Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
09.00, Thursday 8 December 2022
Room 3, Sandford Education Centre, Cheltenham General Hospital
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			09.00
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 10 November 2022**	Approval	Enc 1	
5	**Matters arising from Board meeting held on 10 November 2022**	Assurance		
6	**Chief Executive's Briefing** *Deborah Lee, Chief Executive Officer*	Information	Enc 2	09.05
7	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Assurance	Enc 3	09.15
8	**GMS Governance Proposal** *Deborah Lee, Chief Executive Officer*	Approval	Enc 4	09.20
9	**Any other business**		None	09.30
Close by 09.30				

Gloucestershire Hospitals NHS Foundation Trust

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 10 November 2022, 10.15, Shire Hall Gloucester			
Chair	Deborah Evans	DE	Chair
Present	Suzie Cro	SC	Deputy Director of Quality
	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director (joined the meeting virtually)
	Robert Graves	RG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	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
	Sally Moyle	SM	Associate Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Director of Safety
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director for People and Organisational Development
Attending	Jamie Ashton	JA	Armed Forces Advocate (item 6 only)
	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Alan Dyke	AD	Operational Lead for Armed Forces (item 6 only)
	Mark Gibbs	MG	Lead Armed Forces Advocate (item 6 only)
	Katie Parker-Roberts	KPR	Head of Quality and Freedom to Speak Up Guardian
Observers	Three governors, staff members and members of the public observed the meeting virtually. Two governors observed the meeting in person.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting. DE noted that a particular highlight from the last month had been shadowing MP on a Saturday morning shift at Cheltenham General Hospital, where DE had observed outstanding clinical leadership, interaction with patients, and witnessed pressure on services. The implementation of electronic prescribing was also underway, with floor walkers supporting early adopter wards. DE had accompanied some of the floor walkers and seen clear benefits to the system, including improved safety and timeliness of discharge, and interaction with primary care. DE was very proud of the work that was ongoing and noted the progress being made in many areas of the Trust.
2	**Apologies for absence** Matt Holdaway, Chief Nurse and Director of Quality (SC deputising), Mark Hutchinson, Executive Chief Digital and Information Officer, Qadar Zada, Chief Operating Officer.
3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 13 October 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 13 October 2022**

	All matters arising were noted.
6	**Staff Story** The Board received a presentation on the Trust's Armed Forces Covenant and the support provided for veteran patients. The Trust was acknowledged as a trailblazer in this area, with a number of key achievements including close partnership working with Councils and charities in the area, 325 veterans visited during their inpatient stays, reaccreditation to the Veterans Healthcare Alliance and a strong focus on patient experience. The Board was advised on the team's next steps, which focused on quality improvement to engage more patients, ensure support to wider armed forces community, and commencement of data collection. The Board was inspired by the presentation and reflected on the fantastic the work of the team and how much it meant to the people of Gloucestershire. The team advised that their work was being shared widely through staff communications, and they would seek to use filming opportunities to enhance this. There was also a plan to establish a council that would engage veterans and allies, including reservists and people with family involved in the armed forces. The team invited the Board to accompany them on some of their visits. DL noted that the team was funded non-recurrently for two years and asked them to ensure a robust evaluation process was in place to aid in securing recurrent funding in the future.
7	**Chief Executive's Briefing** DL briefed the Board as follows: • The Board was advised that nurses had voted for industrial action, with 90% in favour the South West compared to 50% nationally. CR informed the Board of the preparations, including the establishment of a HR readiness group which was in liaison with the Emergency Preparedness, Resilience and Response (EPRR) team, a specific work plan and risk log created, oversight of key workstreams, and regular meetings with Staff Side and the ICS to coordinate a local health system approach. The Board was also advised that temporary resourcing was being explored. RG asked if there would be a financial impact and whether elective recovery fund (ERF) monies would be affected. KJ advised that temporary staffing would be reported as a financial pressure although this would be offset by non-payment to nurses who chose to take industrial action; however, ERF monies would be unaffected. • Conversations with staff continued around the CQC report; the desire to improve behaviour and leadership was resonating with people around the organisation and there was a collective will to move forward with a positive culture. There was work to do to enable people to develop teams and leadership, and to support middle managers to lead with positive culture. • The CQC had recently reviewed Radiotherapy and issued an improvement notice for a single breach related to documentation. The Board was advised that this had been remedied. • The Trust continued to perform positively in relation to ambulance handovers; the Trust had maintained its position from Reset Week for the seventh week and was now the strongest performer in the region and tier one. DL advised that the pre-empting and boarding measures taken to achieve this position remained key to the improved performance but stressed that the Trust aimed to move away from these practices as soon as possible. The Board would be advised of the recommendations and findings from Newton which had the potential to release significant acute beds, which would eliminate the need for pre-empting. CF queried the CQC's response to the situation in the Trust at the moment, and DL confirmed that people were receiving safe care in hospital that, whilst not optimal, was saving lives and was better than patients waiting for ambulances and receiving no care at all. National and regional conversations continued with the CQC to understand meeting fundamental standards of care and what it entailed for corridor care in the current circumstances. The Trust had offered to be a pilot for the work and DL reminded the Board that MHo had invited the CQC to walk the urgent and emergency care pathway to see the practice and policies in action. A visit was planned for 1 December 2022, which would

	also offer an opportunity for the CQC to speak to staff in the Emergency Department and staff on wards affected by pre-empting. • The implementation of electronic prescribing continued, and DL had spent time with three early adopter wards and Pharmacy to observe the benefits of the new system. • Vivien Mortimore, Head of Midwifery, had retired after twenty-two years with the Trust, but would be returning to support midwifery staff through the bank system. • Kate Hellier had been appointed Deputy Medical Director. • One Gloucestershire had won a HSJ Patient Safety Award for Safeguarding.
8	**Board Assurance Framework** The Board received the Board Assurance Framework, noting that the risk rationalisation exercise had almost concluded and would be thoroughly reviewed by executives in December. A new risk related to external partnerships was in development.
9	**Trust Risk Register** The Board noted a nil report, as no changes were recommended from the Risk Management Group. MN encouraged reflection of industrial action within the risk register.
10	**Quality and Performance Committee Report** AM advised the Board of key issues discussed during October's meeting, including one serious incident which was reviewed in detail. The Committee continued to note the operationally challenging environment, and discussed the pre-empting and boarding of patients which aimed to distribute risk throughout the organisation and achieve best possible care for patients in the community and those waiting for ambulances. Consideration would be given to how boarding and pre-empting would be formally reported to the Committee. AM noted that she had met with one of the maternity improvement advisors who was working with the Trust; the meeting had been positive, with the advisor noting the good work the Trust was doing, and the positive engagement of staff with the improvement work. RP asked the extent to which GMS had been involved in the pre-empting and boarding work in terms of fire safety. MP advised that full risk assessments had been undertaken, with patients and environment continually monitored; this included full fire safety assessments. DL added that patients were only allowed into designated spaces which were included on the Electronic Patient Record (EPR) system within the ward footprint which allowed for greater monitoring of numbers of patients, length of stay, and completion of observations. BH asked for more information in relation to discharge delays. MP advised that a Discharge Quality Summit was being planned and would be facilitated by the Quality Academy. The Board was also advised of the Trust's cancer performance, noting that the Trust was meeting or was ahead of average of the national standards. The key challenges to the Trust were the number of referrals being received for the two week wait pathway, and the poor performance against the 62-day referral to treatment time which was driven by poor performance in urology, and colorectal pathways, both high volume specialities. Some improvement was being made against the 62-day standard, however DL advised that a deep dive had been arranged for December's Elective Recovery Group which would result in a recovery plan and trajectories.
11	**Maternity Reports** The Board received the Perinatal Quality Surveillance Report for quarter two, Midwifery Safer Staffing Report and findings and recommendations from the East Kent review. The Board noted the following for compliance: ***Safety action 1: National Perinatal Mortality Review Tool (PMRT)***

The Perinatal Quality Surveillance (PQS) report provided evidence that the PMRT has been used to review all eligible perinatal deaths and that the required standards have been met (100% for each area). These reports were shared with the Maternity and Neonatal Safety Champions and members of the Maternity Delivery Group.

The Board noted that, for compliance with this standard, the report included details of the deaths reviewed and the consequent action plans, and that standards were met 100% of the time.

Safety action 2: Maternity Services Data Set (MSDS)
The MSDS report was published on 27 October 2022; the Trust was not compliant with two indicators (ethnicity and BMI), but work was ongoing to improve compliance for the next publication. The Board noted current compliance and supported the action plan to improve data collection standards.

Safety action 3: Transitional Care Services in place
Reviews of babies admitted to the neonatal unit (ATAIN) continued on a quarterly basis; reports were shared quarterly with the Board Level Safety Champion at the Maternity Delivery Group and Champions meeting. The Trust's data demonstrated that the Trust was performing well and was below the target benchmark.

