04/2022 11:52:52 Neil Hardy-Lofaro] Scenarios have been developed and considered as the Operational Plan is confirmed This has now been submitted. There will continue to be review throughout the year on a Quarterly basis	11/04/2022	15/04/2022
3536	WC3536Obs	20/05/2021	Maternity	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Stephens, Lisa	National and regional shortage of midwives compounded by the COVID pandemic, resulting in high levels of short term sickness and absence, along with current levels of long-term sickness and significant levels of maternity absence.	local unfilled shifts across both hospital and community based midwifery services	Unable to meet minimum staffing levels in the hospital; unable to cover on-calls in the community and provide a named midwife for every woman during the antenatal and postnatal period. Omissions and delay in care according to National and Local guidelines resulting in harm to mothers and or unborn/newborn babies Poor staff morale Non-mandatory training being cancelled E-Learning not being completed Lack of breaks Staff working unpaid hours as			29/04/2022	Safety	Moderate (3)	Almost certain - Daily (5)	15 - 25 Extreme risk	4 - 6 Moderate risk	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination. Recruitment for the new post of Patient flow coordinator Daily staffing call and twice weekly staffing review between matrons Use of the escalation policy; include use of non clinical midwives and on-call community midwives to support the service;	Attrition of new starters prior to commencing post Payment reward unattractive for on-call rota Potential dismissal of none vaccinated midwives circa 13 WTE across the service Poor compliance with completion of BR Plus acuity tool in GRH Birth Unit	Health Roster analyser collects staffing data for all areas of maternity including unfulfilled bank shifts. Monthly Maternity Acuity Birth Rate Plus® report for Delivery Suite and Gloucester Birth Unit,(to be introduced on to the Maternity ward in early 2022) Safer Staffing for inpatient Maternity areas (maternity ward & Stroud) monthly report LMNS combined Dashboard monitoring of actual birth:midwifery ratio Monitoring of outcomes on monthly dashboard and review of	Implement a rolling program of recruitment.	Woolman, Melanie	[08/07/2021 08:07:11 Melanie Woolman] ongoing recruitment advertising every month lead by T Browning [18/06/2021 12:26:10 Melanie Woolman] vacancy to advert closed on 2nd July, ongoing recruitment every 8 weeks planned.	26/07/2021	08/07/2021
																				review band incentives to support staff to undertake additional bank shifts as required.	Woolman, Melanie	[22/06/2021 13:40:05 Melanie Woolman] financial incentives for all midwifery staff working bank shifts advertised from today for 12 weeks until 14th September 2021	30/06/2021	22/06/2021
																				To review and update relevant retention policies	Wilson, Fran	Nursing Staff internal transfer guidelines now updated on the intranet. The process is proving to be easier and quicker for B5+B2 staff to move internally . Policies to focus on are flexible working (picked up in SPEIG) and retire/return policies. Exit process - work being led by Bilal Pandore	22/11/2019	15/09/2020

3034	C3034N	27/08/2019	All Ward Areas, Theatres	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	Holdaway, Matt	Overall shift fill of registered nursing staff is below 90% for surgery and below 95% for medicine. Overall substantive shift fill is below the organisation agreed standard of 75%Despite extensive recruitment and retention activities our ward based registered nurse vacancies rates have improved, but remain at 100 WTE.	Inability to fill all registered nurse rota gaps.	1, High temporary workforce requirement from agency registered nurses. 2, Agency workers unable to consistently and accurately adhere to Trust policies and procedures. 3, Insufficient registered nurses has been linked to substandard escalation of the deteriorating patient, harm from pressure ulcers and falls. 4, Poor compliance with 'high reliability' procedures such as infection control checks and equipment checks. 5, Additional workload intensity being placed on existing registered nurses and team members. 6, Lack of flexibility in deployment of registered nurses to meet unpredictable demands in patient care, especially during the winter.	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	People and OD Committee, Quality and Performance Committee, Trust Leadership Team	24/05/2022	Safety	Moderate (3)	Almost certain - Daily (5)	15 - 25 Extreme risk	8 -12 High risk	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes.	1, Strategy for international recruitment 2, Review and update of relevant retention policies and retention strategy 3, Staff engagement and well being - understanding what makes staff stay 4, Implementation of a real-time staff feedback tool to gain feedback on ward/department based issues.	1, Recruitment and Retention steering group reporting to PODOG 2, NHS Improvement Retention support programme 3, Nursing Metrics implementation 4, NAAS audits 5, Safety Thermometer 6, Staff survey 7, One Gloucestershire Repair network 8, Monthly review of ward based performance 9, Twice daily staffing calls provide real-time assurance of safe staffing levels.	Set up career guidance clinics for nursing staff	Wilson, Fran	X2 virtual career clinics/webinars were held in September'20 with the RN clinic having approx.50 attendees. Still considering the introduction of job boards and better use of internal adverts for career opportunities. Further scoping of career pathways design has taken place and working with comms to promote and also working with UOG and an IT student with building a careers app	13/01/2020	15/09/2020
																				Review and update GHT job opportunities website	Wilson, Fran	The internet and intranet links to nursing opportunities and vacancies still need improvement. Many links are leading to old branding and information e.g. discounts and benefits. Adverts and job descriptions are variable in quality and templates. There is still a need for a dedicated comms resource to promote jobs on social media, update websites, marketing etc to enhance Attraction of candidates to the Trust also need a dedicated page re career opportunities for staff within the Trust. Roll out of new generic B5 RN and B2 HCA job descriptions to take place by October which will align with the implementation of Trac (new electronic recruitment system)	16/12/2019	15/09/2020
																				Support staff wellbing and staff engagment	Wilson, Fran	Nursing survey completed in November with a return of 462 surveys - this then informed the NHSI retention action plan with staff engagement as a primary driver. Also working with GloStars visiting wards and speaking to NQN's and OSN's. Action to be moved to risk 1437	06/01/2020	17/01/2020
																				Assist with implementing RePAIR priorities for GHFT and the wider ICS	Wilson, Fran	Year 2 Nursing students and mentors event planned with our ICS colleagues and universities for March 4th 2020 at Kingsholm action to be moved to risk 1437	10/02/2020	17/01/2020
																				Devise an action plan for NHSi Retention programme - cohort 5	Wilson, Fran	retention action plan remains in place, needs review and updating	29/11/2019	15/09/2020
																				Trustwide support and Implementation of BAME agenda	Boston, Coral	BME Conference held 11.12.19 Yvonne Coghil and Habib presented WRES data to the Exec Board Further meetings to be arranged	02/03/2020	12/02/2020
																				Devise a strategy for international recruitment	Murrell, Mel	Interim arrangements for sourcing a cohort of 11 Registered Nurses via ID Medical commenced in November 19 with all 11 nurses arriving in February 2020. The long term contract for International Recruitment of Nurses and Medical Staff is currently being managed via a procurement process with contract award anticipated by end of January 2020	27/12/2019	07/01/2020
3295	C3295COOCOVID	20/07/2020	Booking Services	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Zada, Qadar	As a consequence of the Covid-19 pandemic a high number of patients were cancelled (outpatient and inpatient) during the months of March, April and	This results in an increasing backlog of patients for both outpatients and inpatients who experience delayed diagnosis and treatment.	Potential harm to patients, inequity in waiting times and patient complaints.	Divisional Board - Corporate / DOG, Quality Delivery Group	Trust Leadership Team, Quality and Performance Committee	30/05/2022	Safety	Major (4)	Possible - Monthly (3)	8 -12 High risk	4 - 6 Moderate risk	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS	Delivery of RTT performance is reliant on (a) sufficient capacity being available and (b) efficient booking systems to ensure timely and chronological	RTT performance is monitored on a regular basis. However since moving to a CAS no transparency exists of genuine wait times for New	COVID T&F Group to develop Recovery Plan to minimise harm	Troake, Lee		15/09/2020	15/09/2020
																				To resolve outstanding areas of concern	Matthews, Alexandra		10/12/2021	
3507	D&S3507RT	19/04/2021	Gynaecology, Oncology, Radiotherapy	The Safety risk of Radiotherapy patients being cancelled or referred to alternative Trusts due to failure of Microselectron HDR or associated equipment that is past its 10yr life expectancy period.	Moore, Bridget	Microselectron HDR unit, associated applicators and accessories are now past the 10yr expected lifetime. Our most commonly used cervical ring applicator is now obsolete but will remain supported for a short time but consumables can no longer be purchased.	If unable to fix the machine or applicator due to lack of availability of parts this will jeopardise the Trust's position as a Gynae oncology specialist centre. If the required applicator was not available for a particular patient there would be a significant delay to their treatment while other options were investigated - such as treatment at another centre subject to capacity or substandard treatment at this centre.	Patient lists would need to be cancelled or referred to another Trust. We would be unable to undertake the required level of specialist treatments to maintain our reputation. Staff will become deskilled Patients will have to travel longer distances Patients may be delayed and will receive compromised quality of care due to their care being split between us and other Trusts. Loss of revenue	Divisional Board - D & S	Quality and Performance Committee	10/06/2022	Safety	Major (4)	Possible - Monthly (3)	8 -12 High risk	1- 3 Low risk	Routine manufacturer maintenance and regular QA processes Service contract with manufacturer includes software only until July 2022 Stockpiled consumables for use and repair	Need to upgrade to Flexitron (new version of HDR machine) Unable to renew associated applicators, equipment, hardware and software Current software unable to be upgraded due to Windows 10 Due to demand Regional/Nationally, unable to send patients elsewhere for treatment due to the lack of capacity at other centres for HDR If current machine catastrophically fails, there will be a 3 month delay to purchase install and QA new machine to resume service.	QA records Breakdown/service records Datix submissions	To complete business case for replacement equipment	Calvert, Sinead	[18/11/2021 15:28:38 Bridget Moore]	31/08/2021	18/11/2021
																				To complete business case for replacement equipment	Hughes, Nina	[01/11/2021 09:33:10 Nina Hughes] The business case was submitted and is being taken to Risk Management group in November by Mark Petroni as stated in the Radiotherapy Service Managers Report to Radiotherapy subgroup 28/10/21	31/08/2021	01/11/2021
																				Progress business case	Latimer, Penny	[18/11/2021 15:28:30 Bridget Moore] Business case has been added to intolerable risk capital bids. Results expected in April 2022	29/09/2021	18/11/2021
2667	C2667NIC	05/02/2018	All Specialties	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	Bradley, Craig	Increasing numbers of patients experiencing avoidable hospital acquired C. difficile	Increased length of stay for patients, infection of other patients, closure of beds, increased antibiotic usage and poor patient experience and increased levels of avoidable serious harm Exceeding Trust agreed trajectory resulting in regulatory intervention.	The potential for increased patient harm, impact of effective patient flow as a result of high side room occupancy.	Infection Control Committee	Quality and Performance Committee	24/05/2022	Safety	Major (4)	Possible - Monthly (3)	8 -12 High risk	4 - 6 Moderate risk	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	Cleaning standards have not yet reached a satisfactory level. Cleaning standards and the number of hours provided by GMS is required to meet contractual levels. GMS have not provided the detail required on hours available per ward.	Monthly surveillance reporting to the Infection Control Committee and onward reporting to the Quality and Performance Committee.	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Bradley, Craig	Action plan updates given at ICC each month and Q&P quarterly	31/03/2021	08/04/2020
3103	D&S3103Path	27/12/2019	Pathology	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Rees, Linford	Temperature control across the Pathology laboratories is inadequate affecting all departments, but especially Clinical Chemistry. This used to be a problem only in summer but is now all year with temperatures uniformly over 25oC in Chemistry and over 30oC reached in parts of the Chemistry laboratory in winter.	Over summer of 2019 and 2020 temperatures regularly reached 34oC in Chemistry in Gloucester, noting that a temperature of 35oC results in complete shut down of all analytical equipment in the laboratory (Datix W112541 and W112544 & attached emails to GMS). During 2019, the GHT Chemical Pathology laboratories were	Potential for loss of ability to process Pathology, especially Clinical Chemistry samples on one side of the county, leading to delayed turnaround times, inability to support A&E waiting times, and various urgent clinical pathways thus affecting patient safety. Temporary withdrawal of part of the repertoire of tests across all	Divisional Board - D & S, Estates and Facilities Committee, Quality Delivery Group	Finance and Digital Committee, Quality and Performance Committee	24/05/2022	Statutory	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. Quality control procedures for lab analysis	The current ventilation systems do not perform adequately when the external air temperature rises. Temporary air conditioning units do not provide sufficient cooling. The air conditioning units blow cold air onto sensitive equipment which results in fluctuations in operating temperature that requires recalibration. The AC needs to	Daily temperature monitoring of max an min temperatures. Alarms when temperatures exceed limits. Air conditioning equipment downtime log to record breakdowns	Develop draft business case for additional cooling	Walsh, Anthony	Draft business case completed	08/01/2020	08/01/2020
																				Submit business case for additional cooling based on survey conducted by Capita	Walsh, Anthony	Business case not required as risk accepted by Trust and capital set aside for works to take place.	24/02/2020	24/02/2020
																				Rent portable A/C units for laboratory	Hull, Terry	Laboratory used 4 portable A/C units in summer 2019. Will likely need 4 - 5 for GRH and 1 - 2 for CGH.	15/05/2020	01/05/2020
																				to discuss alternative treatment options with upper GI surgeons	Webley, Sian	Discussed - option of bravo capsule to be considered	30/09/2020	24/09/2020
																				review cost implications and resources for treatment option of bravo capsule	Webley, Sian	Obtained finance information. Currently awaiting GI Physiology figures, time for result reading and endoscopy implications. All information obtained and emailed to Felicity Taylor-Drewe	31/12/2020	03/12/2020

3316	S3316	24/08/2020	Lower GI, Upper GI	The risk of not discharging our statutory duty as a result of the service's inability to see and treat patients within 18 weeks (Non-Cancer) due to a lack of capacity within the GI Physiology Service.	Hendry, Tracey	National shortage in GI Physiologists means that the service capacity is currently 7.5 hours per week which does not fit the service demand. Nationally GI Surgeons are undertaking this role however currently no time/ competence for GI surgeons locally to undertake this Backlog of patients due to covid 19	Significantly extended waiting time of patients who require GI Physiology studies (study of pressure, PH, impedance and tone of digestive tract) prior to being offered surgical treatment.	Increase in the number of 52 week breaches due to the waiting time. Currently there are 9 patients > 52 weeks awaiting GI physiology and an additional 105 patients(59 for Colorectal and 46 for Upper GI) < 52 weeks who are also likely to breach. Patient experience Impact on quality of life for patients with reflux symptoms	Divisional Board - Surgery, People and OD Delivery Group, Quality Delivery Group	People and OD Committee, Quality and Performance Committee	06/05/2022	Statutory	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	purchase of anopress machine for use by lower GI surgeons to reduce the numbers requiring GI phys Escalation of patients> 52 weeks to Head of GI physiology to review prioritisation Referral outside of Trust	No qualified competent staff to undertake the greater range of diagnostic tests currently undertaken by GI physiology Funding gaps due to referrals outside trust (loss of income)	RTT monitored through check and challenge	Further individual being trained in GI Physiology by Bev Gray. Individual will work 35.5 hours per week total, not all will be GI Physiology, hours TBC. Will increase GI Physiology capacity by >100%	Gray, Beverley	[06/05/2021 11:31:39 Beverley Gray] Further additional dates for training have been agreed and will start at the end of May. Ad hoc additional days have been booked in May [25/03/2021 14:47:40 Beverley Gray] Staff member has resumed training and is undertaking weekly session plus any additional ones that are run. She is also undertaking some additional sessions practising reporting skill outside of these practical training days. [01/03/2021 11:40:27 Lee Troake] Action re-opened as is not complete. Please confirm whether the individual will be trained after shielding ends and reset action due date. If you no longer plan to retrain anyone please confirm why and raise an action in line with what you plan to do instead to reduce the risk i.e. recruit etc. [16/02/2021 07:33:37 Beverley Gray] Member of staff has been shielding so no training sessions	30/07/2021	06/05/2021	
																				Capital application form completed, Candice Tyers presenting to MEF	Webley, Sian	Capital application completed. Await outcome of MEF. Application approved, equipment order with procurement.	14/12/2020	16/12/2020	
																				VCPs have been submitted / await outcome of approval	Gray, Beverley	[25/05/2021 16:26:51 Beverley Gray] VCP approved and recruitment is being undertaken to backfill the Resp post enabling the current member of staff to spend more time in training	30/04/2021	25/05/2021	
2715	S2715Th	03/05/2018	Theatres	The risk to quality of care of patients remaining in recovery when they require ward-based care	Beamish, Sally	Lack of inpatient beds leading to patients who require ward-based care remaining in Recovery where the appropriate facilities for their inpatient care are not available	Currently 181 incident linked to this risk - majority had potential for moderate harm Patients cared for in inappropriate areas with insufficient facilities e.g. bathrooms - patient have to use commodes Patients discharged from recovery without attending ward Patients unable to receive appropriate specialist care for their treatment pathway At peak times recovery capacity filled resulting in inability to recover postoperative patients with an adverse effect on operating lists and patient cancellations Due to overcapacity of recovery, insufficient staff to provide recovery care to obstetric theatres Breach in single sex rules in breach of national standards Missed outpatient appointments or follow ups when patients are discharged home from recovery	Patient cancellations Increased length of stay Compromised patient care due to inappropriate staffing levels Poor patient experience and complaints Incomplete discharge information Failure to arrange appropriate follow-up Reduction in capacity for emergency caesarean section Delays to treatment for obstetric patients Delays to emergency surgical lists with potential effect on outcome and length of stay	Divisional Board - Surgery, People and OD Delivery Group, Quality Delivery Group	People and OD Committee, Quality and Performance Committee	31/05/2022	Quality	Catastrophic (5)	Possible - Monthly (3)	15 - 25 Extreme risk	8 - 12 High risk	Breaches of policy escalated to bed management Operational policy for DSU Use of agency staff in recovery overnight Daily sit-rep	Lack of adherence to policy No ringfencing of the Recovery area	daily sit-rep incident trend reports Audit of patients staying> 2 hrs	escalate risk to divisional board	Tyers, Candice	Recovery now ring-fenced as per executive instruction in May 2018.	21/05/2018	06/06/2018	
																				escalate issues to execs and chief nurse	Bailey, Helen	issues escalated	31/05/2018	03/07/2018	
																				monitoring of impact winter plan	Chikwanha, Andrew	[15/04/2021 12:45:38 Nicola Holton] Audit report sent to Divisional Director of Operations on 03/03/20. Now ongoing assurance Audit report sent to Divisional Director of Operations on 03/03/20	21/04/2021	15/04/2021	
																				Monthly audit for overnight patients in PACU	Chikwanha, Andrew	ongoing audit	01/12/2020	19/11/2020	
																				collect data on direct discharges from recovery	Chikwanha, Andrew		31/07/2020	18/06/2020	
																				As per request from Liz Bruce please take risk to ECDG	Cooper, David		29/02/2020	18/02/2020	
																				Escalate issues to Div Tri and discuss increasing overnight PACU establishment	Chikwanha, Andrew		25/08/2021		
																				review SOPs	Beamish, Sally	[26/04/2022 17:25:34 Sally Beamish] SOP completed and with DDQN for surgery	31/03/2022	26/04/2022	
3223	C3223COVID	21/05/2020	All Specialties, All Ward Areas	The risk to safety from nosocomial COVID-19 infection through transmission between patients and staff leading to an outbreak and of acute respiratory illness or prolonged hospitalisation in unvaccinated individuals.	Bradley, Craig	•Social distancing cannot be implemented in the majority of clinical activities due the volume of inpatients during the pandemic •Limited evidence that screens between no SD beds are effective •Safe staffing ratios may limit on the Trust ability to open more inpatients areas •Facilities and specialised skills availability may impact on opening more inpatient areas •Asymptomatic COVID positive staff may attend work •Staff eating and drinking in the rest areas within 2m or sharing food •High number of patient moves increases risk to patient •Potential for unintended breaches of COVID infection control transmission based precautions such hand hygiene, changing masks when leaving the clinical area •Uncontrolled community transmission of COVID-19 increasing pressure on hospital	Increased infection transmission, high numbers of nosocomial cases within the Trust. Outbreaks of COVID-19 amongst staff leading to , additional illness and potentially death.	•High proportion of nosocomial (hospital-acquired) cases of COVID-19 cases •Adverse impact on the mortality rate •Green ward patients exposed to COVID-19 – significant numbers of patients isolated, impacting on admissions to the ward and placing green patients at risk of COVID-19 •Wards are closed to admissions a result of outbreaks, impacting on patient flow •Higher inpatient numbers due to prolonged stay •Higher readmission rate via ED •Increased staff absence due to self-isolation, outbreak, adding to pressure on resources during pandemic •Reduced availability of skilled professionals if outbreak occurs amongst specialist staff •Staff absence due to Test and Trace transmission	COVID-19 Task and Finish Group, Capital Control Group, Infection Control Committee, Quality Delivery Group, Risk Management Group, Trust Health and Safety Committee	People and OD Committee, Quality and Performance Committee	24/05/2022	Safety	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	•2m distancing implemented between beds where this is viable •Perspex screens placed between beds •Clear procedures in place in relation to infection control •COVID-19 actions card / training and support •Planning in relation to increasing green bed capacity to improve patient flow rate •Transmission based precautions in place •NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control •H&S team COVID Secure inspections •Hand hygiene and PPE in place •LFD testing – twice a week •72 hour testing following outbreak •Regular screening of patients •minimise transfer of patients from ward to ward	•Increased bed capacity to meet patient demand, which means not all beds have a 2m separation •Minor lapses in adherence to COVID security, PPE or hand hygiene measures can still lead to infection •Unable to social distance within the emergency department (despite RED/GREEN separation) Daily testing requested and not yet in place.	IPC Committee H&S Committee T&F Group TLT DOAG POD and QPC	CAFF inspections to be progressed	Bradley, Craig	[22/01/2021 09:54:46 Lee Troake] Inspections in progress	22/01/2021	22/01/2021	02/06/2021
3682	M3682Emer	22/11/2021	Emergency Department	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Nagle, Pat	Poor patient flow in the Emergency department is caused a lack of available beds throughout the hospital which in turn is a result of large numbers of medically optimised patients occupying inpatient beds. Medically Optimised for Discharge (MOFD) has reached a 12-month high, having increased by 16% to an average of 265 patients per day who no longer require acute hospital care. Patient demand has also changed. For example, with higher number of mental health patients seen in ED in the last 12	•The pressure and congestion in ED, resulting from the lack of flow, impacts on ambulance offloads, with 15-minute triage performance for ambulance arrivals dropping to 28.8% (February) •Ambulance handover delays >30 minutes are 1000+ per month; average of 51 breaches per day •Ambulance handover delays >60 minutes are 1000+ per month and on a steep upward trajectory •Average of 10-14 ambulances	•ED becomes congested with patients staying much longer than is clinically required or is clinically effective •Increased mortality due to delays in care e.g. within 30 days, so may occur outside care with us •Repeated Declaration of Internal Incident or failure to Declare Internal Incident as per policy •Delayed, missed or erroneous clinical intervention - unintended patient deaths, serious incidents or other level of harm to patients on time critical pathways (data	Divisional Board - Medical	Quality and Performance Committee, Trust Leadership Team	06/06/2022	Safety	Catastrophic (5)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	Since October, the ED team has implemented several changes to processes in order to mitigate the impact on the department when there is no admitting capacity. This includes: - Revised roles and responsibilities of key roles in the ED - Reintroduced Patient Safety Huddles 5 times a day - Reconfigured ED layout, bringing cohort area closer to Pitstop and Ambulance bay - Recruited agency paramedics to staff cohort area and release SWAST crews	Within the ED, the key items that would further support timely discharge and flow out of ED are: - Introduction of a team of ED Assistants (VCP submitted) - Introduction of a Flow Coordinator in ED (VCP submitted) - Adherence to Internal Professional Standards by clinical specialties - Increasing funded establishment of clinical workforce to ensure sufficient numbers of Senior Decision Makers and junior doctors are on shift (Workforce paper	- Monthly performance reports - Daily SITREPs - Recruitment and retention monitoring - Audits of response times from specialties	Please can you review Risk, discuss at Specialty Governance or Escalation to Div Board to review and sign off.	Nagle, Pat	[15/03/2022 16:56:01 Lee Troake] reviewed with LT	31/03/2022	15/03/2022	
																				Progress VCPs for Flow Coordinator and ED Assistants	Nagle, Pat		04/04/2022		
																				Increasing funded establishment of clinical workforce in ED to address Trust Risk	Zada, Qadar	[15/03/2022 16:55:43 Lee Troake] PN has emailed for response to Workforce paper	29/03/2022		
																				Ensure meeting to discuss ICS risks is re-established and risk M3682 is discussed with partners	Holdaway, Matt		22/03/2022		
																				1. To create a rolling action plan to reduce pressure ulcers	Bruce, Liz	Annual action plan in place. Plan for 2018-19 developed and has been reviewed by Q&P Committee.	29/09/2017	23/04/2018	
																				2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions	Bruce, Liz	This has now been completed the new RCa is in place.	28/02/2019	14/01/2019	
																				3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting.	Hams, Steve	exec review will now cover this	30/01/2020	08/04/2020	
																				4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing	Hams, Steve	Second NHS Improvement Collaborative event currently in progress. Insufficient progress made during the first collaborative and new leadership now in place.	30/04/2019	04/11/2019	
																				Discuss DoC letter with Head of patient investigations	Bradley, Craig		31/07/2019	22/01/2020	
																				Advise purchase of mirrors within Division to aid visibility of pressure ulcers	Mennie, Kate	Email sent to all surgical ward managers 19/06/19 advising that infection control have no issue with the use of mirrors to check awkward to reach areas - email attached	31/07/2019	26/09/2019	
																				update TVN link nurse list and clarify roles and responsibilities	Maries, Monique	list complete held with the Tissue viability Team	30/09/2019	23/09/2019	
																				implement rolling programme of lunchtime teaching sessions on core topics	Maries, Monique	lunch time sessions planned across both sites commencing 31/07/2019 for 16 weeks	30/08/2019	30/07/2019	
																				TVN team to audit and validate waterlow scores on Prescott ward	Maries, Monique	Audit completed and will be discussed at Preventing Harm Group	08/01/2020	28/10/2019	

1945	C1945NTVN	19/08/2014	All Specialties, All Ward Areas	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	Bradley, Craig	Risk of harm to in-patients due to failure to prevent development of pressure ulcers.	Harm from mild to severe - distress and discomfort to the patient, pain, infection, increased length of stay.	Incidents of avoidable pressure ulcers graded 3-4 have to be reported and investigated as an incident\serious incident due to the level of harm and are potentially safeguarding issues.	Divisional Board - Corporate / DOG, Quality Delivery Group	Quality and Performance Committee, Trust Leadership Team	29/04/2022	Safety	Major (4)	Possible - Monthly (3)	8 -12 High risk	4 - 6 Moderate risk	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1) Provision of pressure relieving equipment is not always timely as it is not consistently in place across all clinical areas in sufficient quantities. 2) Funding to support Trust wide replacement of pressure relieving mattresses and cushions is not identified. A managed service is being considered to allow more timely and consistent supply and replacement.	Six monthly reports to QDG Trust wide Pressure Ulcer prevalence meeting Divisional and speciality minutes Duty of Candour minutes/reports TVN link nurse meeting minutes Matrons observational and assurance visits. Spot audits re compliance with policy by TVN team Annual mattress audit	purchase of dynamic cushions	Maries, Monique	contact made with procurement re purchase of 50 dynamic and 50 static Foam cushions	31/08/2020	13/05/2020	
																				share microteaches and workbooks to support react 2 red	Maries, Monique	documents shared with ward, micro teach and pressure ulcer care booklet.	30/06/2020	13/05/2020	
																				cascade learning around cheers for ears campaign	Maries, Monique	training re this will be delivered to the ward, I am awaiting support from the manufacturer	31/08/2020	22/07/2020	
																				Education and supprt to staff on 5b for pressure ulcer dressings	Maries, Monique	ward invited to take part in link nurse updates and pressure ulcer collaborative	30/09/2020	29/09/2020	
																				Review pressure ulcer care for patients attending dilysis on ward 7a	Maries, Monique	,Patients, nursing notes reviewed in person by myself and all satisfactory, official audit of notes to be completed before the end of September.	30/09/2020	10/09/2020	
																				Proide training to 5b in the use of cavilon advance +	Maries, Monique	[22/06/2021 13:58:58 Monique Maries] ward re arranging training from 3m	30/06/2021	22/06/2021	
																				Provide training to ward on completion of 1st hour priorities	Mustoe, Claire		31/10/2021	25/10/2021	
																				Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed	Mustoe, Claire		26/10/2021	25/10/2021	
																				Bespoke training to DCC staff for categorisation of pressure ulcers	Aplin, Toni	[30/09/2021 14:34:29 Toni Aplin] One session completed staff trained: Gabriella hollow Empress George Anhalor dianna matos angelica casingal Tori gardender lisa smith Emily foxall sheeba aliyalh jossy george [02/09/2021 14:51:44 Toni Aplin] Rapid pressure ulcer categorisation training organised on DCC for 23.09.2021 and 20.09.2021	31/12/2021	21/12/2021	
																				Bespoke training to ward 4a to include 1st hour priorities	Mustoe, Claire		31/10/2021	25/10/2021	
																				produce training document on wound measurements for Rendcomb	Mustoe, Claire	[22/10/2021 13:43:13 Claire Mustoe] This has been completed and sent to ward. Copy has been attached to this datix	30/09/2021	25/10/2021	
																				The provision of RCA support/training for TV issues to be take to pressure ulcer council	Maries, Monique		30/09/2021	30/07/2021	
																				Work with Knightsbridge to support staff TVN training	Maries, Monique		30/09/2021	30/07/2021	
																				Bespoke training in management of pressure ulcer [revention on ward 7a	Mustoe, Claire	[29/11/2021 13:09:51 Claire Mustoe] Training carried out on 25/11/2021 by TVN team	31/12/2021	29/11/2021	
																				TVN to d/w TVN lead regarding use of share care pathway in regards to EPR.	Mustoe, Claire	[03/12/2021 15:43:07 Carol Cooper] This has been done and email uploaded of outcome	03/12/2021	03/12/2021	
																				Implement training programme in management of patient pressure ulcers in ED	Maries, Monique	[07/02/2022 16:12:53 Monique Maries] discussions undertaken , audit completed and actions agreed. ED staff to complete Pressure ulcer Prevention course, review in 3/12 and evaluate effectiveness.	28/02/2022	07/02/2022	
																				Ward 7a W170891 training with HCA's to allow them to assist registered nurses with assessing patient skin and documenting on EPR	Mustoe, Claire	[19/04/2022 15:09:48 Carol Cooper] Telephone call received from C Mustoe, following discussion with ward, the staff of 7a have to book onto TVN training study days, assigned through separate action for ward	28/03/2022	19/04/2022	
3397	IT3397	25/11/2020	All Specialties	The risk of failure of the trust to manage the required move away from the use of Office 2010 and transfer to NHS Digital version of Office 365 or an alternative supported Microsoft office product ahead of the deadline when the product will cease to fully function. Causing widespread disruption to clinical and corporate core business functions	Atherton, Andy	Gloucestershire Hospitals NHS Foundation Trust currently makes extensive use of Microsoft Office 2010. This is no longer a viable option and has been out of support since October 2020, representing a cyber-security and operational risk. NHS Digital has asked NHS providers to commit to having completed their migrations away from the Office 2010 product by May 2022. The date required by NHS Digital for trusts to move away from the use of Office 2010 has been extended from a October 2021 deadline. However this is now a hard stop deadline as after this date Office 2010 will stop communicating with Office 365, meaning that Outlook 2010 will cease to be able to send or receive emails. NHS Digital have negotiated an extension for the NHS with Microsoft for this connectivity until 1st May 2022	All 7000 instances of 2010 office need to be replaced and staff supported to use the new N365 office suite or an alternative supported version such as Office 2016 before May 2022. A change programme to support use of N365 had been initiated, however issues have been identified that require the programme to be re-evaluated without sufficient engagement and direction the change programme may lead to excessive use of more expensive licence options across services. An alternative project approach has now been agreed - an upgrade to Office 2016 is to be implemented by May 2022 as an interim step in the Journey to move away from Office 2010 and to transition to N365	Due to the very different way of working required when using Office 365 including the enforced use of OneDrive and SharePoint a change to using Office 365 will impact on every department and every member of staff radically changing the way they; access, store, retrieve and share documents. This will have significant consequences for every service in the organisation if enormity of this change programme is not accepted and successfully delivered. Over use of the more expensive licence options would result in a £1.7 million annual cost pressure Deferring this option by a using a combination of Office 365 and the use of an alternative supported product as an interim has reduced the change element of this impact. However as Office 2010 will stop communicating with Office 365 in May 2022 the impact of not achieving a migration away from Office by	Digital Care Delivery Group	Finance and Digital Committee	01/05/2022	Business	Major (4)	Likely - Weekly (4)	15 - 25 Extreme risk	4 - 6 Moderate risk	Dedicated Project Manager and two Business Analysts resource Project planning governance	Project in progress but may deadline allows for limited room for any slippage.	Project monitored through weekly EPR PDG	Project approach	Turner, Thelma	[28/03/2022 08:29:50 Thelma Turner] Project continues to be closely monitored [29/11/2021 21:43:19 Thelma Turner] project approach agreed upgrade to Office 2016 to be implemented as an interim. project to be monitored through PDG	01/05/2022		

Report to Board of Directors			
Agenda item:	10	Enclosure Number:	5
Date	12 May 2022		
Title	Quality and Performance Report		
Author /Sponsoring Director/Presenter	Neil Hardy-Lofaro, Deputy Chief Operating Officer Suzie Cro, Deputy Director of Quality Qadar Zafa, Chief Operating Officer Matt Holdaway, Chief Nurse and Director of Quality Alex D'Agapeyeff, Interim Medical Director		

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

Summary of Report

Purpose

This report summarises the key highlights and exceptions in Trust performance for the March 2022 reporting period.

The Quality and Performance (Q&P) committee receives the Quality Performance Report (QPR) on a monthly basis. The supporting exception reports from Quality; Emergency Care; Cancer and Planned Care Delivery Groups support the areas of performance concerns.

Key issues to note

Quality

Number of bed days lost due to infection control outbreaks

Covid

During March the Trust had 335 lost bed days due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways. Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients to prevent the onward transmissions of COVID-19 and hospital acquisition of COVID-19. Outbreak meetings continue to ensure review of all closed areas and weekend working for onsite Infection Prevention and Control Nurses continues.

Number of hospital-onset healthcare-associated Clostridioides difficile cases per month

During March there were 6 health care associated (HO-HA) case. All of these cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re-review. The trust wide C. difficile reduction plan remains in place to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan addresses cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and

isolation of patients with diarrhoea and optimising management of patient with C. difficile infection (CDI). Assurance of action completion will be monitored through the Infection Control Committee. The ICS also continues to engage in the NHSE/I region wide CDI improvement collaborative where as a system we are working on 3 key improvement areas which includes antimicrobial stewardship, optimisation of CDI treatment and management and environmental cleaning/ CDI IPC bundle. We are improving our post infection review form and process to include system wide patient reviews and risk factor data collection to target interventions for improvement.

Number of patient safety incidents resulting in severe harm (major/death)

The statistical increase in serious incidents is undergoing a thematic review which will report into the Patient Safety Systems meeting and seek to align or inform current work. The areas currently under review are as follows:

- Multiple patient moves (SI declared)
- Opening or change of use of areas – (Development of more formal safety sign off process recommended).
- Delay to discharge (Thematic review underway)
- ED triage and handover (SI declared)
- Wrong site and wrong implant Never Events (Improvement Work underway)

Pressure ulcers acquired as in-patient

Reviewing the number of pressure ulcers reported on Datix recently has revealed an anomaly with the reported number through QPR. This is currently being investigated to understand the cause. Patients develop skin and soft tissue damage for multiple reasons in hospital settings. We have seen an increase during the winter period in the development of Category 2, deep tissue injuries and unstageable pressure ulcers across different wards in both hospitals. Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers.

Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now accelerated to monthly to increase throughput.

Falls Update

Number of falls per 1000 bed days

March 2022 saw a rate of 7.9 falls per 1,000 bed days. This is higher than previous months. When comparing to organisations across the South West that share falls data (currently only 4 Trusts) the Trust is performing better with the average falls rate of the other 3 trusts being 9.82 with each organisation also seeing an increase.

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

Number of falls resulting in severe or moderate harm

February 2022 saw a high number of falls resulting in harm, such as fractures and head injuries. There were 9 occurrences. Every falls resulting in moderate harm or worse is reviewed in the weekly Preventing Harm Hub where immediate safety actions and learning are rapidly assessed. Two patients subsequently died and were referred for Serious Incident Investigations.

