GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 14 March 2024 at 13:30

Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

AGENDA

REF	ITEM	PURPOSE	REPORT	TIME
1	**Chair's welcome and introduction**	Information		13:30
2	**Apologies for absence**	Information		
3	**Declarations of interest**	Approval		
4	**Minutes of previous meeting**	Approval	Yes	13:35
5	**Matters arising**	Assurance		
6	**Public questions**	Information		
7	**Patient story** *Katherine Holland, Head of Patient Experience, Lisa Stephens, Director of Midwifery and Susan Hughes, Consultant Midwife*	Information		13:40
8	**Chief Executive's Report** *Kevin McNamara, Chief Executive*	Information	Yes	13:55
9	**Board Assurance Framework** *Sim Foreman, Interim Trust Secretary*	Assurance	Yes	14:10
10	**Trust Risk Register** *Mark Pietroni, Medical Director & Director of Safety*	Assurance	Yes	14:15
AUDIT AND ASSURANCE				
11	**Audit and Assurance Committee Report -** *John Cappock, Non-Executive Director*	Assurance	Yes	14:25
PEOPLE AND ORGANISATIONAL DEVELOPMENT				
12	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director*	Assurance	Yes	14:35
13	**Staff Survey 2023 Results** *Debbie Tunnell, Deputy Director for People & OD*	Information		14:45
14	**Gender Pay Gap Report** *Debbie Tunnell, Deputy Director for People & OD*	Information	Yes	15:00
	Break			15:10
QUALITY AND PERFORMANCE				
15	**Quality and Performance Committee Report** *Alison Moon, Non-Executive Director*	Assurance	Yes	15:20
16	**Quality Performance Report** *Al Sheward, Chief Operating Officer, Mark Pietroni, Medical Director & Director of Safety and Craig Bradley, Deputy Chief Nurse*	Assurance	Yes	15:30
17	**Learning from Deaths** *Mark Pietroni, Medical Director & Director of Safety*	Assurance	Yes	15:50
FINANCE AND RESOURCES				
18	**Finance and Resources Committee Report**	Assurance	Yes	16:00

	Jaki Meekings-Davis, Non-Executive Director			
19	**Financial Performance Report (Month 10)** *Karen Johnson, Director of Finance*	Assurance	Yes	16:10
STANDING ITEMS				
20	**Any other business**	Information		16:20
21	**Governor observations**	Information		16:25
22	**Date and time of next meeting:** 9 May 2024 at 13:00 (Room 3 Sandford Education Centre, Cheltenham General Hospital)	Information		16:30
Close by 16:30				

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST DRAFT Minutes of the Public Board of Directors' Meeting 11 January 2024, 13:00, Sandford Education Centre, Cheltenham General Hospital			
Chair	Deborah Evans	DE	Chair
Present	Helen Ainsbury	HA	Interim Chief Digital Information Officer
	John Cappock*	JC	Non-Executive Director
	Balvinder Heran*	BH	Non-Executive Director
	Matt Holdaway	MH	Chief Nurse and Director of Quality
	Karen Johnson	KJ	Director of Finance
	Kaye Law-Fox	KLF	GMS Chair/Associate Non-Executive Director
	Kevin McNamara	KM	Chief Executive Officer (CEO)
	Jaki Meekings-Davis	JMD	Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Director of Safety/Deputy CEO
	Ian Quinnell	IQ	Interim Director of Strategy and Transformation
	Claire Radley	CR	Director for People and Organisational Development
	Al Sheward	AS	Chief Operating Officer (COO)
Attending	James Brown	JB	Director of Engagement, Involvement and Communications
	Rachel Carter	RC	Ward Manager 4B Vascular (Item 4)
	Adam Curtis	AC	Trauma and Orthopaedic Matron (Item 4)
	Sim Foreman	SF	Interim Trust Secretary (minutes)
	Raj Kakar-Clayton	RKC	Non-Executive Director INSIGHT programme observer
	Sarah Mather	SM	Acting Divisional Director of Quality and Nursing for Surgery (Item 4)
	Lisa Stephens	LD	Director of Midwifery (Item 15)
Observers	Four governors observed the meeting in person. One member of the		
Apologies	Vareta Bryan	VB	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director

REF	ITEM
1	**CHAIR'S WELCOME AND INTRODUCTION**
	The Chair opened the meeting and welcomed everyone
2	**APOLOGIES FOR ABSENCE**
	Apologies from VB, MAG, AM and SM were NOTED.
3	**DECLARATIONS OF INTEREST**
	There were no declarations of interest.
4	**STAFF STORY**
	CR welcomed and introduced SM, RC and AC to share their staff perspectives on ward moves within the surgical division. It was reported that ward moves had been removed from the Staff Side risk register as the Staff Side Chair was content with the implementation and approach adopted by the Trust. This was echoed through SM, RC and AC speaking positively about the moves and staff now felt they had found their home, this followed increased staff engagement which allowed people to have their say and be fully updated. The Board noted the difference a coat of paint made to morale. Areas of learning were identified in relation to a cross divisional sourcing of equipment to utilise existing kit to ensure capacity and safe service provided when

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	costs exceeded allocated budget and the need to create the budget line and allocation earlier in the process to facilitate earlier recruitment (as this had only been possible from May 2023 this time with mitigation through staff rotation). It was confirmed that charitable funds had been used to fund some items and the team were continuing to build a list of items for a further charitable funds bid. KM welcomed the "reinstatement of pride" described by the team and commented that this needed to be part of organisational conversations given there was variability in standards of across some areas he had visited. In response to a question, IQ confirmed that it was possible to document the multidisciplinary team approach process as a template and model for future moves and service changes to move towards these becoming part of business-as-usual activities. SM commended IQ's team for project support and help to ensure the moves and the project kept to time. KJ advised the unintended consequences from the financial and budget learning had proven beneficial and the documentation would be updated to prevent any future delays. **RESOLVED:** The Board thanked SM, AC and RA for their presentation and **NOTED** the staff story on surgical division ward notes.
5	**MINUTES OF PREVIOUS MEETING**
	RESOLVED: The minutes of the meeting held on 9 November 2023 were **APPROVED**.
6	**MATTERS ARISING**
	RESOLVED: The Board **NOTED** the update on OPEN matters arising and **APPROVED** the CLOSED items.
7	**PUBLIC QUESTIONS**
	A public question from Keith Smith had been submitted and responded to in advance of the meeting. Mr Smith had submitted a follow up question in writing and this was read out by the Trust Secretary with MP providing a response. Both questions and responses were shown below: • **Question:** *What - if any - changes to treatment, allocatable to patients, were implemented on Woodmancote Care of the Elderly (COTE) Ward, at Cheltenham General, over the winter straddling 2016 and 2017?* **Response**: There were no changes to the availability of any treatments provided to patients during the time period in question. Treatment pathways are clinically appropriate for individual patients, and personal to their circumstances. • **Follow-up question:** *Can the Board then give the public its definitive assurance that, on Woodmancote Care Of The Elderly (COTE) Ward, over the winter straddling 2016-17: there was no focus on changing levels of treatment; and no consideration whatsoever of anything other than the best interests of its patients?* **Response:** During the period in question, treating patients in their best interests was, as always, the primary goal of the staff. **RESOLVED:** The Board **NOTED** the public questions and responses provided by the Trust.
8	**CHIEF EXECUTIVE OFFICER'S REPORT**
	The written report from Deborah Lee (DL) was taken as read and KM briefed the Board on matters and issues since joining the Trust at the start of January: • The new year period had been operationally challenging, but things were improving. Although the challenges were similar to previous years and as faced by many other trusts, the impact of industrial action had exacerbated the situation this year across the NHS. • Initial reflections highlighted concerns that around a quarter of the beds were filled by patients who could be supported elsewhere and that this impacted on quality and staff wellbeing.

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	• DL had held a direct conversation with Secretary of State (for Health and Social Care) to discuss ambulance handovers demonstrating the level of focus on this issue for the Trust. In support of the Trust's response a cohort area had been established although some concerns had been raised by Emergency Department consultants which would receive a formal response. The Trust had applied mitigations to some of the concerns, but not all, with further changes taking place later in the week. It was noted that ambulance handovers were equally challenging for other organisations and the focus was on supporting the divisional response. • Industrial action during December and January had affected 1600 patients through cancelled appointments, further impacting on 52-week waiters and lists, in addition to financial costs. • The latest cohort of internationally educated nurses and the team supporting them had shown tremendous levels of energy and drive in a meeting with KM and he commended them and that the Trust should be really proud of these colleagues and the initiative itself. • The NHS Oversight Framework Quarter 2 – 2023/24 Segmentation Review outcome confirmed the Trust remained in Segment 3 as per the letter appended to the report. **RESOLVED:** The Board **NOTED** the CEO's report.
9	**BOARD ASSURANCE FRAMEWORK (BAF)**
	The Board NOTED the Board Assurance Framework as presented by the Trust Secretary and discussion took place on whether estates instability should be a standalone strategic risk. MN reminded the Board of discussions following him raising this at the last meeting, as the lack of capital was a constraint to putting things right. The Board heard work was underway to review and develop the risk to cover this ahead of the February committee meetings. **ACTION: IQ/KJ/SF** MN flagged that the Board Assurance Framework included a lot of RED risks which had been rated as such for some time, which he was personally uncomfortable about. The Board AGREED on the need to spend quality time understanding and reviewing strategic risks and how it would use the Board Assurance Framework, particularly in relation to "so what" questions. The Chair and Trust Secretary would develop a timetable for this work. **ACTION: DE/SF.** **RESOLVED:** The Board **NOTED** the Board Assurance Framework and agreed actions to develop how this would be used.
10	**TRUST RISK REGISTER (TRR)**
	The report was taken as read and MP highlighted the following: • Datix - Go live planned for the next week with a divisional rollout in the weeks after that, but flagged that it had not been possible to resolve all of the issues. • Water and Fire Safety risk summary position provided in the report confirmed that there were people in place for all of the Healthcare Technical Memorandums although they were not yet delivering all of the work, but this may be due to a delay in the reporting cycle. • The risks rated 20 on the Trust Risk Register were noted. Board members queried why the Datix Cloud implementation was struggling to gain traction or support from NHS England and HA explained this was due to supplier capacity issues as a result of Datix putting resources into the new NHS England system, and other trusts faced the same challenges as Gloucestershire. The situation was expected to improve once the national system work was finished. Board members also welcomed the items for escalation (in particular the focus on appraisals and benefits to morale) and challenged the number of risks related capital and financial programmes and how movement and progress against these could be shown on future reports

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	and what might improve. MP confirmed that the Trust Risk Register scores were used for prioritisation of resources. The Board discussed each of the risks scored as 20" in turn. In relation to workforce, MH confirmed a review later in the month would show an increase in interaction and improvements in retention and a move closer to full establishment (excepting standard levels of turnover). MH expected the risk score to reduce as a result of this and this would hopefully be shown on the next report. **RESOLVED:** The Board **NOTED** and **RECEIVED** the Trust Risk Register.
11	**QUALITY AND PERFORMANCE COMMITTEE (QPC) REPORT**
	JC presented the Key Issues and Assurance Report and highlighted there were no RED rated items, although the water safety update could have been escalated to this level. There were four AMBER items and an additional meeting had taken place the previous Friday which had included a review of the water safety item and actions had been agreed in relation to this, which would also be presented to other committees for additional scrutiny. The additional meeting had also considered the Maternity Incentive Scheme and were assured that a rigorous process had been applied and the Committee recommended tis for approval at this meeting under the relevant agenda item. The Committee was satisfied that its comments and feedback on a bed deficit plan had been addressed and were now reflected in the winter plan. The Committee had challenged the executive team to identify those areas of focus which provided the greatest opportunity for the Committee to add value and make a difference and the outcome of this would help shape the forward work plan. **RESOLVED:** The Board **RECEIVED** the Quality and Performance Committee report for assurance.
12	**QUALITY AND PERFORMANCE REPORT**
	AS introduced the report on behalf of the executive triumvirate and advised the report from October 2023 now felt dated and the update would concentrate on areas of focus. AS also reported work was underway to enhance the presentation of the pack and feedback from board members on areas of focus was welcomed. **ACTION (All).** The following was highlighted: • **Pre-hospital:** The 30-minute ambulance response time for Category 2 patients was not being achieved, partly due to time spent on ambulance handovers. Although there had been no ambulance handover delays on that day, the average response time was still 35 minutes (against national target of 17 minutes). • **Emergency Department pressures:** Linked to the Chief Executive Officer's update, the Trust had received 135 ambulances on Christmas Day (a level not experienced before) and 160 patients in a department that was built to accommodate 50 to 60 and it was no surprise that consultants were raising concerns. Average daily attendances remained around 400 patients with the same day assessment unit carrying out lots of activity. High bed occupancy rates (92%) in the Trust further constrained things. MP explained that the pressures had been tremendous and difficult and gave huge credit to staff for their professionalism and resilience. It was confirmed that 40 of 110 patients were waiting less than 10 minutes for triage and two hours or less for treatment, showing that the Emergency Department team were mostly doing Emergency Department work. • **Elective care:** Good performance with faster diagnostics achieved in October and largely maintained thereafter. The Trust had set an internal target and goal to eliminate 40-week waiters by June 2024, with energy being put into improving things for this small cohort number of patients. An increase in the level of General Practitioner referrals was being investigated. Although there were no patients waiting over 78 weeks in October 2023, this

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	had since increased to 13. All patients in this group were being reviewed with the aim of dealing with them by end of the month, then moving to eliminate 65-week waiters by the end of March 2024. • **Cancer:** Flagged as a concern with aim of eliminating 104-day breaches by June, tackling the longest waits first then onto 62 days. The 28-day position was good with investigations continuing to ensure that the Trust accurately recorded when the "clock is stopped". • **Boarding:** MH confirmed that boarding of patients continued, with an increase and peak over the Christmas/New Year period resulting in high levels of necessary boarding, although levels had gradually decreased since 3 January 2024. • **Infection Control:** Increase in lost bed days due to infection control outbreaks. • **Safety Huddles:** As reported at the last board meeting, Monday to Friday daily reviews of all moderate harm or staff graded incidents were in place. As Chief Nurse, MH felt assured on the oversight of these incidents and identification of hot spots so action could be taken. As part of follow up to these meetings, welfare checks with staff were carried out which linked to early implementation of the Patient Safety Incident Reporting Framework. MP added the meetings were worthwhile and well attended. • **Industrial action:** Second six-day strike had just ended and the Trust had taken a couple of days to transition to senior staff service, which meant faster decisions, but other work and activity not being carried out i.e. clinical administration, ward moves etc. MP was pleased to report a return to business as usual and with the Trust response to the strike with rotas covered and colleagues covering additional work. Board members' questions were in relation to: • Whether the number of patients arriving by ambulance was specific to the Trust? It was not specific to the Trust and AS explained that government investment in ambulances meant more crews on the road had increased the capacity to bring more patients. There were also issues with agency and junior crew staff who had perverse incentive to take more time for additional pay or hours. The Board was advised the Regional NHS team was involved and were looking at alternative solutions for a number of trusts, including use of the 111 service being able to contact trusts directly. This fell within the scope of the Newton work underway in the Trust. • How the local authority was flexing up to support discharges? It was explained there had been some changes to pathway 2 across the county, but there were more patients identified for the pathway than those waiting to leave. • How could the Board help change behaviours and what were the Integrated Care Board's key performance indicators for 111 service and ambulance pickups? AS explained that discussions were led via Dorset as the lead commissioner for the ambulance service and advised that a conveyance rate of 40-45% was used without reference to a stated denominator and he was keen to move to total conveyances. It was hoped a new Chief Executive Officer at South West Ambulance Service NHS Foundation Trust would help drive some changes, but it was recognised that it was always easier for crews to bring patients into hospital and go home and that accurate data proving a "single version of the truth" would help. **RESOLVED:** The Board **NOTED** the Quality and Performance Report and update from the executive triumvirate.
13	**WINTER PLAN**
	AS delivered a presentation summarising the wider winter plan and reminded the Board that there had been lots of discussion on the current challenges at the Quality and Performance Committee as well as referenced in the Chief Executive Officer's report. Key highlights from the presentation were:

	• Emergency Department attendances and performance was static. • Workshops on 9 February 2024 led by Ian Sturgess would focus on four clinical themes. • AS would bring back more detailed plan to show the impact of the additional national funding for the second half of year (H2) alongside an assessment on whether this achieved the objectives i.e. 62 day cancer performance • Bed modelling scenario work included a rewrite of the Trust's escalation policy in relation to about corridor care and boarding, as well as investigating why there are more patients on Pathway 2 than other areas. It was confirmed this was double what would be expected and a multi-factor approach to enabling discharges was being applied which included slowing down admissions, speeding up discharges and reducing bed days of a stay etc. • The system response included virtual wards and there were more opportunities to utilise these to help. AS advised that in future the winter plan would be reviewed by committees in July with Board approval being sought in September. This was in order to support any recruitment needed to deliver the plan. Board members would be interested to see the outcome on the initiatives related to Pathway Zero especially on those elements on the flow where the Trust had a greater degree of control and accepted that it was possible for more to be done. **RESOLVED:** The Board **NOTED** the Winter Plan presentation and the relevant ongoing actions as assurance related to the ongoing management of Winter pressures.
14	**PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE (PODC) REPORT**
	BH presented the report from the meeting held on 30 November 2024. The Committee maintained the RED rating on recruitment and retention despite the ongoing work to reduce the time to recruit, improved candidate/manager experience and Employer Value Proposition. The Committee requested smarter targets be included in the Board Assurance Framework strategic risks. Work underway to look at staff exit data and a retire and return "myth buster" but no change to the RED rating expected. A development session was planned to look at this alongside the staff survey. The staff survey was rated AMBER and BH commended the work of CR and her team on the improvement in the number of responses. Learning from Gloucestershire Managed Services positive staff survey results would be looked at to identify learning for the Trust. The Committee had also rated the culture and appraisal items as AMBER. The People and Organisational Development dashboard was provided for information following an action at the November 2023 meeting. The document was felt to be exemplary for the clarity and presentation of the information. **RESOLVED:** The Board **RECEIVED** the update from the People and OD Committee.
15	**MATERNITY UPDATE**
	MH and LS presented the update which would cover three areas and reminded that LS, as Director of Midwifery, was provided with direct access to the Board as a result of the Ockenden Review and as part of the Maternity Incentive Scheme.
15.1	**STAFFING** Typically reported bi-annually to demonstrate an effective system for the maternity workforce, the Board RECEIVED a quarterly update to address outstanding audit items and received assurance this had been reviewed in detail by the Quality and Performance Committee in November 2023. It was highlighted that one-to-one midwife care was currently at 98/100 with an action plan in place monitored via the Quality Delivery Group.
15.2	**PERINATAL QUALITY AND SAFETY (Q2 JUNE – SEPTEMBER 2023)** The report contained the dashboard for Quality and Safety with the following highlighted to the Board:

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	• Three Serious Incidents • Four Maternity and Newborn Safety Investigations (two babies needing therapeutic cooling and two neonatal deaths) • Increase in moderate harm incidents attributed to improving governance and staff properly grading incidents. • To note, four neonatal deaths referenced may have been reported prior to the report and some double counting being presented. • Safety - 16 overdue incidents with the team making efforts to reduce and close these. • Training compliance in Q2 was as expected • Safeguarding Level 3 training had been the focus of attention in the latter part of the year. • Peri Prem – Four incidents related to transfers. • Avoiding Term Admissions Into Neonatal Units (ATAIN) data reviewed and reported monthly. Respiratory distress most common issue. • Three overdue action plans from National Institute of Clinical Excellence: 35% of policies being out of date, appraisal rates at 70% and AMBER rating for vacancy rates despite some improvements. • 12 complaints noted with attitude of staff identified as a theme. • Perinatal Mortality Review Tool showed four cases with no issues, one case with a care issue that made no difference to the outcome and one case where care that may have made a difference to the outcome. It has explained there was a lag in reporting but all cases had been noted by NHS Resolution. • Training plan completed for 2023 and had been through divisional processes. The Chair recognised that a lot of information had been presented but that this showed some positive progress, especially in relation to the reduction of overdue investigations from 216 to 17. The Board were also made aware that the percentages could be misleading as 6.1% on the non-respiratory one indicator was one baby. The Chair invited questions and discussion on the papers and information presented. MN thanked LS for the presentation and for contextualising the 633 pages in the pack and asked how the Board could take assurance that the service is safe? MN continued to note that the number of actions plans in place could make the service feel overwhelmed and asked how many of the plans were as a result of the national focus on the Trust or local goals. LS confirmed that action plans were in place to drive change and the Trust was developing a transformation plan with the Local Maternity and Neonatal System. It was recognised that was duplication across action plans, but that once the Maternity Incentive Scheme work was completed then focus would shift over the next four weeks so that the next update to the Board will be focused on transformation. MH supported this and explained that whilst this was mandatory information at present, the Chief Midwife for England recognised that action plans were not helpful and that the Trust could and would change its reporting. In response to the question on assurance MH explained there were a range of ways in which this could be done, from the assurance from the data presented but also taking his own assurance as Chief Nurse. In relation to workforce and team pressures AS asked if the Trust was being more ambitious, particularly in relation to 36.9% recommending the Trust and whether measures such as Friends and Family Test, Pulse survey and Freedom To Speak Up incidents were being used to assess progress and change. LS confirmed that staff had engaged in the NHS Staff Survey, national maternity transformation work and also completed a specific perinatal staff survey and the results and strategy from this work would be presented to the Board.

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15.3	**MATERNITY INCENTIVE SCHEME YEAR 5** The Board was reminded that this was a continuous improvement scheme through NHS Resolution. Following a Care Quality Commission inspection 18 months prior and a resulting Section 29A notice, the Trust's previous submissions were reviewed, leading to a requirement to resubmit years 2, 3 and 4 with the Trust being moved to non-compliance for some indicators. The scrutiny on the Trust for this work had resulted in a risk-averse position regarding implementation and application guidance and requirement to look back at everything. NHS Resolution recognised the scale of what boards were being required to review and changes were expected for Year 6. LS reported that despite the benchmarking in year, the team had continued to deliver other work and engage in the Maternity Incentive Scheme, which focused on patients, safety and quality. The headline updates for each safety action were reported in turn, with compliance achieved on ten actions but with still further work to be done. LS presented each of the safety actions in turn and provided assurance to explain how the Trust was complaint. The approval and review process to date was also highlighted, to show that the report had been to the Quality and Performance Committee on 4 January 2024 ahead being signed off by the Local Maternity and Neonatal System on 9 January 2024. The final deadline for submission to NHS Resolution was 1 February 2024 along with a board declaration signed by the Chief Executive Officer. The Chair thanked LS for the report and update and summarised key points and matters brought to the Board's attention: • The Trust was not meeting all of the British Association of Perinatal Medicine (BAPM) national standards but that an action plan was in place • Birth Rate Plus staffing rate reflects the Trust's establishment. • Saving Babies Lives work and progress. • Perinatal Safety and Quality Report for Q2 • Healthcare Safety Investigation Branch referrals had all been reviewed by the Chair. It was clarified that in relation to 98% of women receiving one-to-one care it was not the case that those two women had no midwife care, but that at times a midwife would be shared between two women in labour, for some of the labour. Recruitment and vacancy rate management were key to this and the Board was assured that AM, as Chair of Quality and Performance Committee had reviewed all the data and actions. KM sought assurance on the level of confidence that there was no recurrent financial investment not covered by the current process, especially given the amount of information presented. LS confirmed that it was covered by previous funding and that any additional activity would seek funding through the cost pressures route, but made clear that any rejection of cost pressure request would not undo anything presented at the meeting. It was confirmed KJ had also raised this at the Finance and Resources Committee. In response to a question on the level of confidence in the self-assessment process (given the extra scrutiny from Years 2 to 4 and detailed review that had taken place). It was explained any areas of uncertainty identified during the self-assessment had been raised with the regulators. Positive assurance had been provided back to the Trust from both NHS Resolution and the Local Maternity and Neonatal System and MH confirmed his own assurance on compliance. It was confirmed that if successful, the assessment could have positive financial implications for the Trust, but no assumptions had been made with regard to this. **RESOLVED:** The Board **REVIEWED** the following items as part of our compliance for each of the following safety actions and **AGREED** the recommendations for each as shown:

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Safety Action 1
RESOLVED: The Board **REVIEWED** and **NOTED** the Perinatal Mortality Review Tool (PMRT) reports for compliance.