Safety action 4: Workforce planning in place to the required standards
Audits monitoring compliance of consultant attendance, for the listed clinical situations when a consultant was required to attend in person, had begun and results were being reviewed. Results showed 83% compliance which was below the 90% target. The non-compliance was due to the consultant attending another patient.
The Board noted Consultants' engagement with the RCOG Roles and Responsibilities document.
The Board noted that the Trust met the BAPM national standards for junior medical staffing.
The Board noted that the neonatal unit met the service specifications for neonatal nursing standards. A Speciality Specific Nursing CRG workforce staffing tool calculation was completed in March 2022. The neonatal unit was funded for 11 WTE neonatal nurses on every shift which was amended based on occupancy and dependency of the babies, as per BAPAM guidelines.

Safety action 5: Midwifery workforce planning in place
The Board noted that a BirthRate plus (BR+) full review of midwifery staffing had been completed and would be shared with the Board when the full report was available.
The Board noted that the Trust was 100% compliant with supernumerary labour ward co-ordinator status. The Board noted the provision of one-to-one care in active labour had not yet reached 100% because of data quality issues, however an improvement plan was in place.

Safety action 6: Saving babies lives care bundle (SBLCBv2)
The quarterly care bundle surveys were being completed; the service had fully implemented SBLv2, including the data submission requirements.

The Board noted that the current data does not meet target compliance in SBLCBv2 elements 1-4, and therefore was not meeting the minimum requirements. Action plans would be put in place and monitored through the Maternity Delivery Group; compliance was expected to be achieved in quarter four. Compliance in CO2 monitoring recording was highlighted as a key risk.

Safety action 7: Service user feedback
A patient experience improvement plan had been developed and would be reviewed by the Maternity Delivery Group.

Safety action 8: Local training plan in place to meet all 6 core modules of the core competency framework
The Board noted that a training compliance plan was in place, with the target of 90% achieved by 5 December. However, this may be affected by staff required to work clinically.

Safety action 9: Maternity Safety Champions

	The Trust was recruiting additional Maternity and Neonatal Safety Champions who would be clinical staff directly involved in care. Monthly meetings were taking place. There was an engagement event with neonatal colleagues in the neonatal unit in September. ***Safety action 10: HSIB and NHSR reporting*** The Board noted full compliance with reporting. MN noted that there were a number of action plans for maternity services which had been consolidated into a single plan and queried how the plan correlated to these reports. SC advised that more recommendations had been received since the consolidation exercise, and that whilst the Trust continued to deliver on the actions, imminent delivery tool guidance would be used to implement a framework that would streamline plans and support priorities so that the team was not overwhelmed. DL noted that improvements and benefits from closed actions would need to be sustained as key metrics, for example, statutory training and appraisal rates.
12	**Freedom to Speak Up Guardian Annual Report** The Board received the report, noting that 120 people had reported to the Freedom to Speak Up Guardian during 2021-22, which was an increase of 22% on the previous year. The majority of contacts were related to staff experience, including bullying and harassment behaviours. Key themes had included unprofessional and unkind behaviour, team culture, staff not feeling listened to or supported, and communication concerns. The Board was advised that recruitment for a full-time Freedom to Speak Up Guardian was in progress, as there was recognition that there needed to be a more proactive approach, with measures in place to build trust and a safe and confidential culture. KPR advised the Board that there was no guidance in relation to targets, however the team did benchmark with other Trusts, and was keen to increase the number of staff using the service. AM reflected that, with culture work ongoing within the organisation, the Freedom to Speak Up Guardian role may be different in the future. CR replied that part of the culture work would be to build relationships so that issues were addressed with line managers in the first instance, however there was more to do in this area. RP was pleased to note that the team sought to increase the diversity and breadth of staff groups, and asked about the reason for the number of detriment cases that had increased from 0 to 15. This was related to a few cases that had been reported by a team rather than an individual and was a reporting requirement. DL advised the Board that an initial increase in FTSUP contacts would be expected as colleagues began to have the confidence to raise their issues and had a renewed sense that the Trust was listening and would take action where appropriate. However, the aim was for concerns to be raised and resolved locally. The Board noted the report, and the progress and improvements being made.
13	**Fit for the Future Programme: Next Steps** The Board received the report, which detailed progress made, feedback received from October's Health and Overview Scrutiny Committee (HOSC), and subsequent discussions with NHS England. SL confirmed that HOSC support had been received for the proposals within scope of phase two, with no challenges anticipated with regards to the recommendation that no further public consultation would take place. The Board formally approved the following recommendations and thanked SL and the team for the work on the programme so far: • No further public involvement or public consultation activities were required • A Decision-Making Business Case would be developed based on the five services in scope of phase two moving to permanent implementation, with the business case presented to the Trust and ICB boards in March 2023 for approval.

14	**Finance and Digital Committee Report** RG briefed the Board on the key areas of focus from October's meeting. The Committee had discussed the significant financial challenge, with particular focus on the recovery plan. The Committee had noted the continuing challenges going into the next financial year, particularly as non-recurrent benefits utilised this year would not be available. There was some positive work taking place around financial sustainability, but challenges remained. The Committee had received an update on the capital programme, which advised that delivery would be weighted towards the end of the financial year; close monitoring of the situation would continue. The Committee had acknowledged the good work delivered by the procurement team, and was encouraged by the positive progress made by the digital team. The Committee had also approved the terms of reference for the Commercial Oversight Group which would formally reported to the Committee once established. ***Financial Performance Report*** The Board noted the following key points: • The Trust reported a year-to-date deficit of £10.9m, which was £9m adverse to plan. The position included one-off benefits of £5m. • The ICS year-to-date position was a deficit of £9.5m, which was £7.9m adverse to plan, which resulted from the Trust's deficit and a year-to-date surplus position from Gloucestershire Health and Care NHS Foundation Trust (GHC). The forecast breakeven outturn for the system remained. • The position at month six was similar to what had been reported throughout the year, with significant pay overspends, mental health pressures, and a financial sustainability gap; although this had slightly improved in month. KJ advised the Board that the Trust was planning longer lead times for financial sustainability programmes, and reviewing the approach to divisional recovery plans. A medium-term financial plan would be discussed at November's Finance and Digital Committee. • The Board was assured that the Trust was working proactively with system partners, with a discussion next month to discuss the likelihood of delivering a breakeven position; NHSEI was aware of this. • Some concern was highlighted around the slippage of the capital programme, which was £6.5m away from plan. The Trust continued to bid for additional monies; KJ advised the Board that the Trust needed to proactively review the programme of works to ensure that there was the capacity to effectively manage bids. • The financial recovery plan set out a number of mitigations to improve the position, including reviewing and challenging divisional recovery plans, reviewing temporary staffing controls, and continuing to identify additional schemes to meet financial sustainability targets. The progress of the recovery plan would continue to be monitored at the Finance and Digital Committee. AM queried progress around job planning and demand and capacity modelling; MP replied that a medical workforce group had been re-established to plan and embed effective processes, and to review agency spend. ***Digital Transformation Report*** The Board received the report and noted continued positive progress on digital workstreams and projects. Cyber security remained a serious threat to organisations globally, and the Trust continued to progress its cyber security action plan at pace. DL advised the Board that significant investment would be needed to effectively mitigate against the ever-escalating risks, which was not currently in the forward capital programme. There may be difficult prioritisation decisions to be made in relation to the limited capital available and the number of high priorities.
15	**People and Organisational Development Committee Report**

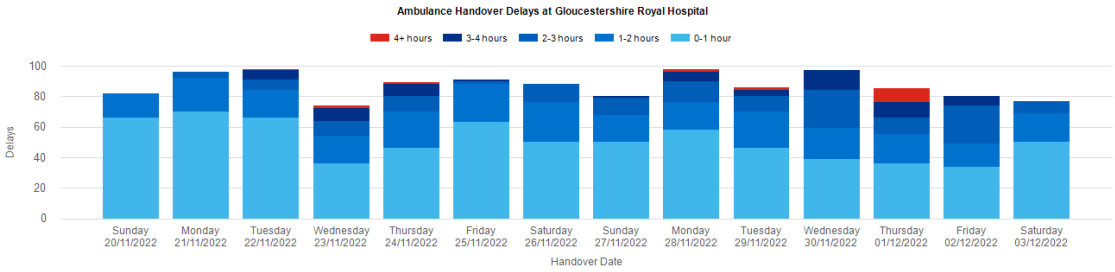
	The Committee had received the new performance dashboard and was pleased with the clarity and metrics. Forward planning for the Committee had been discussed, with strategy sessions to be scheduled and coordination of divisional representatives to be included. The Board was advised that core resource to address workforce and culture was under review, with additional support being explored.
16	**Any other business** None.
17	**Governor Observations** Peter Mitchener reflected that, as a new governor, he had found the meeting very helpful. It had been good to hear about ambulance handovers, which had been featured in the media, and noted the work around maternity. PM had been impressed by how the non-executive directors and executives worked together, with some good challenge and support demonstrated. The Freedom to Speak Up Guardian report had been a highlight of the meeting. Maggie Powell added that a balance between delivering on maternity action plans and ensuring staff were able to do their jobs was needed. There was also an opportunity to discuss mental health support with partners.
Close	