Friends and Family Test

Our overall Trust FFT positive score has decreased to 88%, with a decrease across urgent care (63.5%) and maternity survey (85.7%) scores in particular. This is largely due to operational pressures, with a large increase in the comments focussing on wait times. The divisions have been asked to review their local comments and improvement plans and provide updates to QDG, and the Patient Experience team are looking to review how we report feedback into divisions, combining PALS and FFT data and some thematic analysis to support local improvement plans

% PALS concerns closed in 5 days

In March the team managed over 730 calls, including an increasing number of complex cases, and have maintained a position of closing 77.9% of cases within 5 days. Recruitment is underway with a new advisor who joined the team in March and an additional advisor joining in April/May. Other advisors have now gone part time, and bank administrative support is being put in to support the team in triaging calls so that advisors can focus on managing and resolving complex concerns rather than dealing with enquiries which can be signposted effectively at triage point. The wider patient experience team is also supporting the PALS team with data inputting to release advisor time and capacity.

Performance

Cancer Performance

February's submitted data, the Trust met 6 of the 9 CWT metrics and exceeded national performance in 9 out of 9 of the CWT metrics. A better month for Cancer waits performance with the Trust meeting 2ww performance, 28 day Faster Diagnosis Standard and 31 day new treatment standard. The Trust achieved 68% for 62 day GP referrals, this will rise following a final validation but clearly requires significant improvement. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity.

Elective Performance

In spite of challenging March position operationally, the stabilisation of the February RTT and 52 week position has been maintained. Performance for March is estimated around 71.5% with approximately 1,127 >52 week waits.

Further reductions have been made with the Total incompletes, now being around 56,249 (a reduction of a 1,000 on last month) and well within the H2 target of <60,248. Focus continues to be placed on patients over 78 weeks, which has again reduced in month, and specifically those patients at risk of breaching 104 weeks in this financial year. Delivery of the 2022/23 is a key priority for the Trust.

Emergency Performance

March continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 69.94% to 68.71% compared to the previous month. Ambulance handover delays increased for delays over 30 and 60 minute handovers. Correcting this negative trend remains a priority for the Trust. The department is currently reviewing the potential deployment of a "Static Ambulance Temporary Structure" solution to help with offload times. Poor flow remains the most significant challenge to the ED with patients spending

increased length of time in the department for an inpatient bed. This is a key challenge recognised and being addressed by the ICS.

Diagnostic Performance

The Trust did not meet the diagnostics standard in March however performance improved on last month from 18.3% to 18.0% this month. The total number of patients waiting has increased from 7,795 to 8,790. The overall number of breaches has increased by 161; Performance for all other modalities would be 0.73% with just 48 breaches against 6,561 patients waiting. Echocardiography remains a significantly challenged modality with the loss of some external capacity remains challenged. There is renewed focus to create some additional capacity and revalidate clinical need for the current waiting list.

Recommendation

The Board is requested to receive the report as assurance that the Executive team and Divisions fully understand the current levels of non-delivery against quality and performance standards and have action plans to improve this position, alongside the plans to clinically prioritise those patients that need treatment planned or un-planned during the pandemic as we move forward to recovery.

Enclosures

- Quality and Performance Report

Quality and Performance Report

Reporting Period *March* 2022

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

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Executive Summary

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

During March, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4 hour ED standard, albeit met majority of the H2 metrics, notably zero 104 weeks breaches and Total Incompletes less than 60,248.

March continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 69.94% to 68.71% compared to the previous month. Ambulance handover delays increased for delays over 30 and 60 minute handovers. Correcting this negative trend remains a priority for the Trust, and the ED has implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.

The Trust did not meet the diagnostics standard in March however performance improved slightly on last month from 18.3% to 18.0% this month. The total number of patients waiting has increased from 7,795 to 8,790. The overall number of breaches has increased by 161, if Echo's were to be excluded, performance for all other modalities would be 0.73% with just 48 breaches against 6,561 patients waiting.

For cancer, in February's submitted data, the Trust met 6 of the 9 CWT metrics and exceeded national performance in 9 out of 9 of the CWT metrics. A better month for Cancer waits performance with the Trust meeting 2ww performance, 28 day Faster Diagnosis Standard and 31 day new treatment standard. The Trust achieved 68% for 62 day GP referrals, this will rise following a final validation but clearly requires significant improvement. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity.

For elective care, the RTT performance did not meet the standard at 71.5% (unvalidated) and remains similar to last month. The total incompletes have improved again on last month with a further reduction made. With validation ongoing at the time of this report, the Trusts position is 56,249 with small reductions anticipated prior to submission. The number of 52 week breaches has remained similar to last month with an validated figure of 1,127 breaches in month. Focus continues to be placed on patients over 70 weeks, which has again reduced in month, moving from 185 to 149 in March. At year-end, the Trust had zero 104 week breaches.

The Elective Care Hub continues to work with specialties in telephoning patients but more recently has rolled out a digital survey to increase the ability to contact a wider cohort of patients and more quickly. Although only run has taken place so far, early signs are encouraging, and this will be rolled out to all specialties with cohorts of 1500-2000 patients approached at 3-4 week intervals. For those that are not digitally enabled, a paper copy will be issued.

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

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Performance Against STP Trajectories

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

Indicator		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	362	316	262	253	440	354	500	523	467	446	504	330	328
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	382	237	85	117	475	294	692	752	1074	952	1057	1093	1263
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%	69.64%	68.71%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%
	Actual	69.97%	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.52%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	3061	2657	2263	2016	1724	1554	1598	1590	1492	1430	1273	1112	1127
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	97.10%	94.80%	95.40%	92.80%	91.90%	93.50%	92.00%	93.40%	92.10%	92.30%	87.20%	94.70%	93.90%
2 week wait breast symptomatic referrals	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	98.30%	93.60%	96.50%	90.70%	96.60%	93.20%	90.80%	89.80%	88.60%	84.90%	89.70%	94.60%	91.30%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	99.00%	96.60%	98.30%	98.50%	98.30%	97.10%	95.90%	97.90%	96.30%	95.60%	94.20%	97.70%	97.90%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	100.00%	99.40%	99.50%	99.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	98.60%	98.10%	97.70%	100.00%	97.50%	98.50%	99.40%	100.00%	97.90%	100.00%	99.40%	99.00%	99.40%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	97.60%	90.00%	95.60%	95.80%	94.00%	92.60%	88.10%	91.00%	95.10%	94.40%	88.20%	93.00%	91.20%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	86.70%	85.30%	90.60%	95.70%	92.00%	82.90%	90.80%	76.50%	81.80%	91.50%	85.50%	79.30%	89.90%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	76.70%	90.80%	65.40%	70.60%	82.10%	63.60%	72.10%	87.10%	70.60%	73.10%	75.00%	69.70%	80.60%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	83.40%	82.00%	76.30%	80.30%	77.60%	72.10%	71.00%	69.00%	70.90%	61.90%	65.80%	68.00%	70.90%

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Demand and Activity

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

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

													% growth from previous year	
Measure	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Monthly (Mar)**	**YTD**
GP Referrals	8,956	8,555	8,469	8,955	8,661	7,908	8,301	8,149	8,504	7,154	7,916	8,122	9,097	1.6%	16.3%
OP Attendances	57,846	50,410	51,179	54,944	52,155	47,546	52,912	49,510	56,431	47,616	51,614	48,834	56,767	-1.9%	16.3%
New OP Attendances	17,948	15,998	16,328	17,228	16,158	14,662	16,658	15,956	18,292	15,352	16,399	16,087	18,519	3.2%	19.9%
FUP OP Attendances	39,898	34,412	34,851	37,716	35,997	32,884	36,254	33,554	38,139	32,264	35,215	32,747	38,248	-4.1%	14.7%
Day cases	4,394	4,196	4,558	4,751	4,801	4,525	4,310	4,187	4,536	3,941	4,121	4,196	4,892	11.3%	29.2%
All electives	5,000	5,047	5,424	5,697	5,831	5,469	5,236	5,218	5,492	4,941	4,798	5,051	5,921	18.4%	31.3%
ED Attendances	10,687	11,063	11,930	11,976	12,295	12,006	13,186	13,044	11,988	10,943	11,433	10,545	12,307	15.2%	23.9%
Non Electives	4,108	4,018	4,398	4,642	4,531	4,333	4,244	3,998	3,868	3,445	3,463	2,951	3,327	-19.0%	7.9%

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Trust Scorecard - Safe (1)

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

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset - First positive specimen <=2 days after admission	39	39	3	7	25	120	134	111	188	122	123	174	155	205	534	1,367	No target	
COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	7	7	1	4	11	15	12	14	17	28	51	63	86	113	262	415	No target	
COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	2	2	0	0	1	5	2	0	1	1	24	21	37	50	108	142	No target	
COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	2	2	0	1	1	4	9	1	9	5	25	32	74	80	186	241	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	1	0	0	0	0	0	0	1	0	0	1	2	Zero	
MRSA bacteraemia - infection rate per 100,000 bed days	0.0	0.0	0.0	0.0	3.9	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	0.0	1.2	0.6	Zero	
Number of trust apportioned Clostridium difficile cases per month	75	8	3	14	11	10	15	7	4	12	8	3	7	8	18	113	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	3	3	7	7	5	9	4	1	8	5	2	5	6	13	69	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	5	0	7	4	5	6	3	3	4	3	1	2	2	5	44	<=5	
Clostridium difficile - infection rate per 100,000 bed days	22.7	30.9	13.5	60.2	42.6	34.9	51.1	23.5	13	40.6	27.3	10.2	25.9	27	20.9	30.5	<30.2	
Number of MSSA bacteraemia cases	18	3	1	2	2	2	5	5	0	2	5	3	3	2	8	33	<=8	
MSSA - infection rate per 100,000 bed days	6.4	11.6	4.5	8.6	7.7	7	17	16.8	0.0	6.8	17	10.2	11.1	6.8	9.3	9.9	<=12.7	
Number of ecoli cases	30	2	4	5	3	2	0	3	5	7	5	5	5	2	12	56	No target	
Number of pseudomona cases	6	1	1	2	0	0	1	1	0	1	0	0	0	0	0	6	No target	
Number of klebsiella cases	12	2	2	1	3	3	3	4	2	2	2	0	0	1	1	23	No target	
Number of bed days lost due to infection control outbreaks	9	0	0	6	161	15	60	1	93	176	453	444	637	335	1,416	2,381	<10	>30

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Trust Scorecard - Safe (2)

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	1	1	1	1	0	0	0	1	1						Zero	
Number of falls per 1,000 bed days	6.5	6.6	6.1	6.2	6.2	7.1	7.5	7	6.7	7	6.7	7.3	7.6	8.2	7.7	7.0	<=6	
Number of falls resulting in harm (moderate/severe)	18	6	4	2	3	9	5	5	5	3	9	5	10	9	24	67	<=3	
Number of patient safety incidents - severe harm (major/death)	19	10	7	2	1	9	3	6	7	10	7	7	10	28	45	97	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	0	2	1	0	1	0	0	1	4	No target	
Medication error resulting in moderate harm	2	4	2	2	1	2	3	2	14	4	6	6	2	3	11	47	No target	
Medication error resulting in low harm	34	11	11	4	13	6	4	7	5	11	3	9	8	11	28	91	No target	
Number of category 2 pressure ulcers acquired as in-patient	79	29	16	22	17	24	27	19	22	41	43	37	40	50	127	358	<=30	
Number of category 3 pressure ulcers acquired as in-patient	2	1	1	0	1	0	3	0	1	2	4	2	1	2	5	17	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient	14	1	4	3	4	3	5	1	4	9	9	12	14	10	36	78	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	22	4	1	4	8	9	4	6	1	7	12	13	7	8	28	80	<=5	
RIDDOR																		
Number of RIDDOR	55	4	4	1	3	3	2			3	5						SPC	
Safeguarding																		
Number of DoLs applied for		29	54	73	57	55	59		53	48	68	64	53	69			No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	4	4	3	8	3	3	7	4	6	1	5	2	3	4	9	49	No target	
Total attendances for infants aged < 6 months, other serious injury		1	1	0	0	0	0	0	0		0	0	1				No target	
Total admissions aged 0-17 with DSH	15	15	13	26	15	13	11	18	35	39	18	46	24	35	105	293	No target	
Total ED attendances aged 0-17 with DSH	88	88	62	99	84	65	52	73	102	115	54	125	69	113	307	1,013	No target	
Total number of maternity social concerns forms completed		62	68	58	77	63	46		58	65	52	67	70	71			No target	
Total admissions aged 0-17 with an eating disorder								9	11		8	5	7				No target	

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Trust Scorecard - Safe (3)

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	71.00%		70.00%														>=90%	<50%
Serious Incidents																		
Number of never events reported	2	0	0	2	0	0	1	0	1	1	2	1	2	0	3	11	Zero	
Number of serious incidents reported	13	4	4	3	2	4	4	6	4	4	4	4	3	4	11	44	No target	
Serious incidents - 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	91.2%	92.2%	89.9%	89.8%	89.3%	87.0%	87.1%	92.0%	92.3%	90.7%	90.9%	87.5%	87.1%	90.7%	88.5%	89.5%	>95%	

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Trust Scorecard - Effective (1)

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Maternity																		
% of women on a Continuity of Carer pathway	0.60%	0.00%		10.40%	9.70%	9.70%	10.80%	10.90%	11.80%	10.30%	9.60%	10.20%	14.70%	12.60%	12.10%	10.90%	No target	
% C-section rate (planned and emergency)	29.44%	31.67%	30.43%	28.88%	33.96%	29.04%	32.02%	30.42%	31.59%	31.63%	32.44%	33.19%	31.45%	33.48%	32.76%	31.53%	No target	
% emergency C-section rate	15.56%	17.71%	16.30%	17.72%	16.77%	15.58%	17.98%	16.76%	17.76%	17.05%	15.61%	17.77%	15.72%	18.03%	17.24%	16.94%	No target	
% of women booked by 12 weeks gestation	92.8%	93.6%	93.2%	91.9%	91.2%	91.9%	91.4%	88.8%	91.0%	91.7%	92.6%	91.1%	90.5%	92.1%	91.2%	91.4%	>90%	
% of women that have an induced labour	31.42%	30.63%	28.05%	27.92%	26.40%	25.90%	28.49%	25.41%	25.00%	25.66%	24.95%	29.42%	33.09%	31.21%	31.16%	27.47%	<=33%	>30%
% stillbirths as percentage of all pregnancies	0.39%	0.62%	0.00%	0.22%	0.42%	0.19%	0.00%	0.00%	0.19%	0.00%	0.00%	0.43%	0.00%	0.64%	0.37%	0.17%	<0.52%	
% of women smoking at delivery	10.90%	10.21%	9.42%	8.23%	9.56%	10.48%	8.19%	10.16%	10.07%	8.80%	11.86%	12.58%	10.78%	11.46%	11.65%	10.10%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	56.7%	54.0%	48.7%	49.0%	51.1%	48.4%	53.9%	48.0%	50.3%	48.1%	47.1%	46.0%	46.3%	46.6%	49.4%		
% breastfeeding (initiation)	79.9%	82.4%	81.0%	75.9%	78.4%	78.5%	79.8%	80.8%	81.1%	79.5%	76.3%	78.8%	76.8%	78.2%	78.0%	78.9%	>=81%	
% PPH >1.5 litres	4.4%	5.2%	5.9%	5.0%	4.2%	5.2%	6.7%	4.9%	4.5%	3.4%	4.9%	3.6%	2.2%	3.9%	3.2%	4.5%	<=4%	
Number of births less than 27 weeks	19	3	2	0	2	0	0	1	2	2	0	1	0	1	2	11		
Number of births less than 34 weeks	104	10	7	15	13	8	11	18	13	9	10	7	4	9	20	123		
Number of births less than 37 weeks	379	29	28	44	34	41	33	47	49	32	44	33	19	43	95	446		
Number of maternal deaths	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total births	5,570	483	463	468	486	526	544	558	546	537	497	471	413	473	1,358	5,982		
Percentage of babies <3rd centile born > 37+6 weeks	1.7%	1.0%	2.3%	1.5%	1.7%	1.9%	0.9%	1.4%	1.1%	1.9%	2.4%	3.2%	1.7%	4.2%	3.0%	2.0%		

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Trust Scorecard - Effective (2)

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Mortality																		
Summary hospital mortality indicator (SHMI) - national data	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0						1.0	NHS Digital	
Hospital standardised mortality ratio (HSMR)	107.9	105.2	103.2	104.2	106.2	108.4	108.6	108.3	108.8	106.9	102.6					102.6	Dr Foster	
Hospital standardised mortality ratio (HSMR) - weekend	111.7	107.1	104.6	107.1	109.2	113.4	113.8	113.8	115.6	113.8	109.4					109.4	Dr Foster	
Number of inpatient deaths	129	129	145	154	146	182	156	163	183	191	189	218	183	178	579	2,088	No target	
Number of deaths of patients with a learning disability	19	0	2	4	0	4	2	2	2	4	1	3	1	1	5	23	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	8.31%	8.31%	8.53%	86.20%	9.11%	9.42%	9.54%	9.04%	8.18%	8.10%	8.10%	8.05%	7.32%		7.70%	8.59%	<8.25%	>8.75%
Research																		
Research accruals	4,152	220	575	240	328	183	192	456	426	236	172	185	173	142	500	3,333	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	52.5%	54.4%	53.5%	48.9%				47.5%	51.9%	50.0%	45.8%	72.7%	70.0%	73.4%	70.4%	72.7%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	86.0%	90.2%	83.1%	89.3%	91.8%	82.7%	91.8%	84.9%	66.7%	72.7%	75.4%	46.3%	91.0%			88.2%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	30.70%	49.20%	37.00%	44.10%				12.70%	15.10%	16.70%	8.70%	9.10%	75.00%	56.40%	49.70%	9.10%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	52.30%	60.70%	63.20%	67.90%				44.60%	48.80%	40.50%	39.60%	54.50%	75.00%	59.50%	60.90%	54.50%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	64.1%	64.1%	84.4%	52.5%	66.3%	68.2%	60.7%	56.1%	43.5%	50.8%	47.9%	59.4%	43.4%	50.7%	51.8%	56.6%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	64.06%	64.06%	84.44%	52.54%	66.27%	68.18%	59.02%	56.10%	43.55%	50.77%	47.95%	57.97%	41.51%	50.68%	50.77%	56.26%	>=65%	<55%

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Trust Scorecard - Caring (1)

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	89.6%	88.3%	90.2%	89.7%	87.0%	85.4%	86.4%	85.0%	88.0%	87.8%	89.1%	87.1%	88.3%	88.1%	86.5%	>=90%	<86%
ED % positive	81.4%	77.5%	76.3%	73.6%	74.8%	62.7%	70.5%	60.9%	66.7%	68.0%	78.8%	78.6%	67.6%	63.5%	70.2%	67.5%	>=84%	<81%
Maternity % positive	92.9%	92.6%	96.2%	93.0%	89.2%	92.9%	84.8%	87.7%	82.4%	89.7%	84.3%	94.1%	91.9%	85.7%	89.9%	86.3%	>=97%	<94%
Outpatients % positive	94.0%	94.5%	94.4%	93.6%	94.3%	93.1%	93.7%	93.2%	93.3%	93.9%	94.7%	94.3%	93.4%	93.2%	93.6%	93.8%	>=94.5%	<93%
Total % positive	90.7%	92.1%	91.5%	91.1%	91.2%	90.7%	88.5%	86.2%	85.4%	89.4%	91.2%	91.0%	88.6%	88.0%	89.2%	88.1%	>=93%	<91%
Number of PALS concerns logged	2,394	262	256	275	191	241	238	264	274	248	230	266	248	254	774	3,006	No Target	
% of PALS concerns closed in 5 days	79%	83%	82%	85%	90%	85%	82%	76%	65%	78%	71%	65%	73%	78%	73%	79%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	1	0	0	0	0	1	0	0	0	0	0	0	0	0	1	<=10	>=20

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Trust Scorecard - Responsive (1)

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Cancer																		
Cancer - 28 day FDS (all routes)			79.1%	77.7%	77.3%	79.9%	78.9%	78.3%	83.1%	78.9%	80.8%	77.6%	86.3%	84.9%	80.7%	79.8%	>=75%	
Cancer - urgent referrals seen in under 2 weeks from GP	97.1%	97.1%	94.8%	95.4%	92.8%	91.9%	93.5%	92.0%	93.4%	92.1%	92.3%	87.2%	94.7%	93.9%	90.2%	92.1%	>=93%	<90%
Cancer - 2 week wait breast symptomatic referrals	98.3%	98.3%	93.6%	96.5%	90.7%	96.6%	93.2%	90.8%	89.8%	88.6%	84.9%	89.7%	94.6%	91.3%	91.1%	91.0%	>=93%	<90%
Cancer - 31 day diagnosis to treatment (first treatments)	99.0%	99.0%	96.6%	98.3%	98.5%	98.3%	97.1%	95.9%	97.9%	96.3%	95.6%	94.2%	97.7%	97.9%	95.6%	96.6%	>=96%	<94%
Cancer - 31 day diagnosis to treatment (subsequent – drug)	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	99.4%	99.5%	99.0%	99.4%	99.7%	>=98%	<96%
Cancer - 31 day diagnosis to treatment (subsequent – surgery)	97.6%	97.6%	90.0%	95.6%	95.8%	94.0%	92.6%	88.1%	91.0%	95.1%	94.4%	88.2%	93.0%	91.2%	89.6%	91.6%	>=94%	<92%
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	98.6%	98.6%	98.1%	97.7%	100.0%	97.5%	98.5%	99.4%	100.0%	97.9%	100.0%	99.4%	99.0%	99.4%	99.4%	99.1%	>=94%	<92%
Cancer - 62 day referral to treatment (urgent GP referral)	83.4%	83.4%	82.0%	76.3%	80.3%	77.6%	72.1%	71.0%	69.0%	70.9%	61.9%	65.8%	68.0%	70.9%	68.1%	72.3%	>=85%	<80%
Cancer - 62 day referral to treatment (screenings)	86.7%	86.7%	85.3%	90.6%	95.7%	92.0%	82.9%	90.8%	76.5%	81.8%	91.5%	85.5%	79.3%	89.9%	89.9%	86.9%	>=90%	<85%
Cancer - 62 day referral to treatment (upgrades)	80.5%	76.7%	90.8%	65.4%	70.6%	82.1%	63.6%	72.1%	87.1%	70.6%	73.1%	75.0%	69.7%	80.6%	75.2%	74.6%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	0	2	1	2	3	4	9	10	4	3	2	2	5	9	47	Zero	
Number of patients waiting over 104 days without a TCI date	269	12	14	10	11	9	12	18	21	23	25	14	22	50	86	229	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.03%	18.03%	<=1%	>2%
The number of planned/surveillance endoscopy patients waiting at month end	1,969	1,919	1,773	1,680	1,527	1,482	1,439	1,435	1,397	1,410	1,422	1,334	1,269	1,286	1,296	1,455	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	58.8%	58.8%	61.1%	61.4%	62.2%	62.3%	61.1%	61.7%	60.5%	61.4%	58.5%	58.7%	62.0%		60.3%	61.1%	>=88%	<75%

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Trust Scorecard - Responsive (2)

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department - under 4 hours (type 1)	69.97%	69.97%	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	59.74%	62.67%	>=95%	<90%
ED: % total time in department - under 4 hours (types 1 & 3)	80.16%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%	69.64%	68.71%	70.26%	73.41%	>=95%	<90%
ED: % total time in department - under 4 hours CGH	99.62%	99.62%	99.73%	99.68%	94.75%	84.95%	88.74%	77.05%	83.00%	79.80%	79.03%	79.17%	73.72%	65.48%	72.50%	82.49%	>=95%	<90%
ED: % total time in department - under 4 hours GRH	69.97%	69.97%	64.75%	61.44%	63.34%	53.00%	57.55%	51.82%	52.48%	54.91%	53.96%	55.55%	52.12%	52.87%	53.54%	56.46%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	168	1	0	0	1	10	1	15	53	448	631	300	394	606	1,300	2,459	Zero	
ED: % of time to initial assessment - under 15 minutes	46.3%	46.3%	40.9%	47.3%	43.1%	7.1%	14.8%	15.7%	19.3%	30.3%	37.4%	35.5%	30.0%	22.9%	29.3%	25.6%	>=95%	<92%
ED: % of time to start of treatment - under 60 minutes	26.4%	26.4%	17.5%	15.1%	14.4%	12.3%	13.8%	14.9%	10.7%	24.9%	30.3%	29.5%	24.1%	21.0%	24.8%	15.3%	>=90%	<87%
Number of ambulance handovers over 60 minutes	914	382	237	85	117	475	294	692	752	1,074	952	1,057	1,093	1,263	3,413	8,091	Zero	
% of ambulance handovers < 15 minutes										23.11%	23.53%	24.72%	18.20%	15.73%	20.13%	21.55%	>=65%	
% of ambulance handovers < 30 minutes										42.28%	45.54%	44.45%	34.48%	29.58%	37.12%	40.14%	>=95%	
% of ambulance handovers 30-60 minutes	5.00%	9.82%	8.61%	6.66%	6.73%	11.91%	9.48%	13.85%	14.55%	14.21%	13.90%	15.56%	13.25%	13.17%	14.13%	11.60%	<=2.96%	
% of ambulance handovers over 60 minutes	3.67%	10.36%	6.45%	2.16%	3.11%	12.86%	7.88%	19.16%	20.92%	32.67%	29.68%	32.62%	43.90%	50.70%	41.52%	19.87%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	92.30%	92.00%	87.80%	87.50%	80.95%	89.06%	80.60%	73.75%	74.03%	80.23%	71.60%	93.48%	95.59%		81.58%	>=95%	
Urgent cancelled operations	66	3	0	1	13	12	10	1	44	24	1	1	0	0		107	No target	
Number of patients stable for discharge	110	110	113	114	123	161	159	180	180	220	213	239	252	257	249	184	<=70	
Number of stranded patients with a length of stay of greater than 7 days	384	384	359	334	416	367	421	472	468	503	499	491	537	540	523	451	<=380	
Average length of stay (spell)	5.23	5.23	4.68	4.78	5.14	4.98	4.84	5.32	5.47	6.03	6.02	6.13	6.66	6.69	6.49	5.5	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.56	5.56	5.18	5.25	5.7	5.57	5.39	5.99	6.22	6.97	7	6.78	7.93	8.06	7.56	6.23	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.88	2.88	2.31	2.57	2.64	2.43	2.31	2.25	2.48	2.28	2.46	2.42	2.05	2.13	2.18	2.36	<=3.4	>4.5
% day cases of all electives	87.86%	87.86%	83.12%	84.02%	83.38%	82.32%	82.72%	82.30%	80.22%	82.57%	79.74%	85.87%	83.05%	82.60%	83.75%	82.67%	>80%	<70%
Intra-session theatre utilisation rate	88.63%	88.63%	90.09%	90.92%	88.24%	89.39%	89.42%	85.36%	87.21%	85.46%	83.34%	86.25%	85.20%	87.17%	86.28%	87.42%	>85%	<70%

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Trust Scorecard - Responsive (3)

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.09	2.09	2.06	2.02	2.04	2.1	2.13	2	1.94	1.93	1.96	1.95	1.86	1.95	1.92	1.99	<=1.9	
Did not attend (DNA) rates	5.69%	5.69%	5.89%	6.02%	6.72%	7.05%	7.24%	7.15%	7.17%	7.02%	7.23%	7.63%	7.08%	7.35%	7.36%	6.97%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.59%	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.52%	71.47%	72.29%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,337	6,474	6,541	6,426	6,159	5,713	5,582	5,642	5,593	5,642	5,847	5,272	5,087	5,159	5,173	5,722	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,881	3,747	3,572	3,657	3,320	2,854	2,906	2,946	2,935	2,641	2,605	2,292	2,165	2,186	2,214	2,840	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,416	3,061	2,657	2,263	2,016	1,724	1,554	1,598	1,590	1,492	1,430	1,273	1,112	1,127	1,171	1,653	Zero	
Referral to treatment ongoing pathway over 70 Weeks (number)	127	459	608	667	745	806	611	403	295	228	205	207	185	149	180	426	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	100.0%	100.0%															>=99%	
Percentage of records submitted nationally with valid NHS number	99.9%	99.9%															>=99%	

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Trust Scorecard - Well Led (1)

	20/21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	21/22 Q4	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	83.0%	85.0%	85.0%	84.0%	80.0%	79.0%	78.0%	78.0%	79.0%	80.0%	80.0%	78.0%	77.0%	77.0%	77.0%	>=90%	<70%
Trust total % mandatory training compliance	90%	90%	91%	90%	91%	90%	90%	88%	87%	87%	87%	87%	87%	86%	86%	86%	>=90%	<70%
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	94.82%	93.10%	98.29%	96.75%	91.64%	96.56%	97.22%	99.61%	97.11%	95.93%	89.16%	85.93%	87.53%		86.65%	93.82%	>=75%	<70%
% registered nurse day	93.97%	90.71%	96.38%	96.05%	90.72%	94.84%	95.11%	98.11%	95.49%	94.07%	87.59%	84.20%	85.30%		84.70%	92.23%	>=90%	<80%
% unregistered care staff day	104.90%	101.28%	106.08%	104.33%	95.67%	100.44%	98.32%	96.58%	95.82%	95.07%	84.77%	83.85%	83.66%		83.76%	94.72%	>=90%	<80%
% registered nurse night	96.36%	97.31%	101.83%	97.99%	93.27%	99.57%	101.09%	102.46%	100.10%	99.31%	91.99%	89.02%	91.54%		90.15%	96.69%	>=90%	<80%
% unregistered care staff night	113.19%	108.91%	111.13%	113.00%	103.77%	109.58%	111.39%	111.67%	105.90%	103.45%	94.98%	95.26%	97.78%		96.39%	104.91%	>=90%	<80%
Care hours per patient day RN	5.8	5.8	5.2	5.5	5.3	5.3	4.7	4.6	5	5.1	5	4.9	4.9		4.9	5	>=5	
Care hours per patient day HCA	3.7	3.7	3.7	3.5	3.5	3.5	3.3	3.5	3.2	3.1	3.1	3	3		3	3.3	>=3	
Care hours per patient day total	9.5	9.5	8.9	9	8.7	8.8	8	8.1	8.1	8.3	8.1	7.9	7.9		7.9	8.3	>=8	
Vacancy and WTE																		
% total vacancy rate		4.75%	4.30%	7.12%		7.00%	7.50%	6.82%	6.39%	7.37%	8.09%	11.16%	10.68%	10.45%			<=11.5%	>13%
% vacancy rate for doctors		0.73%	1.38%	4.15%		9.40%	7.80%	7.41%	6.74%	7.45%	7.05%	8.88%	8.35%	7.99%			<=5%	>5.5%
% vacancy rate for registered nurses		7.92%	7.24%	6.60%		8.50%	9.40%	7.89%	7.87%	8.17%	8.64%	14.46%	14.29%	14.09%			<=5%	>5.5%
Staff in post FTE		6653.99	6678.31	6672.09	6672.85	6680.26	6685.55	6730.66	6718.8	6686.83	6627.94	6648.33	6678.52	6707.09			No target	
Vacancy FTE		330.61	298.88	510		505.63	537.29	491.56	457.02	530.17	582.02	834.81	799.75	782.28			No target	
Starters FTE		67.2	86.69	50.85	56.53	36.05	36.53	79.76	42.43	59.94	70.65	77.03	69.31	51.46		1123.04	No target	
Leavers FTE		45.79	36	57.02	62.03	52.16	78.84	68.51	89.94	66.53	81.1	88.76	47.74	84.88		1128.86	No target	
Workforce Expenditure and Efficiency																		
% turnover		9.2%	9.2%	9.5%	10.0%	10.2%	10.7%	11.1%	11.7%	11.7%	12.3%	12.9%	11.8%	13.8%			<=12.6%	>15%
% turnover rate for nursing		9.86%	8.88%	8.96%	9.18%	9.80%	9.77%	9.72%	9.70%	10.52%	10.83%	10.99%	10.69%	12.15%			<=12.6%	>15%
% sickness rate		3.6%	3.7%	3.7%	3.6%	3.6%	3.8%	3.9%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%			<=4.05%	>4.5%

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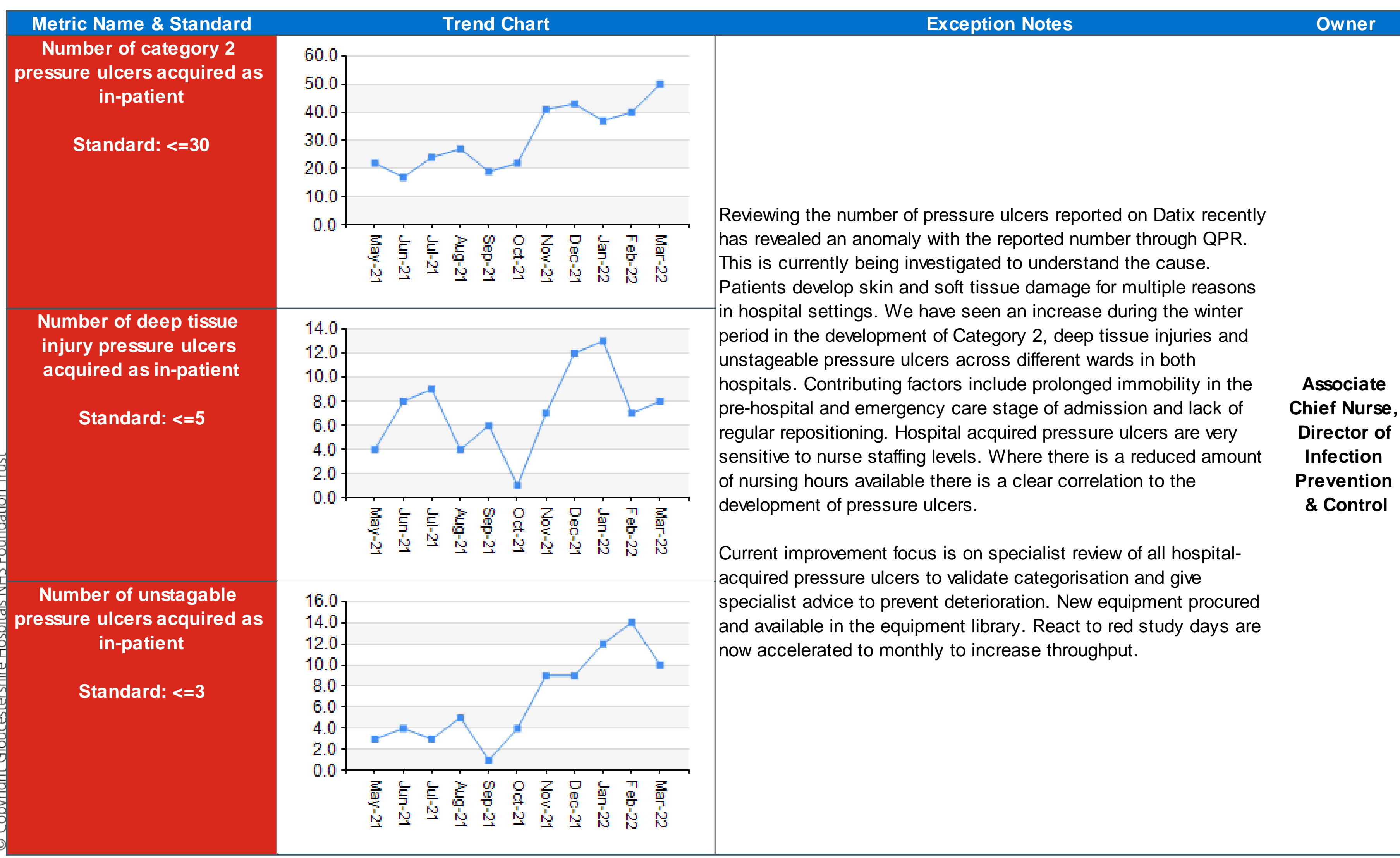
Exception Reports - Safe (1)