Safety Action 2
RESOLVED: The Board **REVIEWED** and **NOTED** that the Trust passed the data quality criteria in the Clinical Negligence Scheme for Trusts scorecard.

Safety Action 3
RESOLVED: The Board **REVIEWED** and **APPROVED** the avoiding term admissions into the neonatal unit (ATAIN) and Transitional Care reports and action plan to expand Transitional Care provision to include babies born from 34 weeks onwards.

Safety Action 4 and 5
RESOLVED: The Board **REVIEWED** the Q2 workforce paper and actions plans listed for compliance with Safety Actions 4 and 5.

Safety Action 6
RESOLVED: The Board **APPROVED** the following be reported to the Integrated Care Board as for compliance:

- The Trust has a dedicated lead midwife (0.4 WTE) and lead obstetrician (0.1 WTE) per consultant led unit for fetal monitoring appointed and in post.
- Job specifications are in place and these posts are appointed to.
- The Trust has in post:
  - An obstetric consultant lead for pre term birth, delivering care through a specific pre term birth clinic, or within an existing fetal medicine service.
  - An identified local preterm birth/perinatal optimisation Midwife Lead
  - A Neonatal consultant lead for preterm and perinatal optimisation
  - A Neonatal Nurse lead for preterm and perinatal optimisation.

Safety Action 8
RESOLVED: The Board **APPROVED** the 2023 Training Plan presented at this meeting for compliance with safety action 8.

Safety Action 9
RESOLVED: The Board **REVIEWED** the Q2 paper presented at this meeting for compliance with safety action 9 which included evidence of the Maternity and Neonatal Board Safety Champions supporting the perinatal quadrumvirate in their work and identifying any support required of the Board.

Safety Action 10
RESOLVED: The Board **NOTED** reportable incidents within the Q2 Perinatal Quality and Safety Report and the evidence that families receive a letter containing information on the role of Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme and information that complied with our statutory duty of candour.

	The corresponding Maternity Incentive Scheme submission report provided assurance to the Trust Board of compliance with all 10 safety actions, presenting the standards and evidence of each safety action (including the evidence included above). **RESOLVED:** The Board **APPROVED** express delegated authority for the Chief Executive Officer to sign the Board declaration form with compliance on all 10 safety actions prior to submission to NHS Resolution.
16	**FINANCIAL PERFORMANCE REPORT (MONTH 8)**
	KJ reminded the Board of the requirement for the system to resubmit the financial plan following the release of new national funding as reported to the Board in November 2023. Alongside this, the national target for elective performance had also dropped. KJ confirmed that the report presented for Month 8 was based on the original financial plan, in line with regional request, so did not reflect the recent announcements. The Month 9 plan would show a balanced plan for the Gloucestershire Integrated Care System but with a deficit for the Trust of £6.4m (balanced by a surplus in Gloucestershire Health and Care NHS Foundation Trust and the Integrated Care Board). It was reported there were no surprises in the plan and the same pressures remained with industrial actions costs being the greatest closely followed by inflationary cost pressures. The Board heard that the financial recovery plan was still being reviewed but KJ felt that some potential upsides were moving the position closer to the best-case scenario. However, the capital position was under more pressure, both from a system and Trust perspective partly due to issues arising from International Financial Reporting Standard (IFRS) 16 related to leases. This would result in a £5.5m issue for the Trust and whilst some things may slip to reduce this to £4.4m it could create problems into the next year (and the position for digital was similar) and that delaying schemes increased costs. The Board was also informed about work on the Medium Term Financial Plan and changes to the Board Assurance Framework over the next year to improve the grip the longer-term sustainable positions. **RESOLVED:** The Board **NOTED** the Financial Performance Report at Month 8 and the update from the Director of Finance.
17	**FINANCE AND RESOURCES COMMITTEE REPORT**
	JMD highlighted the new RED risk related to the capital programme and explained it related to a delay to the orthopaedic theatre and the impact of International Financial Reporting Standard 16 and was the biggest risk to the Trust. Revenue pressures continued to be significant but the Trust was getting ahead of the curve with financial sustainability with a view to positive start to the next year in April 2024. KJ added that there was still a lot of capital to spend on large schemes with large bills, but it was not without some risk. **RESOLVED:** The Board **RECEIVED** the update from the Finance and Resources Committee
18	**AUDIT AND ASSURANCE COMMITTEE REPORT**
	JC presented the report and confirmed there were no RED items. AMBER items were highlighted along with assurance on actions to address these. JC thanked the team for their work in making progress on matters reported to the Committee since becoming chair. Discussion took place on the accountability framework with KM confirming his personal interest and desire to fully establishing this to provide robust governance within the Trust. **RESOLVED:** The Board **NOTED** the Audit and Assurance Committee report.
19	**ANY OTHER BUSINESS**
	Patient Safety Incident Reporting Framework (PSRIF) approval process **RESOLUTION:** The Board **DELEGATED AUTHORITY** to the Quality and Performance Committee to approve the Patient Safety Incident Reporting Framework policy and plans on

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	24 January 2023. All board members would receive the papers in advance of this to allow comments to be considered at the meeting. **ACTION (MP/SF).** There were no other items of any other business.
20	**GOVERNOR OBSERVATIONS**
	Andrea Holder, Public Governor for Tewkesbury and Lead Governor, provided comments on behalf of governors present at the meeting; • Welcome positive messages from the staff story and the increased involvement of staff at all levels and whether it was too early to see any impact on staff exit data. CR responded that more data analysis and time would be need but overall the position related to leavers was greatly improved. • Winter Plan update was great to hear and clear. • Maternity update was harder to hear but governors welcomed the Trust's focus on this and the continued hard work from the team to improve amidst pressures. In response to a question, MH confirmed the Aveta birthing unit would be reopening in Cheltenham.
21	**DATE AND TIME OF NEXT MEETING**
	The next meeting will be held at 13:00 on Thursday 14 March 2024 at the Museum of Gloucester.
Close 15:59	

ACTIONS/DECISIONS			
Item	**Action**	**Owner / Due Date**	**Update**
9. Board Assurance Framework	Review and develop the capital/estates strategic risk ahead of the February committees.	IQ/KJ/SF Feb 2024	Risk updated to reflect the feedback. **CLOSED**
	Develop a timetable for Board to spend time reviewing the Board Assurance Framework.	DE/SF Mar 2024	Date to be confirmed as part of board development programme. **OPEN**
12. Quality and Performance Report	Board members provide feedback on areas of focus for refreshed Quality and Performance Report	All / Apr 2024	Not due. **OPEN.**
19. Any Other Business - Patient Safety Incident Reporting Framework	Policy and plans to be shared with all board members ahead of Quality and Performance Committee on 24 January 2024.	MP/SF Jan 2024	Papers circulated. Policy approved at Quality and Performance Committee on 24 January 2024. **CLOSED**

Chief Executive Report to the Board of Directors - March 2024

1. People and Culture

1.1 BBC Panorama

A BBC Panorama documentary was broadcast on Monday 29 January, which focused on the Trust's maternity services. The Director for Safety & Medical Director, Chief Nurse & Director of Quality and I watched the programme with colleagues in the Maternity Service on the evening of broadcast to support and be on hand to answer questions.

The programme included three very tragic deaths of a mother and two babies in our hospitals, as well as exploring the national and local challenge in recruitment and staffing. The documentary also focussed on the impact on staff experience, where some staff felt unable to speak up about safety concerns or felt that they weren't listed to, particularly in relation to the two baby deaths in 2019 and 2020.

Our Maternity Services continue to go through a transformation process and as a Trust we are determined to learn and change when things go wrong.

The tragic cases highlighted took place between 2019 to 2021 and each one was independently investigated. As a result of those investigations, and Care Quality Commission inspections, we have already made significant improvements to our maternity services including:

- New and expanded senior leadership team
- We have increased the number of midwives and doctors into the service to support women and babies
- Worked with staff to focus on patient safety, learning and continuous improvement
- Introduced a new consultant midwife role, strengthening midwifery oversight of Midwifery led care
- Ongoing recruiting and retention programme to reduce vacancies and turnover
- Introduced a 'Place of birth risk assessment' to prevent delays in accessing urgent care if required
- Three daily safety briefings to review staffing, workload and labour inductions - ensuring concerns are addressed immediately
- Strengthened our internal Freedom to Speak Up service
- Providing a range of support for staff, including wellbeing and psychological services, peer to peer networks, and safety champions.

The changes made in our maternity services have been driven by our staff, working closely with families and communities, to ensure everyone has a voice so that we provide the best and safest care.

Since April 2020 we have invested an additional £1.8 million to increase Maternity staffing, including obstetricians, consultants, administration support and the number of Midwives working in the department has increased from 242.99 (2020) to 263.77 (December 2023). Between September 2023 and December 2023, we welcomed 19

new midwives into the service, this is reflected within our December 2023 figure (offset by staff leaving the service – primarily for career development). Across the whole of Maternity Services there has been additional recruitment and in April 2020 there were 389.84 Whole Time Equivalents contracted staff in post, which has increased to 430.73 Whole Time Equivalents by November 2023.

The Trust expect to have 271.1 Midwives in post by July 2024, based on new starters and prediction around leavers and international recruits.

The vacancy rate for clinically delivering midwives in the Trust has dropped from 15% in the summer 2023 to 7.85% December 2023. With our continued focus on recruiting and retaining Midwives we predict that this vacancy rate will reduce to 5.3% by July 2024.

Since April 2020, two additional Obstetric consultant roles have been established. There are a further three Obstetricians joining the service between April 2024 and August 2024.

As part of the documentary the BBC claimed that the Trust had a maternal death rate that was twice the national average. This was not correct and something that the national experts in maternal and neonatal deaths at Oxford University (MBRRACE) and the Local Maternity and Neonatal System, independently reviewed. They are clear that the data for Gloucestershire is in line with the national average and is not statistically significantly different from the UK rate.

MBRRACE also issued a statement as they were concerned about how the data was being interpreted and noted that “trends in maternal death rates would not be apparent with small amounts of data covering shorter periods of time, or covering individual hospitals or regions”. MBRRACE Statement on Maternal Death Data.

However, the Trust is committed to learning from the tragic cases and will be engaging with the Maternity Improvement Advisor from NHS England and system partners to commission an external party to look at the mortality issues raised to offer a further deep dive and objective review.

We know the programme was difficult viewing for families involved, women who are currently under our care, the wider community and our staff. The challenges across midwifery nationally are well documented and there is no doubt that these are difficult times across the profession.

Although the focus of the programme was on maternity services, how we respond to issues of safety at the department and at the wider Trust level is an important lesson for all of our services. We must develop an open and listening culture that supports staff to speak up and be listened to on issues of patient safety.

The Board is also asked to note that there was a material error in our Board Reports, which was highlighted by the BBC in their investigation. The Trust published within the Board Papers two maternal deaths (noted on page 100 of the November 2023 Board Papers referencing a maternal death in September 2023 and on page 130 of the July 2023 Board Papers, referencing a maternal death for May 2023). These were both incorrect and the reports should have shown no maternal deaths. This issue is being

investigated and an apology was provided to the BBC. Additional controls have been put in place to confirm the data that goes into the maternity report.

1.2 Stroud Maternity Unit

The Trust met with Parliamentary Under Secretary, Maria Caulfield, Stroud MP, Siobhan Bailey, Chairman of the Health Scrutiny Committee, Councillor Andrew Gravells as well as senior representatives from the Care Quality Commission and the Nursing and Midwifery Council to discuss the ongoing temporary closure of postnatal beds at Stroud Maternity Unit.

The six postnatal beds have been closed since September 2022 and midwifery staff have been centralised at the Gloucestershire Royal Hospital to ensure safe staffing levels, and, in particular, one-to-one care in labour and birth.

The Trust welcomed the opportunity to meet with key partners as part of a constructive meeting to discuss the challenges facing maternity services and although good progress has been made in terms of recruitment, there is still more to do to ensure safe staffing levels are achieved to enable the reopening of post-natal beds in Stroud.

The Trust continues to work openly with partners as well as staff on long-term, sustainable solutions.

1.3 The Care Quality Commission national maternity survey

The national survey highlights women's and families' views on all aspects of their maternity care from the first time they see a clinician or midwife, through to the care provided at home in the weeks following the arrival of their baby.

The survey took place in February 2023 and asked women about their experiences of care at three different stages of their maternity journey – antenatal care, labour and birth and postnatal care – and 230 people who accessed maternity care at Gloucestershire Hospitals took part.

The annual survey gives independent feedback about where service users think we are providing outstanding care, and areas in which we need to improve. One key aspect that stands out, is the responses that show teams scored better than average in treating people with kindness and understanding, listening and responding when people are worried during labour and feeling that the team are aware of the mother's and baby's medical history following birth, which is critical in the personalised care we strive to deliver and does link back to some of the concerns raised in the recent panorama documentary from 2018-2021.

Where people highlighted areas experience could improve, we are already working on plans, alongside our local Maternity and Neonatal Voices Partnership (MNVP), to make changes, with a particular focus on feeding and induction.

Overall, there were no statistically significant changes from last year, with 52 questions at the national average, one somewhat better than expected and one somewhat worse than expected.

The Trust was rated particularly highly for the following areas:

- Partners or someone else involved in the service user's care were able to stay with them as much as they wanted during their stay in the hospital
- Women and birthing people could see or speak to a midwife as much as they wanted during their care after birth
- During antenatal check-ups, people were given enough information from either a midwife or doctor to help decide where to have their baby
- Women and their supporters were not left alone by midwives or doctors at times when it worried them during labour and birth
- People felt that if they raised a concern during labour and birth, it was taken seriously

Meanwhile, the Trust was rated less highly for the following areas:

- Being given appropriate information and advice on the risks associated with an induced labour, before being induced
- Being provided with relevant information, support and advice about feeding their baby, both during pregnancy and after the birth of their baby

The full results for England are available on the Care Quality Commission website.

1.4 Staff Survey

A total of 68% (5578 staff) completed the annual NHS Staff Survey in 2023, the highest-ever response rate for the Trust.

The national Staff Survey results are published on 7 March 2024, providing a comparison with the wider data by NHS England and detailed analysis of trends and changes. Our results provide an outline of what colleagues are telling us, areas of improvement and areas we need to focus on. These have begun to be shared with each Division to support learning and future planning.

Encouragingly, both the main two questions of recommending our Trust as a place to work and as a place to receive care have improved slightly:

- Would you recommend this organisation as a place to work? 47% (up from 43% in 2022)
- If a friend or relative needed treatment would be happy with the standard of care? 46% (up from 44% in 2022)

More people filling in the survey means more data to work with, and means more reliability that the data is really reflective of the whole organisation. The good news is that this year, compared to last year, more staff are more likely to recommend this Trust as a place to work or receive care, and for 90% of the questions there has been a modest improvement.

There is a still a long way to go and much more we must still do to improve the overall experience of working in our Trust, and we are absolutely committed to creating the right culture to support this improvement.

2. Operational context

2.1 Reducing waiting times Emergency Department

The Trust recognises the impact of flow and waiting times for our patient and staff experience and the critical impact on safety, and we continue to work hard to improve ambulance delays and waiting times in our Emergency Department.

In response the Trust has been working closely as a system with partners from Newton Europe to help improve this position. Many staff have participated in workshops and seminars to help re-shape the delivery of urgent and emergency care system across Gloucestershire.

Thanks to that diagnostic work we have identified a pretty broad range of issues and opportunities in areas where, as a system, our performance could improve, and crucially how we could, as a result, deliver better outcomes and experiences for our patients. Many elements of this work are now coming online as we look to re-set some of these long-standing issues collectively.

In February we went live with an integrated flow hub (pilot scheme). This means we have an integrated, multi-disciplinary and co-located Hub including Community, Social Care, Virtual Wards and System Partners, to support patient flow from Gloucestershire's acute hospitals. Although we at the very early stages of understanding the benefits and impacts, we have been able to draw on experiences of other systems who have implemented the same approach and we have seen referrals drop from an average of 72 hours to less than half a day.

For the acute hospitals this will mean:

- Open door policy for any queries about discharge, call in and see the team in the Courtyard at Gloucestershire Royal Hospital
- A shorter Single Referral form
- Face-to-face conversations with experts for people in complex circumstances
- Aiming for decisions on pathway the same day

For the system this will mean:

- Escalation of delays to patients
- Real-time support from system partners
- Home First ethos - if not, why not?

This trial is our first step towards ensuring we get timely pathway decisions and better outcomes for patients. We will be iterating the process and getting the appropriate digital solutions.

The Trust has reduced wait times and ambulance handovers, but there is more we need to do to ensure safe care for our patients and a safe environment for staff. In addition, we have reduced No Criteria To Reside (NCTR) patient numbers from a high of 216 on 4 January 2024 to 151 on 25 February, and 168 on 4 March 2024 (at time of this report), and we can see a direct correlation between lower No Criteria To Reside numbers and better flow and reduced delays for patients. There will be ten days of focused actions in March to help improve flow, which have been developed directly from the ideas shared by the 50 clinicians who attended the recent Clinical Vision of Flow workshop.

We are optimistic that these new ways of working, combined with a wider range of initiatives across the system, will help improve care, and in particular, the time it takes. Whilst still acknowledging the very real challenge the NHS is under.

2.2 Industrial Action

The industrial action in January involving Junior Doctors, was followed by a further five-day period of industrial action at the end of February. There has been a total of ten periods of Industrial Action involving Junior Doctors over the last year and a total of 17 separate periods of action by different health staff since December 2022.

As part of our planning, we prioritised maintaining emergency care and in order to do so we temporarily closed Cheltenham's Emergency Department for an extended periods during the Industrial Action.

In addition, we stood down certain elements of planned care and outpatients, but with a focus on minimising disruption for specific area, in particular cancer care, and for those patients who have been on the waiting list a long time.

The number of patients cancelled due to of industrial action in December and January was 725 and 955 respectively – 325 procedures and 1355 outpatient appointments and in February it was 644 – 91 procedures and 553 outpatient appointments.

3. Quality and performance

3.1 Elective Care. Continued focus on planned care recovery

Ongoing industrial action has put pressure on national targets for planned care, but Gloucestershire health and care partners continue to work hard on the challenging task of bringing down waiting times for the people we serve.

As of December, 33 people were waiting more than 78 weeks for treatment (all of whom will be seen before the end of March) and 814 waiting more than 65 weeks. Gloucestershire Hospitals NHS Foundation Trust are running extra outpatient clinics and theatre lists at the weekends and into the evening.

In December, 82.3% of patients were able to access diagnostic tests within six weeks, against a target of 85%. Access to imaging tests has been particularly strong, with Magnetic resonance imaging MRI, computerised tomography (CT), and Non-obstetric ultrasound modalities all performing well.

After a challenging Autumn, cancer performance against the 28-day faster diagnosis target has started to improve with 75% of people in December receiving a diagnosis or all clear following a suspected cancer referral against the 75% target. Several additional waiting list initiatives are supporting cancer recovery and helping to reduce the number of people waiting more than 62 days for treatment with progress being made.

The Trust acknowledges the size of the challenge and that many patients are still waiting longer than they would like. We recognise the impact this has on individuals and families and are working hard to improve this position for all concerned.

3.2 Martha's Rule and Call 4 Concern

NHS England have announced that the first phase of the introduction of Martha's Rule will be implemented across the NHS from April 2024. Once fully implemented, patients, families, carers and staff will have round-the-clock access to a rapid review from a separate care team if they are worried about a person's condition.

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to promptly, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

In response to this and other cases related to the management of deterioration NHS England committed to implement 'Martha's Rule'; to ensure the vitally important concerns of the patient and those who know the patient best are listened to and acted upon.

In Gloucestershire, we began a trial for this approach, called Call 4 Concern, over a year ago to ensure staff, patients, families or carers can call for help and advice from the Acute Care Response Team when they feel concerned about a worsening clinical condition. Call 4 Concern has now been widely rolled out across the Trust and will continue to be embedded and communicated.

What does Martha's Rule involve:

- All staff in NHS trusts must have 24/7 access to a rapid review from a critical care outreach team, who they can contact should they have concerns about a patient.
- All patients, their families, carers, and advocates must also have access to the same 24/7 rapid review from a critical care outreach team, which they can contact if they are worried about the patient's condition. This is Martha's Rule.
- The NHS must implement a structured approach to obtain information relating to a patient's condition directly from patients and their families at least daily. In the first instance, this will cover all inpatients in acute and specialist trusts.

The safety of patients remains the main priority for the Trust and staff, and the successful pilot of Call 4 Concern and the implementation of Martha's rule nationally will add an important step in providing additional support and clinical reviews whenever they are needed.

3.3 Improving accessibility to our hospitals.

Navigating a busy hospital environment can be challenging for anyone, but for those who are blind and visually impaired, it can be particularly difficult. Lack of accessibility can create anxiety, restrict independence, and impact on access to some health services.

In addition, over the last few years, Gloucestershire Royal Hospital and Cheltenham General Hospital have undergone significant transformation and improvement works, and these changes do add further challenges for people.

To ensure our hospitals remain as accessible as possible for all our patients and visitors we are delighted to have partnered with Gloucestershire Sight Loss Council to coproduce a series of audio guides.

The 12 new guides will allow people to access the Emergency Departments on both hospital sites, as well as Ophthalmology and Eye Screening services. They have been created using Artificial Intelligence voice-over, enabling rapid development and testing and significantly reducing costs.

The guides are available on the hospital website and can be accessed from smartphones and tablets, and is believed to be the one of the first NHS navigation audio tools ever developed.

The audio guides provide clear, step-by-step instructions, allowing blind and visually impaired people to navigate hospitals independently and with confidence, ensuring that are able to find their way to appointments and services and reducing anxiety.

It is hoped that further collaboration with the Sight Loss Council and other partners will open up the potential for wider development of more audio guides across other health services.

4. Strategy

4.1 Community Diagnostic Centre (CDC).

The new community diagnostic centre will be offering X-rays, Magnetic resonance imaging MRI, computerised tomography (CT), ultrasound, echocardiogram (ECHO), and DEXA (Bone density) scanning to patients across Gloucestershire and is fully opening in the centre of Gloucester at Quayside House in February 2024. The new centre has been opening in phases, with CT and MRI services operational from earlier this year.

£15m has been invested in the Gloucestershire Community Diagnostic Centre, which will include ‘One Stop Shop’ services such as Liver Disease screening and dietetic assessments, Complex Breathlessness diagnostics, Lung Cancer diagnostics and Sleep Study service, as well as facilities for additional lung function testing and phlebotomy.

The centre will help both hospitals, by reducing the number of diagnostic appointments they are required to provide. This will enable busy hospital staff who are facing high levels of need to focus on providing acute care and should lead to fewer cancelled appointments for patients.

The new Diagnostic Centre has been developed in partnership between Gloucestershire Integrated Care Board and Gloucestershire Hospital NHS Foundation Trust as well as local authority, voluntary organisations as well as the local community and residents.

From a patient perspective the centre will support in reducing the number of appointments/visits they will need to attend prior to getting a diagnosis or not, as it will enable services on site to offer a ‘One Stop Shop’ service model whereby patients can

receive a suite of diagnostic tests on the same day or in as few appointments as possible.