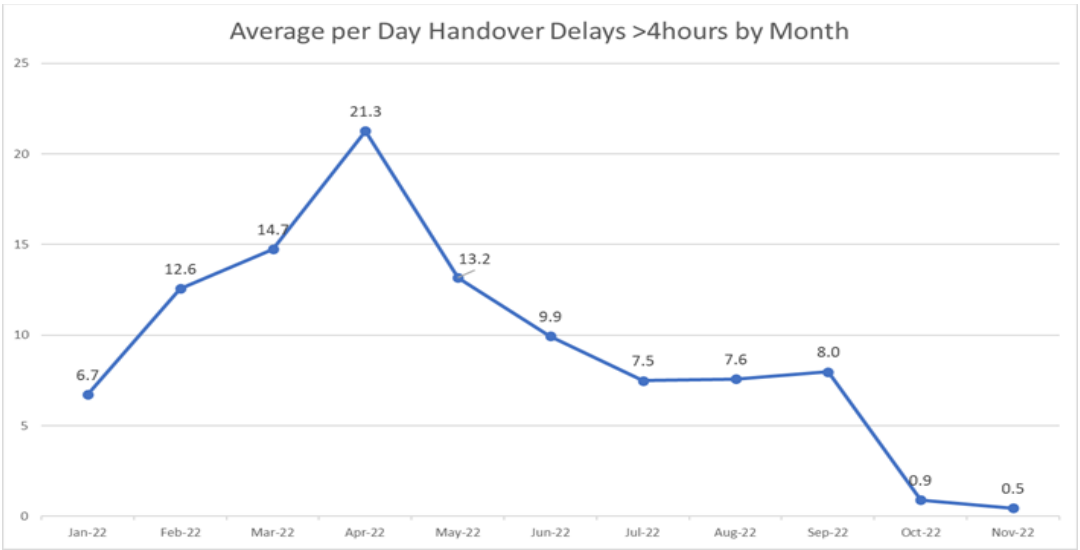
Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Fit for the Future Programme: Next Steps	The Board approved the following recommendations: • No further public involvement or public consultation activities were required • A Decision-Making Business Case would be developed based on the five services in scope of phase two moving to permanent implementation, with the business case presented to the Trust and ICB boards in March 2023 for approval.		
Estates and Facilities Committee Report	A report would be prepared to detail the progress of violence and aggression workstreams to Quality and Performance Committee and Board of Directors.	MHo Nov 22-Jan 23	In progress

CHIEF EXECUTIVE OFFICER'S REPORT

1 Operational Context

1.1 Whilst the Trust remains operationally very busy, recent improvements in urgent and emergency care (UEC) have been maintained. The changes made following the Trust's reset week in early October, continue to pay dividends. Increasing attendances and acuity of patients, has resulted in a larger number of patients waiting more than one hour to be handed over to the Emergency Department but this remains a fraction of previous levels. All of these patients, however, continue to be triaged and have a senior clinical review whilst waiting to be offloaded. The increase in waits over four hours, on the 1st December, reflects the day the ED department moved into the recently opened new buildings.

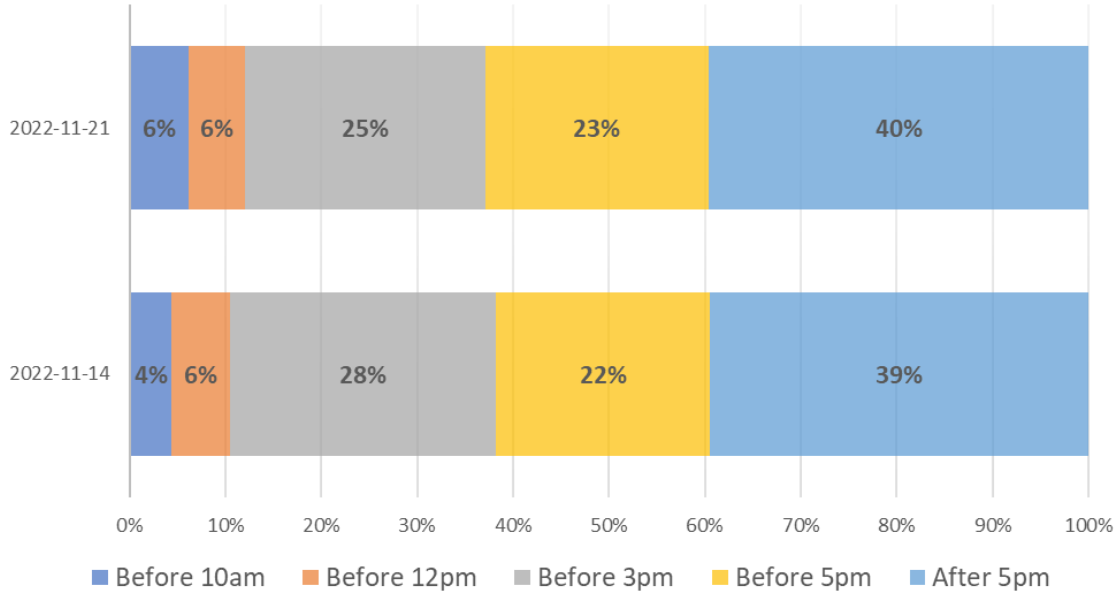




1.2 The reasons for these improvements are multifactorial but the key contributor has been the decision to share risk more evenly across the Urgent and Emergency Care pathway by pre-empting more patients to our wards. This in itself is not without consequence, particularly in respect of quality of care for patients who are pre-empted, which it is being very carefully monitored. Assurance in this regard was presented to the Quality and Performance Committee last month. Last week there was an average of 21 patients pre-empted across 21 wards at CGH and GRH, a reduction of eight from the prior week. A total of 146 patients were pre-empted last week, compared to 235 in the peak week of 10th October 2022.

1.3 The key area of operational focus remains discharge and notably the timeliness of simple discharges. It is hoped that the introduction of electronic prescribing (ePMA) will improve the timeliness of discharge medications which is one reason attributed to delays. Since the launch of ePMA compliance with the discharge checklist has improved from 50% to 97.6%. In efforts to further improve, this issue is now being addressed through a "discharge summit" supported by the Gloucestershire Safety and Quality Academy. Small improvements have been made in the proportion of patients discharged after 5pm from 48% in October to 40% in the latest week. However, the Trust is falling far short of the goal of achieving 25% of discharges by noon and 50% by 3pm with performance of just 10% and 38% respectively.

Discharges By Time of Day



1.4 External partners, Newton, continue their system work on UEC and the programme has moved forward into planning for implementation with Senior Responsible Officers now identified for each of the six programme themes. The Integrated Care System is now proceeding to tender for a partner to support the implementation and delivery phase of the Programme. The Gloucestershire system has recently received £6.7m of the £500m national Adult Social Care Discharge Fund deployed through the Better Care Fund. The fund, aimed at enabling older people and those with disability to remain well, safe and independent at home is particularly targeted for winter 2022/23 at reducing the numbers of patients whose discharge from acute and community hospitals is delayed.

1.5 Elective recovery remains very strong with the Trust holding its position regionally as the top performing Trust. Cancer performance continues to receive the Trust's full attention with strong performance in many areas, including being the only Trust in the Region to be achieving the 28 Day Faster Diagnosis Standard (FDS). This is a particularly important standard as it is the point when patients have a diagnosis of cancer confirmed or ruled out – for the majority of patients this will result in good news and therefore with respect to patient experience is an important measure. The Trust's greatest area of concern remains achievement of the 62-day cancer standard; recovery plans and revised trajectories will be presented to this month's Elective Recovery Board and onward to Quality and Performance Committee.

2 Key Highlights

2.1 Preparation for the industrial action planned by nursing colleagues, who are represented by the Royal College of Nursing (RCN), is well advanced. Clarity is still awaited in respect of the detail for those services which nurses are expected to support and planning on a number of scenarios is in hand. There is an opportunity for Trusts to apply for "derogation" for services that are subject to industrial action but where the provider believes this should not apply due to local circumstances; the oversight group is leading on this work and a number of derogation applications are anticipated. A number of other unions representing healthcare professionals are currently balloting their members with a view to taking industrial action; these include paramedics, occupational therapists, physiotherapists, midwives and junior doctors. The recent ballot of members of Unison did not meet the threshold for action and therefore industrial action will not be taking place in the Trust.