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

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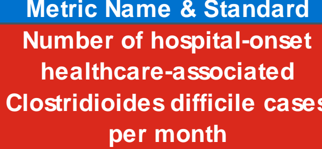
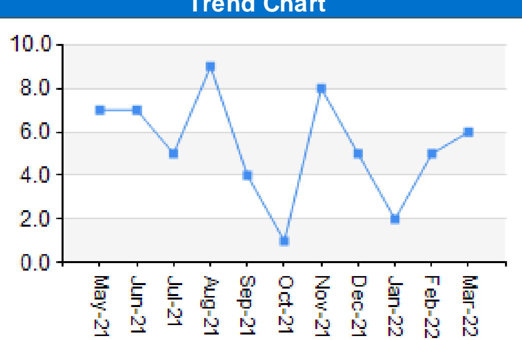
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
 Number of hospital-onset healthcare-associated Clostridioides difficile cases per month Standard: <=5		During March there were 6 health care associated (HO- HA) case. All of these cases will have post infection reviews completed to identify lapses in care and quality; actions to address identified lapses will be implemented and recorded on the PIR and on datix for re- review. The trust wide C. difficile reduction plan remains in place to address issues identified from post infection reviews and PII/ outbreak meetings. The reduction plan addresses cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with C. difficile infection (CDI). Assurance of action completion will be monitored through the Infection Control Committee. The ICS also continues to engage in the NHSE/I region wide CDI improvement collaborative where as a system we are working on 3 key improvement areas which includes antimicrobial stewardship, optimisation of CDI treatment and management and environmental cleaning/ CDI IPC bundle. We are improving our post infection review form and process to include system wide patient reviews and risk factor data collection to target interventions for improvement. As cleaning standards and inappropriate antibiotic prescribing practices have historically been the two predominately identified lapses in cases associated with C. difficile infection focused interventions will be implemented to address both factors. Joint cleaning standard audits undertaken by the Infection Prevention and Control Team and Matrons with GMS to validate the standard of cleaning will continue which more frequency, with any issues being addressed the point of review. Also MDT AMS ward rounds across the trust are ongoing; these are ward based round and undertaken by the Lead Nurse for AMS, Antimicrobial Pharmacists and Consultant Microbiologist. The team make remedial interventions at the time of the round, providing feedback and education to ward teams and collect data on the types of interventions being completed during the round for impact review. These outcomes are feedback to the ward team via email. There are at least 2 AMS ward rounds per week; 1 per site and 1 infection rounds, one on AMU and one ACUC per week. Furthermore, Nurse- led C. difficile ward rounds continue thrice weekly to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients.	Associate Chief Nurse, Director of Infection Prevention & Control

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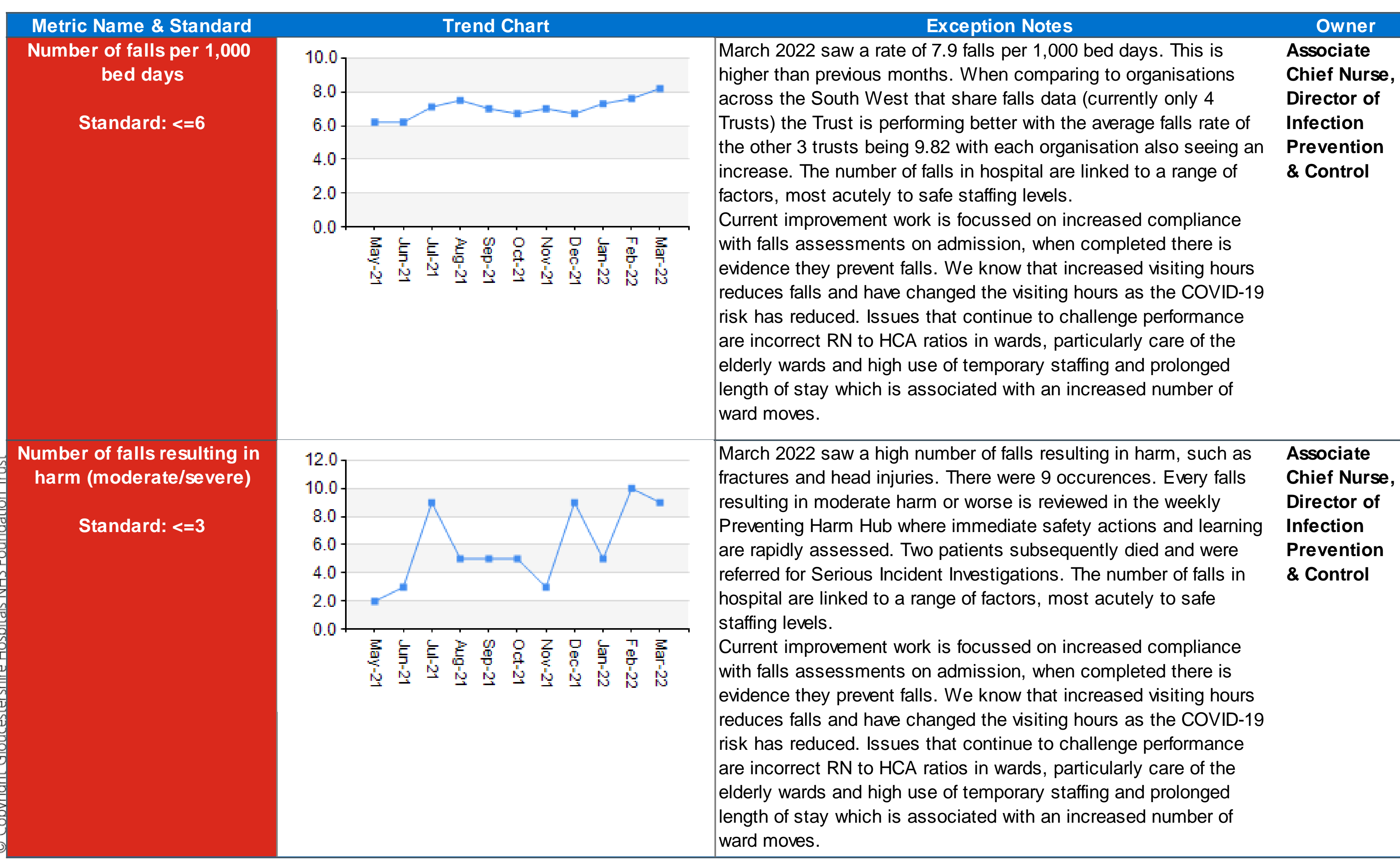
Exception Reports - Safe (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls per 1,000 bed days **Standard: <=6**		March 2022 saw a rate of 7.9 falls per 1,000 bed days. This is higher than previous months. When comparing to organisations across the South West that share falls data (currently only 4 Trusts) the Trust is performing better with the average falls rate of the other 3 trusts being 9.82 with each organisation also seeing an increase. The number of falls in hospital are linked to a range of factors, most acutely to safe staffing levels. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing and prolonged length of stay which is associated with an increased number of ward moves.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		March 2022 saw a high number of falls resulting in harm, such as fractures and head injuries. There were 9 occurences. Every falls resulting in moderate harm or worse is reviewed in the weekly Preventing Harm Hub where immediate safety actions and learning are rapidly assessed. Two patients subsequently died and were referred for Serious Incident Investigations. The number of falls in hospital are linked to a range of factors, most acutely to safe staffing levels. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and have changed the visiting hours as the COVID-19 risk has reduced. Issues that continue to challenge performance are incorrect RN to HCA ratios in wards, particularly care of the elderly wards and high use of temporary staffing and prolonged length of stay which is associated with an increased number of ward moves.	**Associate Chief Nurse, Director of Infection Prevention & Control**

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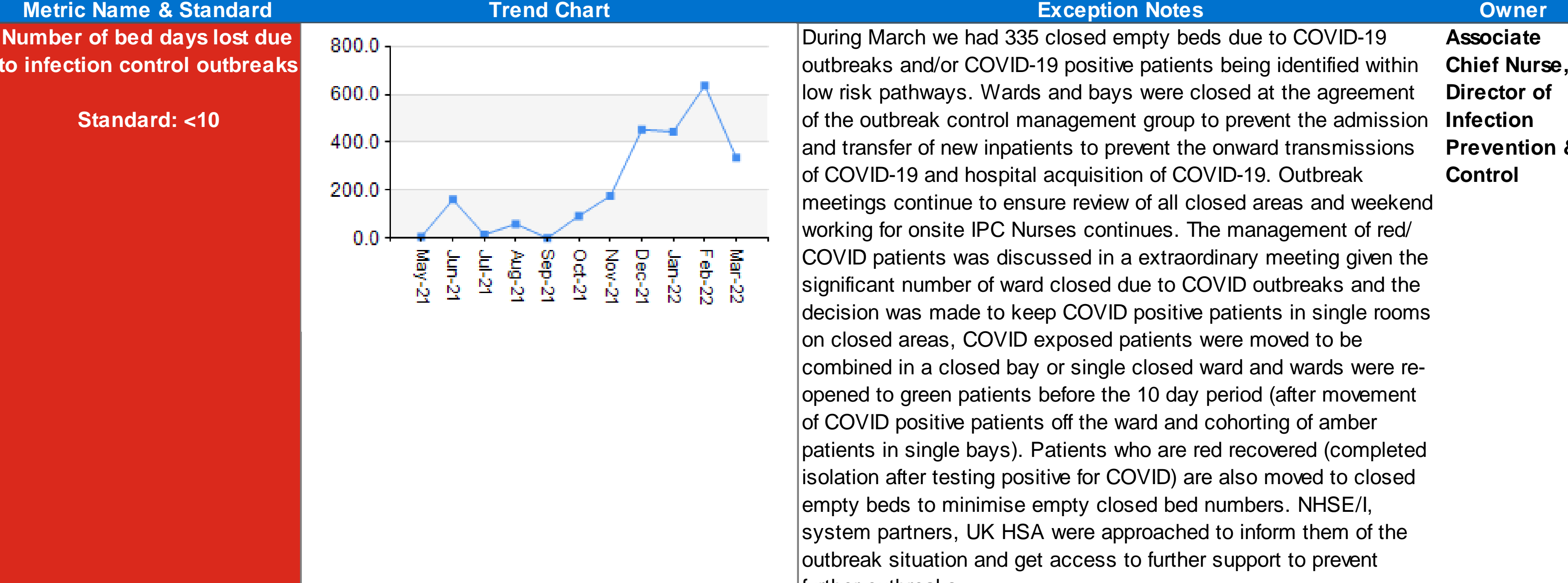
Exception Reports - Safe (4)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of bed days lost due to infection control outbreaks Standard: <10		During March we had 335 closed empty beds due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways. Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients to prevent the onward transmissions of COVID-19 and hospital acquisition of COVID-19. Outbreak meetings continue to ensure review of all closed areas and weekend working for onsite IPC Nurses continues. The management of red/ COVID patients was discussed in a extraordinary meeting given the significant number of ward closed due to COVID outbreaks and the decision was made to keep COVID positive patients in single rooms on closed areas, COVID exposed patients were moved to be combined in a closed bay or single closed ward and wards were re-opened to green patients before the 10 day period (after movement of COVID positive patients off the ward and cohorting of amber patients in single bays). Patients who are red recovered (completed isolation after testing positive for COVID) are also moved to closed empty beds to minimise empty closed bed numbers. NHSE/I, system partners, UK HSA were approached to inform them of the outbreak situation and get access to further support to prevent further outbreaks.	**Associate Chief Nurse, Director of Infection Prevention & Control**

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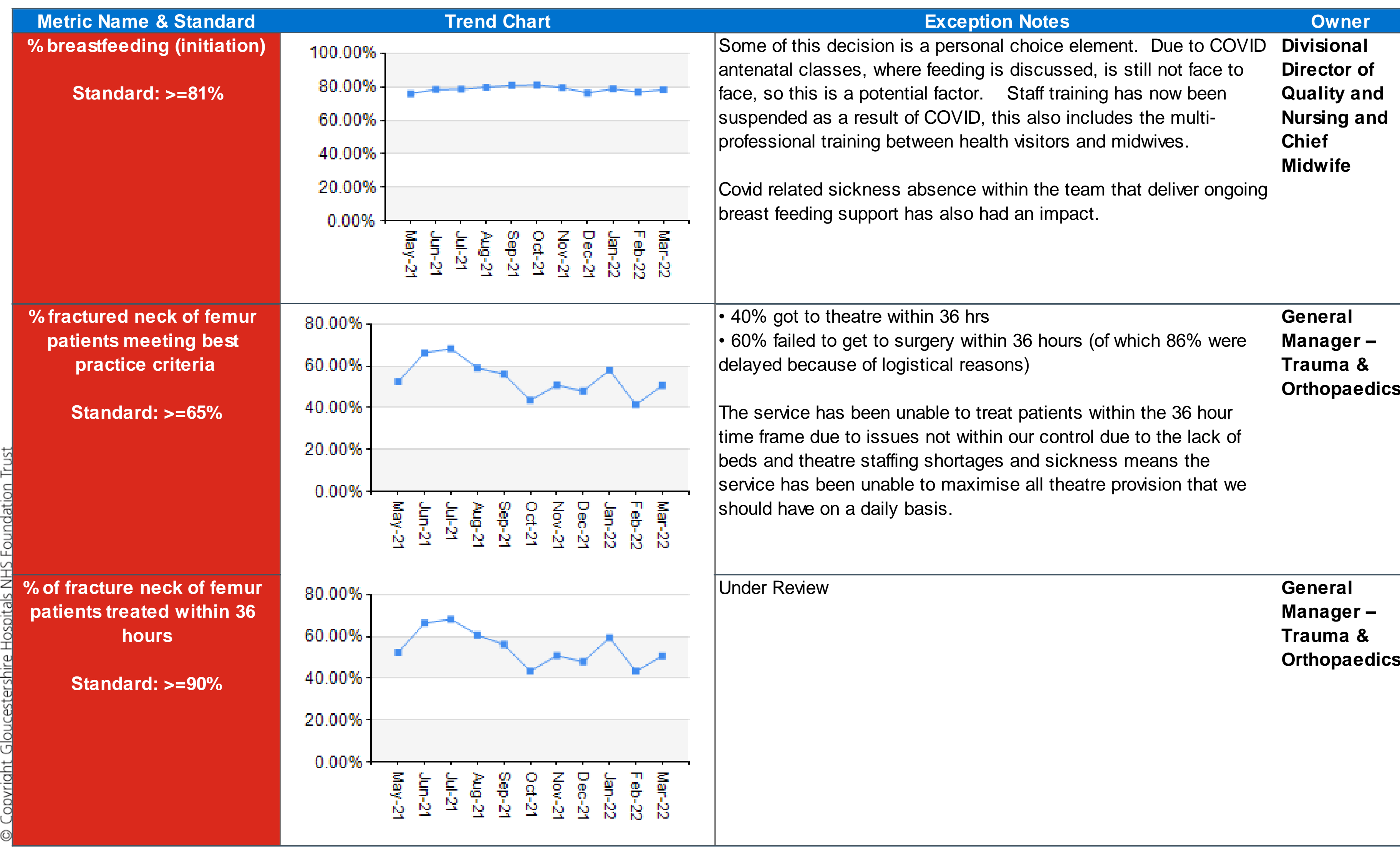
Exception Reports - Effective (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**	100.00% 80.00% 60.00% 40.00% 20.00% 0.00% May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22	Some of this decision is a personal choice element. Due to COVID antenatal classes, where feeding is discussed, is still not face to face, so this is a potential factor. Staff training has now been suspended as a result of COVID, this also includes the multi-professional training between health visitors and midwives. Covid related sickness absence within the team that deliver ongoing breast feeding support has also had an impact.	**Divisional Director of Quality and Nursing and Chief Midwife**
% fractured neck of femur patients meeting best practice criteria **Standard: >=65%**	80.00% 60.00% 40.00% 20.00% 0.00% May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22	• 40% got to theatre within 36 hrs • 60% failed to get to surgery within 36 hours (of which 86% were delayed because of logistical reasons) The service has been unable to treat patients within the 36 hour time frame due to issues not within our control due to the lack of beds and theatre staffing shortages and sickness means the service has been unable to maximise all theatre provision that we should have on a daily basis.	**General Manager – Trauma & Orthopaedics**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**	80.00% 60.00% 40.00% 20.00% 0.00% May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22	Under Review	**General Manager – Trauma & Orthopaedics**

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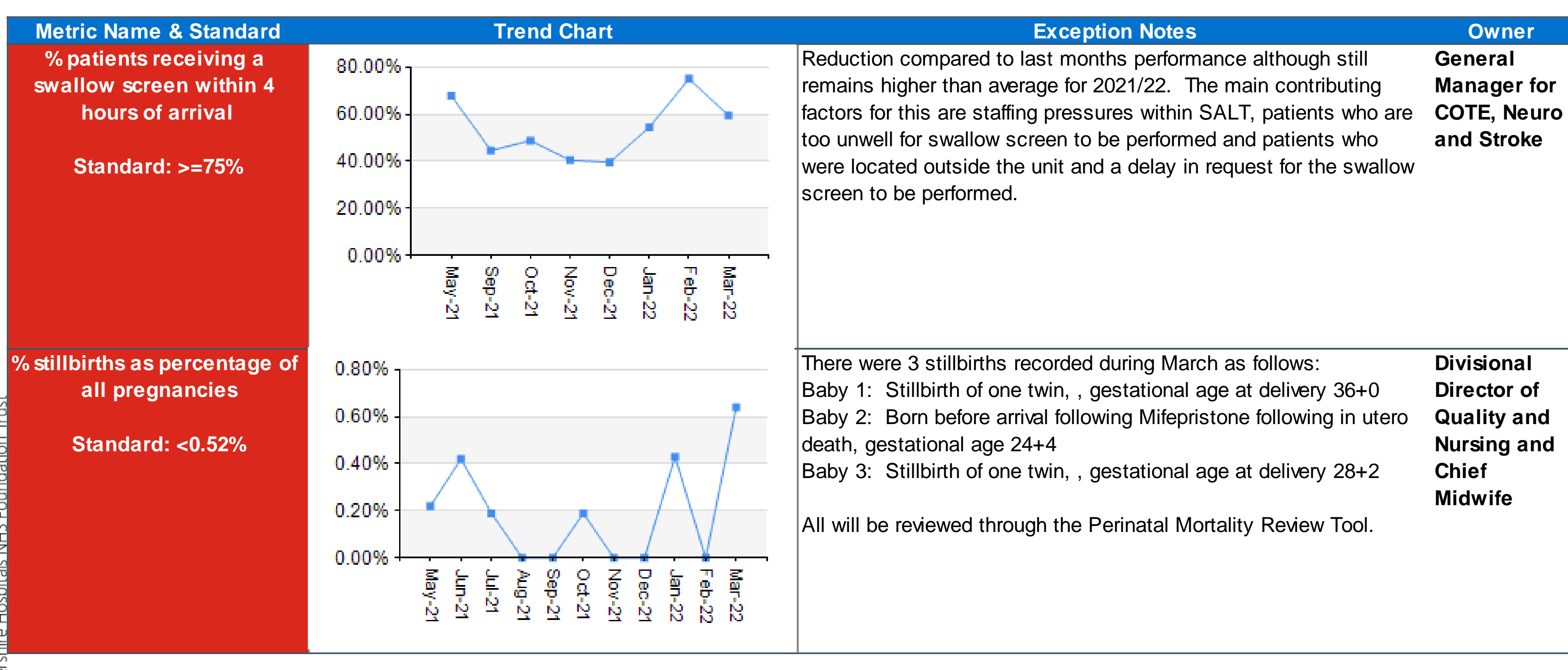
Exception Reports - Effective (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% patients receiving a swallow screen within 4 hours of arrival Standard: >=75%	80.00% 60.00% 40.00% 20.00% 0.00% May-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22	Reduction compared to last months performance although still remains higher than average for 2021/22. The main contributing factors for this are staffing pressures within SALT, patients who are too unwell for swallow screen to be performed and patients who were located outside the unit and a delay in request for the swallow screen to be performed.	**General Manager for COTE, Neuro and Stroke**
% stillbirths as percentage of all pregnancies Standard: <0.52%	0.80% 0.60% 0.40% 0.20% 0.00% May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22	There were 3 stillbirths recorded during March as follows: Baby 1: Stillbirth of one twin, , gestational age at delivery 36+0 Baby 2: Born before arrival following Mifepristone following in utero death, gestational age 24+4 Baby 3: Stillbirth of one twin, , gestational age at delivery 28+2 All will be reviewed through the Perinatal Mortality Review Tool.	**Divisional Director of Quality and Nursing and Chief Midwife**

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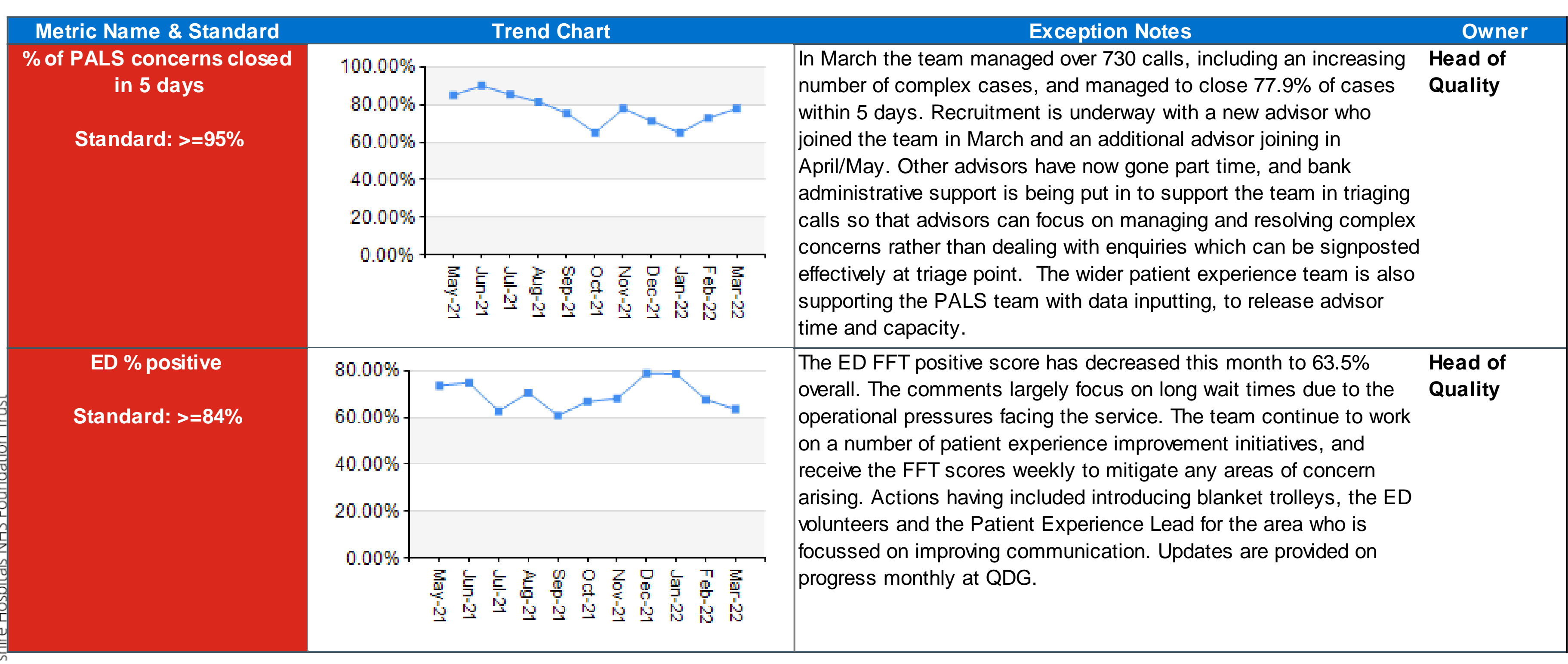
Exception Reports - Caring (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		In March the team managed over 730 calls, including an increasing number of complex cases, and managed to close 77.9% of cases within 5 days. Recruitment is underway with a new advisor who joined the team in March and an additional advisor joining in April/May. Other advisors have now gone part time, and bank administrative support is being put in to support the team in triaging calls so that advisors can focus on managing and resolving complex concerns rather than dealing with enquiries which can be signposted effectively at triage point. The wider patient experience team is also supporting the PALS team with data inputting, to release advisor time and capacity.	**Head of Quality**
ED % positive **Standard: >=84%**		The ED FFT positive score has decreased this month to 63.5% overall. The comments largely focus on long wait times due to the operational pressures facing the service. The team continue to work on a number of patient experience improvement initiatives, and receive the FFT scores weekly to mitigate any areas of concern arising. Actions having included introducing blanket trolleys, the ED volunteers and the Patient Experience Lead for the area who is focussed on improving communication. Updates are provided on progress monthly at QDG.	**Head of Quality**

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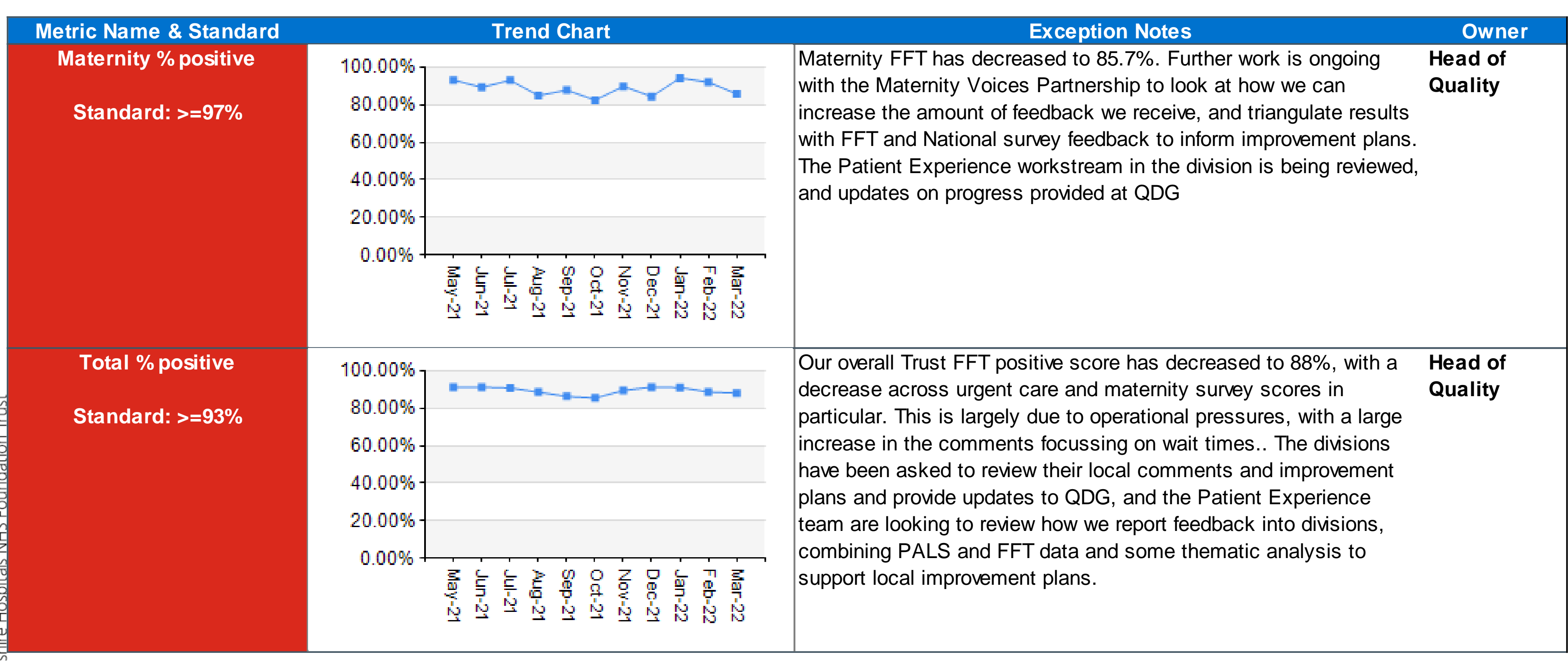
Exception Reports - Caring (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Maternity % positive **Standard: >=97%**	100.00% 80.00% 60.00% 40.00% 20.00% 0.00% May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22	Maternity FFT has decreased to 85.7%. Further work is ongoing with the Maternity Voices Partnership to look at how we can increase the amount of feedback we receive, and triangulate results with FFT and National survey feedback to inform improvement plans. The Patient Experience workstream in the division is being reviewed, and updates on progress provided at QDG	**Head of Quality**
Total % positive **Standard: >=93%**	100.00% 80.00% 60.00% 40.00% 20.00% 0.00% May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22	Our overall Trust FFT positive score has decreased to 88%, with a decrease across urgent care and maternity survey scores in particular. This is largely due to operational pressures, with a large increase in the comments focussing on wait times.. The divisions have been asked to review their local comments and improvement plans and provide updates to QDG, and the Patient Experience team are looking to review how we report feedback into divisions, combining PALS and FFT data and some thematic analysis to support local improvement plans.	**Head of Quality**

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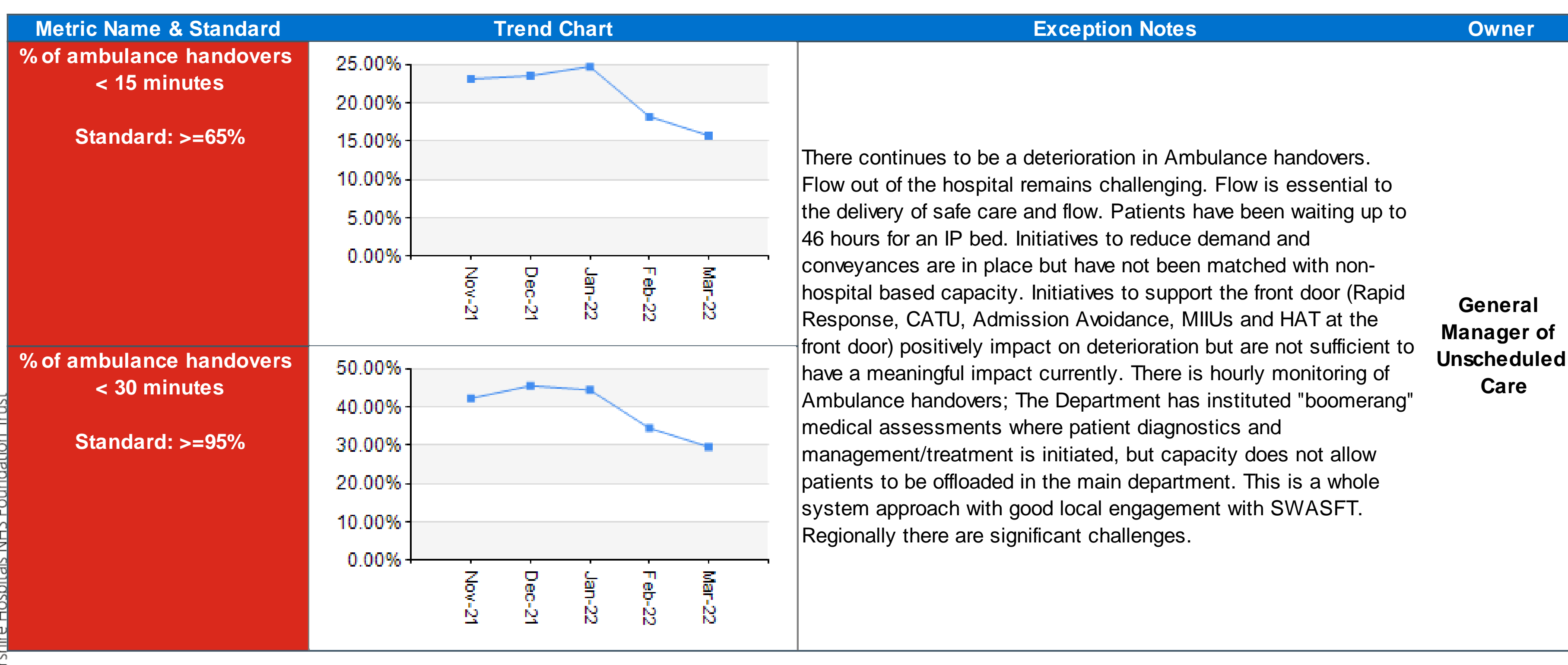
Exception Reports - Responsive (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers < 15 minutes Standard: >=65%		There continues to be a deterioration in Ambulance handovers. Flow out of the hospital remains challenging. Flow is essential to the delivery of safe care and flow. Patients have been waiting up to 46 hours for an IP bed. Initiatives to reduce demand and conveyances are in place but have not been matched with non-hospital based capacity. Initiatives to support the front door (Rapid Response, CATU, Admission Avoidance, MIIUs and HAT at the front door) positively impact on deterioration but are not sufficient to have a meaningful impact currently. There is hourly monitoring of Ambulance handovers; The Department has instituted "boomerang" medical assessments where patient diagnostics and management/treatment is initiated, but capacity does not allow patients to be offloaded in the main department. This is a whole system approach with good local engagement with SWASFT. Regionally there are significant challenges.	General Manager of Unscheduled Care
% of ambulance handovers < 30 minutes Standard: >=95%			

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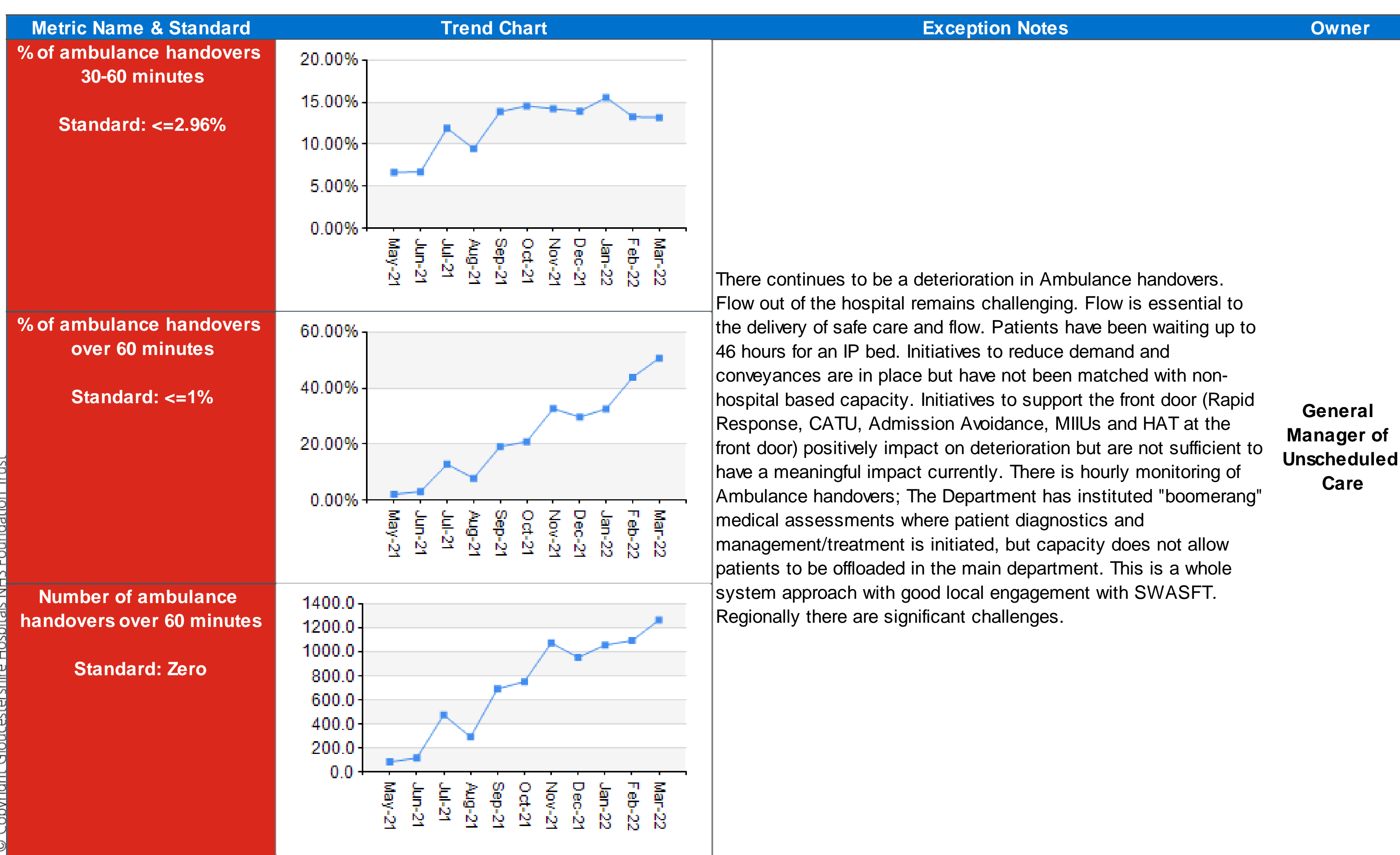
Exception Reports - Responsive (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers 30-60 minutes **Standard: <=2.96%**		There continues to be a deterioration in Ambulance handovers. Flow out of the hospital remains challenging. Flow is essential to the delivery of safe care and flow. Patients have been waiting up to 46 hours for an IP bed. Initiatives to reduce demand and conveyances are in place but have not been matched with non-hospital based capacity. Initiatives to support the front door (Rapid Response, CATU, Admission Avoidance, MIIUs and HAT at the front door) positively impact on deterioration but are not sufficient to have a meaningful impact currently. There is hourly monitoring of Ambulance handovers; The Department has instituted "boomerang" medical assessments where patient diagnostics and management/treatment is initiated, but capacity does not allow patients to be offloaded in the main department. This is a whole system approach with good local engagement with SWASFT. Regionally there are significant challenges.	**General Manager of Unscheduled Care**
% of ambulance handovers over 60 minutes **Standard: <=1%**			
Number of ambulance handovers over 60 minutes **Standard: Zero**			