Furthermore, the look and feel of the centre has been designed using a Patient-Led Assessment of the Care Environment (PLACE) principles to ensure the design and layout of the centre meets the needs of its users.

4.2 Cardiac Catheterisation Labs

The Trust's Cardiac Catheterisation Labs (Cath Labs) are moving from their previous location at Cheltenham General Hospital to Gloucestershire Royal Hospital in a phased move. The moves will locate the Cath Labs in the new Image Guided Interventional Surgery (IGIS) Hub at Gloucestershire Royal Hospital. The new Image Guided Interventional Surgery Hub will establish a 24/7 hub for image guided interventional surgery, comprising interventional radiology, vascular surgery and interventional cardiology. The first move will happen on Monday 5 February.

The Cath Labs form part of the Image Guided Interventional Surgery development, which was included in the Fit for the Future consultation programme in 2020-2022. The outcome report supported plans to establish a comprehensive Image Guided Interventional Surgery service in Gloucestershire so that local people no longer need to travel out of county to access certain services.

4.3 Emergency Department

The Emergency Department at Gloucestershire Royal Hospital is now fully operational with Minors and Children's moving into their new dedicated areas. The new Emergency Department has a much larger footprint and has been colour-coded into zones. This has been a long time coming and thanks go to the support of teams working in a challenging environment while this project was completed.

5 Regulators

5.1 In December we received two further inspections from the Care Quality Commission. On 12 December 2023 we received an announced inspection at Stroud Maternity Unit and in their response letter afterwards the regulator acknowledged areas of good practice as well as identified areas for improvement. Their draft report has been received and we are in the process of factual accuracy checking at the time of writing this report.

5.2 On 13 December 2023 the regulators visited again this time to perform a focused unannounced inspection at Gloucestershire Royal Hospital's Emergency Department. The regulator has advised us of failings relating to fire safety regulations, staff fire training and regular testing of electrical / medical devices. We anticipate that their report will be published in due course.

5.3 Care Quality Commission integrated care system assessments

The Care Quality Commission now has new powers (since 1 April 2023) to review and assess Integrated Care Systems as part of the changes to the Health and Care Act 2022.

The aim is to help the Care Quality Commission understand how integrated care systems are working to tackle health inequalities and improve outcomes for people. This means looking at how services are working together within an integrated system, as well as how systems are performing overall.

The recently published guidance by the Care Quality Commission as to how the assessments will be carried out and this has confirmed that they will use a sub-set of the quality statements in the single assessment framework which Care Quality Commission will be using across all its work.

This will involve using six evidence categories to assess Integrated Care Systems against 17 quality statements (describing what 'good' looks like) mapped against three core themes:

1. Quality and safety
2. Integration
3. Leadership

The new Care Quality Commission system reviews are scheduled to commence from April 2024 and no date has yet been set for Gloucestershire.

5.4 NHS Oversight Framework Quarter 3 – 2023/24 Segmentation Review outcome

The NHS England NHS Oversight Framework provides an overview of the level and nature of support required across systems and to enable support to organisations that may require it. The Frame works places trusts and Integrated care Boards to one of four segments, and the segmentation indicates the scale and support needed, from no specific support needs (segment 1) to intensive support (segment 4).

The most recent quarterly review by NHS England Regional Support Group (RSG) on 5 February 2024, confirmed that Gloucestershire Hospitals NHS Foundation Trust would remain unchanged, segment 3, for Quarter 3, 2023/24

Under the Framework, NHS England confirmed that the areas being reviewed for Gloucestershire Hospitals NHS Foundation Trust related to:

- Maternity – Maternity Safety Support Programme
- Quality - CQC Overall Requires Improvement rating
- Quality – Summary Hospital-level Mortality Indicator (New)
- Workforce – Engagement, Bullying & Harassment, Leadership Culture and Safety Culture
- Finance - Agency Spend

The Trust continues to work closely with Regional NHS England and our One Gloucestershire partners to address the areas outlined and each has established workstreams and plans to manage the requirement. Full details of the NHS England NHS Oversight Framework for the Trust are attached to the Board Papers.

Kevin McNamara
Chief Executive

To Trust CEO: Kevin McNamara

Cc Chair: Deborah Evans
ICB CEO: Mary Hutton

Elizabeth O'Mahony
Regional Director South West
South West House
Blackbrook Park Avenue
Taunton
TA1 2PX
Email: e.omahony@nhs.net

14th February 2024

Dear Kevin

Gloucestershire Hospitals NHS Foundation Trust: NHS Oversight Framework Quarter 3 – 2023/24 Segmentation Review outcome

You will be aware, under the NHS Oversight Framework we are required, as a minimum, to undertake quarterly segmentation reviews to identify where organisations may benefit from, or require, support to improve performance and quality of care outcomes for patients.

In line with the Quarter 2 segmentation review process, we have completed a "light touch" Quarter 3 review, with a focus on identifying areas of improvement or deterioration against the Quarter 2 areas of concern, as well as identifying, by exception, any new areas requiring further consideration.

For Gloucestershire Hospitals NHS Foundation Trust, the areas being reviewed related to:

- Maternity – Maternity Safety Support Programme
- Quality - CQC Overall RI rating
- Quality – Summary Hospital-level Mortality Indicator (New)
- Workforce – Engagement, Bullying & Harassment, Leadership Culture and Safety Culture
- Finance - Agency Spend

During January 2024, NHS England and the ICBs undertook the review of all the South West providers, with the findings and recommendations being presented to NHS England Regional Support Group (RSG). Details of this are attached at **Annex A,** for your information.

On the 5th February 2024, RSG agreed that segment 3 for the Trust would remain unchanged for Quarter 3, 2023/24. Updated exit criteria to support the Trust to return to segment 2, are detailed in **Annex B.**

I would ask that you continue to focus on delivering improvements against your exit criteria. The oversight of delivery remains unchanged and will continue to be managed through the appropriate NHS England regional programme teams, in collaboration with the ICB.

If you wish to discuss the above or any related issues in more detail, please contact Anthony Martin, in the first instance, email: sw.oversightandassurance@nhs.net

Finally, may I take this opportunity to thank you and your teams for your collective efforts in providing the best quality care to patients, in what remains a challenging year.

Yours sincerely

Elizabeth O'Mahony
Regional Director
NHS England – South West

ANNEX A

OVERVIEW OF THE QUARTER 3 SEGMENTATION REVIEW FINDINGS

ORGANISATION	Q2 SEGMENT 23/24	Q1 RATIONALE FOR 2023/24 SEGMENTATION	EXIT CRITERIA	NHS ENGLAND Q3 NARRATIVE UPDATE	ICB Q3 NARRATIVE UPDATE	NHSE / ICB EXCEPTION REPORTING	SEGMENTATION DECISION Q3
Gloucestershire Hospitals NHS Foundation Trust	3	Overall segment 3 for: • Maternity – Maternity Safety Support Programme • Quality - CQC Overall RI rating • Quality – Summary Hospital-level Mortality Indicator • Workforce – Engagement, Bullying & Harassment, Leadership Culture and Safety Culture • Finance – Agency Spend	**Maternity:** • Sustain two consecutive quarters of improvement in line with outcomes of the MSSP diagnostic and supporting action plan.	**NHSE Maternity Update:** Maternity service continues on the improvement phase of Maternity Safety Support Programme. Some gaps in the senior leadership team due to sickness. Regional input being provided to support LMNS to increase pace of change within provider. CQC reinspection of maternity services in July 2023 – further section 29a issued relating to incident management and safeguarding training. Final report published 10 November 2023. .	**ICB Maternity Update:** • In Sept 2023 maternity, for the April 2023 inspection against the S29a warning notice, received a continued CQC section 29a warning notice for compliance with L3 children's safeguarding training (target 85%) and for management of clinical incidents within the Trust KPIs (target 30 days). • The Trust met with CQC on 10 November to provide an update about where they are in relation to the improvement plan. All staff groups will be trained to 85% in L3 Children's Safeguarding by March 2024 and the Trust now has only 17 open incidents. • Maternity received a further 1 must do and 4 should do actions. An improvement plan is being developed. • GHFT therefore remains on the NHSE Maternity Safety Support Programme as it does not meet the exit criteria to leave the programme (CQC rating of good for maternity services). • The maternity service CQC report was published 10 November 2023 and the service remains **rated at inadequate**. • An announced CQC inspection of Stroud Maternity Service took place on 12 December 2023 and verbal feedback was provided to the Trust on 19 December and we await the final report.	**None**	**Remain Segment 3**
			Quality – CQC Overall Requires Improvement: • Appropriate improvement plan in place and the ICB is assured. **Quality – Summary Hospital Mortality Indicator:** • Six months of downward trend in SHMI. Trust to produce Learning from Deaths report to the public Board on a quarterly basis.	**NHSE Quality Update**: • CQC overall requires improvement – the improvement plan delivery continues, ICB assured. • SHMI – Trust has now published the quarterly learning from deaths report as per NQB guidance and is a member of the system mortality group meeting.	**ICB Quality Update**: • The CQC report for CGH and GRH sites for Surgery (and GRH maternity) was published on 10 November. • The overall rating for the Trust remains at requires improvement. • The Surgery service was unrated at this inspection and so the continued rating of inadequate in 2022 remains. • There was a focused inspection in Paediatrics in September 2023 and we are awaiting the final report (this was in response to the care of 2 specific children). • There was a focused inspection in the Emergency Department on 13 December 2023 (in relation to a whistle-blower's concerns and a fire in ED).		

					• The Trust and service improvement plans continue to progress and are monitored at GHFT's Quality and People and OD Delivery Groups. **SHMI:** • Learning From Deaths Report was received by 9 November's Trust Board. Mortality Indicators across most parameters for SHMI have normalised with the exception for weekend admissions. The data analysis shows that a decrease in diagnosis of dementia in the population affects the risk profile (expected death calculation) and adversely affects overall SHMI.		
			Workforce - Perception of leadership culture: • A workforce plan to be in place by end June 2023 that is agreed with the ICB: • High level workforce plan with clear strategic priorities, outcomes and measures to deliver improvements. **Workforce – Engagement:** • A workforce plan to be in place by end June 2023 that is agreed with the ICB: • High level workforce plan with clear strategic priorities, outcomes and measures to deliver improvements. **Workforce – Bullying and Harassment** • A workforce plan to be in place by end June 2023 that is agreed with the ICB: • High level workforce plan with clear strategic priorities, outcomes and measures to deliver improvements.	**NHSE Workforce Update:** • Staff Experience Taskforce launched April 2023 following publication of staff survey results. Comprised of 25 volunteers 4 staff experience projects were identified, which culminated in a presentation of findings and celebration event to Board members in December. • Projects: 1) provision of 24-hour food; 2) A 'just sort it' fund for teams to make small works/changes easily; 3) Development of a Reward and Recognition toolkit for use by local departments; 4) creation of 'new starter packs' to improve orientation and welcome of new staff joining Trust • Teamwork-leadership workstream established to address poor behaviours, improve team effectiveness and psychological safety, and develop leadership capability. Invested funds in an external OD organisation to support delivery of a range of activities over 3-year period across the whole Trust, including: exec/senior leadership development; working with whole service lines to deliver team development days with follow-ups, leader workshops and cross-divisional Action Learning Sets for leaders over a 12 month period. Currently planning delivery which is expected to begin in earnest from February 2024 onwards • Anti-Discrimination Workstream established to address reports of all discrimination and to work towards eliminating this behaviour and addressing the staff survey results of Bullying and harassment. Working closely with the EDI Agenda to identify the foundational pieces of work required such as a reporting mechanism and	**ICB Workforce Update:** • Staff Experience Taskforce launched April 2023 following publication of staff survey results. Comprised of 25 volunteers, 4 staff experience projects were identified, which culminated in a presentation of findings and celebration event to Board members in December. ○ Projects: 1) provision of 24-hour food; 2) A 'just sort it' fund for teams to make small works/changes easily; 3) Development of a Reward and Recognition toolkit for use by local departments; 4) creation of 'new starter packs' to improve orientation and welcome of new staff joining Trust • Teamwork-leadership workstream established to address poor behaviours, improve team effectiveness and psychological safety, and develop leadership capability. Invested funds in an external OD organisation to support delivery of a range of activities over 3-year period across the whole Trust, including: exec/senior leadership development; working with whole service lines to deliver team development days with follow-ups, leader workshops and cross-divisional Action Learning Sets for leaders over a 12 month period. Currently planning delivery which is expected to begin in earnest from February 2024 onwards • Anti-Discrimination Workstream established to address reports of all discrimination and to work towards eliminating this behaviour and addressing the staff survey results of Bullying and harassment. Working closely with the EDI Agenda to identify the foundational pieces of work required such as a reporting mechanism and process that is clear and simple to use, provides important data to enabling key measurables to be worked towards. Ensuring that any process and support mechanisms are co-created and consulted with the Inclusion Network and our Internationally Educated		

				process that is clear and simple to use, provides important data to enabling key measurables to be worked towards. Ensuring that any process and support mechanisms are co-created and consulted with the Inclusion Network and our Internationally Educated Nurses Council. This workstream forms part of the wider EDI Development Plan. • NQPS results (July), which saw an improvement in 8/9 People Promise areas and a significant increase in the response rate.	Nurses Council. This workstream forms part of the wider EDI Development Plan. • Between January and July 2023 the latest National Quarterly Pulse Survey (NQPS) responses demonstrated a modest improvement in staff recommending the organisation as a place to work (January 28%; April 30.8%; July 34%) and happiness with the standard of care provided by the organisation (January 31.3%; April 32.9%; July 38%). Furthermore, all core NQPS questions relating to staff engagement have improved during this time period. • Since April 2023 we have included additional nine questions in our NQPS linked to our three staff experience workstream priorities: 1) Teamwork & Leadership; 2) Anti-discrimination; 3) Building a safe speaking up culture. All questions showed a modest improvement in July compared to when we first asked these in April.		
			Finance Agency Spend • Reduction in rate of spend so that forecast outturn for agency is within the ceiling. • Compliance with pay cap.	**NHSE Finance Agency Spend Update:** M7 HCAT report shows 27% compliance year to date to M7 Vs 100% target. M8 spend of £13.1m exceeds the providers agency plan.	**ICB Finance Agency Spend Update:** Month 8 FOT on agency is £19.3m compared to an actual outturn in 22/23 of £24.6m so a £5.3m reduction from last year. The Trust will not achieve the agency cap ceiling for 23/24 but is working hard on mitigations to reduce this gap. With executive oversight, mitigating actions include: a review of all high-cost agency use, active focus on the recruitment pipeline including hard to fill roles, a review of rate enhancements, improved booking controls, monthly roster reviews in nursing, procurement exercise for a medical e-rostering solution, the conversion of booked agency shifts to booked bank shifts, improved vacancy & change of establishment controls.		

ANNEX B

Q3 EXIT CRITERIA FOR 2023/24		COMPLETION DATE
Maternity:	• Evidence of delivery against agreed MSSP improvement plan and timescales	Quarter 3 24/25
Quality – CQC Overall Requires Improvement:	• Appropriate improvement plan in place and the ICB is assured	Quarter 4 23/24
Quality – Summary Hospital Mortality Indicator:	• Six months of downward trend in SHMI • Learning from Deaths report produced and shared	Quarter 1 24/25
Workforce - Perception of leadership culture:	• A workforce plan to be in place by end June 2023 that is agreed with the ICB • High level workforce plan with clear strategic priorities, outcomes and measures to deliver improvements	Quarter 4 23/24
Workforce – Engagement:	• A workforce plan to be in place by end June 2023 that is agreed with the ICB • High level workforce plan with clear strategic priorities, outcomes and measures to deliver improvements	Quarter 4 23/24
Workforce Staff Survey	• Evidence of Improvement in 2023 Staff Survey (Needs to move 0.1 closer to median score)	Quarter 4 23/24
Workforce – Bullying and Harassment	• A workforce plan to be in place by end June 2023 that is agreed with the ICB • High level workforce plan with clear strategic priorities, outcomes and measures to deliver improvements	Quarter 4 23/24
Finance – Agency Spend	• Reduction in rate of spend in 2023/24 so that actual system outturn for agency is within the ceiling • Compliance with pay cap • A system plan compliant with the agency ceiling for 2024/25. Organisation spend in Quarter 1 in line with that compliant plan • The 2024/25 plan meets the regional planning expectations for agency, specifically the requirement to plan for substantive, bank and agency WTE and spend as per the expected delivery model	Quarter 4 23/24

17 February 2024

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	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	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	Jan 2024	Jan 2024	CNO/MD/COO	QPC	3x3=9	N/A	5x5=25
SR2	Failure to implement the quality governance framework	Dec 2022	Jan 2024	Feb 2024	CNO/MD	QPC	3x4=12	N/A	4x4=16
2.	**We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people**								
SR16	Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve.	Feb 2024	Feb 2024	NEW (will review in Mar 2024)	DFP	PODC	3x4=12	N/A	5x4=20
3.	**Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other**								
SR5	Failure to implement effective improvement approaches as a core part of change management	Dec 2022	Nov 2023	Nov 2023	MD/CNO	QPC	2x3=6	N/A	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**								
SR6	Individual and organisational priorities and resources are not aligned to deliver integrated care	Dec 2022	Oct 2023	Jan 2024	COO/DST	QPC	2x3=6	5x3=15	4x3=12
5.	**Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services**								
SR7	Failure to engage and ensure participation with public, patients and communities	Dec 2022	Sep 2023	Nov 2023	DFP	PODC	1x3=3	3x3=9	3x2=6
7.	**We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources**								
SR9	Failure to deliver recurrent financial sustainability	July 2019	Feb 2024	Feb 2024*	DOF	FRC	4x3=12	N/A	4x4=16
8.	**We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact**								
SR10	Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.	July 2019	Feb 2024	Feb 2024*	DST	FRC	4x3=12	N/A	4x4=16

17 February 2024

Board Assurance Framework Summary

SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Dec 2022	Feb 2024	Feb 2024*	DST	FRC	3x3=9	N/A	3x3=9
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**								
SR12	Failure to detect and control risks to cyber security	Dec 2022	Jan 2024	Feb 2024*	CDIO	FRC	5x3=15	N/A	5x4=20
SR13	Inability to maximise digital systems functionality	Dec 2022	Jan 2024	Feb 2024*	CDIO	FRC	2x3=6	N/A	3x4=12
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**								
SR14	Failure to invest in research active departments that deliver high quality care	Feb 2023	Sep 2023	Oct 2023	MD	CIRG	2x3=6	N/A	3x4=12

The following risks have been developed or progressed with current versions shown in the table above.

Ref	***Strategic Risk***	***Date of Entry***	***Last Update***	***Committee reviewed***	***Lead***	***Assurance Committee***	***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***								
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***								
SR3	*Inability to attract and recruit a compassionate, skilful and sustainable workforce*	*Mar 2022*	*Oct 2023*	*Nov 2023*	*DFP*	*PODC*	*3x4=12*	*N/A*	*5x4=20*
SR4	*Failure to retain our workforce and create a positive working culture*	*Dec 2022*	*June 2023*	*Nov 2023*	*DFP*	*PODC*	*3x4=12*	*N/A*	*5x4=20*
	SR04 merged into SR03 in early 2023. The document in June was a duplication of SR03.								
5	***Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services***								
SR8	*Failure to ensure opportunities and capacity for staff to engage and participate*	*Jan 2023*	*April 2023*	*Nov 2023*	*DFP*	*PODC*	*2x3=6*	*N/A*	*4x3=12*

Archived Risks (score of 4 and below)

17 February 2024

Board Assurance Framework Summary

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	
SR	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.

Heat Map

Consequence

Likelihood	1	2	3	4	5
5			• Individual and organisational priorities not aligned ↑	• Cyber security ↑	• Delivery of urgent and emergency care services
4			• Staff engagement and participation	• Quality governance framework implementation • Effective change management • Financial sustainability ↓ • Capital	• Attraction and recruitment ↑ • Retention
3			• Engagement with public, patients and communities • Net Zero organisation	• Digital systems functionality • Research	
2					
1					

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System**	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 Constitutional standards and pledges.	• Reduced flow out of the Acute Trust setting with high level of patient without a Criteria to Reside (nCTR) who are unable to access community pathways. • Insufficient volume of discharges from the hospital setting, including pathway zero (simple discharges) • Increased acuity of patients being admitted which means that length of stay is extended, and the ability to maintain flow sufficient to achieve KPIs is compromised.	• Sustained and considerable pressure on staff and consequent negative impact on wellbeing. • Potential for increased moderate and serious clinical incidents • Potential for delay related harm • Poor patient experience • Unacceptable numbers of 12 hours breaches • Reduced flow leading to longer waiting times for ED • Failure to adequately support patients in the community be ensuring ambulances are offloaded in an effective manner. • Higher numbers of patients receiving care in non-ward environments	Quality and Performance	TRI	SR2 SR3 SR4 SR5 SR8 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
5x5=25	CQC requires improvement rating (Dec 2019); Congestion within the ED Departments; Impact on staff experience as reflected in the Staff Survey; recruitment, retention and reputation Failure to deliver ED performance standards. OPEL Level 4 and BCI	**Aug 2024** **3x3=9**	Patients are managed within the Emergency Departments with access times at each stage of their journey kept to an absolute minimum. Ambulances are offloaded within 15 minutes of arrival National standard, ICB agreed standard max 40mins offload time; patients triaged within 15 minutes and overall, LOS in ED does not exceed 12 hours There is an intention to reduce the risk gradually. We are currently in Tier 3 escalation.	DEC 2022 Newly developed BAF Risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Range of work programmes to support with managing demand internally and with system partners. • Boarding and Pre-empting and Trust Flow and Escalation Policies revised and operational • Establishments of CADU and Discharge Lounge supporting earlier capacity.	• Additional impact of Industrial Action being noted and mitigations developed as announced, compromised ability to plan in advance for all actions and operational changes. No further dates announced but expected if negotiations break down. Consultant Committee re-balloting. • Non-compliance with National operational standards and KPIs

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

• UEC System Programme Board chaired at ICB level • UEC Improvement Board established and Chaired by CEO • Standardised Data set and Operational Dashboard now BAU • Quality & Performance Committee Report to Board. • Internal Accredited Clinical Environment Audit planned 23 Jan 24	• Ongoing impact of IA predicted to continue. • Service Changes more frequently applied (Closure of CGH ED during JUNIOR Doctor IA)

ACTIONS PLANNED

Action	Lead	Due date	Update
Initialisation and mobilisation of Newton Improvement programme across system	ICB	Ongoing	Mobilisation and project establishment underway.
Continuation of Trust wide Discharge QI programme and development of Virtual Ward models	DofOps (Flow)	Ongoing	Now Monthly BAU bringing together #Red2Green; #EM4EB; End PJ Paralysis etc.
UEC Improvement Board agreement with the PIP (Performance Improvement Plan)	CEO	Ongoing	PIP reaching final iteration and will be BAU for the UECIB • Include Reset weeks (create continuity with pb in right place)

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Friends and Family scores continue to be positive • De-escalated from Tier 1 to Tier 3 monitoring with SW Region **KIAR** Stabilised performance was also reported in Urgent and Emergency Care. A patient improvement plan had been established to review further opportunities and achieve the 80% performance target as set out in the Operational Plan. Reduced incidence of Boarding; now pre-empting frequently but excellent controls in place. Trust Risk Register An improvement programme had been established to coordinate all discharge improvement activity, with an aim to support congestion in Emergency Departments. De-escalation from corridor care in ED. • IA – ongoing negotiations and no further strikes currently planned but possible if negotiations fail	• Delivery of operational standards remains non-compliant (64.2% 4hr; Handover time greater than 15mins) Significant improvements earlier this year not sustained. • Continuation of IA resultant from dispute between BMA and HM Govt requiring significant service changes, loss of capacity and increased time to recover Emergency and Planned care.	Continued monitoring by SW Region at Tier 3 escalation Internal audit reviews 2022-2025

Updated DR – 18 Jan 24

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Quality governance framework

February 2024

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR2	**Failure to successfully embed the quality governance framework**	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 governance 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 Committee	CNO	SR1 SR3 SR4 SR5 SR8 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
5x4=20	The Trust remains rated as "requires improvement" and we are awaiting reports for Maternity (Stroud site), Children and Young People and Urgent and emergency care. These inspections may change our rating as we have moved into the new CQC framework. We have been notified of a CQC S29a in Urgent and Emergency Care and one in Children and Young People Services which has been served again (representations have been submitted and we await the outcome). A refresh of the quality governance framework is being vied again. implemented. CCQ inadequate ratings for maternity (2023) and surgery (2022). CQC "MUST DO" action to improve governance (July 2023). CQC have implemented their new inspection framework 24 November 2023 and so new processes will need to be implemented internally.	**2024/25 Q4** **3x4=12**	Implementation and embedding of the quality governance framework and CQC Requires improvement rating with a new system of regulation having been implemented.	Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee Report to Board • Trust Risk Register Report to Board • Quality and Performance Report (QPR) to Board - Key Issues and Assurance Report (KIAR) • Quality and Performance Committee oversees progress of risks, safety, experience, access/performance and outcome improvement plans in areas where significant issues/concern highlighted • Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board	When CQC inspect is not within our control and it is unlikely that the Trust will receive an Outstanding rating by CQC in the next financial year. The new CQC Inspection Framework is now being delivered which needs to be embedded into the organisation. We are awaiting 3 inspection reports which may change the organisation's rating with new S29a warning notices served for urgent and emergency care and children's services.