2.2 This month we achieved a huge milestone in our strategic capital programme with the occupation of extended parts of the emergency department. This is phase one of the programme, which enables further remodelling of the existing department leading to a significantly expanded ED in summer 2023. Early feedback from teams is positive with respect to the impact of the new environment for staff and patients, however, this intervening period presents some operational challenges particularly in respect of staff deployment which is being closely monitored. A full risk assessment of the impact of the new layout is underway to ensure any new risks are identified, controlled and action taken to mitigate them.

2.3 The Trust achieved another very significant milestone with respect to our Centres of Excellence programme with a proposal for general surgical services having been endorsed by the Trust's Leadership Team. A full decision-making business case will now be prepared for final approval which, if supported, this will see the transfer of c1500 upper gastrointestinal patients from Gloucestershire Royal Hospital (GRH) to Cheltenham General Hospital (CGH) and the centralisation of colorectal resectional surgery, resulting in the move of c140 patients from CGH to GRH.

2.4 Sticking with our Centres of Excellence programme, we are now in the final approval stages of the additional (5th) orthopaedic theatre at CGH following the award of c£10m under NHS England's Target Investment Fund (TIF) aimed at supporting elective recovery. This capital award is being closely linked to demonstrable evidence of services operating productively and as such, the Trust will need to demonstrate theatre utilisation of 85% from the current position of 75%; significant work is already underway and has been supported by external partner Four Eyes, through an NHSE funded initiative.

2.5 Following hot on the heels of the deployment of Electronic Prescribing (ePMA) which was successfully rolled out to Gloucestershire Royal last month, today we are upgrading the Trust's Patient Administration System (PAS) known as TrakCare. This upgrade of the 2018 version will enable a number of further digital advancements including the improvements to our laboratory environments which will improve the operational challenges the team still face following the deployment of TCLE (TrakCare Laboratory Environment), it will enable optimisation of the theatre module to enable improvements in theatre booking and scheduling and will enable the Trust to comply with a number of NHS England mandated reporting requirements including clinical priority of those patients on waiting lists.

2.6 As Chair of the South West Radiotherapy Network, I was delighted last week to have had sight of the national radiotherapy patient experience survey findings carried out over this summer.

All organisations in the South West faired very well and, as we have come to expect, the results for our own service were fantastic and are a testament to the professionalism, expertise and kindness of the team and the quality of the local leadership.

2.7 In more good news, along with nine NHS Trust partners, we have been shortlisted in the HSJ Partnership Awards for the Locums Nest project. For those who haven't heard about this, Locum's Nest is the NHS' first digital collaborative staff bank for doctors, which has been facilitated and supported by collaboration between neighbouring trusts, significantly increasing the staff bank pool and ensuring that more shifts are filled enabling us to reduce reliance on very expensive agency and utilise colleagues that largely already work, or have worked, in our Trust.

2.8 Finally, support for staff and our work on culture continues to dominate the Executive Team's focus. The Trust working group convened to look at how we can best support staff to manage the financial pressures faced by very many, continues to gather momentum. This month, our staff restaurants are offering a bowl of soup and a bread roll for £1, which has been very well received.

Deborah Lee
Chief Executive Officer

6 December 2022

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	7	Enclosure Number:	3
Date	8 December 2022		
Title	Board Assurance Framework		
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

A revised Board Assurance Framework was implemented in February 2022, with iterations of the strategic risks presented for review and discussion at Committee meetings and for overall assurance at each Board of Directors meeting.

Executives and their teams have worked in partnership with Corporate Governance to embed the revised BAF, which has included rationalising and combining risks to ensure a concise, streamlined assurance document that reflects current best practice.

A risk rationalisation exercise was almost complete to provide assurance to the Board that risks had been captured within the new BAF or in divisional or Trust risk registers. There was some additional review work to be undertaken on the IT and Digital risks, which would form part of the Executive team review planned for 12 December. A new Digital Finance risk had been developed and is included for review.

A new external partnerships risk was in progress.

The Board is presented with the full Board Assurance Framework for December 2022.

Recommendation

The Board is asked to note the BAF for assurance, and to continue to support its development.

Enclosures

- Board Assurance Framework December 2022

December 2022

Gloucestershire Hospitals NHS Foundation Trust

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	Nov 2022	CNO/DOQ	3x4=12	4x4=16	5x4=20
2. We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people							
SR2	Failure to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve.	April 2019	Oct 2022	DOP	3x4=12	3x2=6	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	Nov 2022	MD	2x3=6	3x3=9	4x4=16
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	Nov 2022	COO	2x3=6	4x3=12	5x3=15
5. Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services							
SR5	Poor engagement and involvement with/from patients, colleagues, stakeholders and the public.	July 2019	July 2022	DoST	1x3=3	3x2=6	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	Dec 2022	DOF	4x3=12	4x4=16	5x4=20
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	Sept 2022	DST	4x3=12	4x4=16	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	Sept 2022	DST	4x3=12	4x4=16	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	Oct 2022	CDIO	2x1=2	2x2=4	2x2=4

Board Assurance Framework Summary

SR13	That the Trust does not meet the digital objective of achieving HIMSS level 6 through lack of ongoing financial investment, both during the implementation and maintenance phases of the long-term digital programme.	Oct 2022	Oct 2022	CDIO	2x1=2		3x3=9
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	4x3=12	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	4x3=12	4x3=12

Archived Risks (score of 4 and below)

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

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

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**CQC regulations or other quality related regulatory standards are breached**	We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	A range of quality issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance	**Chief Nurse (CN)**	C2803POD D&S3743CHaem M2353Diab WC3257Gyn D&S2404CHaem C2669N D&S2517Path C1850NSafe C1437POD S2976Breast WC3685OBS C1798COO C2819N C3767COO S2424Th C3084 WC3536Obs M2268Emer C3034N C3295COOCOVID C2667NIC S2715 M3682Emer C1945NTVN

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Dec 2023	Dec 2024	Dec 2025			
4X5=20	Risk, control and assurance identification and monitoring processes have highlighted a number of risks to quality and therefore to the strategic objective.	**3x4=12**			A number of quality and workforce plans focused on improved culture would have positive impact on quality.	2019/2020 2020/2021 2021/2022 2022/23 Q2	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee oversees progress of improvement plans in areas of significant concern highlighted by external reviews, incidents, complaints etc. • Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board	• Quality Strategy in need of refresh due to key milestones needing to be reprioritised due to challenges caused by Covid, CQC regulatory inspections 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)

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

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

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Workforce - Monitoring of impact of workforce challenges on quality and performance	DoQ &CN	Q3 22/23	- Safer staffing review paper now due Q3 and for 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	Q3 22/23 Q4 22/23	- Delivery of defined planned operational improvements - Review of new planning guidance for 2023/24
Quality Strategy and QPR - Review and refresh strategy and delivery plan - Review of metrics within QPR - Define quality priorities for 2023/24 - Development of separate Whole Person Care Strategy	DoQ &CN	End of Q3 22/23 Q3 22/23 Q1 22/23	- This work has been delayed and will commence in Nov 2022 after Quality Governance Review led by Chief Nurse. - Work underway – delayed because of CQC regulatory activity. - Complete and Q1 and progress presented to Quality Governors Reviews.
External reviews of services - Develop action plans in response to recent inspections	DoQ &CN	Q3 22/23 Q3 22/23	- CQC unannounced core service inspection of surgery and Well Led report published October 2022 an action plan to be submitted to CQC by 1 Nov 2022. - NHSE/I review of Maternity Service Insights Visit took place in Sept (review report awaited)