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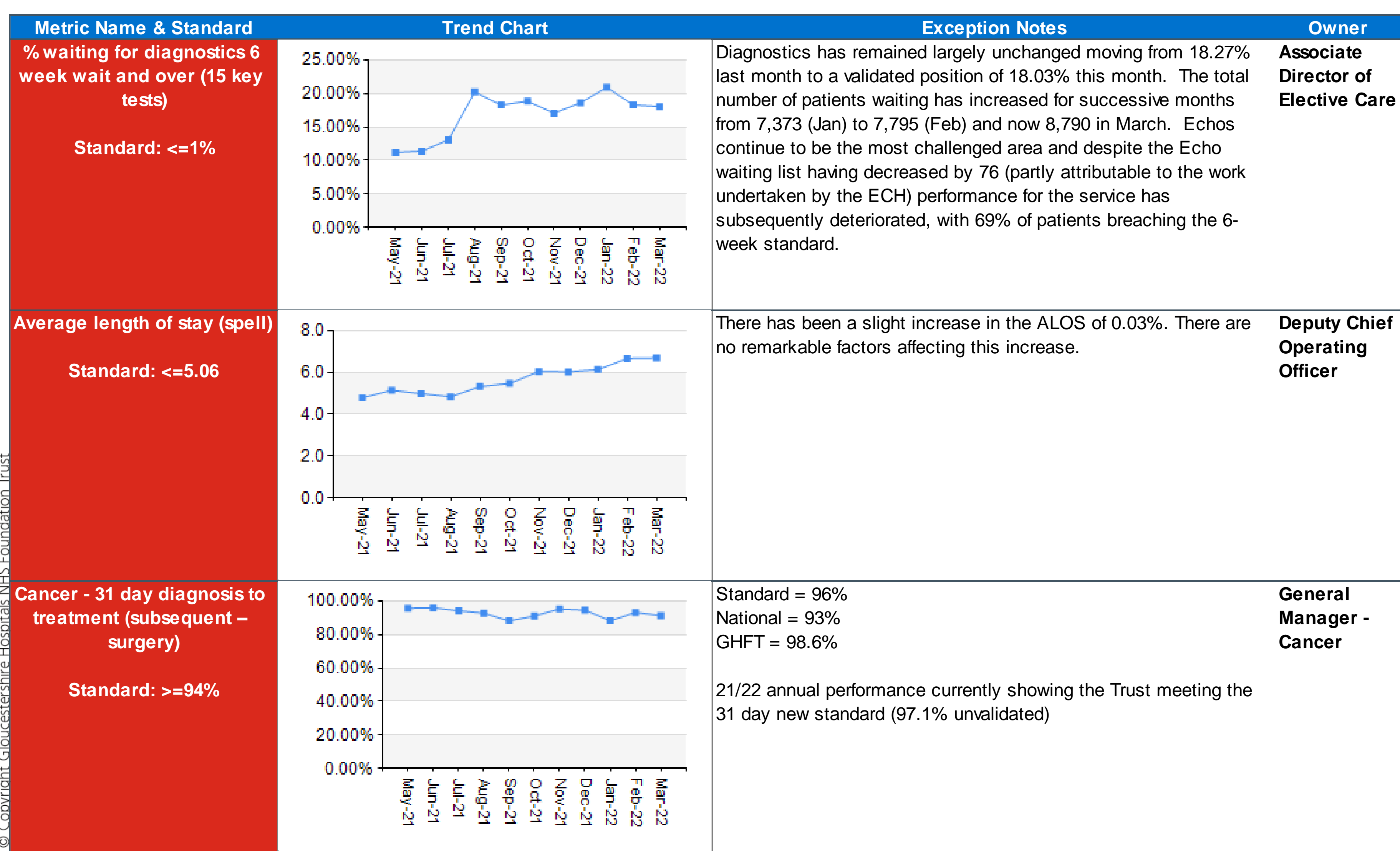
Exception Reports - Responsive (3)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% waiting for diagnostics 6 week wait and over (15 key tests) Standard: <=1%		Diagnostics has remained largely unchanged moving from 18.27% last month to a validated position of 18.03% this month. The total number of patients waiting has increased for successive months from 7,373 (Jan) to 7,795 (Feb) and now 8,790 in March. Echos continue to be the most challenged area and despite the Echo waiting list having decreased by 76 (partly attributable to the work undertaken by the ECH) performance for the service has subsequently deteriorated, with 69% of patients breaching the 6-week standard.	**Associate Director of Elective Care**
Average length of stay (spell) Standard: <=5.06		There has been a slight increase in the ALOS of 0.03%. There are no remarkable factors affecting this increase.	**Deputy Chief Operating Officer**
Cancer - 31 day diagnosis to treatment (subsequent – surgery) Standard: >=94%		Standard = 96% National = 93% GHFT = 98.6% 21/22 annual performance currently showing the Trust meeting the 31 day new standard (97.1% unvalidated)	**General Manager - Cancer**

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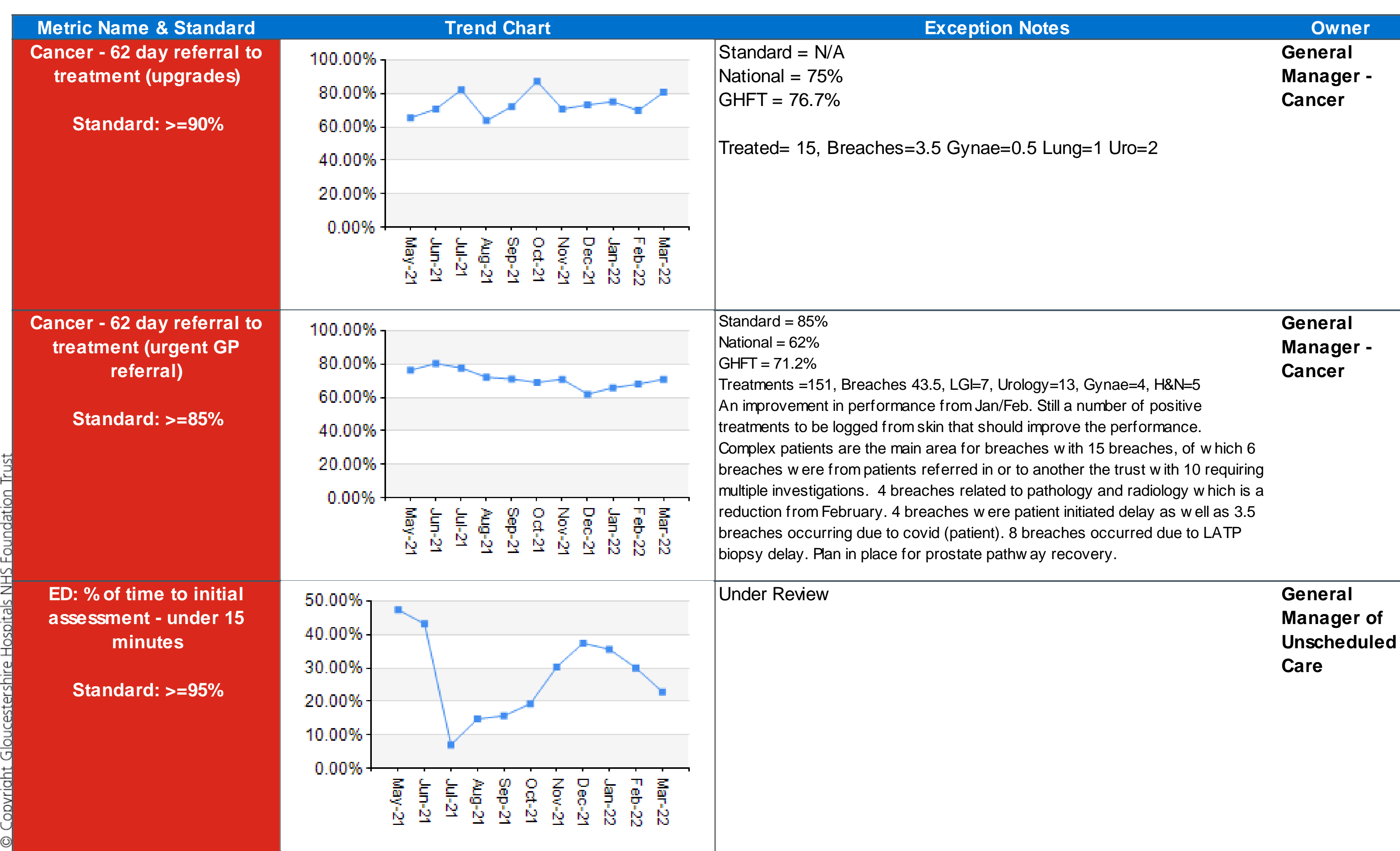
Exception Reports - Responsive (4)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer - 62 day referral to treatment (upgrades) **Standard: >=90%**		Standard = N/A National = 75% GHFT = 76.7% Treated= 15, Breaches=3.5 Gynae=0.5 Lung=1 Uro=2	**General Manager - Cancer**
Cancer - 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		Standard = 85% National = 62% GHFT = 71.2% Treatments =151, Breaches 43.5, LGI=7, Urology=13, Gynae=4, H&N=5 An improvement in performance from Jan/Feb. Still a number of positive treatments to be logged from skin that should improve the performance. Complex patients are the main area for breaches w ith 15 breaches, of w hich 6 breaches w ere from patients referred in or to another the trust w ith 10 requiring multiple investigations. 4 breaches related to pathology and radiology w hich is a reduction from February. 4 breaches w ere patient initiated delay as w ell as 3.5 breaches occurring due to covid (patient). 8 breaches occurred due to LATP biopsy delay. Plan in place for prostate pathw ay recovery.	**General Manager - Cancer**
ED: % of time to initial assessment - under 15 minutes **Standard: >=95%**		Under Review	**General Manager of Unscheduled Care**

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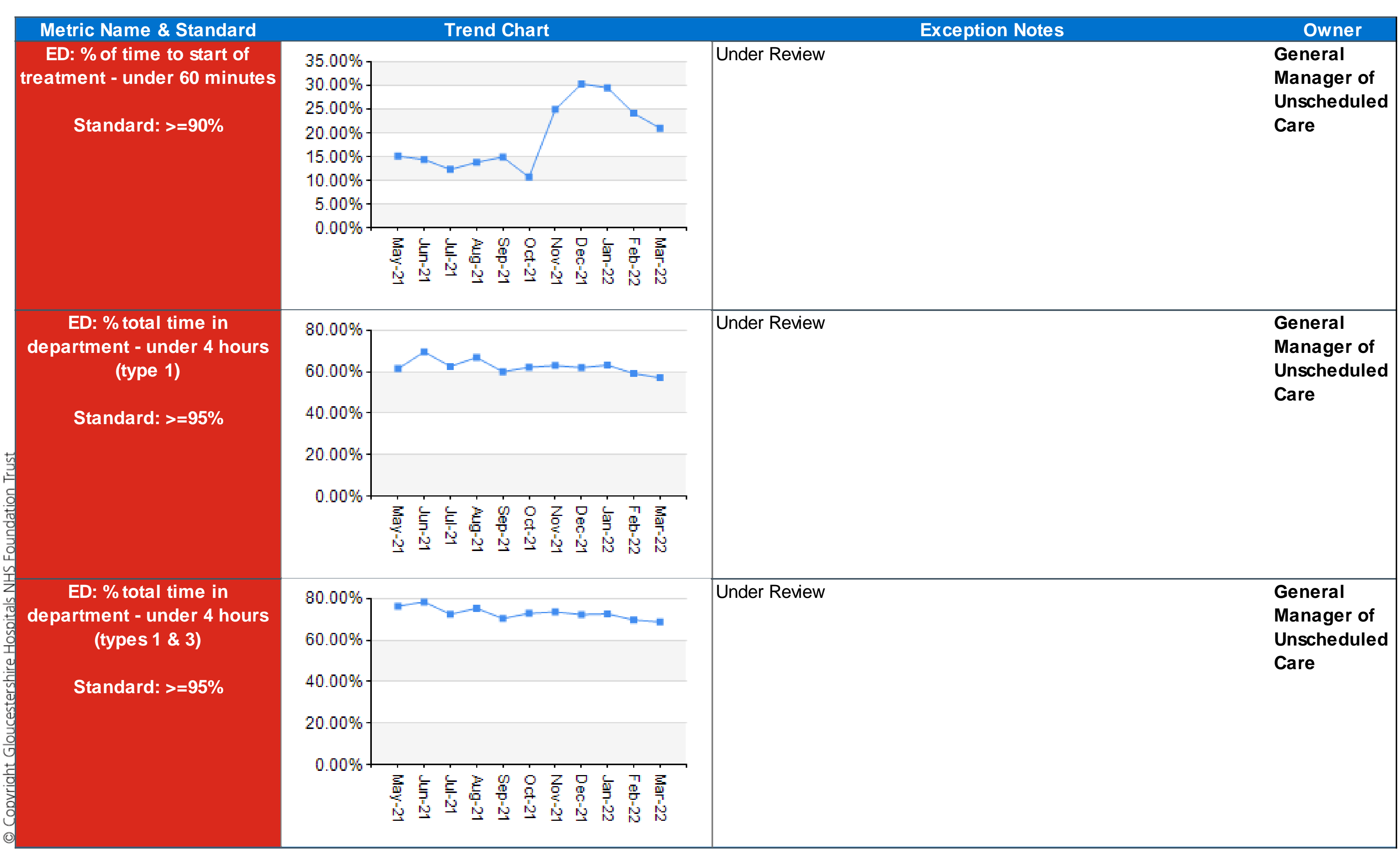
Exception Reports - Responsive (5)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to start of treatment - under 60 minutes **Standard: >=90%**		Under Review	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (type 1) **Standard: >=95%**		Under Review	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (types 1 & 3) **Standard: >=95%**		Under Review	**General Manager of Unscheduled Care**

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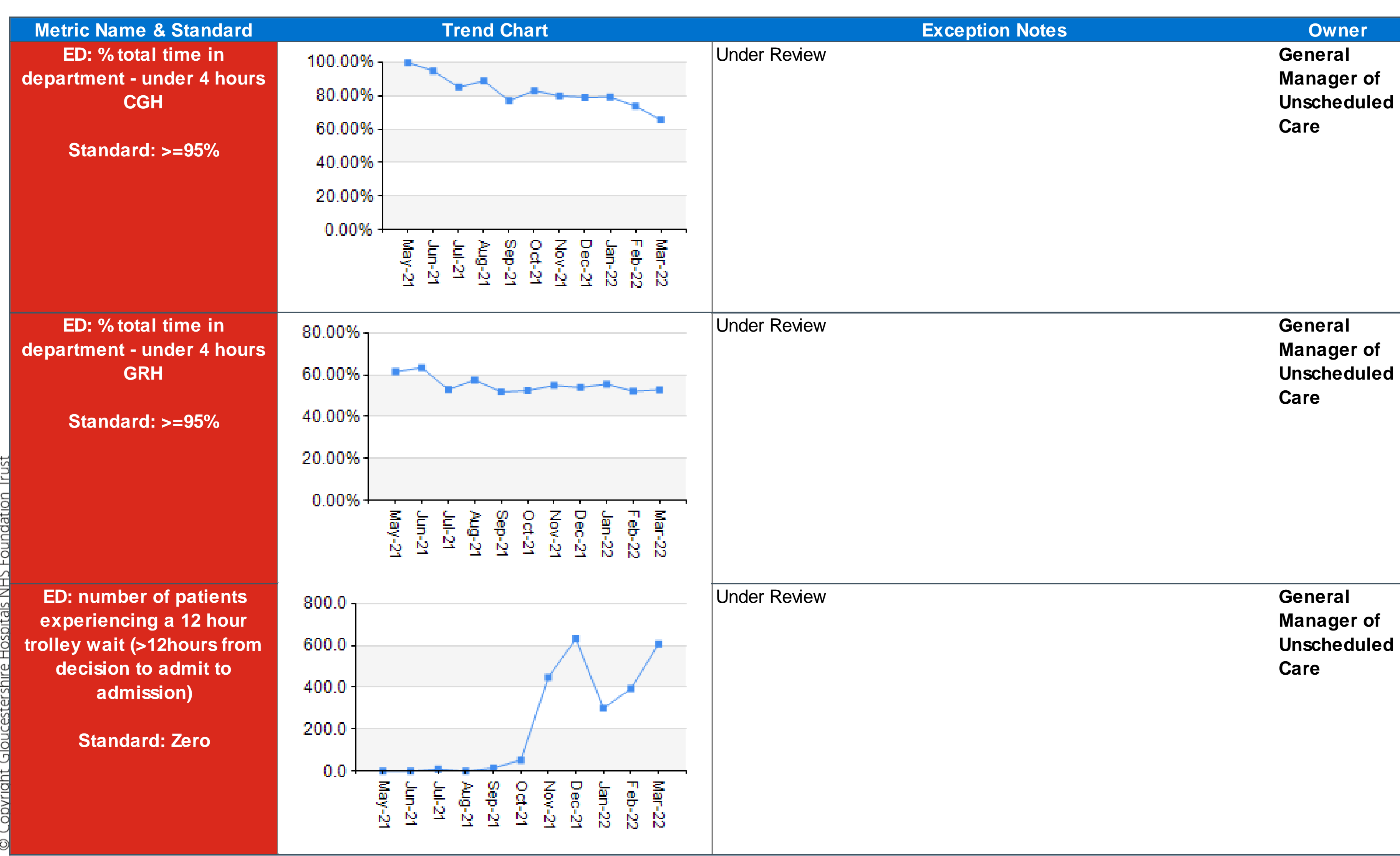
Exception Reports - Responsive (6)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department - under 4 hours CGH Standard: >=95%		Under Review	General Manager of Unscheduled Care
ED: % total time in department - under 4 hours GRH Standard: >=95%		Under Review	General Manager of Unscheduled Care
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) Standard: Zero		Under Review	General Manager of Unscheduled Care

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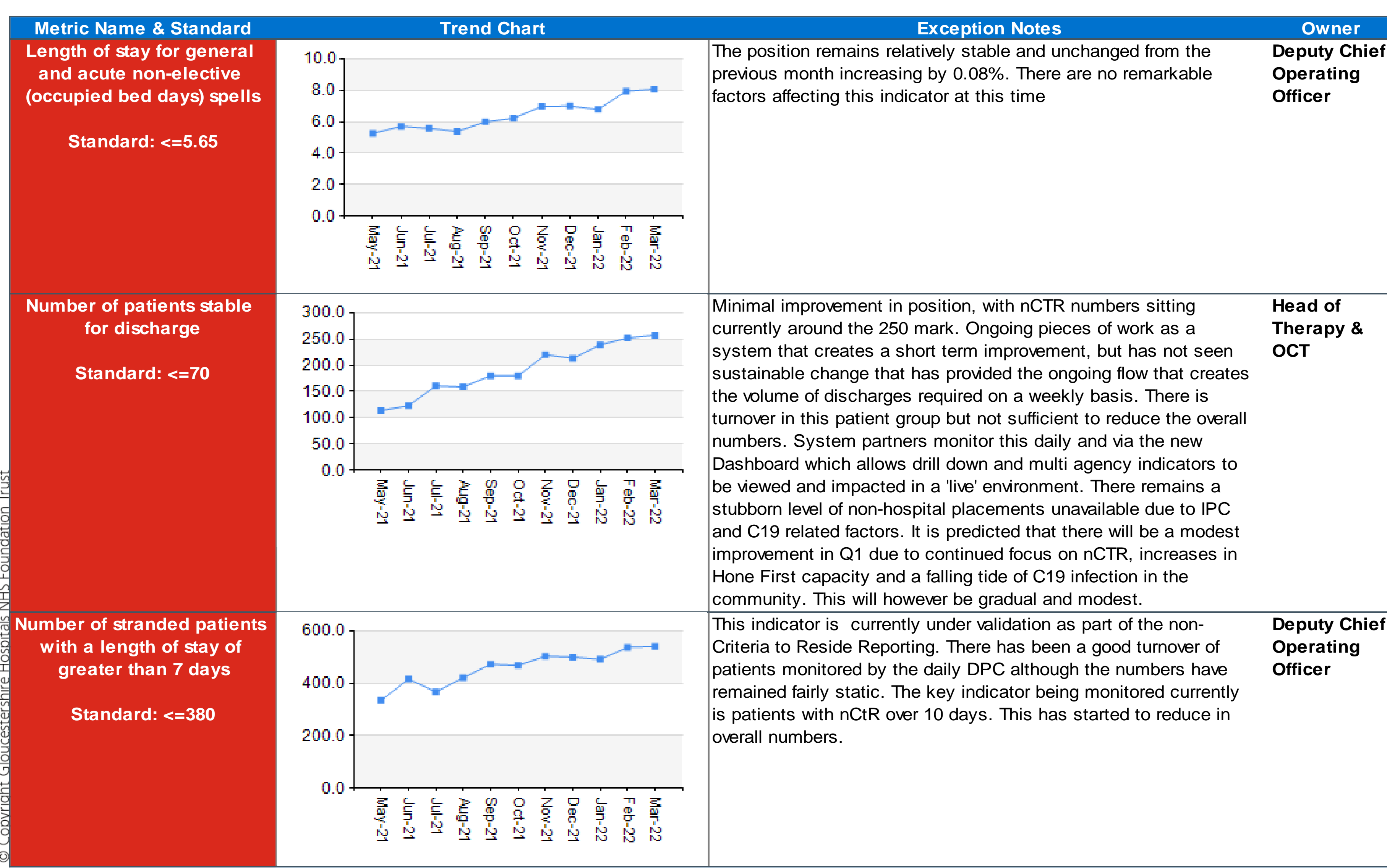
Exception Reports - Responsive (7)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Length of stay for general and acute non-elective (occupied bed days) spells Standard: <=5.65		The position remains relatively stable and unchanged from the previous month increasing by 0.08%. There are no remarkable factors affecting this indicator at this time	Deputy Chief Operating Officer
Number of patients stable for discharge Standard: <=70		Minimal improvement in position, with nCTR numbers sitting currently around the 250 mark. Ongoing pieces of work as a system that creates a short term improvement, but has not seen sustainable change that has provided the ongoing flow that creates the volume of discharges required on a weekly basis. There is turnover in this patient group but not sufficient to reduce the overall numbers. System partners monitor this daily and via the new Dashboard which allows drill down and multi agency indicators to be viewed and impacted in a 'live' environment. There remains a stubborn level of non-hospital placements unavailable due to IPC and C19 related factors. It is predicted that there will be a modest improvement in Q1 due to continued focus on nCTR, increases in Hone First capacity and a falling tide of C19 infection in the community. This will however be gradual and modest.	Head of Therapy & OCT
Number of stranded patients with a length of stay of greater than 7 days Standard: <=380		This indicator is currently under validation as part of the non-Criteria to Reside Reporting. There has been a good turnover of patients monitored by the daily DPC although the numbers have remained fairly static. The key indicator being monitored currently is patients with nCtR over 10 days. This has started to reduce in overall numbers.	Deputy Chief Operating Officer

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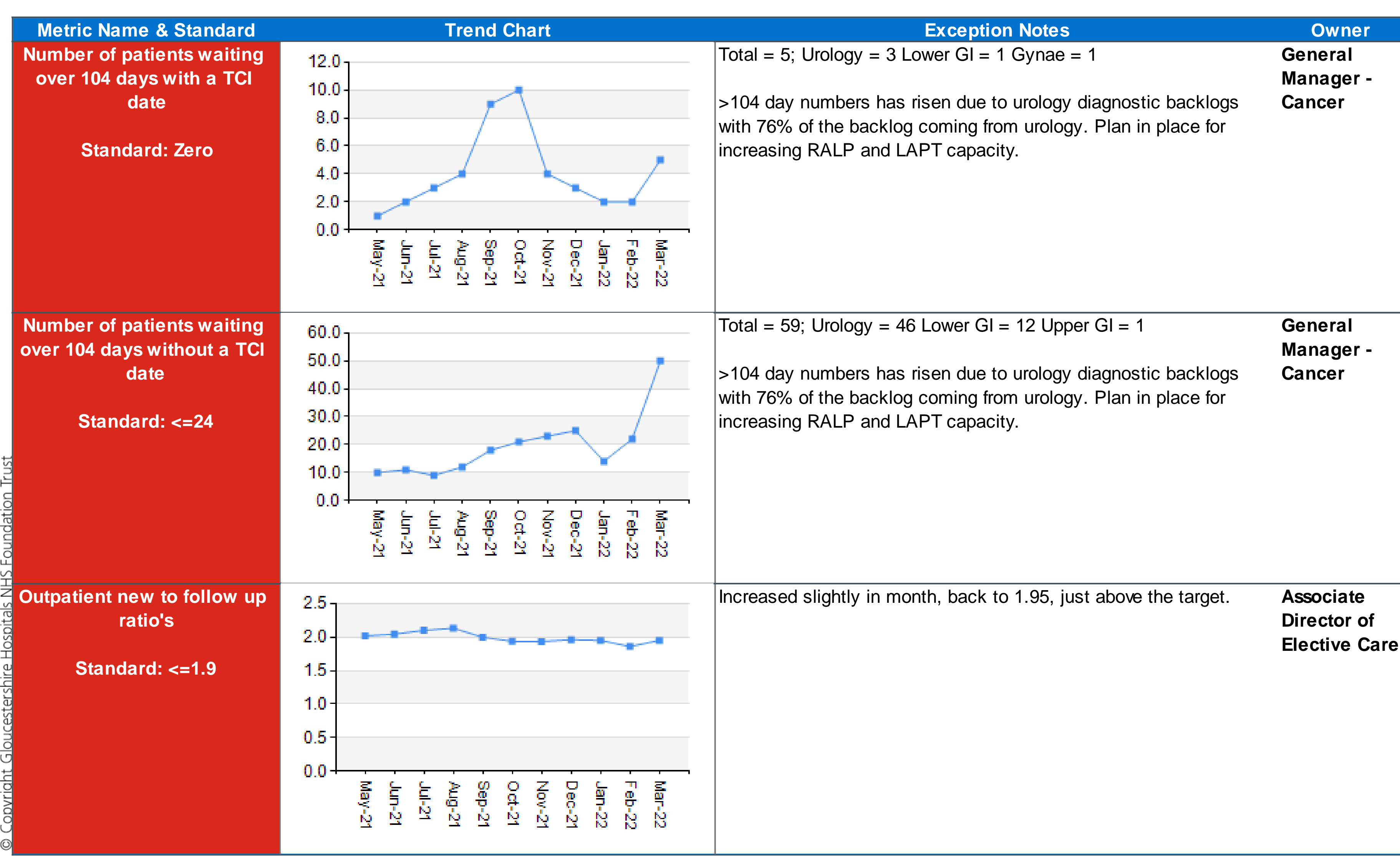
Exception Reports - Responsive (8)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Total = 5; Urology = 3 Lower GI = 1 Gynae = 1 >104 day numbers has risen due to urology diagnostic backlogs with 76% of the backlog coming from urology. Plan in place for increasing RALP and LAPT capacity.	**General Manager - Cancer**
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		Total = 59; Urology = 46 Lower GI = 12 Upper GI = 1 >104 day numbers has risen due to urology diagnostic backlogs with 76% of the backlog coming from urology. Plan in place for increasing RALP and LAPT capacity.	**General Manager - Cancer**
Outpatient new to follow up ratio's **Standard: <=1.9**		Increased slightly in month, back to 1.95, just above the target.	**Associate Director of Elective Care**

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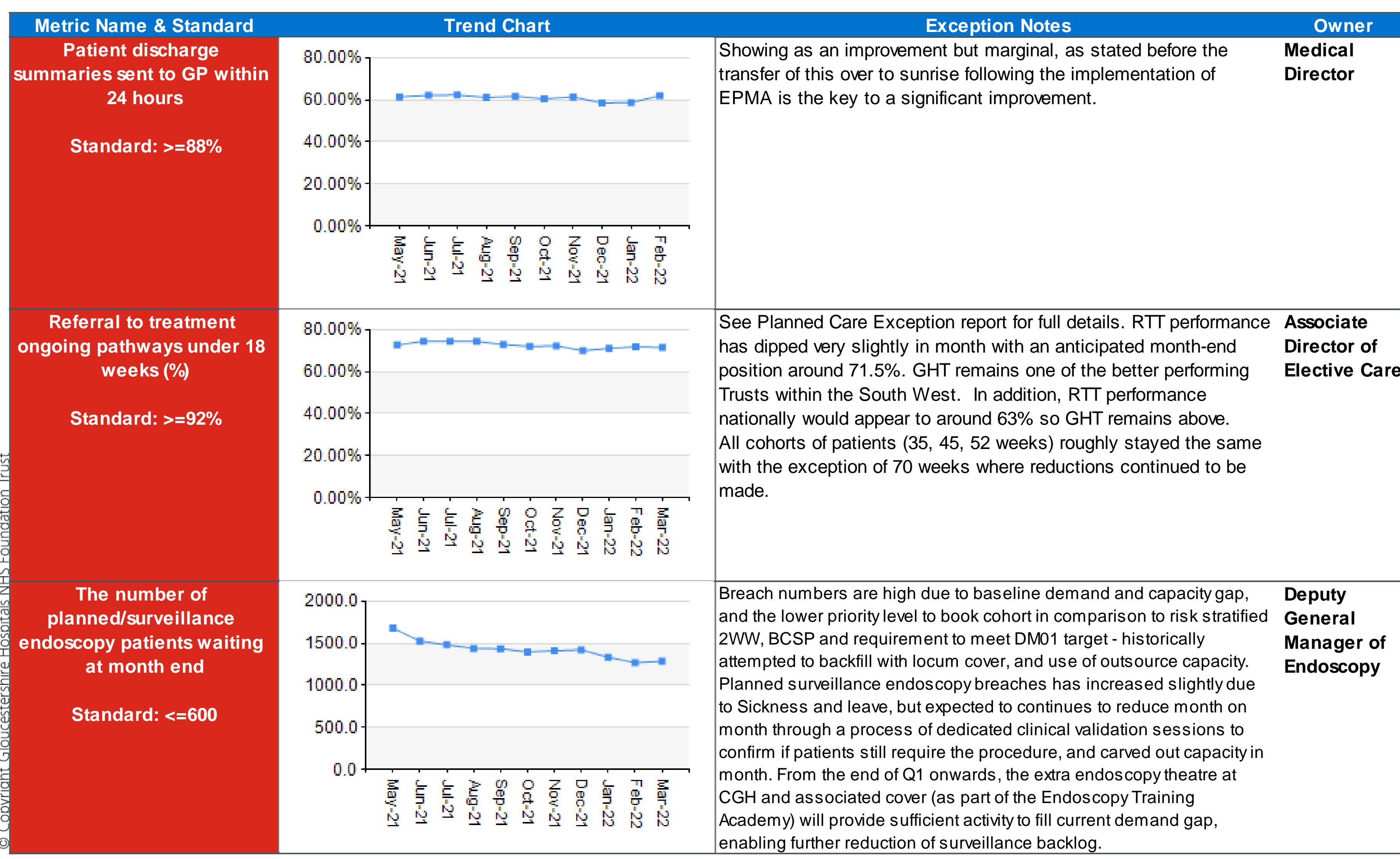
Exception Reports - Responsive (9)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Showing as an improvement but marginal, as stated before the transfer of this over to sunrise following the implementation of EPMA is the key to a significant improvement.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. RTT performance has dipped very slightly in month with an anticipated month-end position around 71.5%. GHT remains one of the better performing Trusts within the South West. In addition, RTT performance nationally would appear to around 63% so GHT remains above. All cohorts of patients (35, 45, 52 weeks) roughly stayed the same with the exception of 70 weeks where reductions continued to be made.	**Associate Director of Elective Care**
The number of planned/surveillance endoscopy patients waiting at month end **Standard: <=600**		Breach numbers are high due to baseline demand and capacity gap, and the lower priority level to book cohort in comparison to risk stratified 2WW, BCSP and requirement to meet DM01 target - historically attempted to backfill with locum cover, and use of outsource capacity. Planned surveillance endoscopy breaches has increased slightly due to Sickness and leave, but expected to continues to reduce month on month through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and carved out capacity in month. From the end of Q1 onwards, the extra endoscopy theatre at CGH and associated cover (as part of the Endoscopy Training Academy) will provide sufficient activity to fill current demand gap, enabling further reduction of surveillance backlog.	**Deputy General Manager of Endoscopy**

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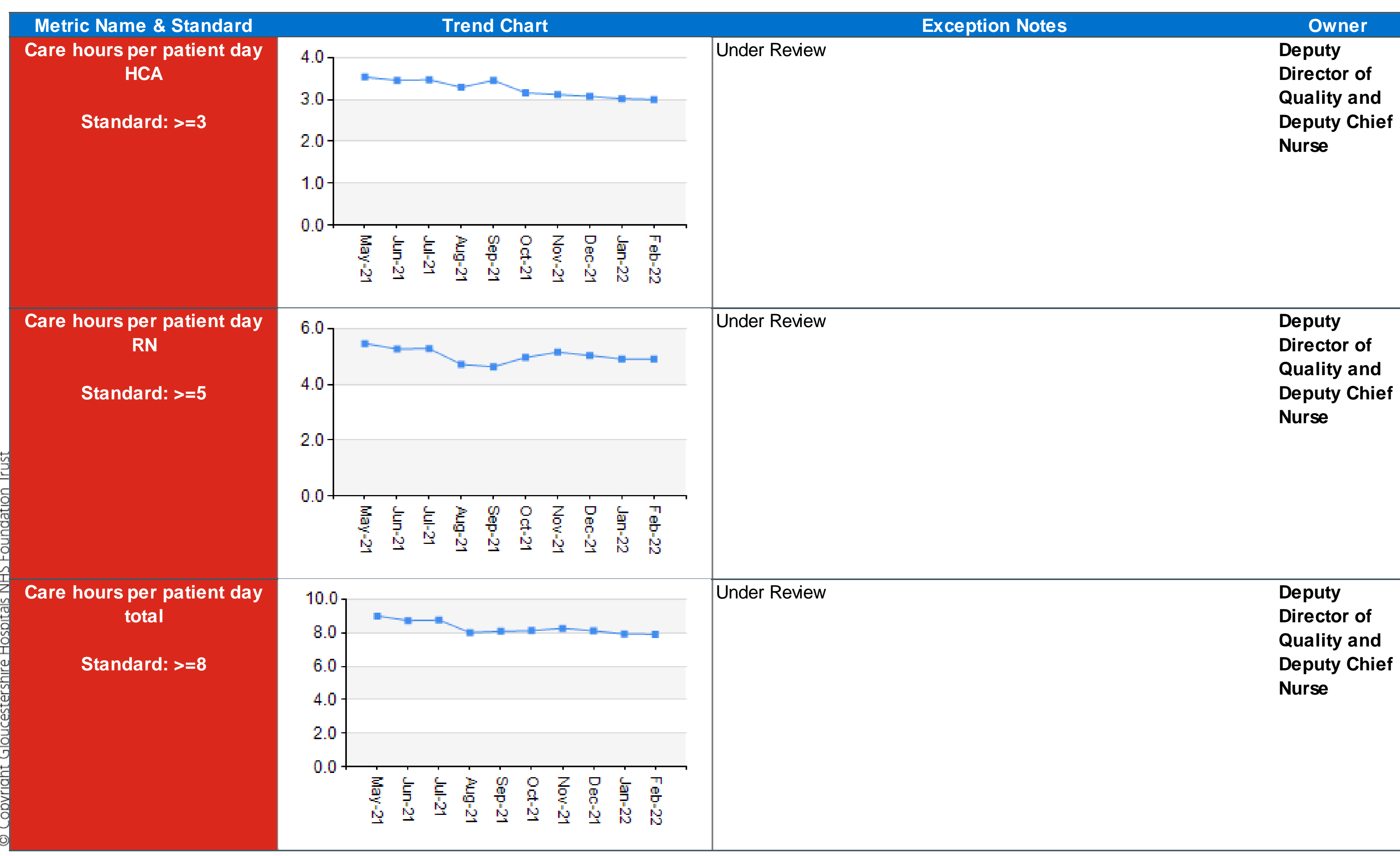
Exception Reports - Well Led (1)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
Care hours per patient day HCA **Standard: >=3**		Under Review	**Deputy Director of Quality and Deputy Chief Nurse**
Care hours per patient day RN **Standard: >=5**		Under Review	**Deputy Director of Quality and Deputy Chief Nurse**
Care hours per patient day total **Standard: >=8**		Under Review	**Deputy Director of Quality and Deputy Chief Nurse**

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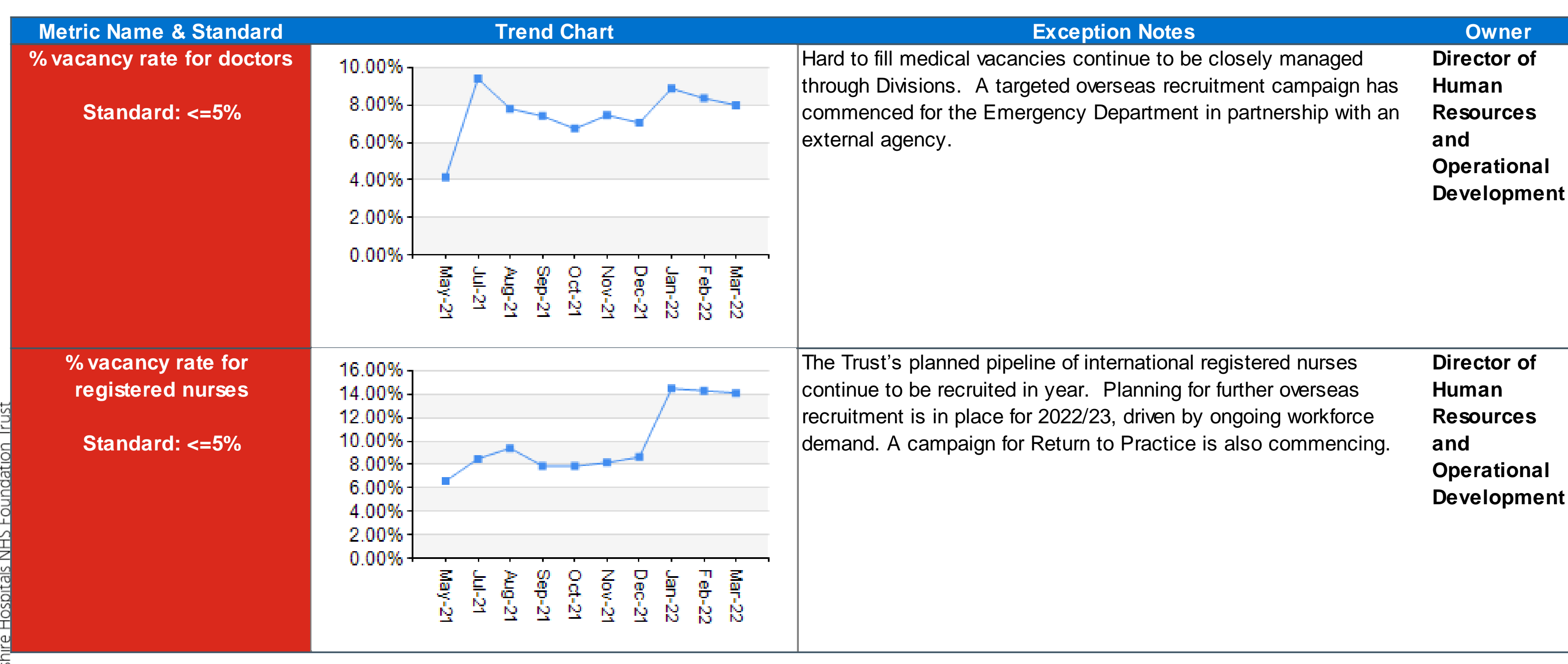
Exception Reports - Well Led (2)



Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors Standard: <=5%		Hard to fill medical vacancies continue to be closely managed through Divisions. A targeted overseas recruitment campaign has commenced for the Emergency Department in partnership with an external agency.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses Standard: <=5%		The Trust's planned pipeline of international registered nurses continue to be recruited in year. Planning for further overseas recruitment is in place for 2022/23, driven by ongoing workforce demand. A campaign for Return to Practice is also commencing.	**Director of Human Resources and Operational Development**

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Quality and Performance Report
Statistical Process Control Reporting

Reporting Period March 2022

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

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Quality	36
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Guidance

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

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

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Executive Summary

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

During March, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4 hour ED standard, albeit met majority of the H2 metrics, notably zero 104 weeks breaches and Total Incompletes less than 60,248.

March continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 69.94% to 68.71% compared to the previous month. Ambulance handover delays increased for delays over 30 and 60 minute handovers. Correcting this negative trend remains a priority for the Trust, and the ED has implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.

The Trust did not meet the diagnostics standard in March however performance improved slightly on last month from 18.3% to 18.0% this month. The total number of patients waiting has increased from 7,795 to 8,790. The overall number of breaches has increased by 161, if Echo's were to be excluded, performance for all other modalities would be 0.73% with just 48 breaches against 6,561 patients waiting.

For cancer, in February's submitted data, the Trust met 6 of the 9 CWT metrics and exceeded national performance in 9 out of 9 of the CWT metrics. A better month for Cancer waits performance with the Trust meeting 2ww performance, 28 day Faster Diagnosis Standard and 31 day new treatment standard. The Trust achieved 68% for 62 day GP referrals, this will rise following a final validation but clearly requires significant improvement. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity.

For elective care, the RTT performance did not meet the standard at 71.5% (unvalidated) and remains similar to last month. The total incompletes have improved again on last month with a further reduction made. With validation ongoing at the time of this report, the Trusts position is 56,249 with small reductions anticipated prior to submission. The number of 52 week breaches has remained similar to last month with an validated figure of 1,127 breaches in month. Focus continues to be placed on patients over 70 weeks, which has again reduced in month, moving from 185 to 149 in March. At year-end, the Trust had zero 104 week breaches.

The Elective Care Hub continues to work with specialties in telephoning patients but more recently has rolled out a digital survey to increase the ability to contact a wider cohort of patients and more quickly. Although only run has taken place so far, early signs are encouraging, and this will be rolled out to all specialties with cohorts of 1500-2000 patients approached at 3-4 week intervals. For those that are not digitally enabled, a paper copy will be issued.

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

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Access Dashboard

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

Key

Assurance			Variation		
Consistently hit target	Hit and miss target subject to random	Consistently fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer - 28 day FDS (all routes)	>=75%	Mar-22	84.9%
Cancer	Cancer - urgent referrals seen in under 2 weeks from GP	>=93%	Mar-22	93.9%
Cancer	Cancer - 2 week wait breast symptomatic referrals	>=93%	Mar-22	91.3%
Cancer	Cancer - 31 day diagnosis to treatment (first treatments)	>=96%	Mar-22	97.9%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – drug)	>=98%	Mar-22	99.0%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Mar-22	91.2%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Mar-22	99.4%
Cancer	Cancer - 62 day referral to treatment (urgent GP referral)	>=85%	Mar-22	70.9%
Cancer	Cancer - 62 day referral to treatment (screenings)	>=90%	Mar-22	89.9%
Cancer	Cancer - 62 day referral to treatment (upgrades)	>=90%	Mar-22	80.6%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Mar-22	5
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Mar-22	50
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Mar-22	18.03%
Diagnostics	The number of planned/surveillance endoscopy patients waiting at month end	<=600	Mar-22	1,286
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Feb-22	62.00%
Emergency Department	ED: % total time in department - under 4 hours (type 1)	>=95%	Mar-22	57.07%
Emergency Department	ED: % total time in department - under 4 hours (types 1 & 3)	>=95%	Mar-22	68.71%
Emergency Department	ED: % total time in department - under 4 hours CGH	>=95%	Mar-22	65.48%
Emergency Department	ED: % total time in department - under 4 hours GRH	>=95%	Mar-22	52.87%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Mar-22	606
Emergency Department	ED: % of time to initial assessment - under 15 minutes	>=95%	Mar-22	22.9%
Emergency Department	ED: % of time to start of treatment - under 60 minutes	>=90%	Mar-22	21.0%
Emergency Department	Number of ambulance handovers over 60 minutes	Zero	Mar-22	1,263
Emergency Department	% of ambulance handovers < 15 minutes	>=65%	Mar-22	15.7%
Emergency Department	% of ambulance handovers < 30 minutes	>=95%	Mar-22	29.6%
Emergency Department	% of ambulance handovers 30-60 minutes	<=2.96%	Mar-22	13.2%
Emergency Department	% of ambulance handovers over 60 minutes	<=1%	Mar-22	50.7%
Maternity	% of women booked by 12 weeks gestation	>90%	Mar-22	92.1%
Operational Efficiency	Number of patients stable for discharge	<=70	Mar-22	257
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Mar-22	540
Operational Efficiency	Average length of stay (spell)	<=5.06	Mar-22	6.7
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Mar-22	8.1
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Mar-22	2.1
Operational Efficiency	% day cases of all electives	>80%	Mar-22	82.6%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Mar-22	87.2%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Mar-22	95.6%
Operational Efficiency	Urgent cancelled operations	No target	Mar-22	0

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Access Dashboard

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

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Outpatient	Outpatient new to follow up ratio's	<=1.9	Mar-22	1.95
Outpatient	Did not attend (DNA) rates	<=7.6%	Mar-22	7.4%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Feb-22	7.3%
Research	Research accruals	No target	Mar-22	142
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%	Mar-22	71.52%
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target	Mar-22	5,159
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target	Mar-22	2,186
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero	Mar-22	1,127
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	No target	Mar-22	149
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%	Mar-22	73.4%
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%	Jan-22	46.3%
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%	Mar-22	56.4%
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%	Mar-22	59.5%
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%	Mar-22	50.70%
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%	Mar-22	50.7%

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Access:
SPC – Special Cause Variation

Cancer - 31 day diagnosis to treatment (first treatments)
GHT Starting 01/04/18

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 9 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Standard = 96%
National = 93%
GHFT = 98.6%

21/22 annual performance currently showing the Trust meeting the 31 day new standard (97.1% unvalidated)

- General Manager - Cancer

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Access:
SPC – Special Cause Variation

Cancer - 62 day referral to treatment (urgent GP referral)
GHT Starting 01/04/18

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Standard = 85%
National = 62%
GHFT = 71.2%
Treatments =151, Breaches 43.5, LGI=7, Urology=13, Gynae=4, H&N=5
An improvement in performance from Jan/Feb. Still a number of positive treatments to be logged from skin that should improve the performance.
Complex patients are the main area for breaches with 15 breaches, of which 6 breaches were from patients referred in or to another the trust with 10 requiring multiple investigations. 4 breaches related to pathology and radiology which is a reduction from February. 4 breaches were patient initiated delay as well as 3.5 breaches occurring due to covid (patient). 8 breaches occurred due to LATP biopsy delay. Plan in place for prostate pathway recovery.

- General Manager - Cancer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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Access:
SPC – Special Cause Variation

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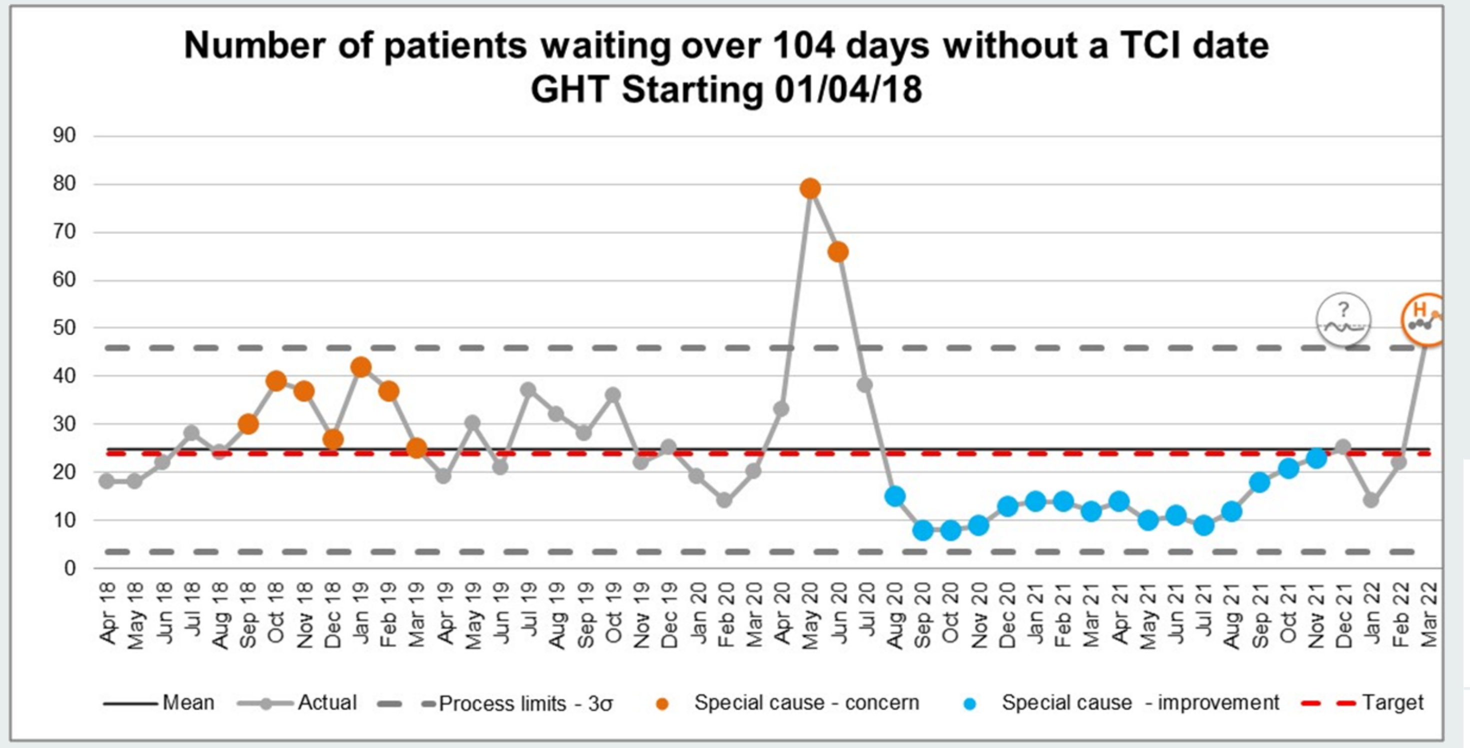

Commentary

Total = 59; Urology = 46 Lower GI = 12 Upper GI = 1

>104 day numbers has risen due to urology diagnostic backlogs with 76% of the backlog coming from urology. Plan in place for increasing RALP and LAPT capacity.

- General Manager - Cancer

Data Observations

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

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SPC – Special Cause Variation

% waiting for diagnostics 6 week wait and over (15 key tests)
GHT Starting 01/04/18

50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean | Actual | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 16 data points which are above the line. There are 24 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Diagnostics has remained largely unchanged moving from 18.27% last month to a validated position of 18.03% this month. The total number of patients waiting has increased for successive months from 7,373 (Jan) to 7,795 (Feb) and now 8,790 in March. Echos continue to be the most challenged area and despite the Echo waiting list having decreased by 76 (partly attributable to the work undertaken by the ECH) performance for the service has subsequently deteriorated, with 69% of patients breaching the 6-week standard.

- Associate Director of Elective Care

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The number of planned/surveillance endoscopy patients waiting at month end - GHT Starting 01/04/18

2,000
1,500
1,000
500
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 21 data points which are above the line. There are 23 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Breach numbers are high due to baseline demand and capacity gap, and the lower priority level to book cohort in comparison to risk stratified 2WW, BCSP and requirement to meet DM01 target - historically attempted to backfill with locum cover, and use of outsource capacity. Planned surveillance endoscopy breaches has increased slightly due to Sickness and leave, but expected to continues to reduce month on month through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and carved out capacity in month. From the end of Q1 onwards, the extra endoscopy theatre at CGH and associated cover (as part of the Endoscopy Training Academy) will provide sufficient activity to fill current demand gap, enabling further reduction of surveillance backlog.

- Deputy General Manager of Endoscopy

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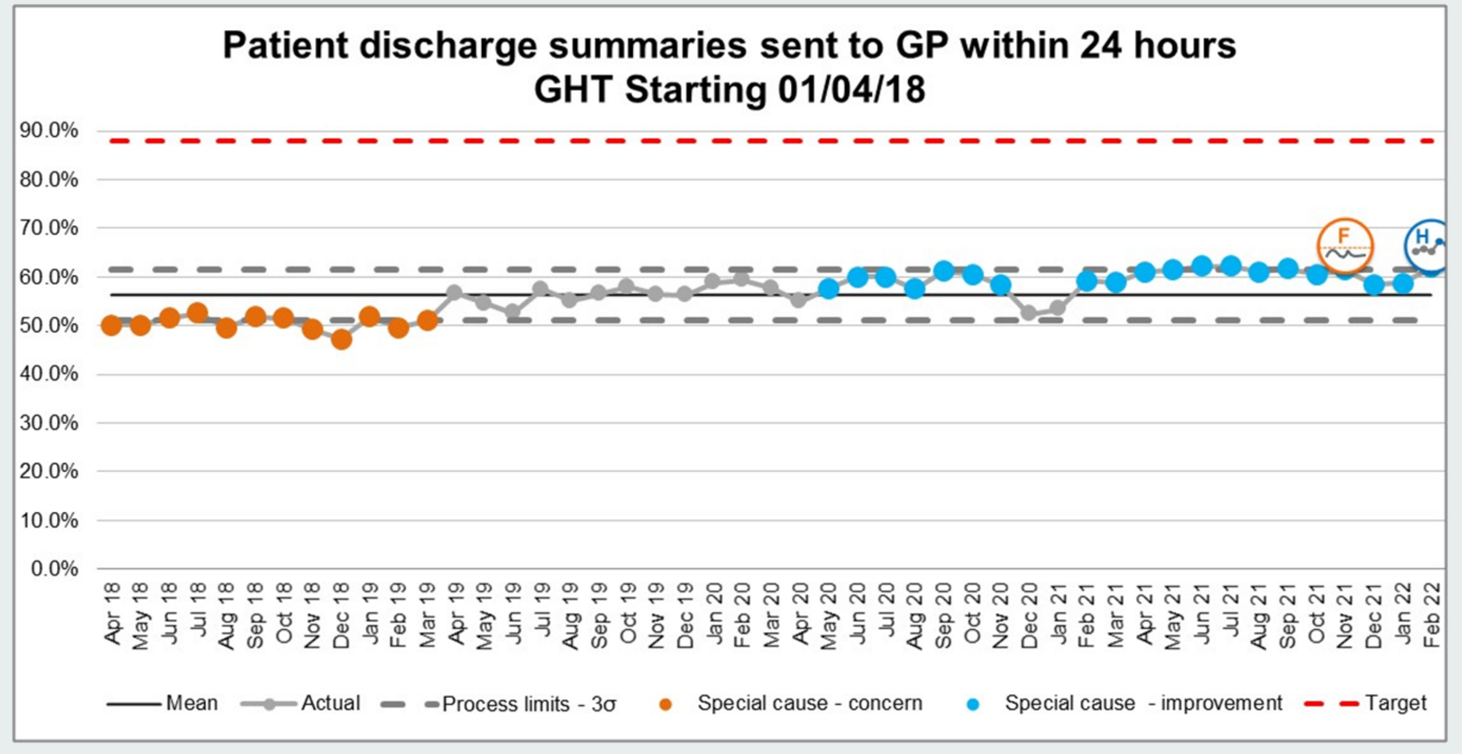

Commentary

Showing as an improvement but marginal, as stated before the transfer of this over to sunrise following the implementation of EPMA is the key to a significant improvement.

- Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 7 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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Access:
SPC – Special Cause Variation

ED: % total time in department - under 4 hours (type 1)
GHT Starting 01/04/18

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

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

Commentary

Under Review

- General Manager of Unscheduled Care

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Access:
SPC – Special Cause Variation

ED: % total time in department - under 4 hours (types 1 & 3)
GHT Starting 01/04/18

100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 22 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Under Review

- General Manager of Unscheduled Care

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Access:
SPC – Special Cause Variation

ED: % total time in department - under 4 hours CGH GHT Starting 01/04/18

105.0%
100.0%
95.0%
90.0%
85.0%
80.0%
75.0%
70.0%
65.0%
60.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Under Review

- General Manager of Unscheduled Care

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Access:
SPC – Special Cause Variation

ED: % total time in department - under 4 hours GRH
GHT Starting 01/04/18

100.0%
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

F
L

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 20 data points which are above the line. There are 12 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Under Review

- General Manager of Unscheduled Care

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ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) - GHT Starting 01/04/18

700
600
500
400
300
200
100
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

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

Commentary

Under Review

- General Manager of Unscheduled Care

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SPC – Special Cause Variation

ED: % of time to initial assessment - under 15 minutes
GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Under Review

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 17 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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Access:
SPC – Special Cause Variation

ED: % of time to start of treatment - under 60 minutes
GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 4 data points which are above the line. There are 7 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Under Review

- General Manager of Unscheduled Care

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Number of ambulance handovers over 60 minutes
GHT Starting 01/04/18

1,400
1,200
1,000
800
600
400
200
0

Apr 18 May 18 Jun 18 Jul 18 Aug 18 Sep 18 Oct 18 Nov 18 Dec 18 Jan 19 Feb 19 Mar 19 Apr 19 May 19 Jun 19 Jul 19 Aug 19 Sep 19 Oct 19 Nov 19 Dec 19 Jan 20 Feb 20 Mar 20 Apr 20 May 20 Jun 20 Jul 20 Aug 20 Sep 20 Oct 20 Nov 20 Dec 20 Jan 21 Feb 21 Mar 21 Apr 21 May 21 Jun 21 Jul 21 Aug 21 Sep 21 Oct 21 Nov 21 Dec 21 Jan 22 Feb 22 Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

F H

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 10 data points which are above the line. There are 29 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

There continues to be a deterioration in Ambulance handovers. Flow out of the hospital remains challenging. Flow is essential to the delivery of safe care and flow. Patients have been waiting up to 46 hours for an IP bed. Initiatives to reduce demand and conveyances are in place but have not been matched with non-hospital based capacity. Initiatives to support the front door (Rapid Response, CATU, Admission Avoidance, MIIUs and HAT at the front door) positively impact on deterioration but are not sufficient to have a meaningful impact currently. There is hourly monitoring of Ambulance handovers; The Department has instituted "boomerang" medical assessments where patient diagnostics and management/treatment is initiated, but capacity does not allow patients to be offloaded in the main department. This is a whole system approach with good local engagement with SWASFT. Regionally there are significant challenges.

- General Manager of Unscheduled Care

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% of ambulance handovers that are over 30 minutes
GHT Starting 01/03/19

20.0%
15.0%
10.0%
5.0%
0.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

F H

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 9 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

There continues to be a deterioration in Ambulance handovers. Flow out of the hospital remains challenging. Flow is essential to the delivery of safe care and flow. Patients have been waiting up to 46 hours for an IP bed. Initiatives to reduce demand and conveyances are in place but have not been matched with non-hospital based capacity. Initiatives to support the front door (Rapid Response, CATU, Admission Avoidance, MIIUs and HAT at the front door) positively impact on deterioration but are not sufficient to have a meaningful impact currently. There is hourly monitoring of Ambulance handovers; The Department has instituted "boomerang" medical assessments where patient diagnostics and management/treatment is initiated, but capacity does not allow patients to be offloaded in the main department. This is a whole system approach with good local engagement with SWASFT. Regionally there are significant challenges.

- General Manager of Unscheduled Care

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SPC – Special Cause Variation

% of ambulance handovers that are over 60 minutes
GHT Starting 01/03/19

60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 20 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

There continues to be a deterioration in Ambulance handovers. Flow out of the hospital remains challenging. Flow is essential to the delivery of safe care and flow. Patients have been waiting up to 46 hours for an IP bed. Initiatives to reduce demand and conveyances are in place but have not been matched with non-hospital based capacity. Initiatives to support the front door (Rapid Response, CATU, Admission Avoidance, MIIUs and HAT at the front door) positively impact on deterioration but are not sufficient to have a meaningful impact currently. There is hourly monitoring of Ambulance handovers; The Department has instituted "boomerang" medical assessments where patient diagnostics and management/treatment is initiated, but capacity does not allow patients to be offloaded in the main department. This is a whole system approach with good local engagement with SWASFT. Regionally there are significant challenges.

- General Manager of Unscheduled Care

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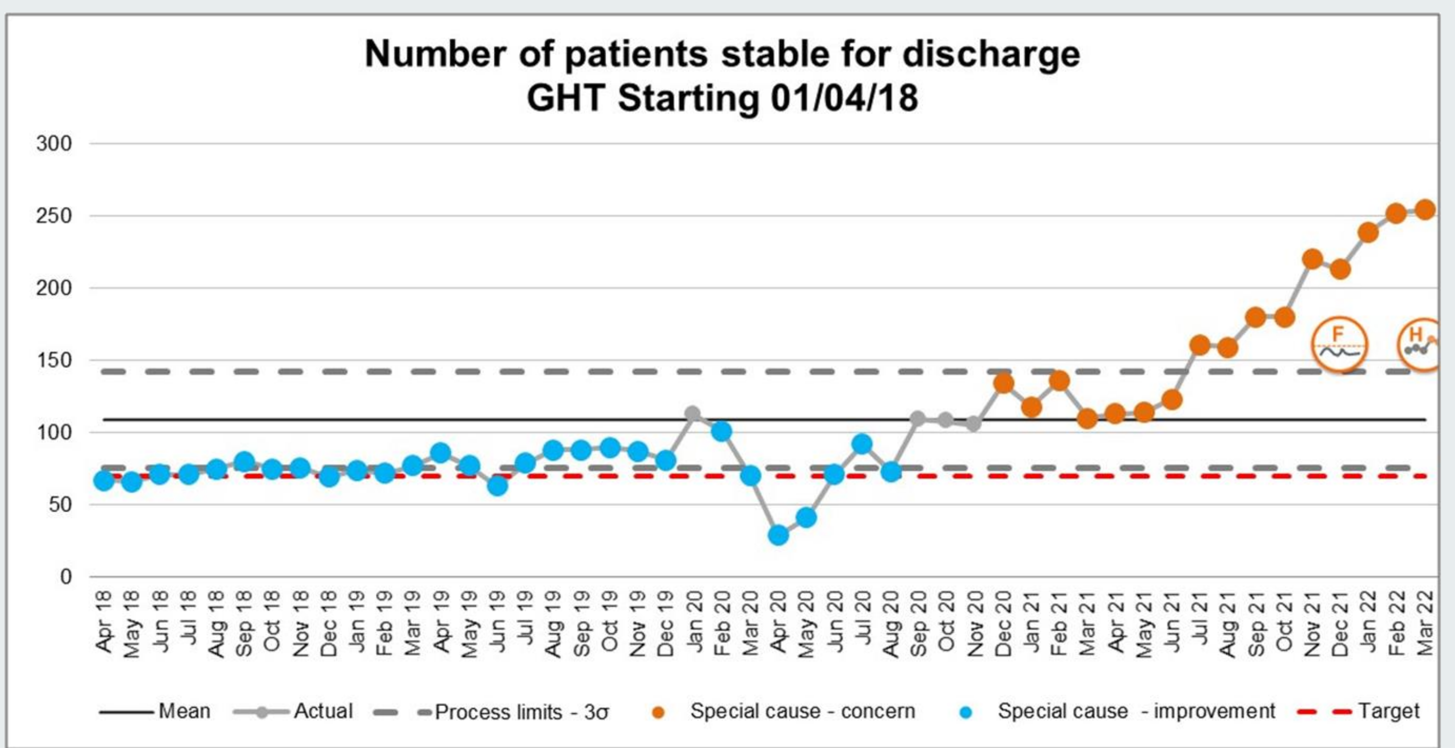

Commentary

Minimal improvement in position, with nCTR numbers sitting currently around the 250 mark. Ongoing pieces of work as a system that creates a short term improvement, but has not seen sustainable change that has provided the ongoing flow that creates the volume of discharges required on a weekly basis.

- Head of Therapy & OCT

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 9 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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Number of stranded patients with a length of stay of greater than 7 days - GHT Starting 01/04/18

600
500
400
300
200
100
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

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

Commentary

This indicator is currently under validation as part of the no-Criteria to Reside Reporting. There has been a good turnover of patients monitored by the daily DPC although the numbers have remained fairly static. The key indicator being monitored currently is patients with nCtR over 10 days. This has started to reduce in overall numbers.

- Deputy Chief Operating Officer

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Average length of stay (spell) - GHT Starting 01/04/18

7.0
6.0
5.0
4.0
3.0
2.0
1.0
0.0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

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

Commentary

There has been a slight increase in the ALOS of 0.03%. There are no remarkable factors affecting this increase.

- Deputy Chief Operating Officer

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SPC – Special Cause Variation

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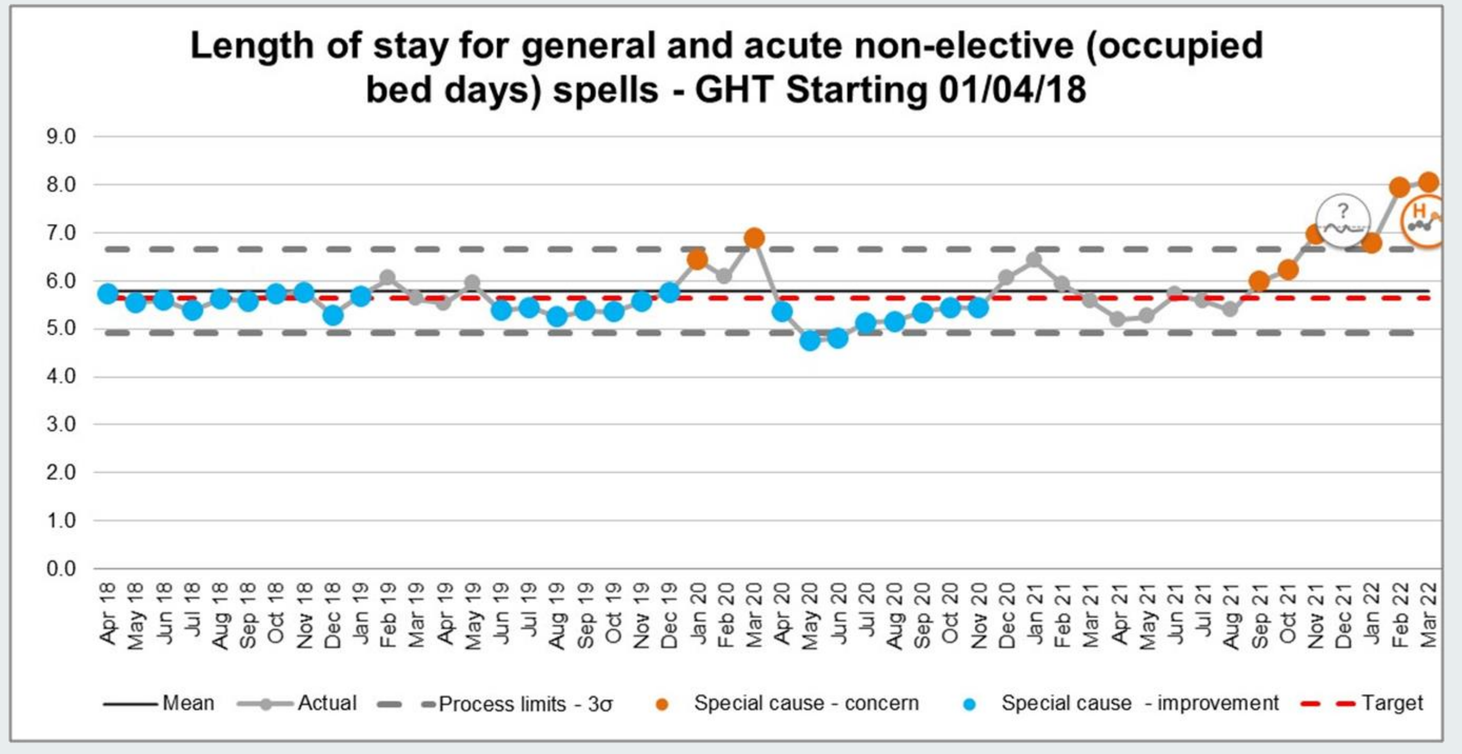

Commentary

The position remains relatively stable and unchanged from the previous month increasing by 0.08%. There are no remarkable factors affecting this indicator at this time

- Deputy Chief Operating Officer

Data Observations

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

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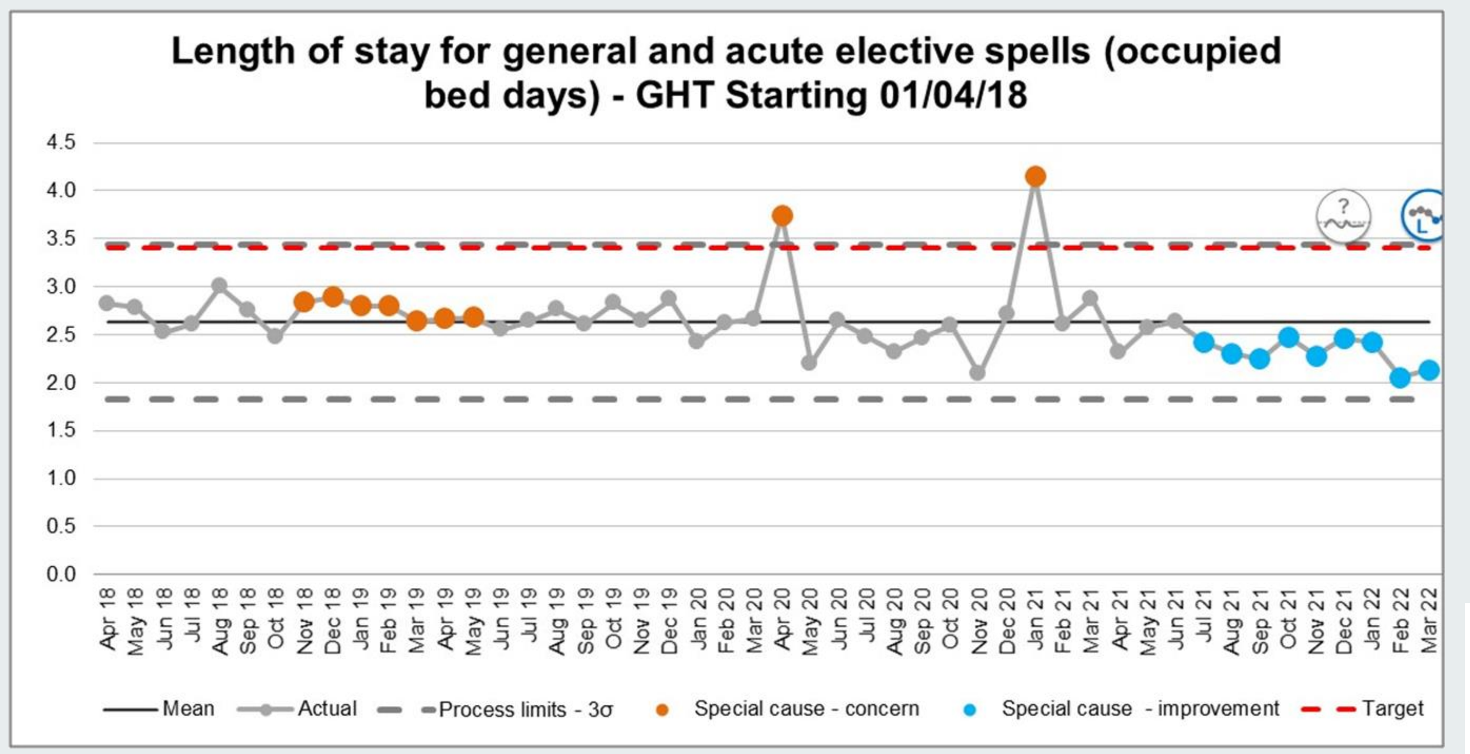

Commentary

A very slight increase of 0.13 days is consistent with a stabilised position. There are no specific indicators for this change. There is a need for some specific actions to drive down LoS as escalation beds are reduced and focus returns to maintaining elective capacity and delivery of 22/23 operational plan. There is a likely to be a positive impact as daycase activity increases and expands

- Deputy Chief Operating Officer

Data Observations

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

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Outpatient new to follow up ratio's - GHT Starting 01/03/19

Mean | Actual | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 4 data point which is above the line. There are 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Increased slightly in month, back to 1.95, just above the target.