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

- Monitoring of performance, access and quality metrics via Quality & Performance Report
- Inspection and review by external bodies (including CQC inspections) reported through the Regulatory Report
- Quality Strategy (insight, involve, improve)
- Risk Management processes
- Quality priorities and reporting through Quality Account
- Improvement programmes
- Executive Review process
- Implementation of Operational and Winter Plans
- Annual Reports for key programmes (complaints, FTSU, equality, safeguarding, infection prevention and control)

ACTIONS PLANNED

Action	Lead	Due date	Update for end Q3
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	CNO	New date end of Q4 2023/24	New proposed governance structures presented to the December Board Development session and the next steps are to provide a more detailed plan by the end of Q4. This plan is in development with the new safety structures and processes being developed first. The new Patient Safety Plan and Policy were signed off as approved at the ICB Quality meeting Feb 2024.
Work in progress to deliver all the actions against the served CQC S29A warning notices (Maternity, Children and Young People and Urgent & Emergency Care)	CNO	New date as continuing S29a end Q1 2024/5	The Trust was served a S9A warning notice in Urgent and Emergency Services at GRH and an improvement plan is in place (significant improvement to be made (by end Feb 2024). Children and Young People Services were served a notice which was then retracted after the Trust representations were all upheld and a procedural error was noted – this notice has been served again and representations have been made. An improvement plan has been put in place as the Trust recognises that medication errors were made. Maternity continue to make improvements against the S29A actions which are being monitored by the Maternity Delivery Group.
Work to improve the ratings of the core services rated as inadequate to improve governance	CNO	New date end of Q4 2023/24	MDG and QDG have oversight of the CQC improvement plan for the S29a, Must do and Should do improvement action plans for Surgery and Maternity. The new Must do's and should do actions are being mapped into new action plans and were presented to Feb MDG/QDG (industrial action has delayed the plans being presented). We await the final reports for Maternity (Stroud) Urgent and Emergency Care (GRH) and Children and Young People Services.
Formal governance review, focusing on quality ward to Board processes	CNO	New date end of Q4 2023/24	Workshop held with Board in December 2023 with Good Governance Institute (GGI). Proposed new meeting structures agreed in principle with a further developed plan to be approved by end of Q4. Director for integrated governance to commence in post Feb 2024. Reporting structures to be agreed by Board and then implemented.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

Maternity Incentive Scheme submission to NHSR Feb 2024 (10/10 standards met). Patient Safety Incident Response Framework (plan, priorities and Policy) Learning from deaths report	Regulatory Report - CQC Section 29a Warning notices for ED, C&YP and maternity. - Human Tissue Authority inspection actions completed and awaiting final sign off. Maternity - CQC rating of inadequate and so NHSE Maternity Safety Support Improvement Programme continues until the service has met exit criteria. - Maternity Governance Review being implemented. - BBC Panorama programme. - L3 Children safeguarding training red rated. Cancer - November submitted performance showed 0 out of 3 headline standards met, with 2 out of 10 local standards meeting the target. Urgent and Emergency Care - Continued pressure within the system with this impacting on quality (safety, experience and effectiveness). CQC - Awaiting the reports from 3 inspections (UEC, C&YP and Maternity (Stroud).	• Reporting to Q&P as per schedule • Internal audit reviews 2022-2025

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR5: Quality improvement methodologies JANUARY 2024

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR5	**Failure to implement effective improvement approaches as a core part of change management**	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	• No agreed approaches for continual and complex improvement (The GHNHST Way) • Lack of improvement capacity built into the Governance system • Limited formal planning and prioritisation processes for Quality improvement • Unclear Ward to Board quality governance arrangements	• Jump to solutions without engaging staff in process • Limited coordination of improvement at all levels • No drive for improvement and limited checks on process and engagement. • Too many priorities and ad hoc activity without resource with poor outcomes • Inconsistent checks and balances to support improvement approaches in change management	Quality and Performance Committee	CMO	SR1 SR2 SR8

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x4=16	Staff and CQC feedback – too many initiatives - reduce Staff engagement scores Need to build a systematic improvement function at all levels Lack of capacity to support improvement	**Dec 2024** **2x3=6**	Implementation of Quality Governance arrangements Implementation of PSIRF Implementation of a prioritisation process for improvement activity from Ward to Board	Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee Report to Board • Strategy and Transformation Board Report to Board • PSIRF implementation that requires a prioritised approach	
•	

ACTIONS PLANNED

Action	Lead	Due date	Update
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	CN	Q4 2023/24 – revised date	Progress delayed because of Trust wide governance review.
Introduction of PSIRF	MD	Q1 2024/25	Board and ICB approval agreed. Business case for additional resource sitting with ICB.
Establish A3 thinking approach to establish a recognised planning and monitoring approach for improvement	CN\MD\IQ	Q3 2023/24	Meeting 18 September 2023 VC/IQ to review progress and next steps. 'Project on a page' tool, is now included in silver and added to the QI resource toolkit on the intranet.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Feedback from staff on safety huddles • Quality Account	• Staff Survey Results • CQC Well-Led Report	• Internal audit reviews 2022-25

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

	• 2 services rated inadequate • QPR metrics	

Updated 18 Jan 24 -DR

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR6: Individual and organisational priorities not aligned JAN 2024

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR6	Individual and organisational priorities and resources are not aligned to deliver effective integrated care	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	Individual organisations have their own strategy and priorities Budget allocation to organisations rather than priorities	• Lack of integration and system working • Inconsistent priorities and lack of single strategy for Gloucestershire • restriction of the movement of resources (including financial and workforce) leading to an impact upon the scope of integration	Quality and Performance	COO/DST	SR1 SR7

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
4x3=12	Development of an Integrated Gloucestershire system (Completed)	**Jan 2023**	**Jun 2023**	**Jan 2024**	Developed and embedded system working	Q2 2021/22	
		4x3=12	**4x3=12**	**2x3=6**		Q4 2021/22	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• System wide development and agreement of Operational Plan (2023/24) • Systemwide STRATEGIC and TACTICAL escalation Groups (SEG, TEG) established as BAU • 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 as BAU • Monitoring of key performance metrics via Quality and Performance Report (QPR) • Quality Strategy, Risk Management and Executive Review processes in place as BAU • Efficiency Board in place • Key issues and assurance reporting (KIAR) • ICB attendance at Q&P Committee • Triumvirates in place for the Operational/Clinical Divisions • Continued delivery of Estate Strategy on both GRH and CGH	• Operational Plan 2023/24 not fully compliant in every domain (Activity agreed to delivery 103%; Financial gap identified and not fully mitigated). • Operational Performance Delivery but with system ownership and buy in. • Ambulance conveyance reductions identified as urgently necessary – system-wide action plan requested by D Coyle. • Both organisational and whole-system risks acknowledgement to patient safety associated with long LOS and inappropriate conveyance required.

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR6: Individual and organisational priorities not aligned JAN 2024

ACTIONS PLANNED

Action	Lead	Due date	Update
Continuation of Operational Plan (2023/24) delivery monitoring at system level	COO	Jun 2023	BAU
Recovery and Reset plan developed and being delivered in response to CAT2 performance and SWAST Offload times	COO	Oct 2023	BAU with assurance offered to Exec Tri, ICB and NHS SW

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Elective Recovery Board in place – delivery continues to be strong • Regular 'systemwide' planning meetings in place • KPI (Cancer performance, diagnostics etc) monitoring meetings are fully established • UEC Performance moved from Tier 1 to Tier 3 escalation (Positive) • Operational Plan 2023/24 monitored via Executive Reviews and Efficiency Board on a BAU basis	• Operational Plan 2023/24 not fully compliant in all domains against National KPIS (Ambulance handover time) • Trust CQC Rating "Requires Improvement" • Deterioration of National Staff Survey Results • Ongoing Industrial Action between BMA and HM Govt reducing capacity and ability to deliver key operational standards • Ambulance conveyance reduction requirements not properly understood or planned (system).	• '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 ○ FFTF improved pathways and flow

Updated 18 Jan 24 - DR

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR9: Financial sustainability FEBRUARY 2024

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR9	**Failure to deliver recurrent financial sustainability**	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. • Service pressures and risk appetite leading to rostering above funded levels	• 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/reporting leading to increased risk of reduced autonomy. • Prevention of investment to enhance services and inability to achieve the strategic objectives • Decommissioning of services to operate within means	Finance and Resources	DOF	SR1 SR3 SR4 SR6 SR10 SR14

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY
4x4=16 4 x 4 = 12	• The plan for 23/24 shows a balanced position. However, there is a level of risk in the plan that is yet to be mitigated, £6.6m gap on the transformational FSP target, £4m on the system led transformational initiatives and £1.4m additional target which was agreed as part of balancing the plan – total risk £12m. • Increase cost of temporary staffing due to workforce challenges including those arising from industrial action. • The lack of flow in the hospital causing restrictions on elective recovery impacting on the ability to earn ERF. • Additional staffing demands above funded levels	**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. • On line financial training to raise awareness of the importance of good financial control. • 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, chaired by the CEO, to start to see the recurrent benefits of financial improvement. • Full review of all non-clinical agency spends showing clear exit plans for those posts that can be recruited to permanently.	Aug 21
		April 2023	**3x4=12**		April 21
		June 2023	**3x4=12**		Sept 20
		Dec 2023	**3x4=12**		July 19
		Jan 2024	**3x4=12**		
		Feb 2024	**3x4=12**		
		Mar 2024	**3x4=12** ~~2 x 4~~		

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

	• 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. • December 2023 - December target risk reduced due to progress on financial recovery progress and anticipated non-recurrent funding announcement on 9 November 2023, however March target March raised to 12 as non-recurrent funding amount not yet confirmed. • Jan 2024 – NHS England (NHSE) allocated financial support to all systems to reflect the additional cost of Industrial Action [as reported to Board in November 2023 and recorded in the minutes]. This will help the Integrated Care System (ICS) being able to achieve a balanced position by 31 March 2024 although the Trust will report deficit within this position. • Feb 2024 – Improvement in no-recurrent sustainability improvement scheme and a review of balance sheet has led to an improvement in the deficit position for the Trust and allowed the Trust to mitigate the December and January industrial action. NHSE have indicated that further additional support for industrial costs may be forthcoming.		• Full review of all vacant posts with a view to removing those that have been vacant for 12 months or more • Development of system transformation programmes to support longer term financial health included Newton • Development and acceptance of a financial recovery plan if applicable – showing clear executive leads. • Review and implementation of divisional governance related to financial controls and forecasting Target risk shifted out to 16 in December, which is aligned with the CURRENT risk. The focus linked to Financial Recovery Plan is for the reduction of the target risk in the final quarter through improved performance and minimising the deficit, although breakeven not anticipated. March target based on receipt of non-recurrent funding. December 2024 – March reduced to 2 x 4 as winter pressure should be known. In addition, the Trust continues to be ambitious around financial recovery and would be looking move toward base case scenario by end of year. January 2024 – Reduction in risk is related to the additional allocation from NHS England to mitigate costs arising from industrial action (as shown in left hand column).	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• PMO proactively supporting operational and corporate colleagues to generate and deliver future sustainable schemes using tools such as model hospital etc • Programme Delivery Group for financial sustainability chaired by the CEO to raise importance of financial balance • 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	• Robust benefits identification, delivery and tracking across major projects • Inability to generate ideas - Looking to get some expert support into the organisation – going through the triple lock process. • Capacity issues to generate and implement ideas at pace i.e., RMN decision making thresholds • No central medical rostering system in place - TLT approved e-Roster procurement on 17 October 2023 with implementation target date of Spring 2024

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

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- Driving productivity through transformation programmes i.e., theatres and OP
- Weekly financial recovery meetings in place with those adversely deviating from plan
- Final draft of an accountability framework has been developed and is being rolled out by the Executive. This is focused on the Executives holding divisions to account, with escalation of issues up to Trust Leadership Team (TLT) for escalation, as appropriate to relevant Board committees. An update will be provided to Audit and Assurance for information linked to internal controls.
- Medicine division have been put into enhanced oversight to provide additional support to improve their position. There are weekly meetings chaired by the COO.
- Established a recovery plan for each division. This will be overseen by the COO via the monthly efficiency Board.
- Review of the National Check and Challenge oversight list to identify further opportunities, or gaps in controls.
- Review of ward nursing establishments
- Controls on high-cost medical temporary staffing are being reviewed
- Systemwide review of RMN pressures and solutions.
- Relaunch business planning for 23-24
- System implementation of triple lock to be implemented effective week commencing 9 October 2023 (accepting that formal documentation is still in progress)
- Developed recovery plan (in place) with key programs of work with named EXEC and SRO
- Rostering rules prior approval to over roster where applicable in place with templates on ESR and Chief Nurse sign off on any over roster requests.
- The approval process for ad-hoc additional medical shifts needs review; Increased controls in Locums Nest to stop ad hoc shifts being approved retrospectively implemented from 1 November 2023.
- Controls on the approval of WLIs/overtime payments strengthened. Additional paid activities (APA) panel in place. Monitoring via divisions and controls through FSP. Bi-weekly Medical Grip & Control meeting reviews all aspects of medical workforce spend.

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- Reporting mechanism for tracking productivity in theatres and Outpatients (Target to introduce from January 2024)
- Reporting to FRC from January 2024 every other month, with deep dive to areas of concerns, progress and successes in the intervening months
- December 2023 - Progress against 2024/25 efficiency plan is showing signs of significant gaps and additional support will be required to help the Trust achieve the national expectation around cost improvement.

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ACTIONS PLANNED

Action	Lead	Due date	Update
Robust benefits identification, delivery and tracking across major projects	DOS	April 2024	The business planning process needs to be re-launched to bring business, workforce and money together in a sustainable plan. Guidance to be produced along with timeframes for development. *Appointment of new Programme Manager for Operational Planning has been completed and has been tasked to undertake the new business planning process. Benefits realisation is now part of all new business cases and tracked by Finance BPs (and FSP PMO for saving schemes).*

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

			Operational Planning lead / DCOO now working on this year's Operational Plan. Benefits realisation continue to be embedded as part of Financial Sustainability Programme.
Drivers of the pressures understood and communicated to system and regulator partners – Based on RUN RATE	DOF	Monthly	Forms part of the regular monthly monitoring, if the RUN RATE starts to move into a deficit, then more formal plans will be developed. Implemented on 6 November 2023. **CLOSED.**
WTE growth from 19/20 actuals to 22/23 establishment understood and challenged	DOP	~~Jul 23~~ Nov 2023	WTE growth was presented to F&D in Sept 22 but further work needed to understand whether WTE growth is still required. Updated in Sept 23 reflect 22/23 WTE growth impact which continues to show WTE increase since 19/20. Exec team peer review and discussion to challenge this. Exec Team reviewed on 13 November 2023 with no significant change to WTE position. In line with finance recovery plan establishment control processes are now in draft and will be discussed with execs in New Year.
Relaunch of business planning for 23/24	DOS	April 2024	The business planning process needs to be re-launched to bring business, workforce and money together in a sustainable plan. Guidance to be produced along with timeframes for development. Appointment of new Programme Manager for Operational Planning has been completed and has been tasked to undertake the new business planning process. Operational Planning lead now appointed and working with the DCOO now working on this year's Operational Plan. Once concluded, the focus will then turn to re-establishing the Business Planning process. Feb 2024 - Internal work underway to ensure triangulation with operational capacity, finance and workforce.
Implementation of divisional governance	DOF/COO	~~Nov 23~~ Feb 2024	The efficiency Board, chaired by the COO, now includes a session on financial recovery and oversight. The initial meeting of this refreshed format is in September. A draft accountability framework has been developed and will provide a structure to move divisions into increased oversight as applicable. This is being rolled out by the Executive. This is focused on the Executives holding divisions to account, with escalation of issues up to Trust Leadership Team (TLT) for escalation, as appropriate to relevant Board committees. An update will be provided to Audit and Assurance Committee (AAC) for information linked to internal controls. *December 2023 - AAC received Accountability framework for information; Execs requested this go back to Trust Leadership Team to support embedding and implementation.* January 2024 – Reviewed by Execs although new CEO has requested time to review this. Update expected to AAC in February 2024.
Greater focus on productivity opportunities within theatres and OPD	DOF	Dec 2023	Clear governance and reporting in place to focus on greatest opportunities with input from system colleagues. *DOF prepared "plan on a page" in November and this will link to the FRC reporting schedule being introduced from January 2024.* **CLOSED.**
Determine and assess output from Recovery Action Plan	DOF	Nov 2023	Initial reporting to FRC in October 2023. Completed and now forms part of month end report from Nov 23 - **CLOSED**
Generate long term transformational plan for the Trust to support Medium Term Financial Plan (MTFP) delivery	DOS	March 2024	FSP PMO are now developing Transformational plans & pipeline of schemes to support the MTFP plan. External specialist support is still be explored to support this piece of work and convert ideas into schemes and delivery plans. This plan will utilise benchmarking sources and will review the top ten opportunities as shared by NHS England.

POSITIVE ASSURANCES	**NEGATIVE ASSURANCES**	**PLANNED ASSURANCE**
• Achieved key annual financial targets in 2020-21.	• Temporary staff spend consistently above target.	• Internal Audits planned 2022-25:

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

• Achieved key annual financial targets in 2021-22. • Achieved key annual financial targets in 2022-23. • Continued the monitoring of financial sustainability with a greater focus on recurrent savings • ERF performance to secure monies for the system • Improved and co-ordinated system working. • Development of productivity analysis at divisional level • Robust financial reporting highlighting key pressures in a timely manner	• Workforce spend is significantly above plan with productivity significantly below plan • Planned Trust and System underlying deficit moving into 23/24 a significant concern. • Continuing under-delivery of recurring efficiency programme. • ERF achievement for 2023/24 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	• 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		
~~**November 2023:** Overall active progress continues on gaps in control with progression as shown above) – key focus is now on reducing the run rate to give best chance of balanced plan for 204/25 and development of a transformational plan to support long term financial sustainability.~~ February 2024: Continued focus on recovery plan showing signs of positive movement, however there remain concerns around 2024/25 position, in particular financial sustainability. The allocation of additional funds from NHS England to offset costs of industrial action will allow the ICS to achieve a balanced position at year end, albeit with the Trust in deficit as part of this. This continues on from previous update.		

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Community engagement and participation — Sept 2023

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR7	**Failure to engage and ensure participation with public, patients and communities**	Patients, the public and communities tell us that they feel involved in the planning, design and evaluation of our services	Insufficient engagement and involvement approach, methodologies or timing.	Communities and external stakeholders feel uninformed	Quality and Performance / People and OD	DoST	SR1 SR6

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		Sept 2023	**Mar 2024**			
3x2=6	External engagement has improved but requires a more systematic approach, including joined up working with partner organisations	**3x2=6**	**1x3**	• Impact mapping and metrics that show increase in public and community involvement. • Recruitment of 1000 people to Citizens Panel • 10% increase in membership, that reflects the diversity of local communities	Sept 2023 Feb 2023 March 2022 Aug 2022	**3x2=6** **3x3=9** **3x3=9** **3x2=6**

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Board approved Engagement and Involvement Strategy • Annual Review of Engagement and Involvement published • Annual Members' Meeting • Engagement Tracker – mapping activity/impact – 8700 contacts over 58 community events / projects • Quarterly patient experience report to Quality and Performance Committee • One Gloucestershire approach to public involvement – codesign of 'Working with People & Communities' Strategy • Community Outreach Worker in post (funded by NHS Charities Together) to support seldom heard groups and identify gaps in engagement. • Successful completion of Fit for the Future programme • Programme to develop a 1000 strong ICS 'Citizens Panel' to support local community engagement	• Objective measurement of impact of public and patient engagement and involvement • Resource gap for engaging, involving and growing Trust Membership. • Review of Engagement Team structure • Engagement Toolkit – joint with ICS partners – to improve the quality and consistency of public/patient involvement. • Revised CQC and NHS England approach in assessing community engagement

ACTIONS PLANNED

Action	Lead	Due date	Update
NHS75 and Windrush75 completed in partnership with other NHS and community groups	DEI&C	July 2023	All Trust staff and a wide number of communities involved in celebration events.
Development of an engagement tracker – in part for NHS CT and also for publication	DEI&C	July 2023	Tracker complete. Plan to publish as part of Annual Review in July 2023
Joint Engagement Toolkit (with ICS partners) – to improve the quality and consistency of public/patient involvement	DEI&C	Dec 2023	ICS Project Group to develop new toolkit, being led by Trust. Using best practice and mapping to the Trust Strategy and ICB '10 Steps to better engagement'.
Annual Members Meeting – community focused event	DEI&C/ Corp Gov	Oct 2023	Plan to host a large face-to-face event for AMM with community partners and aligned to the NHS75 celebrations.