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

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

Quality and Performance Report – Recent improvements in Urgent and Emergency Care for patients waiting to be offloaded from ambulances. – 70% ambulances being handed over within 60 minutes. – Elective recovery remains very strong with the Trust holding its position regionally as the top performing Trust. – Cancer performance continues to receive the Trust's full attention with strong performance in many areas, including being the only Trust in the Region to be achieving the 28 Day Faster Diagnosis Standard (FDS). This is a particularly important standard as it is the point when patients have a diagnosis of cancer confirmed or ruled out – for the majority of patients this will result in good news and therefore with respect to patient experience is an important measure. **Trust Risk Register** - No new risks added to this risk register. **CQC Update** - The Committee received a thorough written report outlining progress against CQC action plans. **Maternity** - Positive feedback after NHSE Regional Insights visit and an increase in the number of standards achieved for Ockendon 1 action plan. **Safety** There had been no further Never Events since the last report.	**NHSE/I Performance framework** - Tier 1 of NHSE/I framework due to ambulance handover delays. **Pre-empting and Boarding patients on our wards** - Concern in relation to temporary corridor care arrangements. **CQC** - Section 29a warning notices for maternity and surgery. - Decrease in ratings for Well Led from "good" to "requires improvement". - Decrease in rating for Surgery from "good" to "inadequate" overall. With inadequate for Well led and Safe Domains. **Maternity** - Stroud Maternity Unit had been temporarily closed due to ongoing staffing issues within the wider midwifery service and this had distressed staff and families in the area. **Staff Survey** - Below average NHS Staff Survey results (metrics for Quality Strategy Delivery) annual. **QPR metrics** - Many access, performance and quality metrics triggering "red" for their performance targets. - The Trust's greatest area of concern remains achievement of the 62-day cancer standard; recovery plans and revised trajectories will be presented to next month's Elective Recovery Board and onward to Quality and Performance Committee. **Safety - Serious Incidents Report** - Staff vacancies, sickness rates and activity levels continued to have a negative impact on completion of complaints, moderate harm Duty of Candour letters, and serious incident	• Inspection and review by an external body - NHSE/I Insights visit for maternity September 2022 (report due November 2022). - NHSE/I diagnostic visit for the Maternity Safety Improvement Programme (MSIP) (report due November 2022). - CQC inspection of BBRAUN (subcontracted service) report due November 2022) - CQC I(R)MER inspection end of October (pass/fail)

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Workforce October 2022

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

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

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

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

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
Transactional recruitment review commenced in June 2022 as part of a formal transformation change programme	DDfPOD	Ongoing	Reporting into the Workforce Sustainability Programme Board, the focussed review continues
Development of a marketing and strategy / plan	DDfPOD	Delayed until November 2022	This will form part of the Workforce Sustainability Programme structure and will include the procurement of an external marketing company to work in close partnership with the Trust to support the design and implementation of innovative and creative attraction solutions. New role of Marketing & Attraction Lead to be advertised, with the aim of establishing a focussed post to develop the Trust's marketing brand, creative advertising initiatives and proactive campaign plans.
Interventions and activities to deliver the workforce plan across the Trust	DDfPOD	Ongoing	Interventions and activities to deliver the workforce plan across the Trust continues. Increased overseas nurse recruitment has been agreed supported by NHSEI funding. The outcome of a further bid is awaited to secure further cohorts between Jan and March 2023. 50 + newly qualified nurses joined the Trust in September 2022. First ICS collaborative recruitment event held for Healthcare Assistants, seeing 240 offers made on the day, 80 of which are going through the recruitment process to work at GHFT.
Immediate focussed planning in response to the 2021 Staff Survey outcomes	Head of L&OD/DoP	Commence April 2022	Commencement of a staff engagement and culture programme has been seen in May, with clear workstreams focussing on organisational values, staff engagement, staff survey responses, and Restorative and Just Learning. **Oct 22** – staff survey 2022 has launched. Workshop planned for Nov 22 to share proposals for behaviours/values work stream as part of Staff Experience Improvement Programme. With view to rollout from Q4 onwards.
Workforce Sustainability Programme	DfPOD	Ongoing	The key workstreams continue under the Workforce Sustainability Programme. A key focus over the last 2 months has been the scoping of improved grip and control around medical and non-clinical agency spend. This is underpinned by an investment bid to build resilience through a fit for purpose service structure within the Trust Staff Bank team.
Staff retention focus	DfPOD	Dec 2022	Establishing a Trust Retention Group is a priority, creating a single oversight of the wide-ranging initiatives being undertaken and setting a clear focus on a range of specific initiatives.
Focussed planning of a Preceptorship Academy and commencement of a master accredited module	ADED	June 2023	Development of an accredited master module as part of the Preceptorship Programme for AHPs and RNs.

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

Financial Wellbeing Plan	Head of L&OD	Commence autumn 2022	Proposals under development for additional financial support which can be put in place to support colleagues through the cost of living crises. Also working with ICS partners on system-wide approach/resource sharing where possible.

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

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

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

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

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Mar 2023	Mar 2024	-		August 22	3x3=9
4x4=16	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 • Consistent Quality Management system to deliver assurance and improvement

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 Chief Nurse	MH	Q3/Q4 22/23	Scoping begun for new milestones
Development of the Just, Learning and Restorative (JL&R) approach	CB	March 23	Planning team established
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	MH\AS \SC	Oct 22	Two engagement workshops completed and regular feedback to QDG.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Progress reported on QS to QPC in October 2021 and forms part of QDG update • Quality priorities agreed • Quality Account published which describes the work of the Quality Strategy priorities	• Staff survey results	• Update to QPC on QS • Improvement Programme for JL&R approach • Improvement Programme for Staff survey

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

• Learning from deaths report		• Internal audit reviews: Workforce Planning; Discharge Processes; Cultural Maturity; Divisional Governance; Cross health economy reviews; Risk Maturity

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR4: Individual and organisational priorities not aligned November 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	• 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	C2803POD F3806 WC3257Gyn F2895 M2613Card C1798COO C3767COO C2628COO WC3536Obs WC3536Obs C3295COOCOVID S2715 M3682Emer

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023	Jan 2024			
5x3=15	Operational pressures on emergency and urgent care pathways. Numbers of medically optimised patients waiting for social care support	**3x3=9**	**3x3=9**	**2x3=6**		Q2 2021/22 Q4 2021/22	

CONTROLS/MITIGATIONS

- Quality and Performance Committee oversees progress of improvement plans in areas of significant concern.
- Delivery Group exception reporting (Maternity, Quality, Planned Care and Cancer)
- Urgent and Emergency Care Board
- Monitoring of key performance metrics via Quality and Performance Report (QPR)
- Quality Strategy in place
- Risk Management processes
- Executive Review processes
- Trust investment plans
- Key issues and assurance reporting (KIAR)
- ICB attendance at Q&P Committee
- Weekly and monthly business cycles in place to monitor/deliver progress against all key KPIs
- Agreed Operational Plan (2022/23) in place
- Triumvirates in place for the Operational/Clinical Divisions

GAPS IN CONTROL

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

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

• Close working relationships between Operational Divisions and Finance/HR proven in delivery of H2 and other priorities • Assurance meeting established twice per month to monitor and mitigate/escalate gaps in control identified (led by Finance/Operations/BI)	

ACTIONS PLANNED

Action	Lead	Due date	Update
Continuation of Operational Plan delivery monitoring (led by BI, Finance and dCOO)	NHL	March 2023	Meeting confirmed and in diaries twice per month. Reporting being finalised
'Flow' Focussed strategy group planned. Sits with Strategy PMO.	IQ	Oct 2022	2 week focused activity to improve flow across the hospitals

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Elective Recovery Board in place • Regular 'systemwide' planning meetings in place • KPI (Cancer performance, diagnostics etc) monitoring meetings are fully established • GIRFT Report – Urology services have made significant improvements **Quality and Performance Report** – A high performer on elective recovery - continued to make significant progress on the number of patients on the waiting list. – A winter ward plan was in development, with 24-34 additional beds for this winter. – Cancer performance. – Plans in place to improve the two-week-wait pathway, – Marginal gains against the 62-day standard.	• Operational Plan 2022/23 not fully compliant • CQC Maternity Service report (inadequate rating) • CQC S29A Warning notice for maternity and Surgery **QPR metrics** Many access, performance and quality metrics triggering "red" and not meeting their performance targets.	• Operational Plan 2022/23 to be monitored delivery on formal basis from June 2022. • CQC Well Led Inspection (report due October 2022) • 'Flow' focussed strategy and delivery group planned • Internal audit reviews 2022-25: ○ Outpatient Clinic Management ○ Discharge Processes ○ Cultural Maturity ○ Clinical Programme Group ○ Patient Safety: Learning from Complaints/Incidents ○ Patient Deterioration ○ Equalities, Diversity and Inclusion ○ Infection Prevention and Control

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

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

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

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

ACTIONS PLANNED

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

POSITIVE ASSURANCES

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

NEGATIVE ASSURANCES

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

PLANNED ASSURANCE

Internal audit reviews 2022-25:

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

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

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

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR7	Failure to deliver value for money in a sustainable way	We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources. We are a Trust with minimal backlog maintenance and fit for purpose equipment.	• The inability to deliver recurrent financial savings creating a financial gap. • Lack of financial accountability within the organisational culture. • Recruitment and retention challenges leading to high-cost temporary staffing. • Current economic crisis around cost of living, inflation and supply chain challenges. • External demands resulting is lack of flow of patients driving escalation costs and reducing productivity. • Conflict between clearing backlog demand v financial sustainability. • The level of resources to support the trust is not sufficient, including the need to maintain our buildings.	• The Trust and ICS continues to have an underlying financial baseline deficit which may grow in size. • Higher sustainability targets for the following year. • Creating an adverse impact on patient care outcomes. • Inability to deliver the current level of services. • Impact on future regulatory ratings and reputation; regulatory scrutiny/intervention leading to increased risk of reduced autonomy. • Prevention of investment to enhance services and inability to achieve the strategic objectives	Finance and Digital	DOF	F3806, F2895, F3070CO OF3633, F3393, F3680, F3681, F3339, F3336