- Associate Director of Elective Care

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Did not attend (DNA) rates - GHT Starting 01/03/19

10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

The DNA rate remains within target, albeit slightly increased to 7.35%. With the exception of one month, the DNA rate has been within target all year. Further improvement are expected when the text reminder service is resumed, which is being managed by IT given a number of technical challenges. This is now anticipated to go live for majority of services on 3 May.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 2 data point which is above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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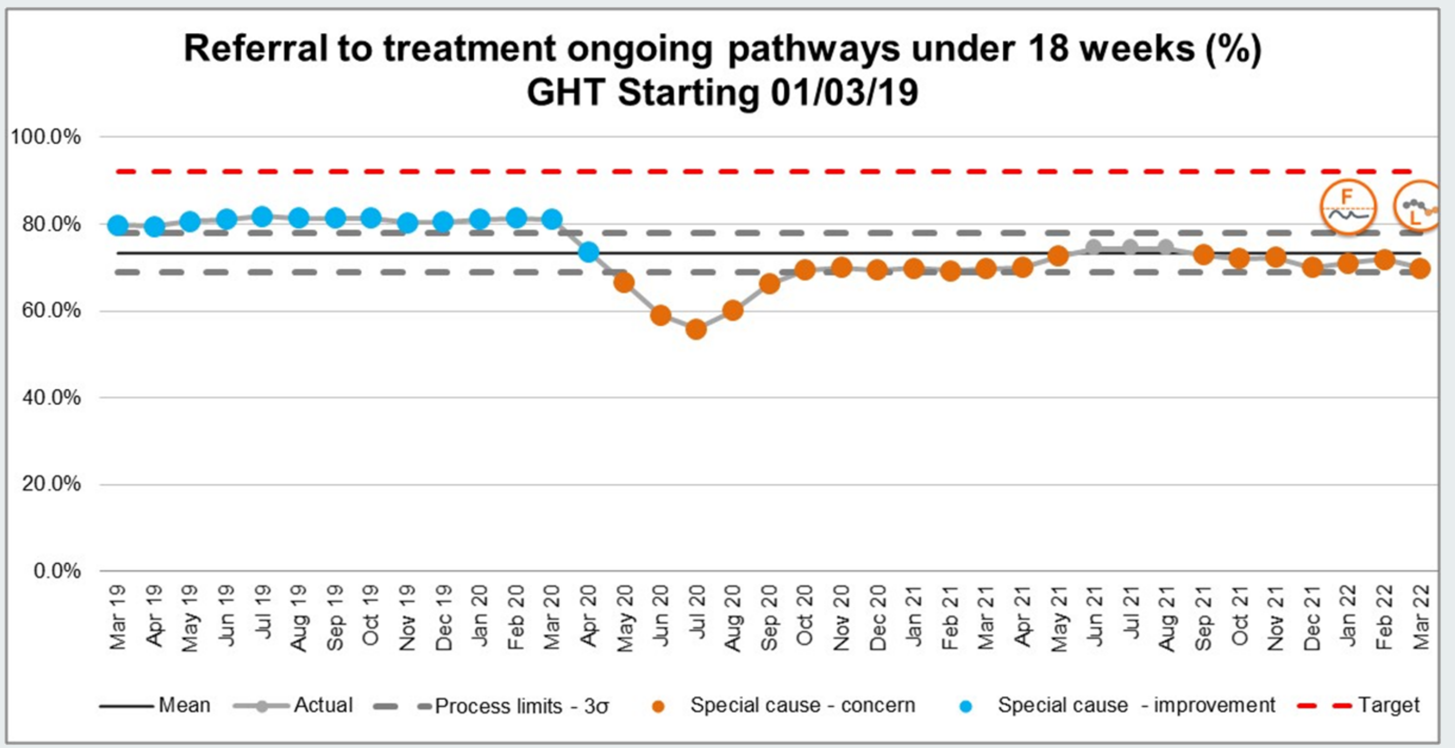

Commentary

See Planned Care Exception report for full details. RTT performance has dipped very slightly in month with an anticipated month-end position around 71.5%. GHT remains one of the better performing Trusts within the South West. In addition, RTT performance nationally would appear to around 63% so GHT remains above. All cohorts of patients (35, 45, 52 weeks) roughly stayed the same with the exception of 70 weeks where reductions continued to be made.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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Referral to treatment ongoing pathways 35+ Weeks (number)
GHT Starting 01/03/19

9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 18 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

An increase of around 70 patients in month, with this still being one of the lowest numbers in year.

- Associate Director of Elective Care

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Referral to treatment ongoing pathways 45+ Weeks (number)
GHT Starting 01/03/19

5,000
4,000
3,000
2,000
1,000
0

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

An increase of around 20 patients in month, with this still being one of the lowest numbers in year.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 16 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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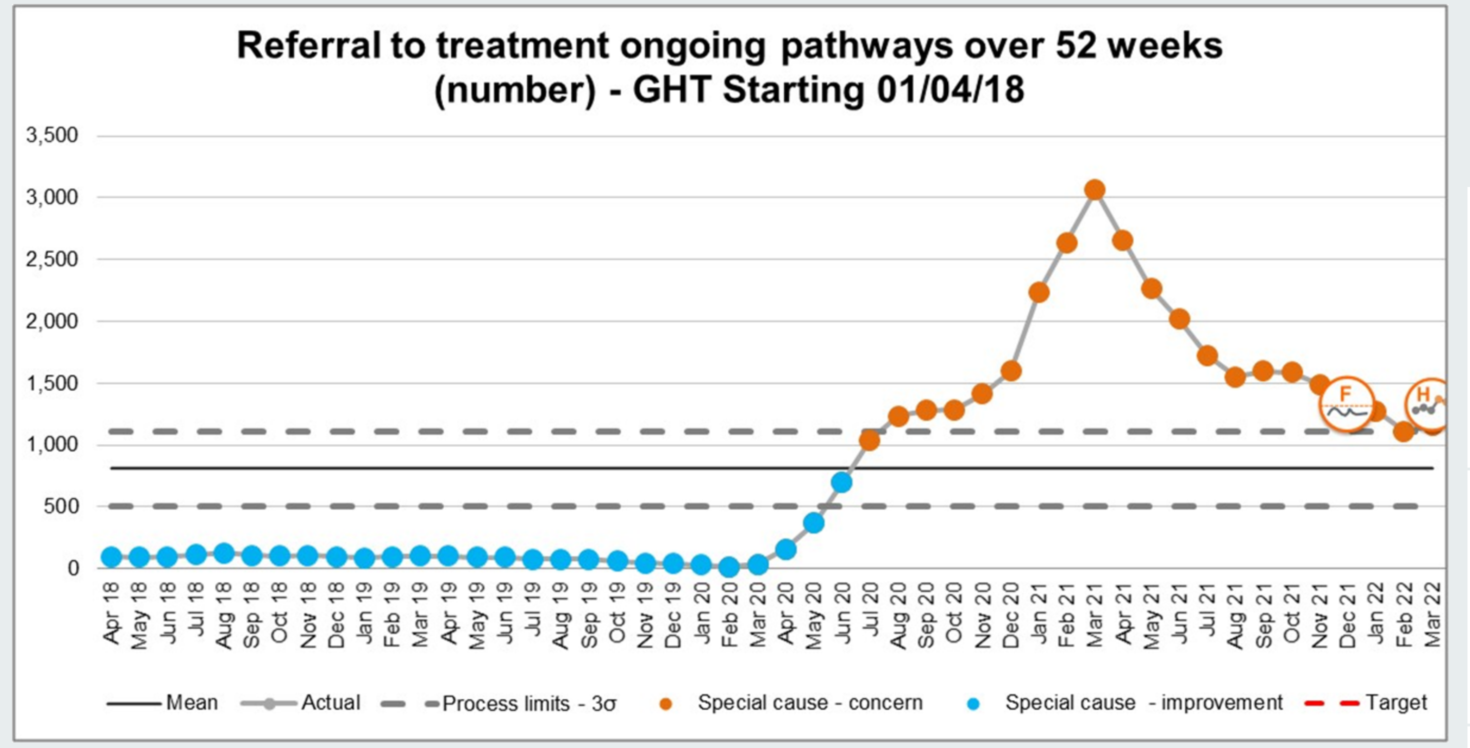

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 20 data points which are above the line. There are 26 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

See Planned Care Exception report for full details. An approximately increase of around 15 patients in month albeit 2 days of validation still remains. With significant ongoing operational pressures, retaining this position is positive

- Associate Director of Elective Care

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SPC – Special Cause Variation

% of fracture neck of femur patients treated within 36 hours
GHT Starting 01/04/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean | Actual | Process limits - 3σ | Special cause - concern | Special cause - improvement | Target

Commentary

Under Review

- **General Manager - Trauma & Orthopaedics**

Data Observations

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

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Access:
SPC – Special Cause Variation

% fractured neck of femur patients meeting best practice criteria - GHT Starting 01/03/19

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

- 40% got to theatre within 36 hrs
- 60% failed to get to surgery within 36 hours (of which 86% were delayed because of logistical reasons)

The service has been unable to treat patients within the 36 hour time frame due to issues not within our control due to the lack of beds and theatre staffing shortages and sickness means the service has been unable to maximise all theatre provision that we should have on a daily basis.

- General Manager - Trauma & Orthopaedics

Data Observations

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

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Quality Dashboard

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

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variation	
Friends & Family Test	Inpatients % positive	>=90%	Mar-22	88.3%
Friends & Family Test	ED % positive	>=84%	Mar-22	63.5%
Friends & Family Test	Maternity % positive	>=97%	Mar-22	85.7%
Friends & Family Test	Outpatients % positive	>=94.5%	Mar-22	93.2%
Friends & Family Test	Total % positive	>=93%	Mar-22	88.0%
Friends & Family Test	Number of PALS concerns logged	No Target	Mar-22	254
Friends & Family Test	% of PALS concerns closed in 5 days	>=95%	Mar-22	78%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Mar-22	0
Infection Control	MRSA bacteraemia - infection rate per 100,000 bed days	Zero	Mar-22	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Mar-22	8
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Mar-22	2
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Mar-22	6
Infection Control	Clostridium difficile - infection rate per 100,000 bed days	<30.2	Mar-22	27
Infection Control	Number of MSSA bacteraemia cases	<=8	Mar-22	2
Infection Control	MSSA - infection rate per 100,000 bed days	<=12.7	Mar-22	6.8
Infection Control	Number of ecoli cases	No target	Mar-22	2
Infection Control	Number of pseudomona cases	No target	Mar-22	0
Infection Control	Number of klebsiella cases	No target	Mar-22	1
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Mar-22	335
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No target	Mar-22	205

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variation	
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	No target	Mar-22	113
Infection Control	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	No target	Mar-22	50
Infection Control	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	No target	Mar-22	80
Maternity	% C-section rate (planned and emergency)	No target	Mar-22	0
Maternity	% emergency C-section rate	No target	Mar-22	18.0%
Maternity	% of women smoking at delivery	<=14.5%	Mar-22	0
Maternity	% of women that have an induced labour	<=33%	Mar-22	31.2%
Maternity	% stillbirths as percentage of all pregnancies	<0.52%	Mar-22	0.64%
Maternity	% of women on a Continuity of Carer pathway	No target	Mar-22	12.60%
Maternity	% breastfeeding (initiation)	>=81%	Mar-22	78.2%
Maternity	% PPH >1.5 litres	<=4%	Mar-22	3.9%
Maternity	Number of births less than 27 weeks	NULL	Mar-22	1
Maternity	Number of births less than 34 weeks	NULL	Mar-22	9
Maternity	Number of births less than 37 weeks	NULL	Mar-22	43
Maternity	Number of maternal deaths	NULL	Mar-22	0
Maternity	Total births	NULL	Mar-22	473
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Mar-22	4.23%
Maternity	% breastfeeding (discharge to CMW)	NULL	Mar-22	46.3%
Mortality	Summary hospital mortality indicator (SHMI) - national data	NHS Digital	Nov-21	1.0
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Dec-21	102.6
Mortality	Hospital standardised mortality ratio (HSMR) - weekend	Dr Foster	Dec-21	109.4

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Quality Dashboard

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

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Mortality	Number of inpatient deaths	No target	Mar-22	178
Mortality	Number of deaths of patients with a learning disability	No target	Mar-22	1
MSA	Number of breaches of mixed sex accommodation	<=10	Mar-22	0
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Dec-21	1
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Mar-22	8.2
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Mar-22	9
Patient Safety Incidents	Number of patient safety incidents - severe harm (major/death)	No target	Mar-22	28
Patient Safety Incidents	Medication error resulting in severe harm	No target	Mar-22	0
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Mar-22	3
Patient Safety Incidents	Medication error resulting in low harm	No target	Mar-22	11
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Mar-22	50
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Mar-22	2
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Mar-22	0
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Mar-22	10
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Mar-22	8
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Apr-21	70%
RIDDOR	Number of RIDDOR	SPC	Dec-21	5
Safety Thermometer	Safety thermometer - % of new harms	>96%	Mar-20	97.8%
Serious Incidents	Number of never events reported	Zero	Mar-22	0
Serious Incidents	Number of serious incidents reported	No target	Mar-22	4

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Serious Incidents	Serious incidents - 72 hour report completed within contract timescale	>90%	Mar-22	100.0%
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Mar-22	100%
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Mar-22	90.7%
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target	Nov-19	95%
Safeguarding	Number of DoLs applied for	No target	Mar-22	69
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target	Mar-22	4
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	Feb-22	1
Safeguarding	Total admissions aged 0-17 with DSH	No target	Mar-22	35
Safeguarding	Total ED attendances aged 0-17 with DSH	No target	Mar-22	113
Safeguarding	Total admissions aged 0-17 with an eating disorder	No target	Feb-22	7
Safeguarding	Total number of maternity social concerns forms completed	No target	Mar-22	71

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Quality:
SPC – Special Cause Variation

% of PALS concerns closed in 5 days
GHT Starting 01/09/20

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

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

Commentary

In March the team managed over 730 calls, including an increasing number of complex cases, and managed to close 77.9% of cases within 5 days. Recruitment is underway with a new advisor who joined the team in March and an additional advisor joining in April/May. Other advisors have now gone part time, and bank administrative support is being put in to support the team in triaging calls so that advisors can focus on managing and resolving complex concerns rather than dealing with enquiries which can be signposted effectively at triage point. The wider patient experience team is also supporting the PALS team with data inputting, to release advisor time and capacity.

- Head of Quality

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Quality:
SPC – Special Cause Variation

Hospital standardised mortality ratio (HSMR) - weekend
GHT Starting 01/04/18

120.0
100.0
80.0
60.0
40.0
20.0
0.0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21

Mean · Actual · Process limits - 3σ · Special cause - concern · Special cause - improvement · Target

Commentary

This metric is improving. This reflects the reduced effect of COVID. Over the last 18 months when you remove COVID activity are HSMR is within the expected range the issue lies with the modelling of expected mortality with viral pneumonia, as the mortality form COVID reduces this will reduce the impact on this metric and the HSMR will over the next 2 -3 months.

- Deputy Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 15 data points which are above the line. There are 11 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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Quality:
SPC – Special Cause Variation

Number of patient safety incidents - severe harm (major/death)
GHT Starting 01/04/18

30
25
20
15
10
5
0

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

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

Commentary

The statistical increase in serious incidents is undergoing a thematic review which will report into the Patient Safety Systems meeting and seek to align or inform current work , the areas currently under review are as follows:

1. Multiple patient moves (SI declared)
2. Opening or change of use of new areas
3. Delay to discharge (Thematic review underway)
4. ED triage and handover
5. Wrong site and wrong implant Never Events (Improvement Work underway)

- Associate Chief Nurse, Director of Infection Prevention & Control

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Quality:
SPC – Special Cause Variation

Number of category 2 pressure ulcers acquired as in-patient GHT Starting 01/04/18

50
40
30
20
10
0

Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

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

- Associate Chief Nurse, Director of Infection Prevention & Control

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Financial Dashboard

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

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

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

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

People & OD Dashboard

Key

Assurance			Variation		
Consistenly hit target	Hit and miss target subject to random	Consistenly fail target	Special Cause Concerning variation	Common Cause	Special Cause Improving variation

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%		Mar-22	77%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%		Mar-22	86%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%		Feb-22	87.5%	
Safe Nurse Staffing	% registered nurse day	>=90%		Feb-22	85.3%	
Safe Nurse Staffing	% unregistered care staff day	>=90%		Feb-22	83.7%	
Safe Nurse Staffing	% registered nurse night	>=90%		Feb-22	91.5%	
Safe Nurse Staffing	% unregistered care staff night	>=90%		Feb-22	97.8%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Feb-22	4.9	
Safe Nurse Staffing	Care hours per patient day HCA	>=3		Feb-22	3.0	
Safe Nurse Staffing	Care hours per patient day total	>=8		Feb-22	7.9	
Vacancy and WTE	Staff in post FTE	No target		Mar-22	6707.1	
Vacancy and WTE	Vacancy FTE	No target		Mar-22	782.28	
Vacancy and WTE	Starters FTE	No target		Mar-22	51.46	
Vacancy and WTE	Leavers FTE	No target		Mar-22	84.88	
Vacancy and WTE	% total vacancy rate	<=11.5%		Mar-22	10.45%	
Vacancy and WTE	% vacancy rate for doctors	<=5%		Mar-22	7.99%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%		Mar-22	14.09%	
Workforce Expenditure	% turnover	<=12.6%		Mar-22	13.8%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%		Mar-22	12.2%	
Workforce Expenditure	% sickness rate	<=4.05%		Mar-22	4.0%	

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People & OD:
SPC – Special Cause Variation

Commentary

Under Review

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

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There is 1 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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People & OD:
SPC – Special Cause Variation

Trust total % mandatory training compliance
GHT Starting 01/06/18

100.0%
80.0%
60.0%
40.0%
20.0%
0.0%

Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

Under Review

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

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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People & OD:
SPC – Special Cause Variation

HR: % turnover - GHT Starting 01/04/18

16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Commentary

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

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

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 7 data points which are above the line. There are 12 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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People & OD:
SPC – Special Cause Variation

HR: % turnover rate for nursing - GHT Starting 01/04/18

14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%

Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Focus on the retention of the Trust's registered nurse workforce is essential both in the immediate future and longer term, ensuring there is a sustainable workforce model. In particular, pastoral care and preceptorship for both newly appointed overseas and newly qualified nurses are key in ensuring the Trust invests sufficiently in a structured, quality transition to guide, transition and support all our new nurses.

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

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HR: % sickness rate - GHT Starting 01/04/18

5.0%
4.0%
3.0%
2.0%
1.0%
0.0%

Apr 18, May 18, Jun 18, Jul 18, Aug 18, Sep 18, Oct 18, Nov 18, Dec 18, Jan 19, Feb 19, Mar 19, Apr 19, May 19, Jun 19, Jul 19, Aug 19, Sep 19, Oct 19, Nov 19, Dec 19, Jan 20, Feb 20, Mar 20, Apr 20, May 20, Jun 20, Jul 20, Aug 20, Sep 20, Oct 20, Nov 20, Dec 20, Jan 21, Feb 21, Mar 21, Apr 21, May 21, Jun 21, Jul 21, Aug 21, Sep 21, Oct 21, Nov 21, Dec 21, Jan 22, Feb 22, Mar 22

Mean — Actual — Process limits - 3σ — Special cause - concern — Special cause - improvement — Target

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 1 data point which is above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Commentary

Ongoing focus is being given to managing staff sickness absence following further surges of Covid-19 and continuing concerns of staff health and welbeing

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

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Report to Board of Directors			
Agenda item:	**11**	**Enclosure Number:**	**6a**
Date	12 May 2022		
Title	Guardian of Safe Working Hours Quarterly Report		
Author /Sponsoring Director/Presenter	Dr Jessica Gunn, Guardian of Safe Working Hours Mark Pietroni, Interim Medical Director		

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

Summary of Report

Purpose

This report covers the period 1 January 2022 to 31 March 2022.

Key issues to note

There were 213 exception reports logged.

There were no fines levied.

61 Datix reports were submitted during this quarter, relating to junior doctor shortages

The total expenditure on junior doctor agency and bank locum cover, across all specialties', over the last quarter was: £3,458,563.00

A further £1202.61 was paid to junior doctors as a result of a total of additional hours worked and 16.5 hours were allocated as TOIL.

Conclusions

The number of exception reports has increased significantly this quarter and has also increased compared with the same quarter in 2021. The cause of this is likely multifactorial including staff related covid sickness absence and staff fatigue and low moral due to ongoing working pressure exacerbated by the pandemic.

Recommendation

The Board should be assured that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly.

Enclosures

- Guardian of Safe Working Hours Quarterly Report

Quarterly Guardian Report on Safe Working Hours for Doctors and Dentists in Training

For Presentation to the Main Board

1. Executive Summary

1.1 This report covers the period of 1.01.22 – 31.03.22. There were 213 exception reports logged.

1.2 During this period, 0 fines were levied.

2. Introduction

2.1 Under the 2016 terms and conditions of service (TCS) for junior doctors, the trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The guardian oversees exception reports and assures the board of compliance with safe working hour's limits. The Terms and conditions have been updated in 2019, with further requirements being monitored.

2.3 The structure of this report follows guidance provided by NHS Employers.

High level data

Number of doctors / dentists in training (total):	417
No. of trainees	70
Trust Doctors	487
Amount of time available in job plan for guardian:	2PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors: (first/additional trainees to maximum 0.5 SPA)	0.25/0.125 PAs

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1-2& GPT**	**IMT & ST3-8**	**Additional training and trust grade vacancies**
ED	0	0	2*	0	**2x ST1/2*** **8X Trust Registrar**
Oncology	0	0	0	0	**1x clinical fellow in palliative care**
T&O	0	0	0	0	**4 x Trust Dr (ST1)**
Surgery	0	0	0	2*	**1x Ophthalmology Clinical Fellow** **1x Trust Registrar Anaesthetic** **2x Anaesthetic St3***
General Medicine	0	0	2*	5*	**1x Renal IMT2*** **1x Cardiology St1/2*** **1x Respiratory IMT2*** **4 x Clinical Medical Education Fellow** **2x General Medicine St1*** **2X Registrar COTE/Stroke***
Paeds	0	0	0	0	**0**
Haematology	0	0	0	0	**0**

(vacant training grade post to which tabulated numerical value corresponds)*

Total Junior Doctor Vacancies **Q4: 30**

Q3: 35

Q2: 37

Q1: 25

4. Locum Bookings

4.1 Data from finance team and HR:

The total expenditure on junior doctor agency and bank locum cover, across all specialties', over the last quarter was: £3,458,563.00

The breakdown of this locum expenditure over the last quarter, according to department, is as follows:

		January	February	March
Medicine	Agency	219,738	334,682	346,321
	Bank	560,142	449,258	385,058
Surgery	Agency	104,216	135,694	16,462
	Bank	154,791	124,253	174,872
Diagnostics & Specialist	Agency	81,503	79,703	98,695
	Bank	26,643	25,354	54,533
Womens & Childrens	Agency	£0	£0	£0
	Bank	62,147	-21,722	46,220

Total agency locum expenditure on junior doctors for all quarters of the last financial year was = **£5,092,755.00 ***

(* please note that this figure is likely to be an underestimate as the locum bank expenditure for junior doctors is not available, at the time of writing, for Q1 and Q2 of the last financial year)

5 Additional Costs

5.1 Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £1202.61 (139.25 additional hours worked.)

Total number of hours given as TOIL as result of exception reporting of additional hours worked: 16.5 hrs

5. Exception Reports

	Exceptions Raised		
Specialty	**Working Hours**	**Educational Opportunities**	**Service Support Available**
General/GI Surgery	11	10	1
Urology	1		0
Trauma/ Ortho	0		0
ENT	0		0
MaxFax	0		0
Ophthalmology	0	2	0
Orthogeriatrics	0	0	0
General Medicine	102	30	15
Geriatric Medicine	4	2	0
Neurology	0	1	0
Cardiology	0	0	0
Respiratory	15	1	0
Gastro	0	1	0
Renal	3	1	0
Endocrine	0	0	0
Acute medicine/ ACUA	1	1	0
Emergency Department	2	0	0
Obstetrics and Gynaecology	0	1	0
Paediatrics	1	0	0
Psychiatry	0	0	0
Anaesthetics	0	0	0
Oncology	1	0	0
Haematology	1	0	0
GP	1	0	0
Other	**4**	**0**	
Total	**147**	**50**	**16**

6. Fines this Quarter

6.1 This quarter there have been no fines levied.

7. Issues Arising

7.1 There were 14 reports listed as 'immediate safety concern'. The nature of all concerns related to workload and reported lack of medical staff/ junior doctors on general medical and respiratory wards and the acute medical take.

Further information was obtained about the nature of these events and this was escalated to the relevant senior staff to assist with resolution. Subsequent to this, at the time of writing, no further ISC reports or concerns about ongoing or unresolved issues have been received.

8. Actions Taken to Resolve Issues

8.1 As above.

9. Correlations to Clinical Incident Reporting

9.1 There were 61 datices submitted over the last quarter, from medical, paediatric and surgical specialties, directly relating to medical/ doctor staff shortages.

The reported consequences of these staff shortages include:

- Lack of junior doctors to support consultants doing ward rounds with a consequent delay in undertaking 'jobs' required to progress patient care, including requesting tests, prescribing discharge medications, writing discharge summaries and liaising with other specialties and patients' relatives. This has a detrimental effect on patient 'flow' through the hospital and a significantly negative effect on patient experience.

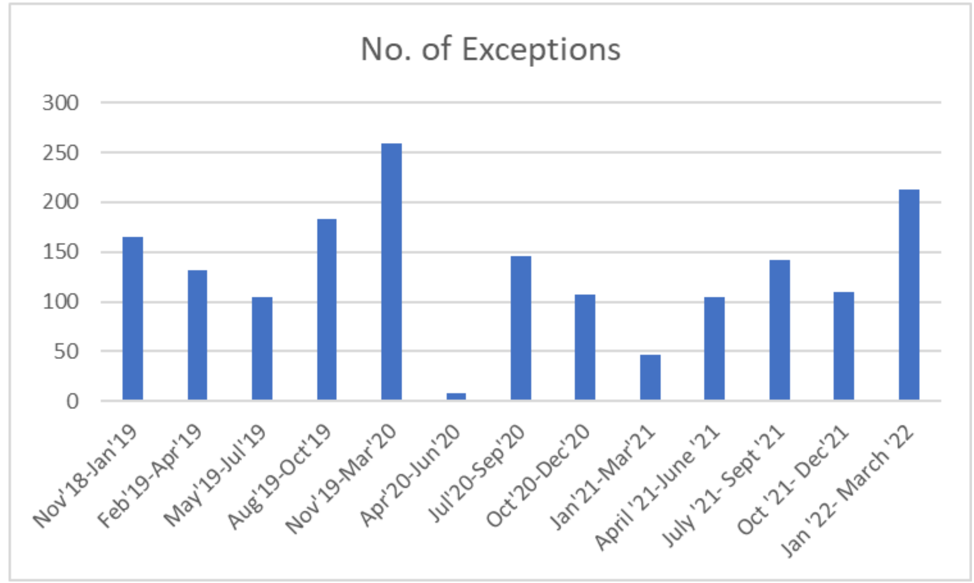
- Delays in patients being seen and assessed when presenting to ED, SDEC, SAU etc with consequent impact on patient care, patient experience and flow through the hospital.

88% of these datices concluded that no harm occurred, 10% that minimal harm occurred and 2% that moderate harm occurred as a consequence of the reported scenario.

10. Junior Doctors Forum

10.1 The Junior Doctor's forum meets every other month. A sub-group has overseen expenditure of the 'fatigue and facilities' funds available and further information about this can be found in the annual report.

11. Trajectory of exception reports



This graph shows the number of exception reports per quarter.

12. Summary

11.1 A total of 213 exception reports have been made from the beginning of January 2022 until the end of March 2022. No fines were levied.

The overall rate of exception reports has risen and is also significantly higher than the same quarter in 2021. However, this latter comparative period may be artificially lower than expected due to nationally recognised changes in exception reporting behaviour as a result of the Covid pandemic.

Furthermore, the current rise in exception reports may in part be attributable to a combination of the currently high levels of staff sickness as a result of covid infection in addition to low levels of staff morale and high levels of staff fatigue as a result of current working pressures as a direct consequence of the pandemic.

Author: **Dr Jess Gunn, Guardian of Safe Working Hours**

Presenting Director: **Prof Mark Pietroni**

Date 30.4.2021

Recommendation

- To endorse
- To approve

Appendices

Link to rota rules factsheet:
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Factsheet%20on%20rota%20rules%20August%202016%20v2.pdf

Link to exception reporting flow chart (safe working hours):
http://www.nhsemployers.org/~/media/Employers/Documents/Need%20to%20know/Safe%20working%20flow%20chart.pdf

Report to Board of Directors			
Agenda item:	**11**	**Enclosure Number:**	**6b**
Date	12 May 2022		
Title	Guardian of Safe Working Hours Annual Report		
Author /Sponsoring Director/Presenter	Dr Jessica Gunn, Guardian of Safe Working Hours Mark Pietroni, Interim Medical Director		

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

Summary of Report

Purpose

This report covers the period 1 April 2021 to the 1 April 2022.

Key issues to note

There were 569 exception reports logged.

There were no fines levied.

The total expenditure on junior doctor agency and bank locum cover, across all specialties', over this reporting period was £5,092,755.00 *

(* please note that this figure is likely to be an underestimate as the locum bank expenditure for junior doctors is not available, at the time of writing, for Q1 and Q2 of the last financial year)

Conclusions

The number of exception reports has increased significantly over the 12 months of this reporting period compared with the previous 12 months. The cause of this is likely multifactorial including staff related covid sickness absence and staff fatigue and low moral due to ongoing working pressure exacerbated by the pandemic.

Recommendation

The Board should be assured that the exception reporting process is robust and the Junior Doctor Forum is functioning well and discharging its duties accordingly.

Enclosures

- Guardian of Safe Working Hours Annual Report

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Annual Guardian Report on Safe Working Hours for Doctors and Dentists in Training

For Presentation to the Main Board

1. Executive Summary

1.1 This report covers the period of 1.04.2021- 31.03.2022.

There were 569 exception reports logged over this period:
71% relating to working hours, 18% relating to educational opportunities, 6% relating to service support available and 5% to pattern of work.

1.2 During this period, 0 fines were levied.

2. Introduction

2.1 Under the 2016 terms and conditions of service (TCS) for junior doctors, the trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The guardian oversees exception reports and assures the board of compliance with safe working hour's limits. The Terms and conditions have been updated in 2019, with further requirements being monitored.

2.3 The structure of this report follows guidance provided by NHS Employers.

High level data

Number of doctors / dentists in training (total):	417
Trust Doctors	70
Total Junior Doctors	487
Amount of time available in job plan for guardian:	2PA
Administrative support:	4Hrs
Amount of job-planned time for educational supervisors: (first/additional trainees to maximum 0.5 SPA)	0.25/0.125 PAs

3. **Annual Vacancy Data Summary**

Trainees within the trust (continued on page 3)

Specialty	Q1		Q2		Q3		Q4		Total Gaps (Average WTE)
	Vacancy Grade	Total Vacancies	Vacancy Grade	Total Vacancies	Vacancy Grade	Total Vacancies	Vacancy Grade	Total Vacancies	
ED	* 4x ST1/2 * 2x ACCS ST1/2	6	*3x ST1/2 * 2x ACCS ST1/2	5	2x ST1/2* 1x GP Trainee* 8X Trust Registrar	11	2x ST1/2* 8X Trust Registrar	10	**8**
Oncology	*1x IMT1 *1x GP Trainee	2	*1x IMT1 *1x GP Trainee	2	N/A	0	1x TD Palliative Care	1	**1.25**
T&O	1 Trust Dr 3 x Trust Dr (ST1)	4	1 Trust Dr 3 x Trust Dr (ST1)	4	2 x Trust Dr (ST1)	2	4 x Trust Dr (ST1)	4	**3.5**
Surgery	1x Surgical Education Fellow 1x Ophthalmology Clinical Fellow	2	1x Surgical Education Fellow 1x Ophthalmology Clinical Fellow 1x DCT1 Oral Max Fax 3x Clinical Fellow Anaesthetic	6	1x Ophthalmology Clinical Fellow 1x DCT1 Oral Maxi Fax 1x Trust Registrar Anaesthetic 2x Anaesthetic St3* 1x F2 Anaesthetics ITU*	5	1x Ophthalmology Clinical Fellow 1x Trust Registrar Anaesthetic 2x Anaesthetic St3*	4	**4.25**
Paediatrics	*1x Paediatric ST4	1	*2x Paediatric ST4 *2x Paediatric St1	4	N/A	0	N/A	0	**1.25**
Obstetrics & Gynecology	N/A	0	N/A	0	N/A	0	N/A	0	**0**

Specialty	Q1		Q2		Q3		Q4		Total Gaps (Average WTE)
	Vacancy Grade	Total Vacancies	Vacancy Grade	Total Vacancies	Vacancy Grade	Total Vacancies	Vacancy Grade	Total Vacancies	
Haematology	*1x ST1	1	*1x ST1	1	N/A	0	N/A	0	**0.5**
General Medicine	*1x Renal IMT2 1x Cardiology Clinical Fellow *1x Cardiology IMT 1x COTE Clinical Fellow *1x COTE IMT1 4x General Medicine Clinical Fellows	9	*1x Renal IMT2 1x Cardiology Clinical Fellow *1x Cardiology IMT 1x COTE Clinical Fellow *1x COTE IMT1 5x General Medicine Clinical Fellows 5X Registrar COTE/Stroke	15	1x Renal IMT2* 1x Cardiology St1/2* 2x COTE St3* 1x COTE IMT1* 1x Respiratory IMT2* 1x Clinical Medical Education Fellow 2x General Medicine St1* 2x ACCS Acute Medicine* 5X Registrar COTE/Stroke*	16	1x Renal IMT2* 1x Cardiology St1/2* 1x Respiratory IMT2* 4 x Clinical Medical Education Fellow 2x General Medicine St1* 2X Registrar COTE/Stroke*	11	**12.75**
Total Vacancies	**25**		**37**		**35**		**30**		**31.75**

4. Issues Arising

Persistent gaps in junior doctor work force, particularly within the medical division as a result of both deanery gaps and vacant trust grade positions, both arising due to a combination of a lack of applicants and appointable candidates.

Difficulty in maintaining acute oncall rotas and safe ward staffing levels as a direct consequence of the afore mentioned work force gaps, exacerbated by additional staff absences as a result of covid associated sickness absence.

Difficulty in trainees being able to attend educational and training opportunities, required for their career progression and development, as a consequence of staff shortages.

Suboptimal provision within the trust of 'Too Tired To Drive' (TTTD) facilities for junior doctors, particularly on the Gloucestershire Royal Hospital Site. Work is ongoing to try and resolve this issue.

5. Actions taken to resolve issues

Ongoing attempts at recruitment within the trust to fill vacant positions combined with utlilisation of both bank and agency locums to fill gaps where possible. In addition, the chief registrar for medicine, along with members of the junior doctor team, have worked incredibly hard to re-write and re-design the medical oncall rota with the aim of making this more manageable for the juniors who work these rota's, whilst also maximising ward staffing levels for the benefit of both patient safety but also to enable junior doctors to participate in learning and training opportunities.

Implementation of the electronic software system 'locums nest' to try and maximise our ability to fill vacant gaps particularly in acute oncall rotas.

Exception reporting data has been utilised to support business cases for an expansion in the foundation doctor numbers within the trust in addition to the appointment of physician's assistants (PA's) in a number of departments with the aim that these measures will help to contribute to improving future staffing levels in the trust.

The Guardian of Safe Working is working alongside junior doctors, the Director for Strategy and Transformation and members of the estates team to try and resolve the situation with respect to the provision of TTTD facilities in the trust.

6. Fatigue and Facilities Expenditure

In 2019, following discussion with the British Medical Association with regards to their 'Fatigue and Facilities Charter', the then Secretary of State for Health and Social Care allocated £10 million total to be allocated to 210 health trusts nationally with the aim that this money was spent to improve the working conditions of junior doctors. Purchases using this money needed to be approved by the JDF (Junior Doctor Forum).

As a trust, we received £30,000 of money to be used for improving our fatigue and facilities for junior doctors.

Over the last financial year a total of £ 14,730.85 of this money has been spent on a variety of items chosen by a fatigue and facilities working group of current junior doctors, after wider consultation, and sanctioned by the JDF.

A full break down of the above expenditure can be found in Appendix 2.

At the time of writing £13,783.15 of these F&F funds remains and has been allocated with the intention of supporting the refurbishment of the Cheltenham General Hospital junior doctor's mess.

7. Questions for consideration

E-rostering software systems:

A significant amount of clinician and administrative time is being utilised in managing the acute oncall rota's, particularly within the medical division. In its current form this is necessary to ensure the smooth running of the rotas, maintain staffing levels and try to pre-emptively fill gaps when they arise. However, this is a labour intensive and fundamentally inefficient way of managing what is a very complex and delicately balanced system and in its current form it is fraught with the potential for human error.

A number of electronic rostering systems are available to use and I would strongly urge that their implementation is considered within this trust. Whilst this obviously has a cost implication, it is to be hoped that, in the long run, their use would help to significantly reduce our locum medical staff expenditure. Furthermore, implementation of such a system would help to improve staff experience, for both staff that have to manage the acute oncall rotas and the junior doctors who have to work them, with consequent reputational benefit.

At the time of writing, I am informed by the acting medical director, Dr D'Agapeyeff, that the trust is about to start a procurement process, anticipated to take several months, for an e-rostering system for all doctors.

8. Fines

No Fines have been issued over this reporting period.

In December 2021, £1627.33 was spent from the previously accrued JD fine monies on stockings and stocking fillers for the 80 junior doctors working in the trust on Christmas day. This was organised by the chief registrar for medicine with the support of the JDF.

£9318.33 remains from previous JD fine monies.