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Community engagement and participation Sept 2023

<table>
<tr><td>Membership Strategy 2023-2025</td><td>Corp Gov</td><td>Sept 2023</td><td colspan="2">Development of refreshed Membership Strategy – engagement workshop with Governors to help influence plan and approach. Due to be published in October 2023</td></tr>
<tr><th colspan="2">POSITIVE ASSURANCES</th><th colspan="2">NEGATIVE ASSURANCES</th><th>PLANNED ASSURANCE</th></tr>
<tr><td colspan="2">• Codesign of One Gloucestershire ‘Working with People & Communities’ Strategy
• Completion of Fit for the Future engagement and consultation programme
• Progress demonstrated in publication of Engagement & Involvement Annual Reviews
• Level of engagement and involvement from Governors
• 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.</td><td colspan="2">• Trust membership has reduced to below 2,000 with limited diversity
• Opportunity to actively elect more divers Governors and grow membership
• Friends and Family Test Scores have dipped, in particular ED and PALS calls have tripled in last 18 months from around 200+ per month to over 600.</td><td>Internal audit reviews 2022-25:
• Patient Safety: Learning from Complaints/Incidents
• Equalities, Diversity and Inclusion
• ICS Citizens Panel</td></tr>
</table>

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR10: Condition of the Estate February 2024

REF.	STRATEGIC RISK	GOAL / ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR10	**The risk to patient safety, quality of care, reputational damage and contractual penalties and as a result of the areas of poor estate and the scale of backlog maintenance.**	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) • Financial constraints with system and Trust capital provision • Age, condition and inefficiency of GHFT buildings & infrastructure (1% built post 2015 and 18% pre 1948) • Previous equipment purchase profile resulting in peaks in end-of-life equipment • Scale of backlog maintenance: £83M (2022 ERIC submission) of which £41M is Critical Infrastructure Risk (2021 6 facet survey)	• Unable to address backlog and critical infrastructure risks resulting in service interruptions impact on patient access, safety and quality • Inability to meet HTM and regulatory compliance resulting in breaches impacting on the quality of patient care • Poor quality theatre and ward environment impacting on patient outcomes & patient & colleague experience • Equipment failures leading to service interruptions impacting on patient access and diagnosis timescales	Finance and Resources Committee	DST	SR9 SR11

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
4x4=16	One Gloucestershire CDEL results in an annual capital budget of c£24M per year for GHFT. This is split across estates, digital and equipment. This allocation is insufficient to address the scale of backlog maintenance (£83M) risk within an appropriate timescale as well as a refurbishment, equipment	**Jan 2023**	**Jan 2024**	• CDEL limits constrain the level of capital investment One Gloucestershire can commit to improving our estate and reducing backlog maintenance • Estate backlog maintenance schemes compete with other strategic and operational priorities, including strategic estate schemes, 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.	Sept 2023	
		4x4=16	**4x4=16**		Apr 2023	
					Feb 2023	
					Sept 2022	
					July 2022	
					April 2022	
					April 2021	

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

	replacement & digital programme. Furthermore, the continued deterioration in the estate is increasing the risk of prosecution for not meeting statutory compliance.			• ICS Partners have greater awareness of risk GHFT is carrying across estates in particular, which could lead to a change in CDEL allocation from 2023/24. • GHFT have a good track record of securing capital from NHSE schemes (UEC, TIF, CDC etc) and these schemes include a backlog maintenance element.	Oct 2020	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Trust Board and ICB sighted on the scale of GHFT estates backlog and Critical Infrastructure Risk • 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 & ICS • Transition to develop 5 year estates capital programme to provide assurance & timescale of when highest risks will be addressed • Exploring options to dispose of estate with capital receipt used to address backlog risks • Emerging ICS CDEL prioritisation process that is starting to recognise the level of risk being carried by each organisation • Developing 'library' of GHFT & ICS estates schemes, some with supporting Strategic Outline Case and feasibility studies to ensure GHFT is well placed to respond to NHSE national capital programmes • Improved awareness across ICS partners of level of risk GHFT is carrying across estate and equipment via monthly meetings taking place.	• Lack of alternative routes to capital other than NHSE/I. • Lack of alternatives to a reliance on capital to address estate, refurbishment and digital investment due to Trust and ICS revenue position e.g. MES • Lack of clarity on scale of national funding and application route for New Hospital Programme post 2025. • Inexperience in progressing and accessing commercial opportunities for the development of the estate. • Ability to horizon scanning on future national capital programmes (business cases ready to go once when funding available)

ACTIONS PLANNED

Action	Lead	Due date	Update
Review equipment MES business case learning from how other Trusts/ ICSs have managed IFRS16	DoF/ DST	Q1 24/25	Project to be re-launched in 2023/24. Will require project resource. Pathology MES business case underway and resourced Viability for a LINAC and Imaging MES to be reconsidered during 2024/25
Improve awareness across ICS partners of level of risk GHFT is carrying across estate and equipment	DoF/ DST	From Q3 22/23	ICS capital group established with DoF and DST. Improved awareness of risk is already influencing CDEL prioritisation decision making Movement to a 5 year capital Programme from 24/25 **COMPLETE** - Monthly meetings in place and ICS fully aware and sighted on level of risk
Review scope, function, priorities and resourcing of ICS Estates Strategy Group	DST	Q1 23/24	Raise via ICS Strategic Executive **COMPLETE** - Monthly meetings in place and ICS fully aware and sighted on level of risk

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

Explore partnership opportunities to develop GHFT estate and/or adjacent sites	DST/ GMS	Ongoing	Opportunities in progress/ being explored with GCC and other potential partners.
Ongoing development of feasibility studies to respond to national/regional calls for business cases.	DST	Ongoing	Latest feasibility study being undertaken for GRH Theatre estate
Regular dialogue with National and Regional NHSE teams to explore funding opportunities and pipeline of bids	DST	Ongoing	Monthly meeting with Regional NHSE Estate leads

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 • New estate comes on line in 2023 (GSSD) providing good quality estate with reduced maintenance requirement. GSSD has addressed areas carrying backlog e.g., Gallery Wing, DSU at CGH. • Estate capital investment has been prioritised in 2023/24 at £14/£24M CDEL. • Recent investment in Radiology has reduced equipment risks (but resulting in lumpy replacement profile) • Board development session in September 2023 to highlight the risks and options being considered	• Level of estate risk is increasing as reflected through risk scores • Unable to fund a ward refurbishment programme until 2024/25	Internal audit reviews 2023-25: • Environmental Sustainability • Estates Management

UPDATE
Sept 2023: actions updated to reflect progression and new actions for 2023-24 November 2023 – revision to causes, rationale and Target risk score for Jan 2024.

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR11: Sustainable healthcare — February 2024

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR11	**Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon footprint NHS organisation by 2040**	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.	Unable to meet our Green Plan objectives. Unable to secure or prioritise investment required to: • Retro-fit existing buildings and/ or construct new buildings to required EPC standard • Increase electrical infrastructure to provide EV charging for patients, visitors, colleagues and fleet • Migrate from fossil fuel energy supplies • Unable to migrate 90% of vehicle fleet to low & ultra-low carbon emission engines by 2028	• Statutory and/or regulatory implications (as yet undefined) • Increase revenue cost of running inefficient estates and fleet using high-cost fossil fuel energy • Potential increase lifecycle cost of Hybrid/EV fleet • Potential impact on recruitment & retention • Reputational impact • Failure to unlock potential funding opportunities	Finance and Resources Committee	DoST	SR9 SR10

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
3x3=9	• Scale of investment required to achieve required EPC ratings and carbon reduction across GHFT estate • Electrical infrastructure investment required to stabilise and then increase capacity to support EVs	**Jan 2024**	**Sept 2023**	GHFT has been successful in securing external grants	Jan 2024	
		3x3=9	**3x3=9**		Sept 2023	
					Apr 2023	
					Feb 2023	
					Dec 2022	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• All new strategic estate schemes designed to meet BREEAM good (refurb) or excellent (new build) ratings • Continue to pursue external grant funding (Public Sector Decarbonisation Scheme – PSDS) to retro-fit existing buildings and migrate energy supplies away from fossil fuels • Invest in GHFT electrical infrastructure to support transition to Hybrid and Electric Vehicles (EV)for i) GHFT/ ICS fleet ii) visitors and colleagues • Board approved Green Plan and supporting governance structure: Executive Lead, Green Champions, Green Council, Climate Emergency Leadership Group reporting into F&R Committee • ICS Sustainability Group established to oversee delivery of ICS Green Plan (Statutory requirement)	• Lack of a programme to determine costs associated with achieving statutory and regulatory standards and targets between now and 2040 to inform investment priorities and impact on estate capital schemes • Lack of clarity on support to be made available to NHS Trusts to achieve NHS Green Plan/ objectives defined in NHS Long Term Plan • Unclear on consequence of not achieving standards and targets, which could influence GHFT and ICS investment decisions • Reliance on goodwill within GHFT to develop and progress sustainability schemes i.e., GMS Sustainability resource is 0.5 wte, Green Council is voluntary, team and individual objectives are not cascaded from Green Plan.

ACTIONS PLANNED

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

Action	Lead	Due date	Update
Progress on delivery against GHFT Green Plan reported through F&R Committee	DST	Ongoing	Process established. Last update in September 2023
Continue to research and respond to external grant applications	GMS (THu)	Ongoing	GHFT secured £13M from latest PSDS scheme or the Tower Block façade & window replacement
Establish EV Task & Finish Group	DST	Q3 2023/24	Term of Reference produced. Group to mobilise in Q3 & link in with ICS ICS Project Group being established in Jan 2024 (GHT/GCC lead)
Engage in ICS/ Gloucestershire County Sustainability groups to make linkages and pursue joint initiatives	GMS (JC) DST	Ongoing	GHFT/ GMS involved in EV strategy group to explore multi-partner options to support transition to EV across public sector organisations and shared use of infrastructure EV identified as a joint priority ICS scheme with GHT/GCC as lead. Other schemes include – Cycle schemes, e-Cargo bikes, public transport connections. Cycle facilities and community awareness and emissions for the Centre of Gloucester.
Explore options within PFI contract to improve EPC ratings of PFI estate ahead of transfer to GHFT in 2035	DST	Ongoing	Will form part of PFI contract review
Explore opportunities to link financial sustainability and Green sustainability schemes and utilise PMO support to deliver	DST	Q4 2023/24	
Recruitment of a Clinical lead to support Green Action Plan	DST	Q4 2023/24	Job description developed – recruitment process to follow shortly
Communication & Engagement strategy to be developed to relaunch 'Green Plan' aligned to Earth Day in April with a on theme of plastic reduction	DofC&E	Q1 2024/25	Relaunch planned for April 2024

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• SSD Programme progressing to plan at BREEAM 'very good' level • £13M (2021/22) and £11M (2022/23) of Public Sector Decarbonisation Scheme (PSDS) funding secured • GHFT declaration of Climate Emergency in 2020 resulting in Board approved Green Plan • ICS Green Plan defined as part of establishing NHS Gloucestershire ICS • Vital energy contract performance is demonstrating reducing emissions and returning power to national grid – enabler to achieving 80% reduction in carbon emissions between 2028 and 2032 • Response to local initiatives by GHFT colleagues e.g., Green Team competition, bids against £50k sustainability budget etc	• Electrical infrastructure capacity constraints • Unlikely to meet GHFT Green Plan objective to transition to electrical fleet by 2025 • Scale of estate challenge • PSDS (phase 4) and other grants schemes are moving to a part funded model, so only 30-50% of carbon reduction schemes are funded meaning Trusts need to fund the rest from existing capital. This is not currently accounted for in our draft 5-year capital plan.	Internal audit reviews 2023-2025: • Environmental Sustainability

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR13: Digital systems functionality January 2024

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR13	**Inability to optimise digital systems functionality and progress as a digital hospital**	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	• Inconsistency of approach and not following digital strategy • Implementing new systems without digital approval – that don't integrate with clinical record (EPR) • Lack of required investment in digital skills, resources and infrastructure • ICS wide strategy not operationalised and/or financial gap to deliver. Poor clinical and operational engagement in what is new developments or optimisations	• 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 contribute to clinical errors and poor safety • Unable to meet expectations of patients, commissioners and regulators.	Finance and Resources Committee	CDIO	SR9 SR12

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
3x4=12	The government requires that all hospitals reach a required digital standard of HIMSS level 6 to ensure safety and consistency across the NHS. Digital hospitals are safer hospitals, are better places to work and provide better patient care and outcomes. Improved data leads to better operational and clinical planning, as well as opportunities for innovation. The five-year strategy has seen the trust move from a digitally immature organisation to almost HIMSS level 5 and this must continue if we are going to reach our target of 2024.	**Feb 2024** **2x3=6**	At time of writing the digital strategy the Trust was aiming for HIMSS level 6. The implementation plan for the last year of strategy intended to achieve HIMSS level 5, and this will be delivered over the remaining months. The HIMSS levels have now been redefined nationally so the original strategic intent has changed in terms of levels. The new strategy and implementation plan for next year is being developed, consequently this BAF risk will be redefined to account for the new year, and new strategy.	**3x4=12 (Sept 2023)**

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Electronic Patient Record (Sunrise EPR) becomes single source of clinical information, implemented to HIMSS level 6- and five-year plan by 2024. • Joining Up Your Information (JUYI) implemented in partnership with external partners and available to access through EPR • Data Warehouse providing one version of the truth supporting clinical and operational dashboards used for planning across the ICS. • Delivery workstreams including clinical/business and IT leads with sufficient seniority and oversight/awareness of wider Gloucestershire strategy and requirements • All projects must meet existing Digital Strategy and contribute to the journey to HIMSS level 6 • Implementations must provide significant patient care and/or safety benefits – and reduce risk • Optimisation of EPR for users as part of a continuous improvement, responding to clinical demand • Support wider organisational journey to outstanding • Development of new Digital Strategy 2024+ aligned to Trust Strategy 2024+ building on delivery of Digital Strategy 2019-2024	• ICS strategy implementation and plan not embedded/complete • Use of different systems across the ICS • Inability to integrate systems bought outside of digital remit (divisional) • Funding stability & competing Trust priorities for capital.

ACTIONS PLANNED

Action	Lead	Due date	Update
PACS | Radiology system replacement		May 2023	This system has now been implemented albeit remaining work to stabilise and optimise
Maternity EPR		June 2023	This system has now been implemented
Blood Transfusion onto EPR (resulting)		July 2023	This system has now been implemented
Internal-referral Rollout/expansion		October 2023	Internal medical referrals have now been implemented. Expansion to surgical is in progress.
Paper-lite Outpatients – Order Communications		Q3 24/25	This will not be implemented in this financial year. Dependencies in Trakcare have been identified which mean order comms in outpatients will not be possible until Q3 of FY 34/25.

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

NHS at Home		July 2023	Initial rollout of virtual ward platform for Respiratory delivered in July followed by surgery in August. Frailty went live in October. And Virtual Hospital went live in November. The Virtual Hospital now has almost 200 beds.
Clinical Documentation Expansion		Ongoing	Regular drops of documentation continue with prioritisation done by the Clinical Design Authority.
Sunrise Mobile		April 24	Sunrise Mobile pilot will likely go live in April 24.
Patient Portal Implementation		September 2023	Procurement by September 2023, implementation leading into next financial year. Procurement has completed, contract has been signed. Dr. Doctor in implementation for first phase go live in April 34.

POSITIVE ASSURANCES	**NEGATIVE ASSURANCES**	**PLANNED ASSURANCE**
	•	• Internal audit reviews 2022-25

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR12: Cyber security — January 2024

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR12	**Failure to detect and control risks to cyber security**	We are digital hospital whose clinical and operational systems are protected from cyber-attacks and data breaches; through proactive monitoring and back-up systems.	• Cyber-attacks from organised groups targeting NHS • Malware attacks • Phishing attacks via emails to staff • Password access through data breaches • Physical breaches (equipment stolen on site) • Inadequate firewall protection and security updates • Location of Trust near to GCHQ	• Whole loss of systems and downtime – with inability to recover quickly • Demands for money to recover data (ransomware attacks) • Access to patient records and personal data that could be published • Access to VIP data and/or GCHQ staff as patients	Finance and Resources Committee	CDIO	SR9 SR13

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
5x4=20	The National Cyber Security Centre (NCSC) is clear that there are groups and individuals who want to target the NHS; and these are no longer carried out by isolated individuals, but are mounted by large and sophisticated criminal groups. Several high-profile public-sector organisations and NHS trusts have experienced breaches in the last two years and suffered cost and data losses – directly impacting patients/residents.	**March 24** **5x3=15**	It is not proposed to reduce the cyber BAF risk at this stage. Outlined below are the key measures and targets to reduce the risk. Anticipation the risk will be presented for reduction in April Finance and Resource Committee.	Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Cyber Security action plan in place, reviewed annually and gaps in security and investment identified • Monitoring systems in place and dedicated cyber security team • Backup systems and disaster recovery in place and regularly updated • Cyber security delivery workstreams – monitoring safety and access • Investment in cyber tools and software	• Insufficient in-house expertise in cyber security team • Inability to recruit specialist cyber staff because of cost (market forces) • Disaster recovery planning around support systems (out of IT control) not consistently in place • Operating model of cyber-technical & cyber-governance currently not optimal • Backlog of cyber-security issues requiring resolution

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

• Regular phishing tests and firewall tests (planned system hacks) • Regular security updates and patches • Monthly reports to Digital Care Delivery Group, Finance & Resources cttee, ICS Digital Execs • NHS national monitoring (alerts) and NCSC alerts • Communications and engagement with users on prevention	• Device estate – assets not adequately recorded and maintained • ICS-wide incident response processes not operational • Inadequate SIEM (Security Incident & Event Management) i.e., monitoring and alerting.

ACTIONS PLANNED

Action	Lead	Due date	Update
• Rationalisation of detection and prevention tooling. Introduction of targeted monitoring and alerting across key systems and entry points. • Establishment of comprehensive asset register for devices including medical devices and internet of things. • Review and robust management of third-party suppliers to prevent downstream implications • Removal of all end-of-life software and hardware.	CDIO	March 24	Implementation of the Security Information and Event Management (SIEM) solution continues, since the last update the Cyber team have completed approximately 40% of the alerting required to ensure confidence in the Trust's SIEM. This does, however, including the training and definition of use cases to incorporate. Asset Register - An audit of end-point user devices has been completed at both GRH and CGH over a weekend in January, follow up work is continuing, including updating the IT asset register and completing areas that were inaccessible over the weekend. Completeness is estimated at 75%. Medical Devices - An options appraisal of a solution to enable enhanced monitoring of medical devices and IoT is underway with a proof-of-concept implementation planned. A successful bid to NHSE is funding this work (NHS England Cyber security risk reduction fund_ End-of-Life Operating Systems - Projects focused on the elimination of end-of-life operating systems and out of support software continue to make progress, engaging with third-party suppliers to upgrade or to find alternative solutions. It is not, and never will be, the expectation this will be at zero, however the risk needs to minimal and managed. ICS Cyber Strategy - The Trust is working with the wider ICS on developing a cyber-security strategy in line with the new National Cyber-Security Strategy and an ICS wide Cyber incident response exercise is planned for March 24. The ICS Cyber Strategy is scheduled for completion in May 24.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
Cyber Action Plan in place and regularly monitored/updated	Difficulty in recruiting enough experienced staff to support our cyber security needs	Internal Audits External Audit (annual)

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

Internal cyber audit for ICS delivered with Design Opinion and Design Effectiveness – Moderate with no high-risk recommendations (note the scope of the audit did not contain the breadth of cyber controls outlined in this BAF risk)		Monthly NHS reporting

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR14: Research

April 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR14	**Failure to enable research active departments that deliver high quality care**	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	• Lack of capacity within R&D department • Lack of willingness of departmental management to support research activities within their department • Financial approval of VCPs delayed by misunderstanding of research funding processes	• Disengagement of staff in research activities • Departure of research active staff to other more research active organisations • Unable to support staff to design, set up or deliver their research studies (own account & portfolio) • Lack of opportunity to secure additional funding for research and generate surplus for Trust • Higher turnover of staff leading to increased locum and bank staff → increased financial burden • Negative impact on reputation • Inability to secure university hospital status	People and Organisational Development	MD	SR5 SR8 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
		Feb 2024		
3x4=12		**2x3=6**		Risk entered Feb 2023

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Review of Research Office processes by new senior manager • Research office working with interested clinical teams to support them	•

ACTIONS PLANNED

Action	Lead	Due date	Update
Analyse results of clinical research survey for nurses	KG	April 2023	June 2023: Quantitative analysis carried out, qualitative analysis in progress. Need to ensure recommendations tie in with Trust research strategy **Sept 2023: Requested update**

Continuous Improvement projects in progress to streamline processes, releasing capacity	CS	Ongoing	Feb 2023: New. June 2023: Set up improvement project completed and implemented Roles and Responsibilities within set up completed Training and induction work ongoing Finance workstream started EDGE work started July 2023 Training & induction, finance and Edge work ongoing EOI process work begun – now under central control and reviewed twice weekly **September 2023:** **Training & induction, finance work still progressing well** **EOI process interim (pre EDGE) system now in place and working well** **EDGE work has been on hold over summer due to staff absence, now repicked up**
Review research sessions for clinical staff	CS	April 2023	June 2023: Ongoing as part of finance workstream processes review. July 2023: Work continues **Sept 2023: Work continues. PA's have been allocated to Dermatology and Respiratory (for vaccines work) to ensure delivery of those growing commercial portfolios. Action to discuss with Medical Education and staffing team to ensure this complements their system.**
Invest to Save paper to TLT in April to address finance and resource issues (or is this an action?)	CS	April 2023	June 2023: Finance work ongoing – new reporting systems being developed in conjunction with Head of Corporate Finance. July 2023: Finance work continues **Sept 2023: The finance work is continuing, template yet to be agreed, once EDGE in place this will capture all finance data.**

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

Strong pipeline of research studies Engaged staff High engagement within Trust **National hold up of studies in HRA is now being resolved so expecting the "bulge" of work to come into R&D quite rapidly. This will enable more rapid opening of our pipeline which has been on hold.** **Excellent repeat business coming through for commercial studies.**	Potential reduction in commercial income nationally Ongoing impact of pandemic	• Internal audit reviews

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR16: Workforce - Culture, Experience and Retention February 2024

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR16 Culture, Experience and Retention	**Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve.**	**To transform the Trust as a place to work and receive care by building a fair and compassionate culture that allows everyone to thrive.**	Staffing issues across multiple professions on national scale. Lack of resilience in staff teams. Increased pressure leading 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	Director for People & OD	SR1 SR5 SR6 SR7 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
5x4=20	'Push' factors can hamper the psychological contract with the Trust which can reduce people's commitment to their job, their team and the organisation. Poor staff experience, low morale, feeling less valued and listened to, unable to speak up and develop trusting relationships with colleagues, all contribute to the Trust's inability to retain its skilled workforce.	**3x4 = 12**	A number of workforce plans focused on retention, improved culture and staff engagement will have a positive impact on the Trust's ability to retain a skilful, compassionate workforce	New risk created for staff retention, separating out from the overarching recruitment & attraction risk	Jan 2023

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Staff Experience Improvement Programme: o Leadership and Team Working o Anti – Discrimination o Raising Concerns and Speaking Up o Taskforce o Colleague Communications and Engagement o Restorative Just principles and practice, four steps approach and people polices and processes • Divisional colleague engagement plans • Proactive as well as reactive Health and Wellbeing interventions including Health and Wellbeing Steering Group • Addressing HCSW remuneration T&Cs • EDI Development Plan	• Increased staff sickness absence including the impact of Long Covid related illness • Pace of operational performance recovery leading to staff burnout • Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience • Lack of protected time for staff to complete e-learning training • Gaps in digital literacy for some staffing groups causing challenges in staff engagement and the completion of eLearning

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

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
Staff Experience Improvement Programme:			
Teamwork and leadership development • Develop Specification for external OD support to deliver a Leadership and Teamwork development programme. • Develop organisation map to support Divisions in determining priority teams to work through the Leadership and Teamwork development programme	Head of L&OD	September 2023 to September 2026	The Leadership and Teamwork workstream continues to progress with the six cohorts of wave 1 of teams across all five divisions being mapped to have sessions with The Wellbeing Collective. Bi-weekly meeting with The Wellbeing Collective is established to maintain relationships, share updates and address any concerns as they may arise. 2023 Staff Survey results will be used to inform the wave 2 of teams to attend development with The Wellbeing Collective. Funding to cover backfill costs has been identified for wave 1, with a requirement to establish a formal process to approve backfill. This process is to be tested with wave 1 and presented back to the Executive for sign off before funding can be approved for future waves.
Anti-Discrimination • Develop full plan for the new workstream as identified by the 2022 Staff Survey results, including aim, deliverables, benefits and milestones in relation to Anti-racism campaign and "looking after our international nurses"	AD of EL&C	Ongoing project throughout 2024 Project plan with specific dates to achieve	Review of Staff Experience Improvement Programme, in November 2023, identified a need to re-design the discrimination workstream. This is based on the need to complete foundation work to support the whole equality, diversity and inclusion agenda. Agreed areas of focus are: 1. Reviewing and updating information on the intranet page 2. Review the current reporting process and develop an appropriate reporting system and process for staff-to-staff discrimination. 3. Review and update the mutual respect policy and develop an anti-discrimination action plan 4. Align activity into the Trusts EDI Development Plan 5. Align activity to the NHSE EDI High Impact Actions 6. Co-Design and produce with the Inclusion Network • The workstream is to be re-named Anti-Discrimination. • Work continues with the EDI team to develop a sufficient intranet page • Review and update of the mutual respect policy continues. • Confidentiality issues have been identified in exploring the use of DATIX as the reporting mechanism. Solutions/alternatives are currently being investigated.
Raising Concerns and Speaking Up • Delivery of 12-month workstream plan	Lead FTSU Guardian	April 2024	Initial deliverables of this workstream have been completed with a positive improvement to the service, which continues to have high case work. Work on a FTSU strategy is paused for two months to manage case load.
Taskforce Group • Establish a taskforce to respond to the question posed to staff "*what is the one thing you would like to change*"	Staff Experience Programme Manager	Feb 2024 for start of imbedding of scoping activity	The Taskforce held a final celebration event in December, drawing projects as close to completion as possible. Each project group is preparing final recommendations and business cases where necessary for further investment to achieve wider roll out. These recommendations will be presented to the Executive team for decision. Consideration will be given in relation to establishing a further Taskforce, taking learning from the 2023 Taskforce, to address the latest staff survey results.