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
5x4=20	• Although final plan for 22/23 showed a balanced position it included £19m of savings which are not materialising. Currently £4.8m gap. • 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. • Productivity information is showing a reduction in activity but not a corresponding reduction in costs to match.	Dec 2022	5x3=15	• Everyone in the Trust (from Board to ward) understands and owns their element of responsibility around good stewardship of public money. • 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. • Continued monthly monitoring to understand the drivers of the deficit. • Drive the financial sustainability programme to start to see the recurrent benefits of financial improvement. • Targeted weekly financial oversight meetings in place for the two divisions who are experiencing adverse movement from budget. These meetings are chaired by the Chief of Service and Director of Finance is there to seek assurance. Early indications show an improved position but one that isn't at breakeven yet.	Aug 21	
		April 2023	4x3=12		April 21	
		June 2023	4x3=12		Sept 20	
					July 19	

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

			• Development of system transformation programmes to support longer term financial health • Development and acceptance of a financial recovery plan – showing clear executive leads.	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• PMO proactively supporting operational and corporate colleagues to generation and deliver future sustainable schemes using tools such as model hospital etc • Programme Delivery Group for financial sustainability • Pay Assurance Group (PAG) • ICS one savings programme to share ideas, resources and drive consistency • Monthly monitoring of the financial position • Controls around temporary staffing • Driving productivity through transformation programmes i.e., theatres and OP • Weekly financial recovery meetings in place with those adversely deviating from plan	• Finance strategy in draft and needs completing • Clear line of accountability with no accountability framework • Robust benefits identification, delivery and tracking across major projects • Controls on the approval of WLIs/overtime payments needs strengthening • Inability to generate ideas • Capacity issues to generate and implement ideas at pace i.e., RMN decision making thresholds

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of the financial sustainability team reporting within the strategy and transformation portfolio	DOF/ DOS	Feb 22 - Closed	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 – Closed	Capacity now in place to develop the process, format and framework around how we capture the benefits. This will be tested during the financial year and where necessary adapted to ensure the process is robust and effective.
Set up weekly meetings for those division that are showing financial pressure	CoS	Jun 22 – Closed	This has been set up and progress is good.
Trust wide communication is being developed and sent out to inform the organisation of the financial position to get the message understood	Comms	Jul 22	Initial comms going out in term briefs in July, Financial sustainability on the agenda for 100 leaders in July. Development of Trust wide workshops to gain more traction on ideas for medium term plan during the financial year.
Financial recovery plan (FRP) developed, drivers of the pressures understood and communicated to system and regulator partners	DOF	Aug 22 - closed	The first draft of the FRP in circulation with exec colleagues, divisional reps, ICB partners. More focus needed on generating more actions with clear expectations around accountability of delivery. Regular reporting to Finance and Digital
HFMA self-assessment tool completed ready for internal audit review	DOF	Sept 22 - Closed	HFMA self-assessment tool completed, final review taking place with final sign off by 30th Sept in preparation for internal audit review early Oct. Report presented to Audit Committee in November. Action plan now being addressed.

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

WTE growth from 19/20 actuals to 22/23 establishment understood and challenged	DOF	Oct 22	WTE growth will be presented to F&D in Sept with next steps clearly articulated.

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 • Move of financial sustainability to Strategy and Transformation to give focus on quality of service which should drive financial improvement • ERF monies being generated by Trust. • Improved and co-ordinated system working. • External Audit VFM report, Jun 22. • Development of productivity analysis at divisional level • Weekly reviews for those deviating from plan	• 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 achievement for H2 is a cause for concern • 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.

UPDATE

December 2022: Planned action due dates updated with a number of actions closed. HFMA self-assessment report presented to Audit and Assurance Committee.

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

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

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

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

CONTROLS/MITIGATIONS

- Strategic Site Development Programme (SSD) Full Business Case secured £39.5M of national funding in 2021
- SSD scheme rated as BREAM 'good'
- £13M of Public Sector Decarbonisation Scheme (PSDS) funding secured in 2021/22
- Further PSDS application to be submitted in September 2022
- Gloucestershire Cancer Institute scheme at OBC stage, but reliant on charitable fundraising anticipated to take 5-6 years (construction start date est. 2027)
- Board approved Green Plan and supporting governance structure: Executive Lead, Green Champions, Green Council, Climate Emergency Leadership Group reporting into E&F Committee
- £50K Green fund secured on non-recurring basis to support local initiatives in 2022/23
- Continue to develop library of capital business cases to respond to future NHSE/I capital schemes
- Continue to explore off-site solutions with ICS partners e.g. Dermatology to GP surgery.

GAPS IN CONTROL

- Maturity of ICS Estates Group impacting on pace of shared use of ICS estate
- Lack of ICS Estates Strategy
- Lack of alternative routes to large-scale capital other than NHSE/I.

ACTIONS PLANNED

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

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

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

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

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

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

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

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

CONTROLS/MITIGATIONS

- Trust is sighted on the scale of backlog and Critical Infrastructure Risk as a 6-facet survey was completed in 2021
- Now ensuring all NHSE/I capital bids include costs of address backlog maintenance risks in immediate and/or linked development areas
- Improved risk reporting of estates risks through GMS, RMG, Committee & Board
- Transition to longer term planning approach to develop a 3-5 year estates capital programme to provide assurance of when highest risks will be addressed
- Exploring options to dispose of estate with capital receipt used to address backlog risks

GAPS IN CONTROL

- Lack of alternative routes to capital other than NHSE/I.
- Lack of a CDEL prioritisation process across the ICS that recognises the level of risk being carried by each organisation
- Lack of clarity on scale of national funding and application route for New Hospital Programme post 2025.

ACTIONS PLANNED

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

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

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

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

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

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR10	That we fail to embrace innovations, engage our workforce or protect our digital infrastructure enough to deliver our digital ambitions for safer, more reliable and improved patient care.	Our electronic patient record provides a single place for clinicians to access patient information; integrated with wider systems and our partners, to drive, safe and responsive joined up care.		• Cyber security weaknesses could disable access to systems or cause a data breach • Reduced ability to innovate, use clinical intelligence and data effectively and plan. • Unable to reach Govt requirements to become a HIMSS level 6 organisation; impacting reputation as well as safety. • Inability to work effectively across the care system, providing poor joined-up care. • Inefficient operational practice and planning/flow. • Inefficient systems/poor data can be a contributing factor in clinical errors and poor safety • Unable to meet expectations of patients, commissioners and regulators.	Finance and Digital	CDIO	

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
3x3 + 9		2022	Given cyber risk now facing organisation, this could increase to 3x4 + 12		

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Electronic Patient Record becomes single source of clinical information, implemented to HIMSS level 6- and five-year plan. • Improved attendance, discharge and outpatient information sent to GPs • Joining Up Your Information (JUYI) implemented in partnership with external partners and available to access through EPR • EPR delivery group provides assurance on delivery • Digital Care Delivery Group representation includes representatives from Gloucestershire Health Partners. • Roll out of access to Sunrise EPR to primary care and community colleagues • Delivery workstreams including clinical/business and IT leads with sufficient seniority and oversight/awareness of wider Gloucestershire strategy and requirements. • Cyber Security action plan in place, reviewed annually and gaps in security and investment identified	• 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 •

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

• Digital Strategy			
ACTIONS PLANNED			
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

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	SR12

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
4x3=12	Unlikely to meet new UHA criteria by 2024.	**Aug 2022**	**Jan 2023**	Impact is low as the Board is committed to improving research, education and university strategic relationships delivering benefits for colleagues, patients and partners	**2021**	
		4x2=8	**4x2=8**			

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
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	• UHA is currently closed to new applications • Establishing x20 honorary contracts is a challenge	Internal audit reviews 2022-25: • Cultural Maturity • Cross health economy reviews

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

• 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	• 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	• 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	SR11

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023		2021	
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 become the growth limiting areas	**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		

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	• 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.