Report to Board of Directors			
Agenda item:	**12**	**Enclosure Number:**	**7**
Date	12 May 2022		
Title	Ockenden Gap Analysis Report		
Author /Sponsoring Director/Presenter	Vivien Mortimore, Chief Midwife and Divisional Director of Nursing and Quality Suzie Cro, Deputy Director of Quality Matt Holdaway, Chief Nurse and Director of Quality		

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

Summary of Report

Background

The Ockenden Final Report from the independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust was published on 30 March 2022 (appendix 1). NHS England and NHS Improvement are working with the Department of Health and Social Care to implement the 15 Immediate and Essential Actions (IEAs) with all Acute Trusts providing maternity services. The IEAs complement and expand on the IEAs issued in the first report.

Purpose

Our Board has a duty to prevent the failings found at Shrewsbury and Telford Hospitals NHS Trust happening within our maternity service and so the purpose of this gap analysis is to provide an initial rapid review against the 15 IEAs as has been recommended by NHSE/I (see letter at appendix 2).

Key issues to note

After reviewing the report, we have created an initial gap analysis using the template provided by the NHSE/I Regional Chief Midwife. We intend to take immediate actions to mitigate any risks identified and we are in the process of developing robust plans against areas where our maternity service needs to make changes, paying particular attention to the report's four key pillars:

1. Safe staffing levels
2. A well-trained workforce
3. Learning from incidents
4. Listening to families

Gap analysis

In the report, there are a total of 15 IEAs to improve care and safety in maternity services and our gap analysis involves the comparison of our current state/performance with the desired state/performance of the IEA. It has

provided us with a framework for the maternity service teams to collaborate on the first steps of creating a strategic plan. This gap analysis has involved the whole maternity team.

The table below shows a summary of the actions that are already being met and those requiring an improvement plan.

Table: Summary of gap analysis review (20 April and 3 May 2022)

Actions	Gap Analysis Standards	Number in each category (20 April 2022)	Number in each category (3 May 2022)
15 IEAs	Met	35	35
	Partially met	28	33
	Not met	18	15
	More Information required	4	4
	Not applicable	5	5
	Total	**92**	**92**

The below table shows a more detailed overview of each of the IEAs.

Table: Detailed breakdown by section as completed on 3 May 2022

IEA	Actions	Met	Partially met	Not Met	More Info	N/A
1. Workforce planning and sustainability	11	1	5	2	1	2
2. Safe staffing	10	5	4			1
3. Escalation and accountability	5	1	3	1		
4. Clinical Governance - Leadership	7	2	3	2		
5. Clinical Governance – Incident Investigation and Complaints	7	6		1		
6. Learning from maternal deaths	3			2		1
7. Multidisciplinary training	7	4	3			
8. Complex antenatal care	5		1	2	2	
9. Preterm birth	4	2	2			
10. Labour and birth	6	2	3	1		
11. Obstetric anaesthesia	8	3	3		1	1

12. Postnatal care	4	3		1		
13. Bereavement care	4	1	2	1		
14. Neonatal care	8	3	4	1		
15. Supporting families	3	2	1			
Totals	**92**	**35**	**33**	**15**	**4**	**5**

Communication plan

The Final Ockendon Report has been shared widely with all relevant staff and the Trust recommends that everyone reads it regardless of their role. An open staffing / Ockendon engagement event took place on April 1st and this was extremely well attended. A further dedicated listening event in response to this report was held on April 29th 2022 to share the outcome of our initial gap analysis and to engage staff in progressing the required actions.

Speaking up

The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We will review our speaking up training for all maternity managers and leaders.

Midwifery Continuity of Carer (MCoC)

The report includes a specific action on MCoC (IEA 2 Safe Staffing page 164) and in response to this we have immediately risk assessed our midwifery staffing position and made the following decisions.

- Firstly, there will be no further teams launched until midwifery staffing across the service has met minimum requirements and the additional posts to support delivery of continuity of care have been fully recruited to.
- Secondly, a risk assessment is being undertaken to identify the consequences of introducing any changes to the existing 3 continuity of care teams that provide continuity of care for 10% of our most vulnerable women and birthing parents.
- Currently, whilst the two free standing birth units remain closed due to COVID related sickness two of the three continuity teams have been asked to support the intrapartum care services on the Gloucester Royal site by providing shift cover, although this is not sustainable in the long term without impacting on continuity of care provided by these three teams. The third Continuity of Care team is holding vacancy and is not providing full continuity of care as it is currently only providing and antenatal and postnatal care and no intrapartum care.

In line with the maternity transformation programme, we have been asked to submit our MCoC plans to NHSE/I by 15 June 2022.

Governance

Progress against meeting all the IEAs will be monitored within the Women and Children's Division through our weekly Maternity J2O Group with monthly oversight from the Divisional Quality Improvement Steering Group. The gap analysis and the immediate actions to mitigate identified risks will be shared at the monthly midwifery team leaders and consultant meetings.

It was agreed at the Maternity Delivery Group that there would be a monthly progress report on delivery of the

action plan and for assurance a quarterly report will be produced for the Quality and Performance Committee.

The Final Ockendon report and this gap analysis will be shared at Board on 12 May 2022, as required by the letter sent to our Trust by NHSE/I dated 1 April 2022.

External to the organisation progress will be reported to the Local Maternity and Neonatal System and to NHSE/I as required.

Conclusion and next steps

The initial gap analysis has enabled us to identify our current position with the desired position and also the gaps between the two. With the time constraints, the analysis has been at a high level and the intention is to be more specific within the next iteration. The maternity team have been involved in the review of the Report and identifying the gaps. The service is keen to reiterate that there will be no delay in developing and implementing our local action plan for this Final Ockendon Report.

We expect there will be further recommendations for maternity and neonatal services to consider later this year given other reviews underway (East Kent and Nottingham).

In addition, NHSE/I will be publishing a detailed breakdown of all the returns with the first Ockendon IEAs at the NHSE/I public Board in May and we will be reviewing the findings and will carry out a benchmarking exercise as soon as these results are published.

Recommendation

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

Enclosures

- Final Gap Analysis Report

Final Ockenden report recommendations 30 March 2022

Essential Actions	Question	Action	Assessment	Position	Immediate Essential Action
ESSENTIAL ACTION 1 WORKFORCE					
Financing a safe maternity workforce **The recommendations from the Health and Social Care Committee Report: The safety of maternity services in England must be implemented**	1	The investment announced following our first report was welcomed. However to fund maternity and neonatal services appropriately requires a multi-year settlement to ensure the workforce is enabled to deliver consistently safe maternity and neonatal care across England	More Information Required	Awaiting confirmation of funding allocation to support further investment in the maternity and neonatal workforce	In preparation for further funding announcements the service will undertake workforce analysis using Birthrate plus - Head of Midwifery, Lisa Stephens (LS) to review and complete in 1 month. Speciality Director Christine Edwards (CE) to review medical requirements within 1 month. The review of staffing will include maternity theatre staff.
	2	Minimum staffing levels should be those agreed nationally, or where there are no agreed national levels, staffing levels should be locally agreed with the LMNS. This must encompass the increased acuity and complexity of women, vulnerable families, and additional mandatory training to ensure trusts are able to safely meet organisational CNST and CQC requirements.	Met	Existing staffing levels set according to 2018/19 Birthrate plus workforce analysis and following National CoC guidance. These are currently under review with a further workforce assessment ongoing for completion in late spring. These will be agreed with the LMNS together with a revised CoC business case.	The above workforce review will inform and support agreement of minimum medical staffing levels in maternity. Divisional Director of Operations Becky Hughes/Christine Edwards to review
	3	Minimum staffing levels must include a locally calculated uplift, representative of the three previous years' data, for all absences including sickness, mandatory training, annual leave and maternity leave.	Partially Met	Uplift for maternity is in line with Trust wide agreement and is not maternity specific, currently 21%. This does not accurately take into consideration absence and maternity mandatory requirements.	HoM (LS) to work with HR to calculate and propose an appropriate uplift for midwifery staffing.
	4	The feasibility and accuracy of the BirthRate Plus tool and associated methodology must be reviewed nationally by all bodies. These	N/A	Action not for the Trust	
Training **We state that the Health and Social Care Select Committee view that a proportion of maternity budgets must be ring-fenced for training in every maternity unit should be implemented**	5	All trusts must implement a robust preceptorship programme for newly qualified midwives (NQM), which supports supernumerary status during their orientation period and protected learning time for professional development as per the RCM (2017) position statement for this	Partially Met	Program in place which meets all requirements other than protected time for reflection on practice. Also meets the NMC Principles for Preceptorship 2020	Practice Development Midwife Asha Dhany (AD) to review current arrangements and make recommendations to DDQN/HoM within 1 month
	6	All NQMs must remain within the hospital setting for a minimum period of one year post qualification. This timeframe will ensure there is an opportunity to develop essential skills and competencies on which to advance their clinical practice, enhance professional confidence and resilience and provide a structured period of transition from student to accountable midwife	Not Met	Currently 3 NQM are allocated to community but working in a hybrid model i.e. in community with one day on delivery suite to support skill development. One midwife is due to start on the same model.	Pause allocation of newly appointed NQM until this recommendation has been further considered and advice from the NMC /RCM considered -HoM (LS) (competency risk assessment to take place)
	7	All trusts must ensure all midwives responsible for coordinating labour ward attend a fully funded and nationally recognised labour ward coordinator education module, which supports advanced decision-making, learning through training in human factors, situational awareness and psychological	Not Met (no national module available at present)	No nationally recognised courses at present. Coordinators attend annual mandatory training which includes decion making, human factors, situational awareness and psychological safety, to tackle behaviours in the workforce.	Await development of nationally recognised labour ward coordinator education and support attendance of all those who coordinate delivery suite -Matron Mel Woolman
	8	All trusts to ensure newly appointed labour ward coordinators receive an orientation package which reflects their individual needs. This must encompass opportunities to be released from clinical practice to focus on their personal and professional development.	Partially met	Individual package in place to support development of existing band 6 to take on the role of coordinator. Package to be developed to support a more consistent offer for newly appointed band 7's	Existing package and offer to be reviewed to ensure opportunities for release from clinical practice to support personal and professional development - Matron Mel Woolman (MW)
	9	All trusts must develop a core team of senior midwives who are trained in the provision of high dependency maternity care. The core team should be large enough to ensure there is at least one HDU trained midwife on each shift, 24/7.	Partially met	Midwives are able to provide high dependency care to women currently but not have attended a specific course. On every shift there is an experienced midwife who is able to provide HDU care and this is part of the skill mix review that takes place when rotas are completed. There is a plan in place for 9 midwives to attend suitable course which will provide 24 hour cover, but the midwives have not been trained yet.	Develop succession plan to make sure that every year midwives are trained-Lisa Stephens

	10	All trusts must develop a strategy to support a succession-planning programme for the maternity workforce to develop potential future leaders and senior managers. This must include a gap analysis of all leadership and management roles to include those held by specialist midwives and obstetric consultants. This must include supportive organisational processes and relevant practical work experience	Partially met	Succession planning is informal and based on individuals and their line managers (through the appraisal process) developing their leadership skills. A clear maternity leadership strategy is not in place and a gap analysis has not been completed. Line managers are responsible for enabling colleagues to prepare for roles by offering the required education and training and supporting secondment opportunities.	Carry out gap analysis and then develop plan as part of the Maternity Workforce Strategy - HoM Lisa Stephens and Speciality Director Christine Edwards. For each post there needs to be a development plan in place for preparing a pool of suitable candidates
	11	The review team acknowledges the progress around the creation of Maternal Medicine Networks nationally, which will enhance the care and safety of complex pregnancies. To address the shortfall of maternal medicine physicians, a sustainable	N/A	**Action not for the Trust** South west maternal medicine network is being implemented , Trust leads identified and will engage with this	
ESSENTIAL ACTION 2 SAFE STAFFING					
All trusts must maintain a clear escalation and mitigation policy where maternity staffing falls below the minimum staffing levels for all health professionals.	12	When agreed staffing levels across maternity services are not achieved on a day-to-day basis this should be escalated to the services' senior management team, obstetric leads, the chief nurse, medical director, and patient safety champion and LMS	Partially met	Currently escalation via site using OPAL escalation tool	Amend distribution list to copy in Divisional Tri, CNO, CMO & Safety Champion to the Daily site OPAL submission if Amber, Red or Black and LMNS -DDOP
	13	In trusts with no separate consultant rotas for obstetrics and gynaecology there must be a risk assessment and escalation protocol for periods of competing workload. This must be agreed at board level.	Partially Met	Separate rota in place. Consultant O&G in place for each 24 hr period 1/3 of time. Outside of those hrs one consultant Obstetrician on site with gynae oncology consultant as support.	Confirm if this has been agreed at Board level, if a risk assessment that has been carried out for current provision and if this provision has been written into any policies/processes for Consultant on call- Christine Edwards
	14	All trusts must ensure the labour ward coordinator role is recognised as a specialist job role with an accompanying job description and person specification.	Met	Specific JD in place for labour ward coordinator	
	15	All trusts must review and suspend if necessary the existing provision and further roll out of Midwifery Continuity of Carer (MCoC) unless they can demonstrate staffing meets safe minimum requirements on all shifts. This will preserve the safety of all pregnant women and families, which is currently compromised by the unprecedented pressures that MCoC models place on maternity services already under significant strain.	Met	Staffing fully reviewed 4th April, staffing significantly below minimum levels due to increase in COVID sickness and absences (long term sickness, annual leave and maternity leave). Recommendations made to the executive team with respect to CoC with a blended plan to support staffing across the service to ensure the best use of the midwifery workforce including those midwives working currently within CoC teams .	
	16	The reinstatement of MCoC should be withheld until robust evidence is available to support its reintroduction	N/A	No teams suspended currently we have 3 teams providing 10% of women with a continuity of midwifery care	
	17	The required additional time for maternity training for consultants and locally employed doctors must be provided in job plans. The protected time required will be in addition to that required for generic trust mandatory training and reviewed as training requirements change.	Met	6 hrs a week for SPA for mandatory training additional study time 10 days for additional study as per contract .	
	18	All trusts must ensure there are visible, supernumerary clinical skills facilitators to support midwives in clinical practice across all settings.	Partially Met	Skills facilitators already in place for Delivery suite (1 WTE) and Community (1 WTE)	Recommendation to be reviewed and plan agreed for midwives to support practice in ANC and on the maternity ward -Practice Development Midwife Asha Dhany
	19	Newly appointed Band 7/8 midwives must be allocated a named and experienced mentor to support their transition into leadership and management roles.	Partially Met	Arrangements are inconsistent Identify a clear plan, strengthen and formalise existing arrangements	Work with Trust OD lead HoM Lisa Stephens
	20	All trusts must develop strategies to maintain bi-directional robust pathways between midwifery staff in the community setting and those based in the hospital setting, to ensure high quality care and communication.	Met	Bi directional care pathways are in place which support a dynamic risk assessment through out pregnancy ,birth and in the early postnatal period	
	21	All trusts should follow the latest RCOG guidance on managements of locums. The RCOG encourages the use of internal locums and has developed practical guidance with NHS England on the management of locums. This includes support for locums and ensuring they comply with recommended processes such as pre-employment checks and appropriate induction	Met	Mostly internal locums used, If locums are not internal Trust processes followed	
ESSENTIAL ACTION 3 ESCALATION AND ACCOUNTABILITY					

Staff must be able to escalate concerns if necessary **There must be clear processes for ensuring that obstetric units are staffed by appropriately trained staff at all times.** **If not resident there must be clear guidelines for when a consultant obstetrician should attend.**	22	All trusts must develop and maintain a conflict of clinical opinion policy to support staff members in being able to escalate their clinical concerns regarding a woman's care in case of disagreement between healthcare professionals.	Not Met	No specific clinical Policy at present although all practitioners are encouraged to escalate professional concerns.	Policy to be developed-Christine Edwards /Lisa Stephens
	23	When a middle grade or trainee obstetrician (non-consultant) is managing the maternity service without direct consultant presence trusts must have an assurance mechanism to ensure the middle grade or trainee is competent for this role.	Met	Clinical competencies in place for each level of trainee to identify areas where clinical supervision is required	
	24	Trusts should aim to increase resident consultant obstetrician presence where this is achievable.	Partially Met	Currently 78 hours covered 8.30-21.30 M-F weekends 8.30-14.30, 20.00 to 21.30.	Review and agree required cover according all available guidance and using professional judgement -Christine Edwards
	25	There must be clear local guidelines for when consultant obstetricians' attendance is mandatory within the unit	Partially Met	RCOG guidance incorporated into a variety of existing clinical polices	Review existing polices that cover roles and responsibilities to list requirement within one place -Christine Edwards
	26	There must be clear local guidelines detailing when the consultant obstetrician and the midwifery manager on-call should be informed of activity within the unit.	Partially Met	Escalation policy in place but no clear trigger for informing the on call manager and consultant obstetrician as professional judgement is used.	Need to clarify within the existing escalation policy - HoM Lisa Stephens/Christine Edwards
ESSENTIAL ACTION 4 CLINICAL GOVERNANCE-LEADERSHIP					
Trust boards must have oversight of the quality and performance of their maternity services. **In all maternity services the Director of Midwifery and Clinical Director for obstetrics must be jointly operationally responsible and accountable for the maternity governance systems.**	27	Trust boards must work together with maternity departments to develop regular progress and exception reports, assurance reviews and regularly review the progress of any maternity improvement and transformation plans	Met	Regular monthly reports to MDG with exception reporting to Q&P and on to Trust Board	
	28	All maternity service senior leadership teams must use appreciative inquiry to complete the National Maternity Self-Assessment Tool if not previously done. A comprehensive report of their self-assessment including governance structures and any remedial plans must be shared with their trust board.	Partially Met	Self Assessment Tool Completed and actions identified shared with MDG and Q&P	To ensure development of a comprehensive action plan and share with board - Divisional Director of Quality and Nursing (DDQN) Vivien Mortimore
	29	Every trust must ensure they have a patient safety specialist, specifically dedicated to maternity services.	Not Met	Divisional Health and Safety Rep in post who is a midwife not a safety specialist	To discuss with Andrew Seaton to better understand the role and explore appropriateness of having a specialist dedicated to Maternity - Vivien Mortimore
	30	All clinicians with responsibility for maternity governance must be given sufficient time in their job plans to be able to engage effectively with their management responsibilities.	Not Met	Designated consultant with responsibility for Governance I PA .	Review time allocation for the role to increase capacity -Christine Edwards
	31	All trusts must ensure that those individuals leading maternity governance teams are trained in human factors, causal analysis and family engagement.	Partially Met	Clinical Governance Midwife has completed training	Training to be arranged for the consultant lead
	32	All maternity services must ensure there are midwifery and obstetric co-leads for developing guidelines. The midwife co-lead must be of a senior level, such as a consultant midwife, who can drive the guideline agenda and have links with audit and research.	Not Met	Identified as a gap and a plan is in place to fund a matron role for Education and Policy development at band 8a	Secure funding to support development of the role - Vivien Mortimore
	33	All maternity services must ensure they have midwifery and obstetric co-leads for audits.	Met	Audit Midwife and Lead Obstetrician in post	
ESSENTIAL ACTION 5 CLINICAL GOVERNANCE – INCIDENT INVESTIGATION AND COMPLAINTS					
Incident investigations must be meaningful for families and staff and lessons must be learned and implemented in practice in a timely manner	34	All maternity governance teams must ensure the language used in investigation reports is easy to understand for families, for example ensuring any medical terms are	Met	The reports shared with families are the HSIB reports these explain clinical terms in full as do complaint responses	
	35	Lessons from clinical incidents must inform delivery of the local multidisciplinary training plan.	Met	Lessons learnt are incorporated into MDT Mandatory training	
	36	Actions arising from a serious incident investigation which involve a change in practice must be audited to ensure a change in practice has occurred	Met	SERG ensure that all actions are evidenced through an audit	
	37	Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred.	Met	SERG require this evidence before they close the action plan to provide monitoring and assurance	

	38	All trusts must ensure that complaints which meet SI threshold must be investigated as such.	Met	All complaints are triaged and where the subject matter indicates SI criteria are met or potentially met, an incident will be reported on Datix and the complaint escalated to SI panel for discussion	
	39	All maternity services must involve service users (ideally via their MVP) in developing complaints response processes that are caring and transparent.	Not Met	Currently all complaint responses are reviewed by the Division to ensure they are appropriately caring and transparent.	Complaints Team to work with the Division to clarify how the MVP are involved in developing the complaints response process -Lisa Stephens
	40	Complaints themes and trends must be monitored by the maternity governance team.	Met	Trends identified and incorporated into the maternity experience action log which is overseen by the Clinical Governance team.	
ESSENTIAL ACTION 6 LEARNING FROM MATERNAL DEATHS					
Nationally all maternal post-mortem examinations must be conducted by a pathologist who is an expert in maternal physiology and pregnancy related pathologies. **In the case of a maternal death a joint review panel/investigation of all services involved in the care must include representation from all applicable**	41	NHS England and Improvement must work together with the Royal Colleges and the Chief Coroner for England and Wales to	N/A	**Action not for the Trust**	
	42	This joint review panel/investigation must have an independent chair, must be aligned with local and regional staff and seek external clinical expert opinion where required.	Not Met	MoU agreed with BSW and Role descriptor for external Expert Opinion developed, not yet implemented	Recruit to clinical expert roles and o follow agreed process as set out in the Framework for Perinatal Quality and Safety Surveillance and Oversight -HoM Lisa Stephens.
	43	Learning from this review must be introduced into clinical practice within 6 months of the completion of the panel. The learning must also be shared across the LMS.	Not Met	MoU agreed and SoP, but not yet implemented	To follow agreed process as set out in the Framework Perinatal Quality and Safety Surveillance and Oversight -HoM Lisa Stephens
ESSENTIAL ACTION 7 MULTIDISCIPLINARY TRAINING					
Staff who work together must train together Staff should attend regular mandatory training and rotas. Job planning needs to ensure all staff can attend. Clinicians must not work on labour ward without appropriate regular CTG training and emergency skills training	44	All members of the multidisciplinary team working within maternity should attend regular joint training, governance and audit events. Staff should have allocated time in job plans to ensure attendance, which must be monitored	Partially Met	Training, governance and audit event attended but need to be incorporated in job plans	Formalise within job plans - Christine Edwards
	45	Multidisciplinary training must integrate the local handover tools (such as SBAR) into the teaching programme at all trusts.	Met	SBAR and handover included within current training programme	
	46	All trusts must mandate annual human factor training for all staff working in a maternity setting; this should include the principles of psychological safety and upholding civility in the workplace, ensuring staff are enabled to escalate clinical concerns. The content of human factor training must be agreed with the LMS.	Partially Met	Incorporated within MDT PROMPT Mandatory training	Agree content of the current training with the LMNS-Consultant Obstetrician Sharan Athwal/PD Midwife Asha Dhany
	47	There must be regular multidisciplinary skills drills and on-site training for the management of common obstetric emergencies including haemorrhage, hypertension and cardiac arrest and the deteriorating patient.	Met	Incorporated within MDT PROMPT Mandatory skills drills, planned drills take place in all practice settings, but plans are in place for more add hoc drills	
	48	There must be mechanisms in place to support the emotional and psychological needs of staff, at both an individual and team level, recognising that well supported staff teams are better able to consistently deliver kind and compassionate care.	Met	Review of service underway led by S Carty PMA's in place , Trim practitioners , staff psychological support also available via the Trust clinical psychologist	
	49	Systems must be in place in all trusts to ensure that all staff are trained and up to date in CTG and emergency skills.	Met	CTG Training in place for all those working in maternity, together with competency based assessment	
	50	Clinicians must not work on labour wards or provide intrapartum care in any location without appropriate regular CTG training and emergency skills training. This must be mandatory	Partially Met	Training in place but there is a need to review compliance of practitioners currently providing intrapartum care to ensure they have undertaken training within the last 12 months.	Review compliance of staff currently providing intrapartum care - Consultant Obstetrician Georgia Smith /PD Midwife Asha Dhany
ESSENTIAL ACTION 8 COMPLEX ANTENATAL CARE					
Local Maternity Systems, Maternal Medicine Networks and trusts must ensure that women have access to pre-conception care. **Trusts must provide services for women with multiple pregnancy in line with national guidance** **Trusts must follow national guidance for managing women with**	51	Women with pre-existing medical disorders, including cardiac disease, epilepsy, diabetes and chronic hypertension, must have access to preconception care with a specialist familiar in managing that disorder and who understands the impact that pregnancy may have.	More Information required	Current provision in both secondary and primary care variable dependent upon speciality /GP practice	Review current arrangements for preconceptual care to identify gaps and determine next steps -CCG/LMNS Lead Helen Ford /Christine Edwards
	52	Trusts must have in place specialist antenatal clinics dedicated to accommodate women with multifetal pregnancies. They must have a dedicated consultant and have dedicated specialist midwifery staffing. These recommendations are supported by the NICE Guideline Twin and Triplet Pregnancies 2019	Not Met	No specialist antenatal clinics for multiple pregnancy	Review current arrangements for specialist care to identify gaps and determine next steps - CCG/LMNS Helen Ford/Christine Edwards

diabetes and hypertension in pregnancy	53	NICE Diabetes and Pregnancy Guidance 2020 should be followed when managing all pregnant women with pre-existing diabetes and gestational diabetes	More Information required	Gap analysis returned as compliant. Email to Richard Hayman and Sally Trower 5/4/22 to confirm that we remain compliant -Chris Edwards	
	54	When considering and planning delivery for women with diabetes, clinicians should present women with evidence-based advice as well as relevant national recommendations. Documentation of these joint discussions must be made in the woman's maternity records.	Partially Met	Evidence based advice given, however capacity for women to be seen in the existing specialist clinics is restricted	Review clinic capacity - Christine Edwards
	55	Trusts must develop antenatal services for the care of women with chronic hypertension. Women who are identified with chronic hypertension must be seen in a specialist consultant clinic to evaluate and discuss risks and benefits to treatment. Women must be commenced on Aspirin 75-150mg daily, from 12 weeks gestation in accordance with the NICE Hypertension and Pregnancy Guideline (2019).	Not Met	No specialist antental clinics for women with hypertension	Review current arragements for specialist care to identify gaps and determine next steps - Christine Edwards IEA
ESSENTIAL ACTION 9 PRETERM BIRTH					
The LMNS, commissioners and trusts must work collaboratively to ensure systems are in place for the management of women at high risk of preterm birth. **Trusts must implement NHS Saving Babies Lives Version 2 (2019**	56	Senior clinicians must be involved in counselling women at high risk of very preterm birth, especially when pregnancies are at the thresholds of viability.	Met	Pre term birth antenatal clinical in place led by obstetricians who work closely with neonatologists	Need to work with commissioners to fund this service -GM Zoe Cliffe
	57	Women and their partners must receive expert advice about the most appropriate fetal monitoring that should be undertaken dependent on the gestation of their pregnancies and what mode of delivery should be considered.	Partially Met	Not always consistent or fully documented	Review information and documentation to improve consistency and ensure we can evidence this - Consultant Obstetricians Georgia Smith/Rebecca Swingler
	58	Discussions must involve the local and tertiary neonatal teams so parents understand the chances of neonatal survival and are aware of the risks of possible associated disability.	Partially Met	Not always consistent or fully documented Bhakthavalsala	Review information and documentation to improve consistency and ensure we can evidence this - Rebcecca Swingler /Consultant Neonatologist and lead Shayam Bhakthavalsala
	59	There must be a continuous audit process to review all in utero transfers and cases where a decision is made not to transfer to a Level 3 neonatal unit and when delivery subsequently occurs in the local unit.	Met	Subject to continuous audit	
ESSENTIAL ACTION 10 LABOUR AND BIRTH					
Women who choose birth outside a hospital setting must receive accurate advice with regards to transfer times to an obstetric unit should this be necessary. **Centralised CTG monitoring systems should be mandatory in obstetric units**	60	All women must undergo a full clinical assessment when presenting in early or established labour. This must include a review of any risk factors and consideration of whether any complicating factors have arisen which might change recommendations about place of birth. These must be shared with women to enable an informed decision re place of birth to be made	Met	Policy recently reviewed and part of the annual audit programme	
	61	Midwifery-led units must complete yearly operational risk assessments	Not Met	Annual operational risk assessments have not been completed	To be completed by the external consultants in conjunction with the midwifery leads -HoM Lisa Stephens June 2022
	62	Midwifery-led units must undertake regular multidisciplinary team skill drills to correspond with the training needs analysis plan.	Met	All members of the MDT including midwives working in MLU take part in the same skills drills in addition to local training which is provide in their place of work	
	63	It is mandatory that all women who choose birth outside a hospital setting are provided accurate and up to date written information about the transfer times to the consultant obstetric unit. Maternity services must prepare this information working together and in agreement with the local ambulance trust.	Partially Met	Information provided is general and written information is not updated regularly, although midwives provide verbal updates when the service is experiencing ambulance delays	To strengthen existing arragements - GM Zoe Cliffe
	64	Maternity units must have pathways for induction of labour, (IOL). Trusts need a mechanism to clearly describe safe pathways for IOL if delays occur due to high activity or short staffing.	Partially Met	Escalation Policy and management decisions taken evidenced by Birthrate plus acuity management tool which captures actions taken	Review IOL policy and procedures and create a SOP to clarify the pathway - Rebecca Swingler
	65	Centralised CTG monitoring systems must be made mandatory in obstetric units across England to ensure regular multi-professional review of CTGs.	Partially Met	Centralised CTG monitoring is available on the CDS but not on the maternity ward	Review need for central monitoring on the maternity ward as part of the review of IOL SOP as above -Lisa Stephens
ESSENTIAL ACTION 11 OBSTETRIC ANAESTHESIA					

In addition to routine inpatient obstetric anaesthesia follow-up, a pathway for outpatient postnatal anaesthetic follow-up must be available in every trust to address incidences of physical and psychological harm. Documentation of patient assessments and interactions by obstetric anaesthetists must improve. The determination of core datasets that must be recorded during every obstetric anaesthetic intervention would result in record-keeping that more accurately reflects events. Staffing shortages in obstetric anaesthesia must be highlighted and updated guidance for the planning and provision of safe obstetric anaesthesia services throughout England must be developed	66	Conditions that merit further follow-up include, but are not limited to, postdural puncture headache, accidental awareness during general anaesthesia, intraoperative pain and the need for conversion to general anaesthesia during obstetric interventions, neurological injury relating to anaesthetic interventions, and significant failure of labour analgesia.	Met	Outpatient postnatal patients referred to obstetric anaesthetic lead directly through community midwives or obstetric consultant.	
	67	Anaesthetists must be proactive in recognising situations where an explanation of events and an opportunity for questions may improve a woman's overall experience and reduce the risk of long-term psychological consequences.	Partially Met	Arrangement in place, patient reviewed and debriefed by a consultant anaesthetist in presence of birthing partner, with offer for further follow-up option. This is arranged via community midwife if the need arises. Documentation in maternity notes.	Review existing policies and consider the need for supporting SOP Michelle Poole May 2022
	68	All anaesthetic departments must review the adequacy of their documentation in maternity patient records and take steps to improve this where necessary as recommended in Good Medical Practice by the GMC	Partially Met	Anaesthetic department currently is reviewing and developing obstetric specific anaesthetic chart that will improve and standardise anaesthetic documentation.	Implement obstetric specific anaesthetic chart - Consultant Anaesthetists Martina Nejdlova
	69	Resources must be made available for anaesthetic professional bodies to determine a consensus regarding contents of core datasets and what constitutes a satisfactory anaesthetic record in order to maximise national engagement and compliance	N/A	**Action not for the Trust** .This is for national anaesthetic professional bodies, Trust will await if any recommendations made following Ockenden report.	
		Obstetric anaesthesia staffing guidance to include:			
	70	The role of consultants, SAS doctors and doctors-in-training in service provision, as well as the need for prospective cover, to ensure maintenance of safe services whilst allowing for staff leave.	Met	Service provision in obstetric in line with RCoA / Ockenden recommendations. Full Consultant & SAS doctor with specialist interest in obstetric cover, including prospective cover. OOH cover SAS doctors and trainees with appropriate competencies. OOH non-obstetric consultant cover competencies currently under review, awaiting national guidance.	
	71	The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cover, as well as teaching, attendance at multidisciplinary training, and governance activity	Partially Met	The full range of obstetric anaesthesia workload including, elective caesarean lists, clinic work, labour ward cove, as well as teaching, attendance at multidisciplinary training, and governance activity is in place. Gap is around cover for opening a 2nd obstetric theatre out of hours. Agreed plan in place to utilise existing on call theatre team at CGH to support opening of a second obstetric theatre out of hours at GRH as required.	Confirm start date for agreed solution-Becky Hughes
	72	The competency required for consultant staff who cover obstetric services out of hours, but who have no regular obstetric commitments	More Information required	OOH non-obstetric consultant cover competencies currently under review, awaiting national guidance.	Before national guidance available, local agreement on competency requirements to be completed by M Nejdlova and agreed by Anaesthetic Department.
	73	Participation by anaesthetists in the maternity multidisciplinary ward rounds as recommend within 14	Met	Participation by anaesthetists in the maternity multidisciplinary ward rounds is in place and there is already on-going audit in place of attendance of the whole multidisciplinary team, including Anaesthetists. Results regularly reviewed & distributed.	Complete gap analysis and audit compliance -Martina Nejdlove
ESSENTIAL ACTION 12 POSTNATAL CARE					
Trusts must ensure that women readmitted to a postnatal ward and all unwell postnatal women have timely consultant review. Postnatal wards must be adequately staffed at all times	74	All trusts must develop a system to ensure consultant review of all postnatal readmissions, and unwell postnatal women, including those requiring care on a non maternity ward.	Met	Under normal circumstances admitted and reviewed via Maternity Triage, all presenting via ED are referred to obstetrician. All discussed with the consultant at the twice daily safety huddle	
	75	Unwell postnatal women must have timely consultant involvement in their care and be seen daily as a minimum.	Met	Admitted via Maternity Triage all presenting via ED are referred to obstetrician. All mentioned at the twice daily safety huddle and seen with 14hours	
	76	Postnatal readmissions must be seen within 14 hours of readmission or urgently if necessary	Met	All discussed at the twice daily safety huddle with the consultant and seen within 14hours	
	77	Staffing levels must be appropriate for both the activity and acuity of care required on the postnatal ward both day and night, for both mothers and babies.	Not Met	Staffing issues throughout the service at present and on the Trust risk Register. Escalation policy in place and Staffing action plan in place	Post natal birth rate plus acuity tool being implemented on the ward to improve oversight and monitoring of staffing and activity -Lisa Stephens
ESSENTIAL ACTION 13 BEREAVEMENT CARE					

Trusts must ensure that women who have suffered pregnancy loss have appropriate bereavement care services.	78	Trusts must provide bereavement care services for women and families who suffer pregnancy loss. This must be available daily, not just Monday to Friday	Not Met	Cover 30 hrs /week , out of hours women are supported by the experienced band 7 staff .	Review service provision and consider expansion - Lisa Stephens and Bereavement Midwife
	79	All trusts must ensure adequate numbers of staff are trained to take post-mortem consent, so that families can be counselled about post-mortem within 48 hours of birth. They should have been trained in dealing with bereavement and in the purpose and procedures of post-mortem examinations.	Partially Met	Bereavement midwife (ND) trained but only available 30 hrs /week and no annual leave cover	Check registrar training - Christine Edwards
	80	All trusts must develop a system to ensure that all families are offered follow-up appointments after perinatal loss or poor serious neonatal outcome.	Met	All women are offered a consultant appointment with an obstetrician or neonatologist as appropriate	
	81	Compassionate, individualised, high quality bereavement care must be delivered for all families who have experienced a perinatal loss, with reference to guidance such as the National Bereavement Care Pathway.	Partially Met	Some inconsistencies in service provision (see action 78)	Review capacity as above i.e. 78
ESSENTIAL ACTION 14 NEONATAL CARE					
There must be clear pathways of care for provision of neonatal care. **This review endorses the recommendations from the Neonatal Critical Care Review (December 2019) to expand neonatal critical care, increase neonatal cot numbers, develop the workforce and enhance the experience of families. This work must now progress at pace.**	82	Neonatal and maternity care providers, commissioners and networks must agree on pathways of care including the designation of each unit and on the level of neonatal care that is provided.	Met	Already in place and following SWODN pathways	
	83	Care that is outside this agreed pathway must be monitored by exception reporting (at least quarterly) and reviewed by providers and the network. The activity and results of the reviews must be reported to commissioners and the Local Maternity Neonatal Systems (LMS/LMNS) quarterly	Met	All babies cared for outside the pathway currently monitored by network exception reporting forms that are e-mailed to the ODN	
	84	Maternity and neonatal services must continue to work towards a position of at least 85% of births at less than 27 weeks gestation taking place at a maternity unit with an onsite NICU.	Partially Met	GRH NICU is Level 2.We currently follow place of birth pathway and is monitored through exception reporting, in utero transfer out for those less than 27 weeks is constrained by the presenting condition and cot availability	QI project in place to improve compliance with births <27 weeks in a Level 3 NICU -Consultant Neonatologist and Chief of Service Simon Pirie
	85	Neonatal Operational Delivery Networks must ensure that staff within provider units have the opportunity to share best practice and education to ensure units do not operate in isolation from their local clinical support network. For example senior medical, ANNP and nursing staff must have the opportunity for secondment to attend other appropriate network units on an occasional basis to maintain clinical expertise and avoid working in isolation.	Partially Met	Currently we do have opportunity for feedback between our unit and tertiary centres, but no opportunity for secondment. This may not be practically feasible currently due to staffing issues on the unit.	To discuss at the next network board meeting - Shyam Bhakthavalsala
	86	Each network must report to commissioners annually what measures are in place to prevent units from working in isolation	Not met	Currently we do have opportunity for feedback between our unit and tertiary centres, but no opportunity for secondment. This may not be practically feasible currently due to staffing issues on the unit.	To discuss at the next network board meeting - Shyam Bhakthavalsala
	87	Neonatal providers must ensure that processes are defined which enable telephone advice and instructions to be given, where appropriate, during the course of neonatal resuscitations. When it is anticipated that the consultant is not immediately available (for example out of hours), there must be a mechanism that allows a real-time dialogue to take place directly between the consultant and the resuscitating team if required.	Partially Met	Consultants are easily accessible on the phone and support from tertiary centre available through NEST.	Neonatal 'attendance at delivery' action card to be developed- Shyam Bhakthavalsala
	88	Neonatal practitioners must ensure that once an airway is established and other reversible causes have been excluded, appropriate early consideration is given to increasing inflation pressures to achieve adequate chest rise. Pressures above 30cmH2O in term babies, or above 25cmH2O in preterm babies may be required. The Resuscitation Council UK Newborn Life Support (NLS) Course must consider highlighting this treatment point more clearly in the NLS algorithm.	Met	Currently this is current practice although not within NLS Training	Whilst awaiting revised algorithm, provide clear guidance for clinical teams and highlighting this treatment point within existing local simulation training -Shyam
	89	Neonatal providers must ensure sufficient numbers of appropriately trained consultants, tier 2 staff (middle grade doctors or ANNPs) and nurses are available in every type of neonatal unit (NICU, LNU and SCBU) to deliver safe care 24/7 in line with national service specifications.	Partially Met	Ongoing challenges with junior medical vacancies. An ANNP workforce review is currently underway.	To support succession planning for ANNP to support the junior medical rota. Business plan submitted to divisional Tri and awaiting approval- Shyam

ESSENTIAL ACTION 15 SUPPORTING FAMILIES					
Care and consideration of the mental health and wellbeing of mothers, their partners and the family as a whole must be integral to all aspects of maternity service provision Maternity care providers must actively engage with the local community and those with lived experience, to deliver services that are informed by what women and their families say they need from their care	90	There must be robust mechanisms for the identification of psychological distress, and clear pathways for women and their families to access emotional support and specialist psychological support as appropriate.	Partially Met	Antenatal screening with pathway for referral to the perinatal service.	Review postnatal screening and referral pathway Lisa Stephens and Matron (SM)
	91	Access to timely emotional and psychological support should be without the need for formal mental health diagnosis, as psychological distress can be a normal reaction to adverse experiences	Met	Lets Talk service	
	92	Psychological support for the most complex levels of need should be delivered by psychological practitioners who have specialist expertise and experience in the area of maternity care	Met	Perinatal mental health team and pathway in place	

Report to Board of Directors			
Agenda item:	13	Enclosure Number:	8
Date	12 May 2022		
Title	Finance Report		
Author /Sponsoring Director/Presenter	Shofiqur Rahman, Finance Manager Craig Marshall, Projects Accountant Karen Johnson, Director of Finance		

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

Summary of Report

Purpose

This purpose of this report is to present the Financial position of the Trust at Month 12 to the Trust Board.