Restorative & Just Culture • Review of the Trust's people policies, establish procedures and tools which utilise the four-step model within people processes and investigations and establish resources, advice and guidance to support line management practice	AD of HR&R	April 2024	A briefing paper is in development which will set out the recommendations for implementation as well as expectations of Executives and senior leaders to champion the approach. The recommendations include: ▪ Review and refresh all Trust people policies ▪ Develop documented procedures that support the four steps principles, including ensuring all people involved in the application of the procedures are fully trained and competent ▪ Adherence to best practice and learning ▪ Clearly articulate expectations of managers ▪ Clearly articulate expectations of People and OD team
Colleague Health & Wellbeing Priorities Identified as: • Preventative Wellbeing • Responsive Wellbeing • Health and Wellbeing Steering Group for Governance and Collaboration	AD of EL&C	Review and strategy March 2024 H&W Steering Group commencing Jan 2024 – ongoing bi monthly	Lead for Colleague Health and Wellbeing in post from Nov 2023. Needs analysis commenced, informed by engagement with key stakeholders at GHT, review of the current wellbeing offer, review of available data (including staff survey and sickness data), and review of national and local guidance including the People Plan, NHS H&W Framework, Long-term Workforce Plan, etc). New Workplace Wellbeing Steering Group (WWSG) established, with first meeting in January 2024, intended to enhance collaboration across all providers of wellbeing resources and services across GHT. The Steering Group will feed into PODG. Strategic priorities, objectives and action plan for workplace wellbeing at GHT have been drafted; and will go through the WWSG for review. This will inform a new GHT Workplace Wellbeing Strategy, to be written by end of March 2024. Specific activities already underway include: ▪ 'Wellbeing Champion' voluntary peer model is in design stage, with plan to roll out across the Trust with a specific communications campaign in February 2024. ▪ New 'suicide prevention' process has been drafted, with plan to roll out across the Trust with a specific communications campaign in February 2024. ▪ New approach to presenting and communicating the wellbeing offer is currently in development, to address lack of clarity.
Equality, Diversity and Inclusion **EDI Development Plan.** • To create a clear and concise development plan outlining the HIA's, data sets, measurable indicators, Trust actions, BRAG rated, aligning of current activity and actions within WRES/WDES/EDS22 to ensure a working document of activity and gaps identified.	AD of EL&C	EDI Plan reviewed March 2024 Actions within measured monthly	**Trust priorities** – EDI and Recruitment processes, Anti-Discrimination and Allyship **Alignment of** NHSE EDI Improvement Plan six High Impact Actions throughout out Trust Actions. **Mapping of activities** commenced to align and provide a gap analysis of actions required. **Action planning** – 31 actions condensed to eight actions: ▪ Board requirements -HIA 1 ▪ EDI Training – Plan and integration, including, Cultural Competence, Globis Sessions, Allyship, Review of current training offers and weaving and integration into training offerings ▪ EDI Team Actions – Reports, Data, ▪ Internationally Educated Colleagues ▪ Recruitment actions and alignment ▪ Divisional Action Plans

			▪ Patient and Colleague EDI Collaborative Plans ▪ SEIP
Retention • National Programme for B2-B3 HCSW Job profiles and pay drift. To include addressing GHT's legacy of varying pay and sick pay T&Cs for this staff group	DDfPOD	Plans reflect roll out by 31 March 2024 There are delays however with ongoing negotiations with UNISON	Negotiations continue with UNISON which are creating risks to delivery in 23/24. These discussions are with both GHC and GHFT. Both organisations remaining committed to a joint System roll out. Full launch and comms programme is ready, with a wide-reaching programme of staff engagement planned.
• Becoming a Real Living Wage Employer (ICS collaboration)	DDfPOD	Commitment to commence a formal review in 24/25	National Pay Awards and Living Wage uplifts have been applied where applicable in 23/24. The broader review of the Trust's apprenticeship rates and those pay bands where staff are on the National Living Wage, in partnership with the ICS, is still to formally commence. The System wide HCSW Programme, highlighted above, further offers the opportunity to address these pay issues.
• Establish a Trust wide Retention Group focussing on 2-3 core initiatives at a time, informed by expert exit data analysis	HOL&OD	March 2024 for 3 project delivery	The Retention Group, as part of the Workforce Sustainability Programme, has been meeting monthly since November 2023. Three projects have been identified to take forward for delivery in Q4 23/24: ▪ Improving the Exit process; ▪ Flexible Retirement policy and process; ▪ Improving the transition of substantive leavers onto the Bank. Project deliverables, benefits and timescales are currently being finalised.
Colleague Engagement and Communications • Implementation of strengthened internal communication and engagement channels • NHS Staff Survey was highest ever uptake	DofComms	Jan-April 2024	Delivery of all actions are underway: • Summary Staff Survey results to be shared via Senior Leadership Forum and Divisions • January NQPS launched • New virtual monthly Staff Forums to start in January 2024 • Programme of work to support the CEO Transition • Significant high profile media issues and planning underway • Winter Pressure Comms Campaign • Development of four Communications and Engagement Policies: ○ VIP & Visitor Policy ○ Media Policy ○ Social Media Policy ○ Branding Policy National Award and recognition for Community Engagement Lead Development of annual planner and monitoring for Engagement and Media

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Ability to offer flexible working arrangements • Inclusion Network with three sub-groups (ethnic minority; LGBTQ+, and disability). • Compassionate Behaviours Framework • Technology Enhanced Learning and Simulation Based Education	• Below average staff survey results • Diversity gaps in senior positions • Gender pay gap • WRES and WDES indicators • EDS22 ratings • Cost of living increases	• Staff Experience Improvement Programme • Internal audit reviews 2022-25: ○ Cultural Maturity ○ Cross health economy reviews ○ Equality, Diversity and Inclusion

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

• Divisional colleague engagement plans • Proactive Health and Wellbeing interventions covering physical, mental and financial wellbeing	• Exit interview trends • Inconsistent Pay T&Cs for HCSWs	○ Health and Wellbeing ○ Staff Engagement

Key:

RAG Rating	RAG Definition
Blue	Completed
Green	On track to be delivered within planned timeframes
Amber	Delays to delivery within planned timeframes
Red	Risk to achievement

Report to Board of Directors			
Date	14 March 2024		
Title	**Trust Risk Register**		
Author / Sponsoring Director/ Presenter	Lee Troake, Head of Risk and Safety Mark Pietroni, Medical Director and Director of Safety		
Purpose of Report (Tick all that apply ✓)			
To provide assurance	✓	To obtain approval	
Regulatory requirement		To highlight an emerging risk or issue	✓
To canvas opinion		For information	
To provide advice		To highlight patient or staff experience	

Summary of Report

Purpose

The Trust Risk Register (TRR) enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. Following Risk Management Group on 10 January, 7 February and 6 March 2024 the following changes were made to the Trust Risk Register:

Key issues to note

TRR updates:
- Three new risks were approved onto the TRR
- No risks were proposed for approval with a TRR score to be held at divisional level
- No risks were downgraded from the TRR
- One risk was closed

For further details see enclosed Trust Risk Report (Appendix 1) and Trust Risk Register Summary (Appendix 2).

Risk Management Strategy

The revised Risk Management Strategy was approved in January 2024.

Risk and Incident Performance KPIs

The following is a summary of the Trust's performance against the KPIs:

- Trust performs well in relation to the following indicators for risk management:
  - Recording controls
  - Duty of Candours investigations
  - Serious Incident investigations
  - Health & Safety harm related investigations

- Performance requires improvement for the following indicators:

- Investigation and learning from no/low harm incidents that are high risk
- Timely completion and sign-off of actions

▪ Recording active actions to reduce risks Note that the transfer of risks to Cloud, closed actions were not individually uploaded due to the admin and were attached on a PDF for reference. Only open / on-going actions are recorded within the actions on the system. This has resulted in greater number of risks showing as having no actions as there is no current action on-going to actively reduce the risk. RMG agreed a period of two months from March for risk owners to upload their active actions onto the new system. The full Risk Assurance Report is provided in Appendix 3.
Risks or Concerns
See Trust Risk Register
Financial Implications
Approved by: Director of Finance / Director of Operational Finance | **Date:**
Recommendation
The Board is asked to **NOTE** the report.
Enclosures
Trust Risk Register Summary and RMG Trust Risk Report

TRUST RISK REGISTER UPDATE

1.0 NEW RISKS ACCEPTED ON TO TRR

C4009POD / Cloud # 154

Operational Lead: Maria Smith
Executive Lead: Claire Radley

Inherent Risk

The risk of colleagues identifying with certain minority protected characteristics (EM, Disabled and LGBTQ+) continuing to report a worse experience and higher levels of discrimination, leading to low morale, poor health and wellbeing, and which in turn may lead to reduced performance/team effectiveness and increased turnover

Cause

- Lack of EDI Specific training – linking into risk C4065POD (no EDI specific trainer)
- Lack of an understanding/appreciation/promotion of Allyship throughout the organisation
- Minimal use of the Inclusion Network to drive and promote inclusivity
- Lack of a structured reporting mechanism regarding discrimination, with a lack of structured support mechanisms for both the staff member experiencing discrimination but also the line manager to investigate.
- A perceived lack of safety in speaking up about discrimination, pattens, witnessed discrimination

Impact & Effect

- Colleagues who identify with minority protected characteristics are statistically more likely to be on the receiving end of discrimination, bullying and harassment, and unfair treatment. Having experiences such as these throughout all or part of one's life can already predispose someone to having mental health issues.
- Having adverse experiences in the work environment can perpetuate existing trauma in individuals and reinforce organisational cultural practices and behaviours which discriminate against minority groups
- Such experiences can impact wellbeing, safety, commitment and satisfaction levels at work
- Poor experiences at work can lead to poor patient and staff experience, potential increased attrition/sickness absence and associated costs as well as mental health issues.
- The Trust will not be an Employer of choice and our reputation will be harmed

Risk Category (domain)	Consequence	Likelihood	Rating
Workforce	4	4	16

Evidence of scoring

3 linked risks

Key Controls

Inclusion Network established, supported by an Inclusion Council and 3 subnetworks for EM, Disability and LGBTQ+.

Staff Experience Improvement Programme which has four workstreams collectively aiming to improve the experience of colleagues:

1. Teamwork and leadership development
2. Anti-Discrimination
3. Speaking up and raising concerns
4. Staff experience taskforce

Gaps in Controls
Discrimination workstream deliverables to be defined and delivered. Poor and inconsistent approach to accountability of staff for poor behaviours. Fear/mistrust in raising concerns because of retribution, inaction
Actions

• Anti – Discrimination Workstream with KPIs,
  ○ Discrimination reporting,
  ○ Support for Line Managers and those reporting discrimination
  ○ Line management awareness or tackling discrimination
  ○ Linking in with Restorative and Just Culture and Mutual Respect Policy additions
  ○ Utilisation of data of discrimination themes through NSS, Datix, FTSU
• A renewed focus as a Trust regarding Freedom to Speak up, to work with the Anti-Discrimination workstream of themes.
• Re-aligning actions within the wider Trust EDI Action Plan to work towards the NHSE Improvement Plan HIA's – specifically HIA 6 (bullying and harassment), 4 (health inequalities), to link in with our WRES/WDES results and recommended indicators action plans and towards the BAF.
• Scoring discussion with EDI team
• Allyship focus and work towards HIA 1 (measurable objectives on EDI for Chair, Chief Exec and board Members).
• New co-chairs of the Staff Inclusion Network have now been appointed– with specific work with each staff group
• Specific work with the IEN council chairs of what support IEN's need
• EDI Pastoral Officer role via charity for 12 months – to link in with the Anti-Discrimination workstream
• New Lead for Colleague Health and Wellbeing –work specifically with the disability network and assistance with the Reasonable Adjustments work
• Utilisation of exit interview themes and data
• Utilisation of vacancy factor to address the lack of EDI specific training – also towards risk C4065POD)
• Review and adaptation of pre-paid Globis Training sessions to be aligned to Trust actions and priorities, including Allyship to commence in 2024

C3550POD / Cloud #83
Risk Lead: Lee Troake
Executive Lead: Claire Radley

Inherent Risk
The risk of physical or psychological harm to patients, relatives, public and staff during incidents involving challenging, aggressive, abusive, threatening and offensive behaviour or physical violence
Cause
Incidents stem from factors such as clinical conditions including dementia, confusion and delirium, alcohol and drug misuse, social factors, long wait times leading to frustration, poor welfare facilities, lack of information and inadequate mental health facilities for the demand.
Impact & Effect
• Staff are subjected to adverse behaviours including the use of profanities, abuse, kicking, punching, biting, scratching, pushing and spitting • Minor injuries to staff on a daily basis, major injuries on a weekly basis

- Incidents can involve the use of a weapon (e.g., a knife, needle) resulting in stab wounds
- Incidents may involve bodily fluid (e.g., urine, saliva, blood) leading to exposure to blood borne virus
- Staff are subjected to racial abuse / abuse in relation to a protected characteristic
- Psychological harm to staff - emotional distress, fear, intimidation, harassment and discrimination
- Staff drawn away from their primary role to resolve V&A incidents has an associated impact on hospital efficiency
- Increased calls to the police / police attendance and incidents of armed response
- Staff and portering teams are not trained to deal with complex mental health issues leading to an inability to de-escalate an incident without restraint or avoidable harm to the patient
- Patients and visitors witness distressing incidents during their time in the hospital
- Poor staff morale and willingness to attend work - poor staff retention
- Increased staff sickness absence
- Risk of litigation for non-compliance with the mental capacity / health act
- S29a linked to violent patients who are chemically sedated
- HEE report that ED are is unsafe – withdrawal of doctors
- Risk of investigation and / or prosecution under the Health & Safety at Work etc Act - failure to provide a safe working environment
- CQC intervention - unsafe care, poor facilities
- Insufficient number of porters to attend more than one incident at a time, leaving staff and patients at risk
- Delays to patient care and flow caused by protracted V&A incidents
- Limited facilities and resources to support patients with mental health issues and to provide a calm / safe environment for care
- Limited security surveillance and presence within ED/ USC and wards - reactive, not proactive response
- Staff, patients and public do not feel safe when at the hospital
- Damage to equipment and environment and associated repair and replacement costs
- Increased prosecutions of perpetrators via the police - staff have to attend court
- Complaints from inpatients or relatives
- Civil personal injury claims from staff, patients or public

Risk Category (domain)	Consequence	Likelihood	Rating
Safety	3	4	12

Evidence of scoring

- Up to 8 moderate harm incidents a month
- Average of over past two years is 1 moderate harm incident per week **(e.g., Consequence 3 x Likelihood 4)**
- Up 39 minor harm incidents per month (1+ per day)
- Average over the past two years is 11 minor harm incidents per week or 1.5 per day
- Up to 105 no harm incidents per month (3 per day)
- Average over the past two years 52 incidents per week

Score of risk has also increased due to increased challenges in relation to the capacity of the response team to attend incidents which leaves staff and patients at greater risk of injury during a V&A incident

Key Controls

- Pin point alarms in ED
- Behaviour Standards Charter in place for patients / visitors

- 4 level response process to V&A incidents - verbal warning, written warning, conditional order, injunction,
- Collaborative work and weekly liaison between Behaviour Standards Panel and homeless team - to coordinate response where V&A relates to homeless person,
- Suicide Prevention Action Plan - agreed with SABA to reduce risk of incidents in Tower car park
- Logging of V&A calls onto MyPorter (GMS)
- Review and revised Restraint Policy including Body Mapping records for restraint
- Dementia Friendly Ward (environment) Specification developed for use in new build or refurb
- Agreed number of safer rooms / anti-ligature in ED
- Safer rooms available in Paeds for vulnerable patients
- Safer holding pods purchased for Paeds
- Liaison with local police in relation to criminal activity
- CCTV cameras & footage retrievable to support action taken against perpetrators
- Working with the Police to secure civil injunctions in specific cases
- V&A Group established in 2021 - meets quarterly. Chaired by Director of Safety and Quality
- V&A risk assessments completed in all high-risk areas
- Wards physical security on external doors and internal doors
- Conflict Resolution Training / Safer holding training
- V&A response team support with difficult incidents
- Behaviour Standards Panel - meets weekly. Has a ToR. Reviews all incidents where perpetrator has capacity (or capacity is unsure)
- Abuse, Aggression and Violence policy
- Vulnerable Patients Framework
- Proposal for security provisions reviewed by TLT
- V&A Action plan
- Psychological support for staff post-incident and general Mental Health is available via the Hub 2020
- Trauma Risk Incident Management programme (TRiM) Peer network - supports staff after significant incident
- Patient Information Leaflet has been trialled and approved
- Training Needs Analysis completed for each identified group of patients in the Vulnerability Framework
- V&A Response Team are appropriately licensed and trained in safer holding,
- Noise acoustics review conducted for new ED area - to support those that are sensitive or experience anxiety in relation to sound
- Gap analysis completed against V&A Reduction Standards
- Investigation pro-forma for abuse and aggression incidents improved to better support lessons learnt and feedback
- Information Governance review completed on Behaviour Standards Panel process
- Provision of female responders within the V&A response team
- SOP/ pathway and training for staff required for safer holding for patients with NG feed tube
- 'No abuse' posters designed and displayed with QR code to Behaviour Charter,
- Provision of water, charging points and vending machine in ED - to support patient welfare while waiting,
- H&S team workshops on new V&A policy to highlight changes and process to staff

Gaps in Controls

- Porters not always available to respond when on critical tasks, on another V&A call or not sufficient number in shift

- Hospital wards are not suitable environments for patients with specific mental health issues; environment can trigger distress, confusion and change in behaviour
- Use of porters impacts on operations and flow as they cease doing portering role when at an incident
- Safe holding training not available to all staff that may need it
- Body camera trial on hold whilst DPIA is signed off - unable to launch the trial
- Training tender has not been completed – no training available after March 2024
- No allocated funding for the safer holding training (approx. £70K)
- Porters do not have PPE e.g., high vis, steel toe caps, stab vest etc.
- Lack of CCTV 24/7 active monitoring which prevents early intervention before incident escalates
- CCTV policy need to be reviewed
- Security Group has not been running for some time
- No review of physical security in high-risk areas
- No review of CCTV provisions in high-risk areas
- No security presence in ED - which can act as a deterrent to abuse and violence or allow early intervention
- Lack of compatibility between training of the RMNs, porters and staff
- Training provider is maybo technique which is specific - needs ICB approach
- V&A team need further training on mental health
- Paediatric team do not have in-house Mental Health skills /competencies to support children and young people with behavioural issues
- Patient specific risk assessments required - not always done
- Not all wards are dementia friendly - environment causes distress to these patients and leads to adverse behaviour
- Patients have no personal TVs at bedside - few activities to keep occupied which can lead to boredom and distress

Actions

- External security consultant to be commissioned to carry out security review – to develop separate security response
- External Security Consultant to be commissioned to carry out training review
- Funding to be identified and allocated to training budget
- Body cam trial to be implemented in ED
- CCTV policy to be updated
- Security Group to be re-established
- Security Group to review physical security provisions of high-risk areas
- GMS to review Porters/V&A response team’s PPE
- Paediatric team to explore in-house Mental Health skills /competencies to support children and young people with behavioural issues
- Promote patient specific risk assessments for V&A
- Patient experience to explore options for patient entertainment
- Paeds to receive training on Pods

Cloud # 764
Risk Lead: Syd Walsh
Executive Lead: Mark Pietroni

Risk Description			
S2045 The risk of reduced quality of care in the fractured neck of femur pathway due to lack of resources and theatre capacity leading to poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal Hospital			
Cause			
In 2014, GHFT had the worst #NOF mortality rate in the country at 12.5%, and, as a result, the RCS were invited to review. In 2016 GHFT had both a BOA review and joined the Scaling Up Programme for Hip Fracture Improvement, which led to improvements on two key metrics: time to theatre and thirty-day mortality. Throughout much of 2018 GHFT remained above the national average for these metrics. In 2019 there was a breakdown in pathways coupled with a reduction in trauma bed-base at GRH, increasing demand on the service and a reduction in Care of the Elderly (COTE) input to patients. This has contributed to the poorer outcomes for patients since 2019 and a failure to meet time to theatre and 30-day mortality requirements for the treatment of fractured neck-of-femurs (#NOF).			
Effect			
• Average time to theatre: 42.5 hours (target 36 hours) • % of patients to theatre within 36 hours is 39.1% • Crude average mortality: 8.4% (target 6%) • Average time to ward 3A was 29 hours for 86% of patients and average time to an orthopaedic ward was 31 hours • 13.6% patients were not admitted to 3A and 6% of patients were not admitted to an orthopaedic ward • Prolonged bed rest pending Theatre associated with increased poor wound healing, pain control, nutrient and hydration, poor mental health/ confusion and hospital acquired infections. • Delirium post-op is associated with increased non-compliance with care / therapy and increased length of stay and dependency on discharge • Mortality rate on other wards 9.7% compared to 5.6% for those cared for on ward 3A • Financial impact as best practice tariff not paid for patients who do not go to theatre within 36hrs, orthogeriatric involvement. Current performance against best practice tariff will cause a loss of income. The last 18-months performance represents a loss of £900,000 for 2022 – BPT = 41.8% of 799 cases (£604,000 lost). 2023 (up to October) – BPT = 38.8% of 352 cases (£280,500 lost) • Statutory intervention, Coroner intervention and civil claims			
Risk Category (domain)	**Consequence**	**Likelihood**	**Rating**
Quality (clinical standards)	4	4	16
Evidence of scoring			
• Average time to theatre: 42.5 hours (target 36 hours) • % of patients to theatre within 36 hours is 39.1% • Crude average mortality: 8.4% • Average time to ward 3A was 29 hours for 86% of patients and average time to an orthopaedic ward was 31 hours • 13.6% patients were not admitted to 3A and 6% of patients were not admitted to an orthopaedic ward			
Key Controls			
• Early pain relief • Prioritisation of patients in ED and admission proforma			

- Volumetric pump fluid administration
- Anaesthetic standardisation
- Post op care bundle / return to ward card bundle
- Supplemental patient nutrition with nutrient assistant
- Medical cover / Orthogeriatric consultant review and therapy services at weekends
- Theatre Coordinator / Golden Patients on theatre list,
- Discharge planning and onward referrals at point of admission
- Since July 2023, the service has made improvements in time to theatre within 36 hours, increasing from 20% in May and June to above 40% between July and October, however, this still remains well below the national standard and leaves us as an outlier
- Action Plan developed to reduce the Trust's crude mortality for NOFs to 6% within the next 6 months (November 2023- May 2024),
- Recent opening of an extra ward for Trauma increasing bed capacity
- Quote to convert existing TATU into a 4 bedded bay

Gaps in Controls

- Insufficient theatre capacity
- Insufficient social worker input
- Insufficient medical cover at weekends
- Pre-ward pathway fast track admission protocol required with the engagement of ED
- Site team and Frailty team
- Ward Pathway required to ensure admission to ward 3A
- Reduce the general trauma length of stay and improve overnight reviews for sick patients
- Theatre pathway required to improve compliance with pre-op and post-op protocols and review Theatre processes (36 hours)
- Gaps in staff competency training required across all staff from ED, to ward to discharge team, including Trauma Coordinators, medical staff, nursing staff and nutrient staff
- Delayed discharges relating to social care placements, community beds and care packages

Actions

- Assess COTE consultant numbers now and pre-covid
- Conduct a scoping exercise to review the wte of therapists involved in the NOF pathway
- Create a kit list for a MOPs theatre in the existing outpatients #clinic in order to develop a MOPS theatre
- Devise a proposed NOF pre-alert fast track pathway to be submitted to the division for approval
- Ensure increased utilisation of Trauma lists in GRH to maximise daily number of cases
- EPR team to urgently implement NOF admission proforma on EPR
- Expand number of designated NOF beds
- Increase trauma operating theatres capacity
- Obtain a quote to convert existing TATU into a 4 beded bay
- Run a training programme for 3A nurses
- Run training sessions for ED nursing workforce, particularly around catheterisation
- Submit a bid to move TATU to Orthopaedic Outpatients
- Submit a business case to the division for the case to create a 4-bedded bay including the capital implications
- Submit proposal for additional weekend physio provision on 3rd floor
- Warming blankets - funding proposal
- Work with BI to create a dashboard for tracking NOFs in ED and their length of stay live
- Work with the NOF MDT to crease a ward team starter training package for T&O juniors

2.0 RISKS WITH AGREED TRR SCORE FOR HOLDING AT DIVISIONAL LEVEL

None

3.0 DOWNGRADE OF TRR RISK TO DIVISIONAL / SPECIALTY RISK REGISTER

None

4.0 CLOSURE OF RISKS ON TRR

Cloud # 515
Risk Lead: Lisa Jones
Executive Lead: Matt Holdaway

Note: SAU now has a larger footprint on ward 5b. Bed head services now available in all areas.