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

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.	• 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.
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

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

• 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.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR13: IT and Digital financial investment — October 2022

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR13	That the Trust does not meet the digital objective of achieving HIMSS level 6 through lack of ongoing financial investment, both during the implementation and maintenance phases of the long-term digital programme.	The Trust's digital strategy targets a global and NHS standard of reaching HIMSS Level 6, because evidence shows that Level 6 hospitals deliver safer patient care. A key enabler is investment in infrastructure and systems to enable the implementation of an electronic patient record system across our hospitals.	The financial investment required to deliver the digital programme is assessed on an annual basis which means there is no guarantee that the appropriate funding is available following annual budget setting to meet the needs of the long-term digital plan.	• Failure to deliver the trust wide 5-year digital strategy • Poor digital maturity and an inability to realise the benefits associated with HIMSS level 6 from a quality, safety, efficiency and financial perspective. • Negative reputation in failing to deliver to published commitments, impacting on recruitment and retention. • Inability to advance ICS wide strategy and digitally joined-up patient care. • Unable to meet expectations of patients, commissioners and regulators.	Finance and Digital	CDIO	IT3450

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
3x3 + 9				

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Commitment to allocating funding required to deliver against agreed plans • Working regionally and nationally to seek additional funding streams where relevant • Clear communication of benefits of implementing EPR and digital systems • Regular reporting against targets on delivery of Digital Strategy and funding required • Clear prioritisation plans and processes in place to ensure the most essential digital projects are funded • Governance and involvement from digital experts supported by Clinicians; Clinical Digital Strategy Group, EPR Programme Boards, DCDG, F&D.	• Unable to confirm trust funding priorities/capital priorities in advance because of restricted or limited budgets. • Limitations in team ability to bid for external or national funding when available because of internal requirements • Limitations of budget available in support of the Intolerable risk process

ACTIONS PLANNED

Action	Lead	Due date	Update
Annual report of funding position and requirements to deliver digital priorities in budget setting	CDIO	Nov 22	

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR13: IT and Digital financial investment October 2022

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Regular reviews to Finance and Digital Committee	• Digital maturity assessment • Independent reviews	

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

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	8	Enclosure Number:	4
Date	8 December 2022		
Title	GMS and Trust Governance Arrangements		
Author /Sponsoring Director/Presenter	Kaye Law-Fox, Chair of GMS Deborah Lee, Chief Executive 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

The Trust and Gloucestershire Managed Services (GMS) Boards met on 10 November 2022 to consider recommendations for refreshing governance arrangements in line with good governance practice, in response to the PwC Report Gloucestershire Managed Services: Strategic Review (March 2022), post-pandemic, considering recent CQC commentary, and after four years of GMS operation.

Recommendations were supported and cover three main areas of governance with the aim of realising the vision for GMS:

- Strengthening working relationships between Trust and GMS
- Strengthening Trust and GMS contributions to the success of the subsidiary company model
- Trust nominations to GMS Board of Directors

The attached report describes the proposed arrangements in detail, for approval.

Recommendation

The Board is asked to approve the following recommendations:

- GMS Chair accountability to move to Trust (Group) Chair from current arrangements of reporting to Trust CEO.
- GMS Chair to become a member of the Trust Board as an Associate Non-Executive Director.
- Invite GMS Chair and Managing Director to join Trust Board Development Sessions.
- Review and clarify levels of accountability and delegation between Trust and GMS including a review of the Schedule of Matters Reserved and Delegated.
- Company Secretary to update Standing Orders, Standing Financial Instructions when Governance model changes are approved by Trust and GMS Boards.
- Invite GMS Managing Director to become a member of Trust Leadership Team (TLT) and GMS Director of Operations to the Directors Operational and Assurance Group (DOAG).

- Standing invitation to GMS Board Members to attend (as observers) Trust Board Committees where GMS related activity is integral to Group delivery success.
- GMS relationship with the Group Audit & Assurance Committee to remain as at present.
- Increase the scope of the Contract Management Group (CMG) remit to strengthen reporting on capital projects and performance, and to include reporting on Service Level Agreements for services delivered to GMS. Reporting through Finance & Resources Committee and GMS Board.
- Trust relinquishes the two Director nominations to the GMS Board (currently Associate Director of Operational Finance and Deputy Director of People and OD), and these be replaced by two independent non-executive directors, thereby retaining six Board Directors, (four independent NEDs, one of whom is Chair, and two of whom are Executives).
- Review and present options that will enable investment in the subsidiary company to support development in systems and practices and the realisation of efficiencies and delivery of benefits as defined in the original Subco business case.
- Review of assurance of the effectiveness of these governance changes by Group Audit & Assurance Committee c. April 2024 and review the continuation of the contract with GMS c. October 2025

Enclosures

- GMS and Trust Governance Arrangements Report

NHS
Gloucestershire
Managed Services

TRUST / GMS GOVERNANCE ARRANGEMENTS

GMS Board Meeting, 23 November 2022

Trust Board Meeting, 8 December 2022

1. INTRODUCTION

Trust and Gloucestershire Managed Services (GMS) Boards met on 10 November to consider recommendations for refreshing governance arrangements in line with good governance practice, in response to the PwC Report *Gloucestershire Managed Services: Strategic Review* (March 2022), post-pandemic, considering recent CQC commentary, and after four years of GMS operation.

Recommendations were supported and cover three main areas of governance with the aim of realising the vision for GMS.

1. Strengthening working relationships between Trust and GMS
2. Strengthening Trust and GMS contributions to the success of the subsidiary company model
3. Trust nominations to GMS Board of Directors

2. BACKGROUND

In November 2021 PwC were commissioned to undertake a post implementation review, as prescribed in the original business case for the development of a wholly owned estates and facilities subsidiary company, with a view to understanding whether GMS had delivered against the original business model; whether the governance model was suitable to satisfy the needs of the relationship between the Group, Trust and GMS, and whether the purpose of GMS needed to be re-established to ensure it continues to add value to the Group / Trust. It was intended that review would help to inform the future direction of Gloucestershire Managed Services (GMS) and the way it works with the Trust and Group.

The PwC Report was reported to Estates & Facilities Committee (E&FC) in March 2022 where it was agreed to:

1. establish an action plan to respond to the key findings of the review and report progress into E&FC
   - a joint *Trust and GMS Operational Improvement Action Plan* was developed in March 2022 to address the operational actions identified. Timelines and critical paths are being jointly managed and are reported to E&FC.
2. review the governance structure and processes through which GHFT and GMS interact as customer, supplier, and shareholder.
   - a joint Boards meeting was arranged to re-confirm the purpose of GMS and to

review the governance model and processes between the Trust and GMS after four years of operation.

In October 2022, Trust Board took a '*GMS Options*' paper and supported the conclusion of

> "It is apparent that the vision for GHSC [GMS] has not yet been realised and that the factors that have contributed to that are both internal and external. The PwC report provides insights into the reasons for this and identifies a number of opportunities to reset the nature of the relationship between the Trust and its subsidiary, as well as opportunities for GHSC [GMS] and the Trust to strengthen their own contributions to the success of the model…
>
> … short- and medium-term focus should be on strengthening the working relationships and governance, with the commitment to a formal review of this position in three years' time."

3. GMS BOARD GOVERNANCE ARRANGEMENTS

Considering the opportunities highlighted within the PwC Report and after four years of operation, GMS Board initiated a review of internal delegated governance arrangements, with the intention of reducing the burden of frequency of reporting and quantum of papers. These internal arrangements will remain consistent with revised governance arrangements and Reserved Matters and are yet to be finalised.

4. RELATIONSHIP BETWEEN THE TRUST AND ITS SUBSIDAIRY

It is acknowledged that there are opportunities for strengthening the partnership, governance and relationships between the Trust Board and GMS Board. When considering the nature of the relationship between Group, Trust and GMS, there is a natural tension between being part of the Group and GMS Board needing to demonstrate [to HMRC] independent control. It is appropriate, post-PwC review, to consider the relationship / control dynamic.

Currently, GMS Board and Trust Board have no points of direct contact. Every interaction between GMS Board and Trust Board is through the filter of Committees or Groups. GMS receives Trust strategic direction; it receives approval for its corporate / business plan and annual budget. Discussions and agreements are reached through individual relationships and conversations. The current governance model is not optimised for GMS to contribute to strategic thinking for areas of the business for which it has been brought about.

Working relationships between Trust and GMS NEDs are dependent on those forged by individuals, and therefore the benefits of a culture of mutual understanding and professional respect currently have no environment within which to flourish.

In-year update on Trust priorities and NHS context is shared with GMS Board by Trust nominated GMS NEDs or Executives attending individual meetings, and while it would be

important within any review not to lose this feedback, it is appropriate to recognise that it could be more appropriately formalised.

5. REVIEW OF THE TRUST CONTRACT WITH GMS

The '*GMS Options*' paper taken to Trust Board in October supported the conclusion of … "a formal review of this position [continuation / termination of the contract with GMS] in three years' time."