Key issues to note

The draft Month 12 Finance position was £516k surplus which was as expected and reported to NHSEI. The overall year end system position is a surplus of £6.8m.

Month 12 overview

The draft Month 12 Finance position was £516k surplus which was in line with expected forecast reported in the Trust and to NHSE during H2. The final Trust capital position was £326k overspend, however as a system there was an overall £3k underspend due to a £329k underspend reported by GHC. Impairments for the year were £1.7m.

Activity delivered 100% of the 19/20 activity levels, and 123% of the March 2020 levels.

2022/23 Planning update

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

Conclusions

The Trust is reporting a year end I&E surplus of £516k as was expected and a £326k co-ordinated overspend on capital.

Recommendation

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

Enclosures

- Finance Report

Report to the Trust Board

Financial Performance Report
Month Ended 31 March 2022

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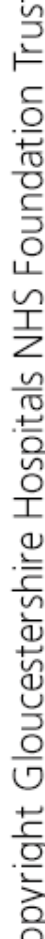
Revenue



Director of Finance Summary

System Position for Full Year

For H1 (April 2021 – September 2021) the Gloucestershire System reported a small surplus of £11k. The Trust contributed to this by delivering £6k of the £11k surplus. For H2 (October 2021 – March 2022), the ICS partners worked together to review and mitigate the overall system's financial position. For H2 (October 2021 – March 2022) the system initially planned for a breakeven position.

The overall year end system financial position is a surplus of £6.8m. Of this c£4-5m is linked to additional ERF income generated from performance within the independent sector.

Month 12 overview

The draft Month 12 Finance position was £516k surplus which was in line with expected forecast reported in the Trust and to NHSE during H2. The final Trust capital position was £326k overspend, however as a system there was an overall £3k underspend due to a £329k underspend reported by GHC. Impairments for the year were £1.7m.

The draft revenue and capital positions have been reported to NHSEI.

Activity delivered 100% of the 19/20 activity levels, and 123% of the March 2020 levels.

2022/23 Planning update

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

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Month 12 headlines

Headline	Compared to plan	Narrative
I&E Position full year is £516k surplus	↔	Overall financial performance is £516k surplus.
Income is better than plan at £682.5m full year.	↑	The year end position was £39.4m better than plan, predominantly due to £11.7m Salix grant funding (removed in the final reported position), £6m high cost drugs and devices above plan, £3.1m Elective Recovery Fund (ERF) above plan, £3.2m Winter ERF Funding above plan, £3.8m pay award funding, £2.9m Covid (outside envelope) funding, less £0.4m net of under-recovery of income (including private patients, road traffic accident, overseas visitors, catering and recharges to other organisations)
Pay costs are more than plan at £407.4m full year.	↓	The year end position was £13.5m adverse to plan. The main reasons are pay award cost amounts to £4.0m, Covid outside envelope not included in the plan was £0.5m with Covid inside envelope overspends of £1.4m. Health and wellbeing days contributed c2.7m. Waiting List Initiatives of £1.3m, Registered Mental Health Nurses £1.1m. There was a total agency overspends of 2.8m and Bank overspend of £4.3m.
Non-Pay expenditure is more than plan at £255.3m full year.	↓	The year end position this was £14.5m adverse to plan. The main drivers of this are the £6m high cost drugs and devices above plan and Medical Surgical equipment (£2.3m). Other areas of overspend included GMS VAT provision (£6m), Covid inside envelope costs overspend (£1.4m), Glanso expenditure (£1.1m), Xray equipment (£0.7m), Training and Travel (£0.5m),Transport costs (£0.4m). Fixed asset impairment was £1.7m.
Financial Sustainability schemes delivered £8.16m for the year	↑	The Trust has delivered £8.16m of efficiency for the year. This is £1.2m ahead of full year plan. These additional savings have mitigated some of the overspends seen in our Medicine division to date.
The cash balance is £71.5m.	↑	The decrease in cash reflects the use of cash reserves to fund capital

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Month by Month Trend

Gloucestershire Hospitals
NHS Foundation Trust

The table shows the run rate from Month 11 to Month 12 with a £383k surplus in month. The change in month on month position includes prior anticipated mitigations that were transacted in month to meet overall surplus position.

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

We had another Salix grant in month; (full year £11.7m) this passes through to GMS for capital expenditure but must be shown in Trust accounts and then adjusted against our bottom line.

	6 months' Run Rate Actuals						
	M07	M08	M09	M10	M11	M12	Month 11 to Month 12 change
Pay	(33,498)	(32,746)	(32,824)	(33,535)	(34,345)	(35,779)	(1,434)
Non Pay	(19,939)	(20,939)	(21,230)	(22,190)	(20,742)	(23,233)	(2,490)
Pay - Covid (in envelope)	(309)	(327)	(389)	(348)	(400)	(795)	(395)
Non Pay - Covid (in envelope)	(279)	(212)	(412)	(207)	(218)	(348)	(130)
Covid Costs (in envelope)	(588)	(539)	(801)	(555)	(618)	(1,143)	(525)
Pay - Covid (outside envelope)	(128)	(98)	(171)	(162)	0	(90)	(90)
Non Pay - Covid (outside envelope)	(229)	(121)	(52)	(254)	(103)	(192)	(89)
Covid Costs (outside envelope)	(357)	(219)	(223)	(416)	(103)	(282)	(179)
Non-operating Costs	(765)	(769)	(795)	(730)	(653)	(524)	129
Remove impact of Salix Grant	(1,249)	(693)	(722)	(350)	(608)	(4,523)	(3,915)
Remove impact of Donated Asset Depreciation / impairments	48	49	48	49	124	1,716	1,592
Total Cost	(56,348)	(55,857)	(56,547)	(57,728)	(56,945)	(63,768)	(6,823)
Run Rate Funding / Billable Income	57,127	55,034	56,190	57,179	56,709	64,368	7,660
Est Elective Recovery Fund Income		0					0
Covid Income (outside envelope)	357	219	223	416	103	282	179
Excluding Donations Income Charitable Funds							0
Total Reported Surplus / (Deficit)	**1,136**	**(604)**	**(135)**	**(133)**	**(133)**	**383**	**516**

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M12 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The year end financial position reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity, and excludes the Hosted GP Trainees (which have equivalent income and cost) each month.

The year end Group's consolidated position was a £516k surplus.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 12 Financial Position	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s *** **	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	595,861	599,241	3,379			0	595,861	599,241	3,379
PP, Overseas and RTA Income	3,489	4,011	523			0	3,489	4,011	523
Other Income from Patient Activities	3,465	9,759	6,294			0	3,465	9,759	6,294
Elective Recovery Fund	3,000	6,071	3,071			0	3,000	6,071	3,071
Operating Income	32,971	58,176	25,205	60,624	78,929	18,305	37,246	63,455	26,209
Total Income	**638,786**	**677,258**	**38,472**	**60,624**	**78,929**	**18,305**	**643,062**	**682,537**	**39,476**
Pay	(372,183)	(386,081)	(13,899)	(21,763)	(21,378)	384	(393,946)	(407,460)	(13,514)
Non-Pay	(260,613)	(274,471)	(13,858)	(36,483)	(54,447)	(17,964)	(240,748)	(255,268)	(14,520)
Total Expenditure	**(632,796)**	**(660,552)**	**(27,756)**	**(58,246)**	**(75,826)**	**(17,580)**	**(634,693)**	**(662,727)**	**(28,034)**
EBITDA	**5,991**	**16,706**	**10,715**	**2,379**	**3,104**	**725**	**8,368**	**19,810**	**11,441**
EBITDA %age	**0.9%**	**2.5%**	**1.5%**	**3.9%**	**3.9%**	**0.0%**	**1.3%**	**2.9%**	**1.6%**
Non-Operating Costs	(6,550)	(5,597)	953	(2,379)	(3,104)	(725)	(8,927)	(8,700)	227
Surplus / (Deficit)	**(559)**	**11,109**	**11,668**	**0**	**0**	**0**	**(559)**	**11,109**	**11,668**
Fixed Asset Impairments	0	1,716	1,716					1,716	1,716
Surplus / (Deficit) after Impairments	**(559)**	**12,825**	**13,384**	**0**	**0**	**0**	**(559)**	**12,825**	**13,384**
Excluding Donated Assets & Salix grant	565	(11,808)	(12,373)				565	(11,808)	(12,373)
Excluding Donations Income Charitable Funds		(500)	(500)					(500)	(500)
Control Total Surplus / (Deficit)	**6**	**516**	**510**	**0**	**0**	**0**	**6**	**516**	**510**

* Trust position excludes £37.5m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £73.0m of inter-company transactions, including dividends

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

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Balance Sheet

	Opening Balance 31st March 2021 £000	GROUP Balance as at M12 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	6,666	(1,614)
Property, Plant and Equipment	276,161	314,292	38,131
Trade and Other Receivables	6,149	4,444	(1,705)
Total Non-Current Assets	**290,590**	**325,402**	**34,812**
Current Assets			
Inventories	8,934	9,370	436
Trade and Other Receivables	18,054	26,500	8,446
Cash and Cash Equivalents	77,216	71,530	(5,686)
Total Current Assets	**104,204**	**107,400**	**3,196**
Current Liabilities			
Trade and Other Payables	(87,606)	(79,991)	7,615
Other Liabilities	(11,585)	(14,401)	(2,816)
Borrowings	(3,404)	(3,403)	1
Provisions	(10,824)	(26,200)	(15,376)
Total Current Liabilities	**(113,419)**	**(123,995)**	**(10,576)**
Net Current Assets	**(9,215)**	**(16,595)**	**(7,380)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(5,971)	546
Borrowings	(37,438)	(34,287)	3,151
Provisions	(2,892)	(1,489)	1,403
Total Non-Current Liabilities	**(46,847)**	**(41,747)**	**5,100**
Total Assets Employed	**234,528**	**267,060**	**32,532**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	361,605	29,572
Reserves	27,975	19,822	(8,153)
Retained Earnings	(125,480)	(114,367)	11,113
Total Taxpayers' Equity	**234,528**	**267,060**	**32,532**

The table shows the M12 balance sheet and movements from the 2020/21 closing balance sheet. The opening balances have been adjusted to reflect the final audited position for 2020-21.

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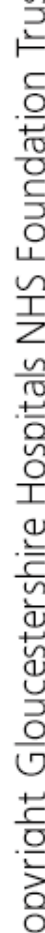
Capital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Director of Finance Summary

Funding

The Trust's capital funding for the 21-22 financial year finished at £67.3m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£29.0m), IFRIC 12 (£0.9m) and Government Grant/Donations (£13.0m)

Year End Out-turn Position

The Trust had goods delivered, works done or services received to the value of £67.6m, a £0.3m overspend against the Trust's system capital allocation.

	In Month	Outturn		
Programme Allocation	Actual £000's	Funds £000's	Actual £000's	Variance £000's
System Capital	8,087	24,404	24,730	(326)
National Programme	10,360	29,022	29,022	0
Donation and Government Grants	2,671	12,973	12,973	0
IFRIC 12	72	874	874	0
Total Programme	**21,190**	**67,273**	**67,599**	**(326)**

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21/22 Programme Funding Overview

The Trust's capital funding for the 21-22 financial year finished at £67.3m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£29.0m), IFRIC 12 (£0.9m) and Government Grant/Donations (£13.0m)

This increased by £1.1m due to GMS being able to maximise the delivery of the Salix Project (increased by £0.8m) and the donated assets within the charitable funds being £0.3m higher than expected.

	M11 Forecast	Outturn Funding	Change
Programme Allocation	**£000's**	**£000's**	**£000's**
System Capital	24,404	24,404	0
National Programme	29,022	29,022	0
Donations and Government Grants	11,847	12,973	1,126
IFRIC 12	874	874	0
Total Programme (Reported)	**66,147**	**67,273**	**1,126**

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21/22 Programme Spend Overview

Project / Area	FOT at M11	Actual Outturn	Variance
Digital	15,354	16,194	(840)
Estates	38,754	39,272	(518)
Medical Equipment	11,080	11,197	(116)
Slippage from 20/21 and Other	91	63	28
IFRIC 12	874	874	0
Grand Total	66,153	67,599	(1,446)
Funding	66,147	67,273	(1,126)
Balance	(6)	(326)	320

The Trust had goods delivered, works done or services received to the value of £67.6m, a £0.3m overspend against the Trust's system capital allocation. The breakdown of this expenditure by programme allocation is shown in the table below.

This position was a co-ordinated position within the ICS, with GHC reporting an underspend of £0.3m and therefore the system effectively reported a breakeven system position.

The main drivers for the variances and causes of the reported overspend were as follows;

Digital	£000's
Cyber Security Software	598
End User Hardware refresh	353
Other Digital	(111)
Total Digital Variance to Forecast	840

A £0.3m additional cost for end user hardware and Digital assisting in the deployment of a late mitigation to the capital programme position through the purchasing of £598k cyber software.

It was hoped that the Trust would be able to reclaim the VAT associated with spend to a specific supplier that was incurred in March. However, following conversations with the Trust's VAT advisors, it was determined that the nature of the spend was different to the spend incurred earlier in the year and therefore it was deemed that none of the March spend was recoverable. This meant that the Digital outturn position ended £840k over the allocation and the overall programme position to outturn at £326k over.

Medical Equipment	£000's
CDC - Community Diagnostic Equipment - Echo Slippage	310
CDC - Community Diagnostic Equipment - Underspend	296
22/23 Brought Forward - Theatres Equipment Replacement	(236)
Flexitron Brachtherapy Unit	(259)
Urology Ultrasound	(71)
Donated Equipment	(215)
Other Medical Equipment	58
Total Medical Equipment Variance to Forecast	(116)

The key reasons contributing to the £116k overspend against the medical equipment allocation were

- Slippage of the echo machines after they were delayed going through customs (£310k)
- An underspend against the community diagnostic equipment due largely driven by purchasing the items through GMS enabled the VAT to be reclaimed (£296k)
- Additional theatres kit from 22/23 was brought forward to mitigate the position (£235k)
- Through closely working with the supplier, managed to get the important and urgent Flexitron Brachtherapy Unit (£259k) and Urology Ultrasound (£71k) delivered in 21/22.
- When assessing the charitable accounts, the donated equipment was higher than expected (£215k)

Estates	£000's
Energy Efficiency (Salix)	(838)
GMS Capital Staff Costs	139
IGIS Enabling Works	174
Other Estates	7
Total Estates Variance to Forecast	(518)

The key driver behind the increase in the outturn was that GMS were able to deliver more of the Salix project than had been forecast (£838k) This was income backed by government grant income.

Capitalisable project management costs that were previously forecast against the GMS capital staff costs budget line were reallocated against the Salix project.

The IGIS design and enabling works delivered £174k less than expected.

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Recommendations

The Board is asked to:

- Note the Trust is reporting a Draft Final Year end position £516k surplus which was as expected and reported to NHSEI.
- Note the overall year end system position is a surplus of £6.8m.
- Note the final Trust capital position was £326k overspend.

Authors: **Shofiqur Rahman, Interim Associate Director of Financial Management**
Caroline Parker, Head of Financial Services
Craig Marshall, Project Accountant

Presenting Director: **Karen Johnson, Director of Finance**

Date: **April 2022**

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Report to Board of Directors			
Agenda item:	**14**	**Enclosure Number:**	**9**
Date	12 May 2022		
Title	Digital and EPR Programme Report		
Author /Sponsoring Director/Presenter	Nicola Davies, Digital Engagement & Change Mark Hutchinson, Executive Chief Digital & Information Officer		

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

Summary of Report

This paper provides updates and assurance on the delivery of Digital workstreams and projects within GHFT, as well as business as usual functions. The progression of this agenda is in line with our ambition to become a digital leader. Highlights of the report:

- Sunrise EPR clinical documentation optimisation drops are underway in five phases.
- Business Intelligence team is leading on a system-wide dashboard aimed at improving patient flow with at-a-glance visibility of the whole system.
- Digital teams are supporting implementation of new Clinically Ready to Proceed reporting.

The importance of improving GHFT's digital maturity in line with our strategy has been significantly highlighted throughout the COVID-19 pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, but needs to continue at pace.

Recommendation

The Board is asked to note the report.

Enclosures

- Digital and EPR Report

DIGITAL AND EPR PROGRAMME REPORT

1. Purpose of Report

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

2. Sunrise EPR Programme Update

This report provides status updates on Sunrise EPR work-streams and interdependent digital projects. Detailed information on each work-stream, including RAG status is provided in the report.

2.1 EPR High Level Programme Plan

The programme plan below details the EPR functionality already delivered and planned for 2021/22. *Blue indicates projects already delivered.*

Functionality	Estimated Go-live	Delivered
Nursing Documentation (adult inpatients)	June 2020	November 2019
E-observations (adult inpatients)	June 2020	February 2020
Order Communications (adult inpatients)	December 2020	August 2020
Order Communications (other inpatient areas)	February 2021	February 2021
Cheltenham MIIU (all functionality)	March 2021	March 2021
Pharmacy Stock Control (EMIS)	April 2021	April 2021
Doctor's Handover Document (HDS/EDD)	May 2021	12th May 2021
Cheltenham MIIU transition to ED (additional functionality & training)	9 June 2021	9 June 2021
TCLE – replacement lab system (replacing IPS)	23 June 2021	23 June 2021
Gloucester Emergency Department (all functionality)	7 July 2021	7 July 2021

Sepsis documentation	22 Sept 2021	22 Sept 2021
EMM (Electronic Medicines Management)	Oct 2021	Oct 2021
Upgrade of Sunrise EPR	30 Nov 2021	
Clinical Data Storage Platform (Onbase)	Jan 2022	
Clinical documentation	February 2022	23 Feb 2022
EPR Additional nursing documentation	February 2022	23 Feb 2022
Order Communications (theatres & outpatients expansion)	TBC	
Electronic Prescribing & Medicines Administration (known as ePMA)	Early adopters summer 2022 Adult inpatient/ED Autumn 2022	

3. EPR Project Summaries and Status Updates

This section provides the latest status on EPR projects currently reporting through the EPR Programme Delivery Group. These updates are correct as reported to Programme Delivery Group on 29th March 2022.

Key issues to note:

- Preparation continuing for implementation of Phase 1 of the Clinical Data Storage Platform (Onbase) to conclude.
- Work is progressing to deliver ePMA, with configuration and build continuing.
- Use of the FDB database without a contract in place has been agreed to enable ePMA allergy testing to progress.
- TrakCare Upgrade testing is progressing towards completion.
- Three optimisation drops have been made for clinical documentation on EPR (launched 23 Feb).
- The implementation of Pre-Assessment Digital Workflows has been delayed.
- Work is progressing in preparation for the delivery of the new maternity system, with a preferred option for proceeding determined.
- Work has commenced on the scoping and development of a model of care using virtual wards across Gloucestershire ICS, although further engagement is required.
- EPR continuous improvement is continuing and reporting to EPR PDG.

3.1 Clinical Documentation and Flowsheets

In the last month we saw the first major implementation of clinical documentation, bringing ward rounds and clinical notes onto EPR for the first time, impacting doctors and AHPs. This was a significant step change for clinicians; and for many their first experience of using Sunrise EPR in their daily routines.

We are now readily able to see the following clinical information in real time for adult inpatient areas:

- If patients have been seen, clerked and followed up by a consultant.
- How long each stage has taken.
- Greater visibility of patients in ED who have been clerked and post-taked prior to admission.
- If the patient has been seen by the speciality.

A programme of post go-live optimisation is now underway, phased into five drops, based on feedback and improvements suggested by clinical teams as they begin to make the documentation part of daily routines; and see the opportunities to improve process using the EPR.

3.2 Clinically Ready to Proceed

Changes have been made to the Emergency Department documents in EPR to support the implementation of the new national metric *clinically ready to proceed* (CTRP) from 1st April. At appropriate points in the care journey, EPR will require ED clinicians to declare whether a patient is CTRP.

Once completed, this generate a flag on the EPR tracking board (Green arrow = Ready, Red arrow = Not Ready) and a timestamp in the CRTP column if the patient is clinically ready to proceed. This will provide a report for submission nationally.

Data quality and compliance monitoring is ongoing, with positive completion rates above 90% on day one.

	DischargeDate	Patients_Discharged	Has_CRTP	No_CRTP	PercentComp
1	2022-04-01	66	61	5	92
2	2022-03-31	294	287	7	97

4. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO). Since the last report no projects have been completed and closed and one project has gone into closure.

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

- The Data Centre Refurbishment project has moved into closure.

- Further activities relating to both CGH and GRH Data Centres, regarding air conditioning and fire suppression upgrades have been descoped from the Data Centre Refurbishment and will form part of a separate project for delivery in the 2022-2023 financial year.
- The N365 for the GCCG project has moved into closure.
- The impact of interface issues and sick leave have delayed the completion of the Civas project.
- A project to install Infrastructure for a New Portering System (MyPorter) has commenced and is progressing.
- A project to deliver a new Appraisal & Re-validation System (Phase 1 - Procurement) has commenced and is progressing at pace.

4.1 Areas of concern and mitigating actions

CVIS
The project has not completed as planned following the identification of interface issues that require resolution before the system can become operational. Work is continuing to ensure that solutions are in place as soon as possible to enable the project closure and transition to business as usual.

SQL Migration & Windows 2003 Upgrade
Work has increased at pace owing to the increasing cyber risk associated with unsupported operating and database systems. The focus is on upgrading operating systems and migrating ageing SQL to the Always-on 2017 SQL Cluster.
Where this is not possible servers are being isolated and access to them limited using micro-segmentation (SDDC) or Windows firewall (VMWare).

Windows 7 Dependant Applications Eradication
An additional 12 months of Extended Security Updates (ESU) has been put in place to ensure that the continuing cyber risk is mitigated whilst removal of Win7 is completed. This ESU deployment included PACS workstations (managed by Philips), although work is almost complete to upgrade these to Win10. The urgent focus has been on the remaining Windows XP devices (5), either upgrading to Windows 10 or isolating them from the network until they can be removed.

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

5. ICS System Wide Dashboard

The Trust is under considerable scrutiny from NHSE/I regarding the high number of patients in hospital beds who do not meet the criteria to reside (No Criteria to Reside - NCTR). In addition, the trust is under similar scrutiny regarding ambulance handovers and pressure at the front door. Improving performance in these areas is considered to be the highest priority from a regional and national perspective.

During 2021 the trust implemented an NCTR reporting function in Sunrise EPR, as part of the doctor's medical handover launched in May 2021. This enabled the data for Criteria to Reside (CTR) and Non-Criteria to Reside (NCTR) to be captured and

designated across all the pathways defined within the National Hospital Discharge and community services policy.

In order to ensure patients do not experience delays in their pathway and receive the correct level of support when leaving the acute hospital, the process of discharge often involves communication between multiple stakeholders across a number of services within the wider ICS. These include community, home first services, adult social care and brokerage.

The inability for operational staff to view patient level data as a collective through a single point of access has resulted in:

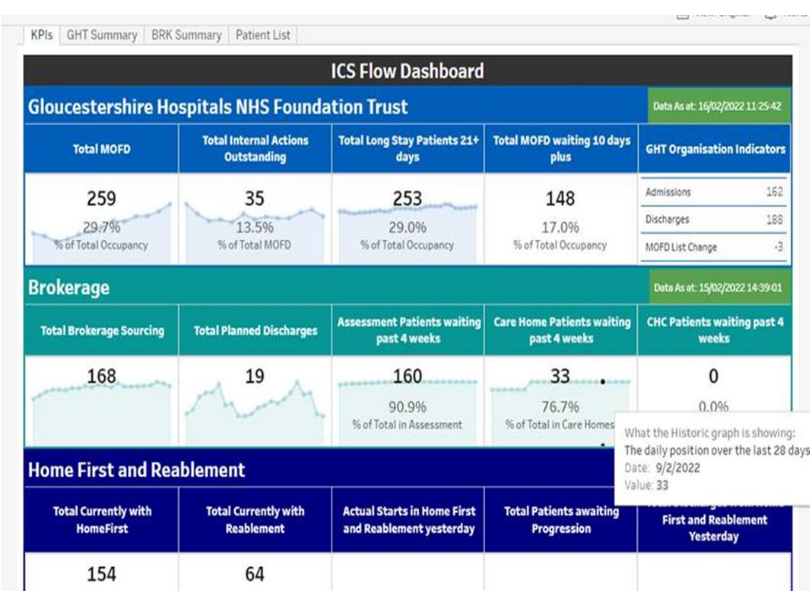
- inefficient use of clinical resource;
- delays to patient discharge;
- poor data quality and understanding across the system of discharge pathways;
- an inability to monitor and track patients across more than one provider.

The GHFT BI team, working collaboratively with system partners across acute, community health and social care, proposed building a system-wide dashboard to provide oversight of all patients on a discharge pathway.

5.1 Digital solution

Using data readily available from clinical and operational systems, the dashboard provides an accessible, easy to understand live dashboard, giving teams the ability to monitor and track patient movement across the health and social care sector. The dashboard supports clinical and operational communication across the ICS and as a result, will improve the safety and reliability of services for patients. It is not used in isolation but is part of a set of digital solutions being used to improve urgent and emergency care in the county.

A screenshot of the dashboard is below.



5.2 Benefits of the digital dashboard

There are immediate and longer-term benefits to providing a real time monitoring tool. Those identified so far include:

- Real time monitoring tool to support and improve completion of CTR and NCTR data within EPR as part of the Hospital and Community Services Discharge policy implementation.
- Through identification of patients who are not designated to a pathway; reduce the risk associated with the 'stranded patient' and provide clinical leaders with the ability to track and monitor pathway designation and ensure all patients either meet the CTR appropriately or have an active discharge pathway.
- Provide real time data to support the 'check and challenge' required at ward level to progress the patient treatment pathway, reduce length of stay and expedite discharge to the most appropriate destination to deliver the optimum outcome for the patient.
- Enable operational and clinical staff to monitor progress against local, regional and national key performance indicators relating to both admission and discharge.
- Reduce the amount of time spent by clinical teams procuring information from across multiple stakeholders before decisions regarding patients discharge destination can be made or onward progress agreed.
- Provide a platform for clinical operational and managerial teams to share information and support collaborative working across the ICS to improve patient health and social care.
- Provide the ability to monitor demand and capacity across discharge pathways to inform commissioning of services to meet population needs.

Over time the data will also provide trend analysis that could support predictive modelling of system flow requirements across health and social care. As well as:

- Data to support the implementation of the 'criteria to admit' to ensure that where possible, patients are signposted to the most appropriate service in the most appropriate setting to meet their health and social care needs.
- Improve timeliness of access to discharge services for patients.
- Provide the ability to track patient length of stay and patient outcomes across multiple discharge pathways and providers.
- Reduce data and information 'silos' across the ICS.

6. Countywide IT Service (CITS) Annual Report

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

- Improvements in performance against SLA for both CCG and Primary Care with call answering figures up.
- However, overall performance down for CITS due to demand and slower response times because of new starter training.
- High demand in GHFT includes the Clinical Documentation EPR go-live during February, which was supported by a range of IT staff.

7. Information Governance

This section provides updates and assurance on the Information Governance Framework in operation within the trust to ensure the senior team is regularly briefed on Information Governance issues and the broader Information Governance agenda. The detailed information on Data Security and Protection (DSP) Toolkit 2021/2022 requirement and monthly local Incident and ICO position (February 2022) are reported separately.

-Ends-

Report to Board of Directors			
Agenda item:	15	Enclosure Number:	10
Date	12 May 2022		
Title	Use of Trust Seal Report		
Author /Sponsoring Director/Presenter	Kat Cleverley, Trust Secretary		

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

Summary of Report

The Trust's Standing Orders require that the use of the seal is authorised by the Board of Directors and entered in the Register of Sealings. The seal is used to execute deeds (e.g. conveyances of land) or where it may be required by law.

The Trust Secretary is Custodian of the Trust seal.

The seal was used on the following documents on 22 March 2022:

- 1stseconds Limited and GHNHSFT Lease relating to Ground Floor 9 Pullman Court Gloucester
- 1stseconds Limited and GHNHSFT Lease relating to First Floor 9 Pullman Court Gloucester

The seal was used on the following document on 23 March 2022:

- GHNHSFT and Saba Infra Gloucestershire Limited Deed of Variation of the project agreement relating to the free parking manifesto

The seal was used on the following documents on 29 March 2022:

- Markel International Insurance Company Limited and GHNHSFTnAdvance Payment Bond
- The Tandy Association Ltd Pension Scheme and GHNHSFT, Lease relating to 5 Pullman Court

Recommendation

The Board is asked to endorse the use of the Trust Seal.

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 27 April 2022		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Urgent and Emergency Care Update	• The first Urgent and Emergency Care Improvement Board was due to take place this week. An intelligence sharing event had been held at system level, with a focus on data and a review of frailty. Discussions on calling a risk summit were ongoing, with next steps taking place from July. • Ambulance performance had further deteriorated. • Four-hour wait performance had deteriorated. • 12-hour breaches in urgent care had increased since the emergence of Covid-19, and mostly related to bed issues. The Committee noted that 15% of patients breached the 12-hour standard.	Risk register to reflect delay-related harm, and consolidation of Emergency Department risks. A delay-related harm report would be brought to May's meeting.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	Key points were noted as follows: • Patient flow remained an issue within the Trust. • Cancer performance was stable, with progress being made on the 62-days standard. • The waiting list backlog had reduced and continued to reduce on a weekly basis. • A number of initiatives and actions had been put in place to manage flow at the front door of the Trust, with little demonstrable impact. However, additional resource had been invested, including funding for a second Deputy COO to focus on transformation. • Friends and Family Test feedback was at 88% this month, mostly driven by the impact of emergency care. • New colleagues had joined the PALS team to manage the increase in contacts; improvements were already being seen. • New Infection Prevention and Control guidance had been released, which would impact positively on patient flow. There were no changes to care home guidance.	The staffing model for the static cabin was currently under review, along with potential plans to convert the cabin into a minor injury and illness unit.
Pressure Tissue Damage and Falls Review	A comprehensive review of harm associated with falls and pressure ulcers had been undertaken; there was clear evidence that fewer cases of harm occurred when care hours per patient per day were improved, and use of temporary staff did not correlate with harm.	The Committee was supportive of the Falls and Pressure Ulcer Prevention annual programme. Further work would be undertaken to review ward moves and correlation to harm.
Serious Incidents Report	There had been no further Never Events reported since last month. Four serious incidents were reported, two related to falls, one related to delay to cancer follow-up, and one related to missed cancer diagnosis. An annual summary of complaints figures was provided, showing a twenty per month increase since last year. The Committee was assured that clinical responses were escalated, with a named person confirmed for each specialty.	None.
Never Events Report	Work was progressing, with good governance systems embedded; procedures had been refreshed to incorporate NICE guidance on hip replacements. Additional safety mechanisms would be reviewed, including safety sign off processes and threat and error procedures.	Further reports would be received as work progressed.
Ockenden Gap	Out of 92 actions, the Trust was compliant with 29, partially compliant	A quarterly report would be

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

Analysis	with 36, with 18 not met. The report had been shared with relevant staff as work was underway to become fully compliant; a number of engagement events were planned to discuss concerns and questions. No further Continuity of Carer teams would be launched until midwifery staffing reached full establishment. Current CoC teams would continue to provide care to the most vulnerable patients.	received at Quality Delivery Group, with exception reporting to Committee.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None.		

Items not Rated		
System feedback	CQC update	Terms of Reference and Committee Effectiveness Review

Impact on Board Assurance Framework (BAF)
The first iterations of the Committee's risks were reviewed; the Committee was supportive of the new format and processes, and noted that further refinement of the BAF would take place over the coming months.

KEY ISSUES AND ASSURANCE REPORT **People and Organisational Development Committee, 26 April 2022**		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Staff Survey Results Action Plan	The Committee was disappointed with the results, as they reflected an overall worse experience compared to previous years. All theme scores were below average for acute Trusts, with significant decreases in Staff Engagement and Morale. The Trust's performance against WRES and WDES experience indicators had also worsened, with all scores lower for BME and disabled colleagues. There was a small reduction in the percentage of BME staff reporting experiences of harassment, bullying or abuse from fellow colleagues. The Committee encouraged a review into external organisations to gather and utilise best practice but were assured by the new approach that is being taken to respond to the results at corporate and divisional levels.	Divisional results to be shared with colleagues. Divisional and Trust-wide organisational development and culture improvement plans to be developed. The National Quarterly Pulse Survey would be utilised to track and measure improvements and impact on a more regular basis.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Staff Health and Wellbeing and 2020 Hub Update	An annual summary of the health and wellbeing services, including the Hub and the psychology team was received; the Committee was advised that Covid-related issues were the key reason staff contacted the Hub, with more contacts being made about mental health and anxiety. The Committee was assured by the variety of wellbeing initiatives on offer for staff and the demonstrable impact of the services.	None.
Employee Relations Report	179 live cases remained as at February 2022, reduced from 266. The Committee was assured by the ongoing scrutiny and oversight of the management of cases by the People and OD team, and was also assured by the development of a work plan to take forward the Just, Learning and Restorative culture approach.	The Committee would receive further detail on the Just, Learning and Restorative approach at the next meeting. The Committee requested further information on trends to identify any potential areas of concern.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None.		

Items not Rated			
Risk Register	ICS Update		
Impact on Board Assurance Framework (BAF)			
The Committee approved the risk score and recommended to Board. Further updates would take place and would be reviewed at each meeting.			

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