Risk Description			
The risk to quality of continued poor patient experience on SAU for patients requiring admission to a ward			
Cause			
Lack of beds within hospital to move patients from SAU onto wards within 4 hours, once decision to admit made, thereby creating mixed sex breaches. Inadequate patient beds in SAU to meet demand for patients to transfer in to, currently 22 EGS beds predicted requirement is 48.			
Effect			
• Lack of flow through SAU • Patients waiting for extended periods to be assessed in SAU • Self-discharges related to extended waiting times • Failure to provide timely reviews for patients requiring assessment • Impact on staff morale • Mixed sex breaches • Overcrowding in ED • Potential for patients deteriorating whilst waiting for assessment or having additional care needs that cannot be met in the environment • Delay in formulation and delivery of management plans for patients including delays in procedures • Potential increase in morbidity, mortality and overall length of stay • Poor patient experience – staying for prolonged periods on chairs and trollies; often overnight • Recruitment and retention difficulties • Increase in financial spend on agency / bank to manage increased numbers in SAU • Financial impact due to fines incurred as a result of mixed sex breaches			
Risk Category (domain)	**Consequence**	**Likelihood**	**Rating**
Quality (ICB)	4 downgraded to 1	4 downgraded to 3	3
Evidence of scoring			
SAU now has a larger footprint on ward 5b. Bed head services now available in all areas.			
Key Controls			

- 20 chairs and 2 side room capacity plus swabbing
- NEWS 2 taken by nursing team 4 hourly
- Escalation via site to obtain inpatient bed
- SOP with criteria for admission
- Referral to Register / ARCT if deteriorates whilst waiting for assessment
- Use of assessment rooms as side rooms with gold approval
- Staff visible within bay / just outside
- Trainee ACPs to review patients
- Posters to set patient expectation of waiting times
- Recliner chairs
- Ongoing recruitment and retention plan
- Portable suction / O2 cylinder available
- All trolley spaces have access to a nurse call bell
- MSA mitigated with screens / curtains
- Funding for 5a/ SUA now reviewed and realigned
- Active recruitment for RNs and HCAs

Gaps in Controls

- Inadequate patient to beds to meet transfer demand, currently 22 EGS beds – predicted requirement is 48
- No control over bed base – receive medical outliers on weekly basis
- ACPS still in training until April 2024

Actions

- 1–3-year strategy for SAU / 5th floor

5.0 OVERDUE REVIEWS OF TRR RISK

There are no overdue risks on TRR. All overdue risk review dates have been reset to the end of February 2024 to allow owners a reasonable period to conduct a review.

6.0 OVERDUE ACTIONS ON TRR RISKS

Risk ID	Inherent Risk	Action Title	Action Assigned To	Action Due Date
96	3826 Risk of delays in managing formal employee relations cases due to limited investigating officer capacity.	Establish a structured and consistent governance assessment of all cases to ensure investigations are appropriate and proportionate	Deborah Tunnell	31/12/2023
122	3755 The risk of significant disruption to service delivery, patient safety and financial position in the event of a successful cyber attack	Weekly Cyber risk review	Thelma Turner	21/11/2023
123	3898 The risk of delayed arrivals, poor candidate experience and withdrawals of overseas nurses due to a lack of available Trust accommodation.	Establish responsibilities and method of joint working between stakeholders in the contract	Richard Giles	30/11/2023

		Set up a collaboration with the local University	Richard Giles	29/12/2023
154	4009 The risk of colleagues identifying with certain minority protected characteristics (EM, Disabled and LGBTQ+) continuing to report a worse experience and higher levels of discrimination, leading to low morale, poor health and wellbeing, and which	Re-aligning actions within the wider Trust EDI Action Plan to work towards the NHSE Improvement Plan HIA's	MariaL Smith	31/01/2024
264	2404 Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Bespoke recruitment incentive	Asha Johny	04/10/2023
355	3941 The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal hospitals	Complete evaluation of waterless bathing trial	Kerry Holden	30/09/2023
		Formalised process to prioritise augmented care flushing	Steven Grantham	31/10/2023
		Purchase of water safety system	Daniel Pike	28/10/2023
		Review of birthing pool testing	Adekunle Olayiwola	30/09/2023
		Review water tanks	Daniel Pike	30/09/2023
		To create staff engagement methods for water safety	Kerry Holden	29/09/2023
		To provide list of outlets	Daniel Pike	07/12/2023
		Trust wide audit of outlets	Daniel Pike	31/10/2023
374	3930 The risk of fires caused by lithium battery chargers affecting the safety of all users, but particularly affecting ward environments. Risk of statutory breach of duty leading to enforcement notices from Fire Service/HSE/CQC	Conclude RAG audit of areas across the Trust	Daniel Pike	11/11/2023
		Fire team trainer to add information to mandatory training package	Daniel Pike	31/10/2023
		Identify any works required for alternative locations	Daniel Pike	31/10/2023
		Rolling replacement programme for batteries	Fraser Frizelle	28/10/2023

		To ascertain staff training requirements and roll-out	Fraser Frizelle	31/10/2023
		To roll-out new SVF process	Bernie Turner	30/12/2023
385	3876 The risk of reduced quality of care for dying patients due being unable to discharge to a place of their choice and dying within hospital	Job description review	Samantha White	30/09/2023
		Monthly rapid discharge home to die meeting established	Samantha White	31/10/2023
		Solution for the digital storage and completion of national documents for application for CHC funding	Jon Stone	30/09/2023
409	3845 Risk of first trimester screening offer being missed (if dating scan occurs after 14+1 weeks gestational window for screening), affecting patient pregnancy options and care pathway.	undertake review of ANSCO hours	Trine Jorgensen	26/12/2023
443	2815 The risk to patient safety due to delays in the acute stroke pathway for patients attending Gloucestershire Royal Hospital (GRH) Emergency Department.	Reducing ED pressures to allow staff to work safely and prioritise patients appropriately	David Cooper	01/11/2023
		To work with ICB to improve patient awareness of stroke services not going to GRH	Kate Hellier	30/11/2023
472	3743 The risk of failing to deliver the necessary support to the Laboratory due to insufficient staffing levels and lack of appropriate skill sets, leading to a delay to diagnosis or treatment within the clinical service and harm to the patient.	Bespoke Recruitment Incentive	Asha Johny	09/11/2023
507	3481 The risk of severe harm to patients requiring emergency obstetric surgery caused by an inability to meet a minimum staffing requirement when opening a second obstetric theatre. The risk of harm to the wellbeing of staff when working outside mini	2nd Obstetric theatre paper Gateway to TLT by 18 April	Michael Dobb	30/09/2023
515	3337 The risk to quality of continued poor patient experience on SAU for patients requiring admission to a ward	1-3 year strategy plan for SAU and 5th floor	Tracey Hendry	30/11/2023

The table below shows the Trust risks that have closed actions but no ongoing / actions in process to reduce the risk further. This would indicate that the risk can no longer be actively reduced. Owners should ensure that any ongoing action or planned actions are added to the risk on Cloud.

Risk ID	Inherent Risk	Action Title	Risk Lead
79	1437 The risk of being unable to recruit sufficient suitably qualified clinical staff including Medical & Dental, Registered Nurses & Midwives and Allied Health Professionals, thereby impacting on the delivery of the Trust's strategic objectives		Shirley Daniels
143	1850 The risk of ineffective care, prolonged stay and harm of a child or young person (12-18yrs) with significant emotional dysregulation or mental health needs at Children's Inpatients Gloucestershire Royal Hospital. This risk of harm to other patients		Karen Pudge
160	1945 The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls.		Craig Bradley
161	2667 The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.		Craig Bradley
233	2669 The risk of harm to patients as a result of inpatient falls		Craig Bradley
348	3963 Risk of increased harm, breach in regulations, distress and poor quality experience to patients, staff and visitors when boarding patients in wards.		Craig Bradley
407	3103 The risk of total shutdown of the Clinical Chemistry Pathology laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.		Linford Rees
413	3767 The risk of harm to patients and staff due to being unable to discharge patients from the Trust		Neil Hardy-Lafaro
426	2268 The risk of patient deterioration, harm and poor patient experience when care is provided in the corridor during times of overcrowding in ED		Samantha James
499	3536 The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.		Lisa Stephens
525	3034 The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability) and reduced patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire		Matt Holdaway
534	2895 There is a risk the Integrated Care Board (ICS)/ Trust has insufficient capital due to the Capital departmental expenditure limit (CDEL) and/or is unable to secure additional borrowing to address critical digital, estate or equipment risks and/o		Karen Johnson
538	2819 The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in a failure to recognise, plan and deliver appropriate urgent care needs.		Andrew Foo

Trust Risk Register

Risk ID	Risk	Type	Subtype	Risk owner	Date opened	Initial rating	Current likelihood	Current consequence	Current rating	Target rating	Movement	Trend	Next Review Date
79	1437 The risk of being unable to recruit sufficient suitably qualified clinical staff including Medical & Dental, Registered Nurses & Midwives and Allied Health Professionals, thereby impacting on the delivery of the Trust's strategic objectives	Workforce	Recruitment & retention	Shirley Daniels	12/03/2012	8	5	4	20	12			29/02/2024
83	3550 The risk of physical or psychological harm to patients, relatives, public and staff during incidents involving challenging, aggressive, abusive, threatening and offensive behaviour or physical violence.	Safety	Abuse and Violence	Lee Troake	18/06/2021	10	4	3	12	4			29/02/2024
96	3826 Risk of delays in managing formal employee relations cases due to limited investigating officer capacity.	Workforce	Recruitment & retention	Jenny Turton	17/06/2022	12	4	3	12	2			29/02/2024
122	3755 The risk of significant disruption to service delivery, patient safety and financial position in the event of a successful cyber attack			Thelma Turner	11/09/2023	20	4	5	20	2			29/02/2024

123	3898 The risk of delayed arrivals, poor candidate experience and withdrawals of overseas nurses due to a lack of available Trust accommodation.	Workforce	Recruitment & retention	Richard Giles	31/08/2022	12	4	3	12	4			30/06/2024
141	4007 The risk that substantive non-medical staff are not fully compliant with their appraisal requirements and they receive a low-quality appraisal experience	Workforce	Staffing & competency	Abigail Hopewell	20/02/2023	16	4	3	12	8			02/04/2024
143	1850 The risk of ineffective care, prolonged stay and harm of a child or young person (12-18yrs) with significant emotional dysregulation or mental health needs at Children's Inpatients Gloucestershire Royal Hospital. This risk of harm to other patie	Safety	Abuse and Violence	Karen Pudge	16/01/2014	9	4	3	12	4			29/02/2024
154	4009 The risk of colleagues identifying with certain minority protected characteristics (EM, Disabled and LGBTQ+) continuing to report a worse experience and higher levels of discrimination, leading to low morale, poor health and wellbeing, and which	Workforce	Equality, Diversity and Inclusion	MariaL Smith	20/02/2023	16	4	3	12	8			29/02/2024

160	1945 The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls.	Safety	Infection Control	Craig Bradley	19/08/2014	9	4	3	12	6			29/02/2024
161	2667 The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	Safety	Infection Control	Craig Bradley	05/02/2018	16	3	4	12	6			15/04/2024
233	2669 The risk of harm to patients as a result of inpatient falls	Safety	Clinical Assessment	Craig Bradley	06/02/2018	15	3	4	12	6			29/02/2024
236	2803 The risk that staff morale, productivity and team cohesion are eroded by adverse workplace experiences and/or significant external events, which in turn adversely impacts patient safety, job satisfaction, colleague wellbeing, and staff retention	Workforce	Equality, Diversity and Inclusion	Abigail Hopewell	16/10/2018	4	4	4	16	6			29/02/2024
264	2404 Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Workforce	Recruitment & retention	Asha Johny	02/12/2016	9	4	4	16	6			29/02/2024

266	3682 The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Statutory	Integrated Care Board	Susan Macklin	22/11/2021	15	4	4	16	6			29/03/2024
281	3834 The risk of not being able to provide a pharmacy manufacturing service and losing MHRA Specials Licence due to staff shortage.			Martin Pratt	15/09/2023	12	4	4	16	1			31/05/2024
333	3968 Risk of a delay to follow-up appointments leading to significant reduction of vision due to insufficient resources to correctly prioritise patients on the waiting list.	Workforce	Staffing & competency	Cathryn Biston	14/12/2022	9	3	4	12	6			29/02/2024
348	3963 Risk of increased harm, breach in regulations, distress and poor quality experience to patients, staff and visitors when boarding patients in wards.	Quality	High patient demand	Craig Bradley	18/09/2023	15	5	3	15	4			29/02/2024
355	3941 The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal hospitals	Statutory	Breach of legislation	Bernie Turner	01/11/2022	15	2	5	10	2			29/02/2024

374	3930 The risk of fires caused by lithium battery chargers affecting the safety of all users, but particularly affecting ward environments. Risk of statutory breach of duty leading to enforcement notices from Fire Service/HSE/CQC	Statutory	Estates	Bernie Turner	17/10/2022	10	3	5	15	5			29/02/2024
385	3876 The risk of reduced quality of care for dying patients due being unable to discharge to a place of their choice and dying within hospital	Quality	Integrated Care Board	Samantha White	05/08/2022	16	4	4	16	2			30/03/2024
407	3103 The risk of total shutdown of the Clinical Chemistry Pathology laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Statutory	Breach of legislation	Linford Rees	27/12/2019	12	4	4	16	4			31/05/2024
409	3845 Risk of first trimester screening offer being missed (if dating scan occurs after 14+1 weeks gestational window for screening), affecting patient pregnancy options and care pathway.	Safety	Delayed diagnosis and treatment	Trine Jorgensen	04/07/2022	8	4	4	16	6			31/05/2024

413	3767 The risk of harm to patients and staff due to being unable to discharge patients from the Trust	Quality	Integrated Care Board	Neil Hardy-Lofaro	18/03/2022	16	4	4	16	6	↔		29/02/2024
425	2424 The risk to business interruption in theatres due to the failure of the ventilation to meet the statutory required number of air changes	Business	Facilities	Michael Dobb	16/01/2017	4	4	4	16	6	↑		14/05/2024
426	2268 The risk of patient deterioration, harm and poor patient experience when care is provided in the corridor during times of overcrowding in ED	Statutory	Integrated Care Board	Samantha James	29/09/2015	16	4	4	16	4	↔		25/06/2024
436	2517 The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT	Quality	Facilities	Sarah Brown	15/05/2017	8	2	5	10	4	↑		29/02/2024
442	2613 The risk to patient safety as a result of laboratory failure due to ageing imaging equipment within the Cardiac Laboratories.	Safety	Equipment	Tom Millard	29/11/2017	16	3	4	12	4	↓		29/02/2024

443	2815 The risk to patient safety due to delays in the acute stroke pathway for patients attending Gloucestershire Royal Hospital (GRH) Emergency Department.	Safety	Delayed diagnosis and treatment	Kate Hellier	30/10/2018	16	3	4	12	6			29/02/2024
472	3743 The risk of failing to deliver the necessary support to the Laboratory due to insufficient staffing levels and lack of appropriate skill sets, leading to a delay to diagnosis or treatment within the clinical service and harm to the patient.	Workforce	Staffing & competency	Asha Johny	07/02/2022	15	4	3	12	4			29/02/2024
499	3536 The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Workforce	Recruitment & retention	Lisa Stephens	20/05/2021	15	5	4	20	6			30/04/2024
507	3481 The risk of severe harm to patients requiring emergency obstetric surgery caused by an inability to meet a minimum staffing requirement when opening a second obstetric theatre. The risk of harm to the wellbeing of staff when working outside mini	Workforce	Staffing & competency	Natalie Ball	02/03/2021	9	4	4	16	4			29/02/2024

510	3084 The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance.	Quality	Digital	Lee Troake	21/11/2019	20	5	3	15	4			02/04/2024
515	3337 The risk to quality of continued poor patient experience on SAU for patients requiring admission to a ward	Quality	Integrated Care Board	Lisa Jones	25/09/2020	16	4	4	16	10			29/02/2024
525	3034 The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability) and reduced patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire	Workforce	Recruitment & retention	Matt Holdaway	27/08/2019	20	5	4	20	9			29/02/2024
534	2895 There is a risk the Integrated Care Board (ICS)/ Trust has insufficient capital due to the Capital departmental expenditure limit (CDEL) and/or is unable to secure additional borrowing to address critical digital, estate or equipment risks and/o	Environment	Breach of legislation	Karen Johnson	05/03/2019	8	4	4	16	6			29/02/2024

538	2819 The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in a failure to recognise, plan and deliver appropriate urgent care needs.	Safety	Delayed diagnosis and treatment	Andrew Foo	06/11/2018	8	4	3	12	6			31/04/2024
609	2976 The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Workforce	Recruitment & retention	Richard Hunt	09/07/2019	15	5	3	15	4			30/04//2024
764	S2045 The risk of reduced quality of care in the fractured neck of femur pathway due to lack of resources and theatre capacity leading to poorer than average outcomes for patients presenting with a fractured neck of femur at Gloucestershire Royal Hospital	Quality	Clinical standards	Syd Walsh	18/06/2020	6	4	4	16	8			06/06/2024

RISK MANAGEMENT GROUP
RISK SYSTEMS ASSURANCE REPORT – MARCH 2024

1. KPI DASHBOARD

KPI	Medicine	Surgery	D&S	W&C	Corporate /IT/Finance	Trust
Risks without identified controls	1/72 1%	1/90 1%	3/137 2%	0/43 0%	0/130 0%	5/472 1%
Risks without identified actions	35/72 48%	13/90 14%	62/137 45%	23/43 54%	52/130 40%	185/472 39%

*Note that the transfer of risks to Cloud, closed actions were not individually uploaded due to the admin and were attached on a PDF for reference. Only open / on-going actions are recorded within the actions on the system. This has resulted in greater number of risks showing as having no actions as there is no current action on-going to actively reduce the risk.

KPI	Medicine	Surgery	D&S	W&C	Corporate /IT/Finance	Trust
Risks not reviewed by due date	0/72 0%	0/90 0%	0/137 0%	0/43 0%	0/130 0%	0/472 0%
Moderate/ major harm incidents not reviewed within 7 days as % of those reported in the 7-day reference period	0/6 0%	0/6 0%	0/2 0%	1/3 33%	0/0 0%	1/15 7%
No/ low harm with high or extreme risk not reviewed within 7 days as % of those reported in the 7-day reference period	5/79 6%	49/36 136%	0/10 0%	0/16 0%	3/3 100%	57/144 40%
No and minor harm incidents with high or extreme risk rating not investigated as % of those reported in the last 12 months	227/1878 12%	168/1725 10%	84/471 17%	39/454 9%	38/163 23%	549/4691 12%
Overdue priority moderate+ harms within the division / Trust as percentage of those reported in the last 12 months	7/32 21%	6/33 18%	1/13 8%	12/89 13%	0/2 0%	26/169 15%
DOCs overdue as percentage of the total declared in the last 12 months	2/62 3%	1/13 8%	0/5 0%	0/6 0%	0/0 0%	3/86 3%
SIs overdue as percentage of the total declared in the last 12 months	1/24 4%	2/6 33%	0/3 0%	2/19 10%	0/0 0%	5/52 10%
Health and safety harm incidents affecting staff with no contributory factors identified on DATIX (before closure) for relevant month	0/28 0%	0/6 0%	0/1 0%	0/4 0%	0/3 0%	0/42 0%
Overdue actions as a percentage of all open actions in division/ Trust	92/142 65%	145/209 69%	64/117 55%	46/100 46%	141/208 68%	489/776 63%

RAG key is provided at the end of the report.