In the meantime, it is recognised that investment in the subsidiary company and/ or a review of reserved matters/autonomy linked to performance is a key enabler to support development in systems and practices that have moved on since GMS's inception in 2018, and in keeping with the realisation of efficiencies and delivery of benefits. This may take the form of de-risking in relation to obsolete systems and practices.

6. RECOMMENDATIONS ON GOVERNANCE ARRANGEMENTS

The following recommendations are in response to the limitations and opportunities described above, the 2025 review of the contract with GMS, and supporting detail in Appendix 1.

1. GMS Chair accountability to move to Trust (Group) Chair from current arrangements of reporting to Trust CEO.
2. GMS Chair to become a member of the Trust Board as an Associate Non-Executive Director.
3. Invite GMS ~~Chair and~~ Managing Director to join Trust Board Development Sessions.
4. Review and clarify levels of accountability and delegation between Trust and GMS including a review of the Schedule of Matters Reserved and Delegated.
5. Company Secretary to update Standing Orders, Standing Financial Instructions when Governance model changes are approved by Trust and GMS Boards.
6. Invite GMS Managing Director to become a member of Trust Leadership Team (TLT) and GMS Director of Operations to the Directors Operational and Assurance Group (DOAG).
7. Standing invitation to GMS Board Members to attend (as observers) Trust Board Committees where GMS related activity is integral to Group delivery success.
8. GMS relationship with the Group Audit & Assurance Committee to remain as at present.
9. Increase the scope of the Contract Management Group (CMG) remit to strengthen reporting on capital projects and performance, and to include reporting on Service Level Agreements for services delivered to GMS. Reporting through Finance & Resources Committee and GMS Board.
10. Trust relinquishes the two Director nominations to the GMS Board (currently Associate Director of Operational Finance and Deputy Director of People and OD),

and these be replaced by two independent non-executive directors, thereby retaining six Board Directors, (four independent NEDs, one of whom is Chair, and two of whom are Executives).

11. Review and present options that will enable investment in the subsidiary company to support development in systems and practices and the realisation of efficiencies and delivery of benefits as defined in the original Subco business case.
12. Review of assurance of the effectiveness of these governance changes by Group Audit & Assurance Committee c. April 2024 and review the continuation of the contract with GMS c. October 2025

NEXT STEPS

Action	Owner	Due Date	Progress
GMS Board to review and agree proposals	Interim Chair	25 Oct 22	Complete
Recommendations presented to Board to Board	Interim Chair / Trust CEO	10 Nov 22	Complete
Agreed proposals approved by GMS Board	Interim Chair	~~23 Nov 22~~ 20 Dec 22	Incomplete not quorate
Agreed proposals approved by Trust Board	Trust Chair	8th Dec 22	
SOs / SFIs / RMs *et al* to be reviewed / amended in line with Trust Board approvals	CoSec	31 Mar 23	
Review of assurance of the efficacy of governance changes	Audit & Assurance Committee	April 2024	
Review of contract with GMS	Trust Board	Oct 2025	

Appendix 1

GMS Board Membership

Background

Current GMS board membership structure is derived from *Visioning the future Business Case for set-up of an Estates and Facilities Subsidiary company* (March 2018 p.44), included the appointment of six GMS Company / Board Directors, including Trust directors of Finance and Corporate Governance, two independent non-executive directors (one of whom will Chair) and two GMS executive directors. Trust nominations are currently Director of Operational Finance and Deputy Director for People and OD. Declarations of interest are recorded at every formal meeting of GMS Board.

Interim arrangements have been in place since the retirement of the substantive Chair of GMS in July 2021. The substantive independent NED role is currently Interim Chair, and the temporarily vacant independent NED post is filled by a Trust Associate NED as the Interim GMS Independent NED. A recruitment exercise will be conducted in due course to the substantive independent NED chair and board member roles.

Therefore, in the unitary Board of six, two GMS company directors (board members) are appointed from each of the following

- Independent non-executive directors, one of whom is chair
- Trust nominated non-executive directors
- GMS Executive Directors

Timing

Trust and GMS are considering and refreshing governance arrangements to respond to CQC commentary, the PwC Report *Gloucestershire Managed Services: Strategic Review* (March 2022), post-pandemic and after four years of GMS operation.

- Is it appropriate to include consideration of the make-up of GMS Board directors now?

Governance and Control

GMS is a company registered at Companies House. For that reason, and to fulfil the requirements of HMRC, the GMS company must demonstrate independent control (Chapter 2 of the Companies Act (2006)), and it does this via the established GMS Board of Directors, compliance with the governance requirements of the Companies Act (2006) and the Schedule of Matters Reserved and Delegated.

As a subsidiary company and part of the Trust Group, Trust Board would rightly expect to be as assured as possible of appropriate discharge of delegated responsibilities and accountabilities, and part of that risk mitigation includes making two nominations to the GMS

Board of Directors. At the outset the choice of discipline of the appointment was to strengthen the professional resources available to GMS.

Regarding Trust nominations to the GMS Board, the PwC Report *Gloucestershire Managed Services: Strategic Review* (March 2022) recommended

> "including the Trust Director of Finance, Trust Chief Operating Officer, and Trust Associate Director Estates as representatives on the GMS Board gives the Trust assurance and visibility as a key stakeholder on the detailed performance of GMS. Over time this may step down to the [Trust] Deputy Director of Finance and Deputy Chief Operating Officer".

Acceptance of this recommendation would add further strain to the availability of Trust senior resources at a time of severe pressure. This recommendation would give a majority share of GMS Board directors to the Trust and could be open to challenge by HMRC in relation to appropriateness of exercise of control over the separate company.

It was also advised in the original SubCo business case (p.47) that "*Trust should be particularly mindful of the duty to avoid conflicts of interest... actual and potential*…". HMRC may consider the appointment of Trust Director of Finance and Chief Operating Officer to be a conflict of controlling interest too far.

Trust exercises parent company control through the provisions of the Schedule of Matters Reserved and Delegated.

- Is having Trust nominations to GMS Board the most appropriate governance mechanism for Trust to "*gain assurance and visibility … on the detailed performance of GMS*"?
    - Does the Trust wish to retain these two nominations?
- As a member of the Trust Group, with Trust nominations on the GMS Board, is now the time to consider the subsidiary company having a seat on the Trust Group Board?

Effective Scrutiny and Challenge

In a unitary Board, GMS Executive Directors are accountable to Board for GMS performance, they author, direct or control content of information and assurance papers presented to GMS Board. While they add detail and colour to topics under discussion, they are not able to scrutinise content or directly challenge the assurance they themselves are providing to Board. It is natural for NEDs to 'stay in their lane' of subject expertise; it is, after all, why they are there. Trust nominated NEDs may additionally be compromised by the amount of scrutiny and challenge they are able to provide on areas within their operational purview. Therefore, at times the most vocal contribution to robust scrutiny and challenge comes from the two independent NEDs. This could be interpreted as two of six board members appearing to have

the most influence on direction or the requirement for assurance evidence. Therefore, the benefit of the widest possible independent challenge, scrutiny and dialogue may not be realised with the current Board make up.

Conflict of Interest of Service Providers to GMS

The two Trust nominated GMS Board Members are also providers of key services to GMS (more so operational HR given the current challenges to provision of HR across the Trust and GMS) and have direct provider relationships with GMS Executives. This conflict of interest is accommodated at GMS Board through declarations of interest, but also risks limiting potential challenge of those important areas of services received from Trust by all GMS Board Directors.

- If Trust nominations to the GMS Board were relinquished, it would be important to have alternative mechanisms in place for in-year context to be brought into the GMS Board.
- When the interim independent NED, (Trust Associate NED) reverts to GMS independent NED, it would be important to have alternative mechanisms in place for feedback from Trust Board, Committees and Groups to be brought into the GMS Board.

Current Environment

It is the case that the NHS is experiencing unprecedented pressure and operational impact of loss of staff following the Covid-19 pandemic, mandated vaccine requirement and Brexit, preference for remote working, backlog waiting lists, vacancy numbers; management availability and regulatory challenges also contribute to that pressure. Therefore, time availability and priority to GMS business competes with substantive roles of Trust nominated NEDs. While this is understandable, it places additional pressure on the individuals to focus on GMS Board matters. This time pressure and conflict of interest is particularly compounded regarding the current paucity of HR resources. The GMS NED, Deputy Director of People and OD, has a significant draw on their time, acting in a senior HR resource capacity for GMS. This clearly impacts on their ability to engage in the robustness of scrutiny and challenge as a NED. This will be alleviated with the appointment of a senior HR resource for GMS – currently under discussion.

For the avoidance of doubt, any question of changing GMS Board director make up is not made in relation to the ability of those NEDs nominated by the Trust. Neither is it reflective of a lack of contribution or commitment to their GMS role. GMS Board values the professional contribution and Trust context provided by these appointees.