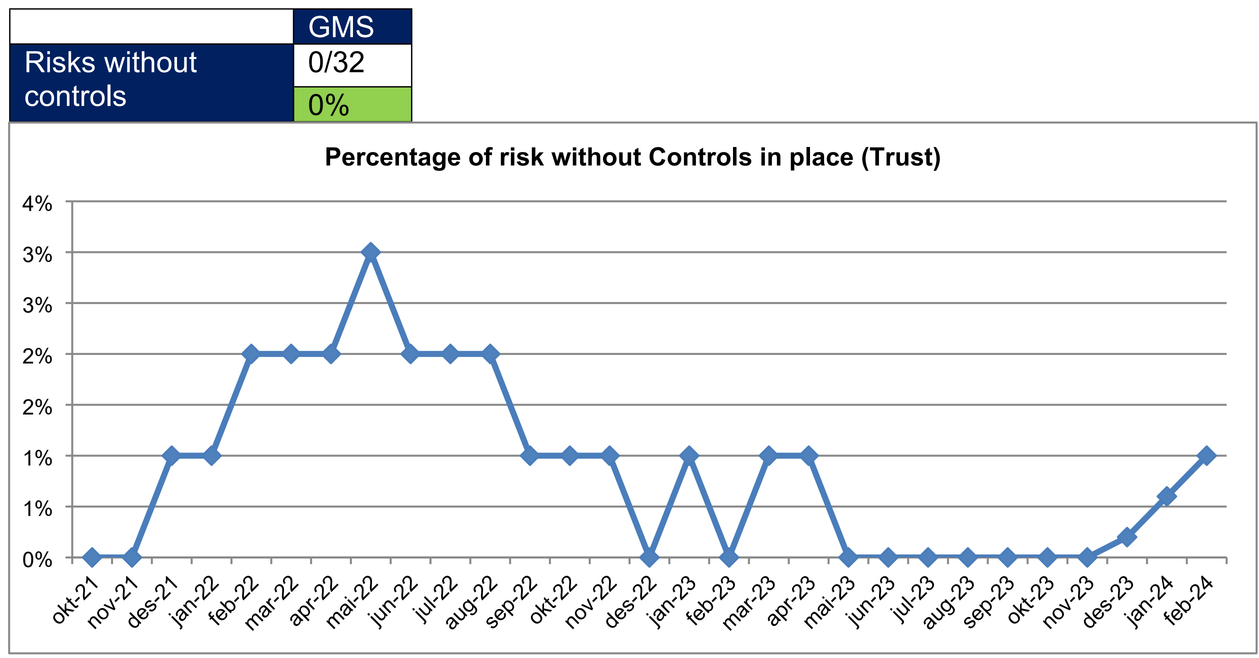
2. INTERIM PERFORMANCE DATA FOR RISK

2.1 All risks must have controls

Performance is excellent for this KPI. 99.8% of risks have controls.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
Risks without controls	1/72	1/90	3/137	0/43	0/130	5/472
	1%	1%	2%	0%	1%	1%

	GMS
Risks without controls	0/32
	0%



The risks without controls are:

#	Risk Title	Service	Risk owner	Risk Register
257	3601 The risk of delays to discharge due to suitable mobility aids not being available1	Therapy	Christopher Williams	Diagnostics and Specialties Divisional Risk Register
685	4109 Risk of harm to patients and staff with evidenced loss of service quality due to reduction in staff numbers and inability to train, retain and effectively workforce plan across the Nutrition and Dietetic department as a whole.	Dietetics	Sarah Williams	Diagnostics and Specialties Divisional Risk Register
742	The risk to patient safety of prescribing errors between the ward and theatres	Theatres	Jonathan Lightfoot	Surgical Specialty Risk Register
752	The risk of lab-acquired infection due to NHS Mail MFA implementation	Pathology	Jonathan Lewis	Diagnostics and Specialties Specialty Risk Register
766	risk to patient safety for patients being transferred to FAU overnight without any medical clerking or prescription charts	Care of the Elderly	Claire Dales	Medical Specialty Risk Register

2.2 All risks must have actions

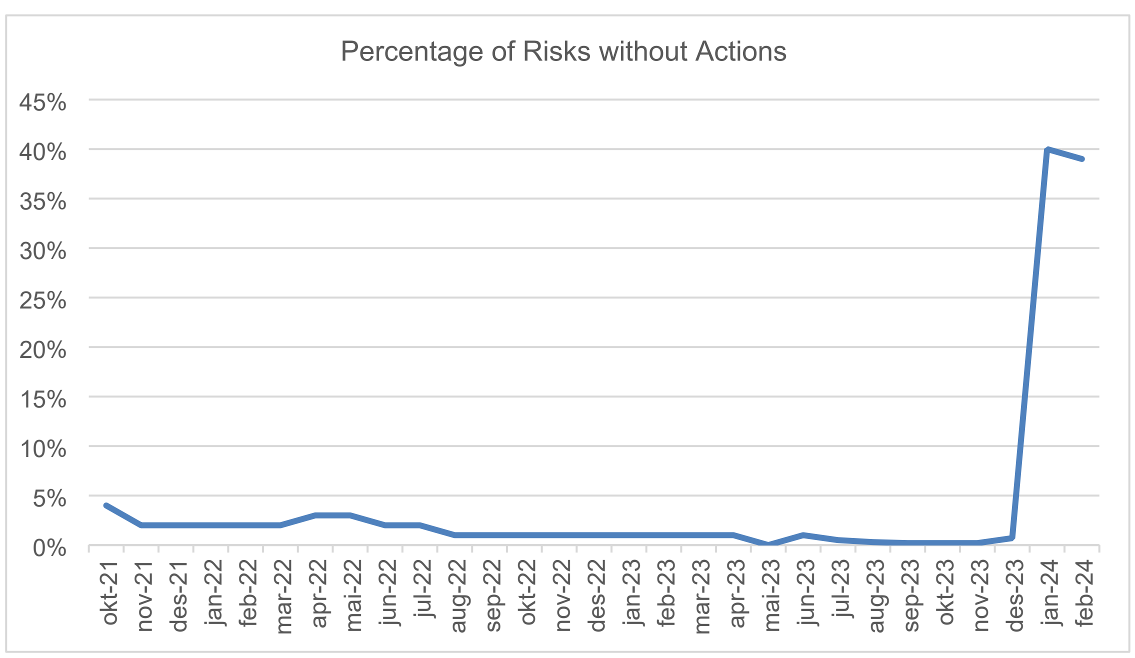
On transfer to Cloud closed actions were added as an attachment to the risk, therefore on Cloud only open / on-going actions are recorded within the actions field on the system. This has resulted in greater number of risks showing as having no actions.

At RMG in February 2024, it was noted that all risks should have actions in progress to actively reduce the risks, unless it has been accepted that there are no further actions that can be taken to reduce the risk and the risk is being tolerated at its current level.

The Chair of RMG requested in February that risk owners review their risks and add current actions.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
Risks without actions	35/72	13/90	62/137	23/43	52/130	185/472
	48%	14%	45%	54%	40%	39%

	GMS
Risks without actions	16/32
	50%

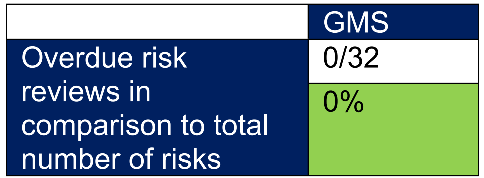


Risks with no actions are shown in Appendix 1

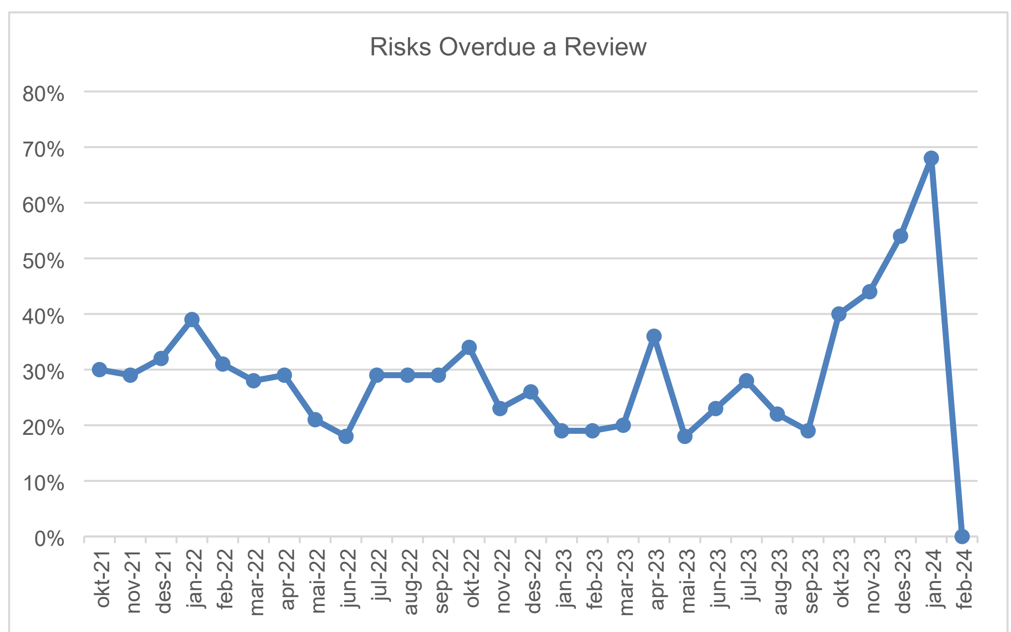
2.3 Risks to be reviewed by specified review date

Compliance is at 100%**.** All overdue review dates were moved to 29 February 2024 when Datix cloud went live to staff on 15 January 2024. This was to allow a period of grace for staff to review risks.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
Overdue risk reviews in comparison to total number of risks	0/72	0/90	0/137	0/43	0/130	0/472
	0%	0%	0%	0%	0%	0%



	GMS
Overdue risk reviews in comparison to total number of risks	0/32
	0%



2.4 Risk Closures

In February there 16 new risks opened across all registers and 11 closed. These are enclosed in Appendix 1.

Risks open and closed per month

This charts shows the number of risks opened and closed per month for the past rolling 12 months.

3.0 INTERIM PERFORAMNCE DATA FOR INCIDENTS

3.1 Initial Review of Reported Incidents

3.1.1 Initial Review of No or Minor Harm Incidents reported with high or extreme rating

The data below shows no/ low harm incidents that were reported as high / extreme risk in a 7-day period and the number/percentage of these that were not reviewed within 7 days.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
No or Minor Harm Incidents reported with a high or extreme rating not reviewed within 7 days as % of all those reported in 7-day period	5/79	49/36	0/10	0/16	3/3	57/144
	6%	136%	0%	0%	100%	40%

	GMS
No or Minor Harm Incidents reported with a high or extreme rating not reviewed within 7 days as % of all those reported in 7-day period	6/5
	120%

3.1.2 Initial Review of Moderate harm incidents

One moderate or above harm incidents has not been reviewed within 7 days within the Trust.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
Incidents reported as moderate harm+ not reviewed within 7 days as % of all those reported in 7-day period	0/6	0/6	0/2	1/3	0/0	1/15
	0%	0%	0%	33%	0%	15%

	GMS
Incidents reported as moderate harm+ not reviewed within 7 days as % of all those reported in 7-day period	0/2
	0%

3.2 Investigations of High Risk or Moderate+ Harm Incidents

3.2.1 Low Harm Investigations with an Identified High/extreme Risk Rating

The data below shows no/low harm incidents that were reviewed as agreed for investigation due to an identified high / extreme risk which remain open beyond the prescribed investigation period, (excluding bereavement incidents and incidents that are deemed the responsibility of partner organisations).

	Medicine	Surgery	D&S	W&C	Corporate	Trust
No or Minor Harm Incidents with high or extreme rating not investigated as % of all those reported in last 12 months	227/1878	168/1725	84/471	39/454	38/163	549/4691
	12%	10%	17%	9%	23%	12%

	GMS
No or Minor Harm Incidents with high or extreme rating not investigated as % of all those reported in last 12 months	31/318
	10%

3.2.2 Priority Category Moderate Harm+ Patient Safety Incidents Investigations (exc. SI & DOC)

Priority categories for moderate+ harms that are not declared a DOC or SI are:

- Care, monitoring and review incidents
- Diagnosis and assessment incidents
- Falls
- Hospital acquired pressure ulcers
- Maternity foetal incidents
- Maternity maternal incidents
- Medication incidents

The data below shows the number that have not been investigated within the 60-day timeframe in comparison to the number reported in a rolling 12-month period.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
Priority Moderate Harm+ open beyond the deadline date as % of those reported in last 12 months	7/32	6/33	1/13	12/89	0/2	26/169
	21%	18%	8%	13%	0%	15%

	GMS
Priority Moderate Harm+ open beyond the deadline date as % of those reported in last 12 months	0/3
	0%

3.2.3 Confirmed DOCs - Investigations

Any DOC that was declared more than 60 working-days ago will have exceeded the investigation deadline. The data below shows DOCs that have exceeded the deadline in comparison to the number declared in a rolling 12-month period.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
	2/62	1/13	0/5	0/6	0/0	3/86

DOCs open beyond the deadline date as % of DOCS declared in last 12 months	3%	8%	0%	0%	0%	3%

Those overdue are:

Ref	Division	Description	Date Due	Investigator
W193023	Medical	Retrospective datix as reviewing data for deteriorating patient CQUIN. Pt had deterioration over the evening, observations were taken hourly from 21:00 until a resuscitation call was put out at 23:00. Observations documented by the nurses suggest that this patient had a NEWS 10 and was unresponsive at 22:00 but this was not escalated until 23:00 when the next set of observations were taken and the Resus call instigated. On further investigation nursing staff had retrospectively put the observations and documentation onto the system following the resuscitation call.	15/11/2023	Schorah, Catherine
W194749	Surgical	Patient listed for ureteroscopy + laser for kidney stone in IR theatre at CGH during surgery power supply to laser failed. Surgeon forced to abandon surgery	18/07/2023	Wills, Jessica
W201567	Medical	Patient returned from Hartpury suite post pacemaker insertion, instruction written in medical notes to restart IV heparin and warfarin 5mg at 9pm, this was stopped at 8am 25/1/23 prior to procedure. Unfortunately this was not prescribed and it took a while for ward cover to prescribe as all of our doctors had finished their shift. This resulted in patient receiving his heparin/warfarin later than planned. The patient began to have trouble with his speech around midnight and at 8 am 26/1/23 this was escalated by the morning staff.	27/12/2023	Schorah, Catherine

3.2.4 Confirmed Serious Incidents (SI) – Investigations

Once confirmed as an SI, an additional 60-working day (12 weeks) investigation time commences, unless an extension is granted. The data below shows SIs investigations that have exceeded that date in comparison to the number declared in a rolling 12 months period. This data excludes SI still open on the system pending the completion of the action plan.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
SI open beyond the deadline date as % of SI declared in last 12 months	1/24	2/6	0/3	2/19	0/0	5/52
	4%	33%	0%	10%	0%	10%

Those overdue are:

Ref	Division	Description	Patient Safety Investigator	Deadline inc. extension
W218387	Medical	Patient came in via A&E for CXR. CXR showed opacities that had increased in size since previous CXR in October 2022. The report from Oct 2022 recommends a fast track	Windscheffel, Dieter	28/12/2023

		CT scan to investigate, but this was not arranged. PT confirmed that they did not have a private CT scan		
W192721	Surgical	High-risk bladder cancer. Previous left kidney removal for a similar cancer. Bladder tumour resection 15 July 2022. Delay to MDT > 2 months. Brought to MDT clinic 3 months after the surgery. Pathology result from the operation 3 months ago suggests very aggressive bladder cancer with a suspicion of invasion in to deeper muscle. Patient also brought to clinic as deteriorating with blood tests abnormal and for CT report. Had a CT 13 days ago, but no report available as yet. Issues: 1. serious delay to results and MDT, 2. CT report delay, 3. May now have spread of cancer - serious potential harm	Jelski, Joseph	18/02/2024
W214340	Surgical	Patient discussed at MDT on 29th June 2023 following a 2WW referral from GP for epigastric pain and weight loss. Had CT scan which was discussed which showed an extensive HCC. Disease not resectable and patient too frail for systemic treatment so is on enhanced supportive care pathway (Palliative Care). On review of previous imaging, had an MRI liver in November 2021 which was suspicious for HCC and recommended a follow up CT. This was requested by the medical team and took place on 10th Feb 2022. This highlighted likely HCC as a red alert. There was no MDT referral / follow up	Windscheffel, Dieter	22/02/2024
W191854	W&C	Non re-assuring CTG 22.9.22 -plans initially made to deliver baby, however the plan was changed by consultant on 22.9.22 to send the woman home/GBU as the CTG had normalised . BS 0 - therefore woman sent home 30.9.22 the woman returned with reduced fetal movements on 30.9.22 when sadly an IUD was confirmed	Heaven, Wendy	11/01/2024
W213115	W&C	This is based on a verbal complaint made by parents during their clinic visit and a wish to obtain more information about missed diagnosis. Antenatal scan on 24/02/2023 showed a dilated bowel loop and a plan was made to review in foetal medicine. This never happened and parents weren't told about the bowel in follow up scans. Baby was delivered in GRH and admitted to NNU for respiratory distress. She deteriorated around 24 h of age and developed a pneumoperitoneum. Transferred to Bristol, underwent surgery which showed a perforation secondary to bowel atresia	Baldwin, Lisa	16/02/2024

3.2.5 H&S harm incidents closed within the last month with no contributory factors

Contributory factors play a key role in identifying the cause and ultimately the learning from an adverse event. These help to identify the underlying issues that have led to the harm event.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
H&S harm incident closed without contributory factors identified as % of the number closed in the relevant month	0/28	0/6	0/1	0/4	0/3	0/42
	0%	0%	0%	0%	0%	0%

	GMS

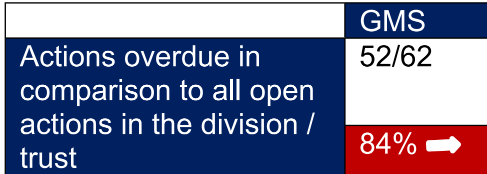
H&S harm incident closed without contributory factors identified as % of the number closed in the relevant month	0/6 0%

3. Overdue Actions

In the incident module, currently 155/251 (62%) are overdue for completion
In the risk module currently 338/529 (64%) of actions are overdue.

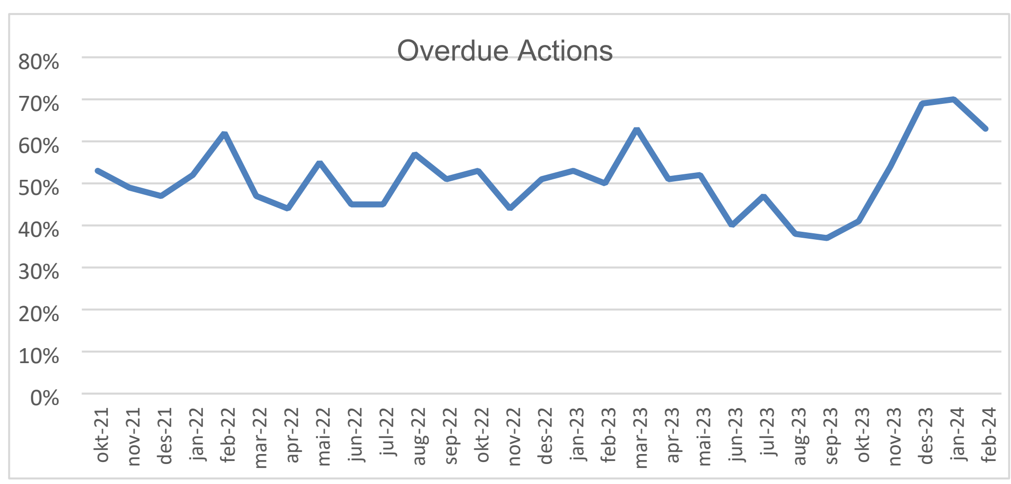
Performance against this KPI continues to require improvement. The data below shows the number of actions overdue in comparison to all open actions in the division / trust.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
Actions overdue in comparison to all open actions in the division / trust	92/142 65% ⬇	145/209 69% ⬇	64/117 55% ⬇	46/100 46% ⬇	141/208 68% ⬇	489/776 63% ⬇



	GMS
Actions overdue in comparison to all open actions in the division / trust	52/62 84% ➡

The graph below shows that the management of actions has remained an issue for the past 2 years. Appendix 1 – shows all actions overdue.



RAG KEY

Measure	Target
Risks without identified controls	5% green, 6-25% amber, 26% or more red
Risks without identified actions	5% green, 6-25% amber, 26% or more red
Risks not reviewed by due date	5% green, 6-25% amber, 26% or more red
Moderate/ major harm incidents not reviewed within 7 days	5% green, 6-25% amber, 26% or more red
No/ low harm with high or extreme risk not reviewed with last 7 days as % or those reported in last 12 months	1-10% green, 11-25% amber, 26% or more red

No and minor harm incidents with a risk rating of high or extreme not investigated % or those reported in last 12 months	1-10% green, 11-25% amber, 26% or more red
Overdue priority moderate+ harms overdue within the division as percentage of all open priority moderate+ harm	1-10% green, 11-25% amber, 26% or more red
DOCs overdue as percentage of the total declared in last 12 months	1-10% green, 11-25% amber, 26% or more red
SIs overdue as percentage of the total declared in last 12 months	1-10% green, 11-25% amber, 26% or more red
Health and safety harm incidents with no contributory factors identified (before closure) as % of total closed in last month	1-10% green, 11-25% amber, 26% or more red
Overdue actions as % of open actions	1-10% green, 11-25% amber, 26% or more red

KEY ISSUES AND ASSURANCE REPORT AUDIT AND ASSURANCE COMMITTEE – FEBRUARY 2024		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
	There were NO items rated as RED	
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Internal Audit	**Progress report** – Good progress noted. Rated amber in light of previous concerns but seeing continued sustained progress between meetings backed up by feedback from the Internal Auditors.	Continued sustained performance needed.
	Mental Health Act report – Overall limited assurance assessment for design and operational effectiveness. Report was commissioned by Management to obtain candid assessment of current position with a range of helpful recommendations, all of which were accepted by management. Helpful feedback from Chief Nurse around value of the work undertaken. No matters identified around patient safety and action plan will be prepared by early May. Rated as amber given proactive nature of commissioning and intent around implementation of lessons learned. This will be overseen by the Quality and Performance Committee.	Evidence of implementation and improved performance as a result.
	Organisational readiness report – Overall moderate assurance for design and limited for effectiveness. As per the previous report, this was commissioned by Management to obtain candid assessment of current position with a range of helpful recommendations, all of which were accepted by management. Helpful feedback from Chief People Officer around value of the work undertaken. Rated as amber given the limited assessment but currently being overseen by People and OD Committee and a clear priority for the Trust	
	Follow up report – Generally looking far better and clearly a lot of work has gone in to get us to this point. Currently on track to deliver the plan by the end of financial year along with some additional work. Rated amber as some long-standing outstanding actions have the potential to impact the annual internal audit opinion but these are being followed up by the Executive team.	Good sustained progress and delivery of the annual plan.
External Audit	Interim pre year end audit is progressing well. Good cooperation and work between Trust team and external audit. Detailed year end plan submitted. Rated amber pending delivery of year end process.	Good plan which now needs to be seen actioned and will be kept under review by the Committee.

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

Terms of Reference	Considered in the meeting. Extensive feedback provided outside of the meeting and this will be considered and incorporated into updated Terms of Reference prior to next meeting.	
Gloucestershire Managed Services (GMS)	A number of audit recommendations where further progress is needed.	
Board Assurance Framework (BAF) and Risk Register	Board Assurance Framework and Risk register position noted. Concern around Datix noted and extent of areas showing high and fairly long-term risk scores. Committee keep to see a Board Development session on long term areas of concern to assess and learn from these.	
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
High quality papers - circulated well in advance of the meeting which made prep easier.		
Follow up actions between meetings – Very good progress.		
Good focus on non-traditional audit Committee areas, with focus on patient added value.		
Matters arising. All outstanding matters were closed off.		
Counter Fraud report – Excellent, clear digestible report. Good progress reported against various ongoing cases. Evidence of added value particularly around input to raising fraud awareness across a range of staff groups.		
Approved Internal Audit and Counter Fraud work plans for 2024/25.		
Cyber Security Audit – joint audit covering a range of Gloucestershire health economy partners, good level of assurance provided along with some added value lessons learned.		
Committee discussed plans for self-assessment process.		
Single tender actions report - No retrospective tenders, total value of single action tenders £1M, all with accompanying justifications		
Losses and compensations – Two low value ex gratia payments made and approved write off of 190 low value invoices totalling approx. £3.5K.		
Annual debt report – Noted.		

Items not Rated			
N/A			

Investments			
Case	**Comments**	**Approval**	**Actions**
N/A			

Impact on Board Assurance Framework (BAF)
None noted.

KEY ISSUES AND ASSURANCE REPORT People and Organisational Development Committee, 25 January 2024		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Recruitment and Attraction	Board Assurance Framework (BAF) risks being reviewed ensuring they remain fit for purpose including how BAFs for other Committees are reported for greater shared learning. Highlights included • Time to Hire' continued to reduce. • Staff focus groups taking place to support development of employer value proposition along with marketing plan to improve recruitment and retention and dedicated Trust recruitment website. • National operational guidance for workforce planning not yet received but work commenced with finance, workforce and operational leads to triangulate early indications of targets and plans. • Areas still facing challenges having focussed reviews to support recruitment plans to mitigate risks of carrying ongoing hard to fill positions, particularly where high-cost agency is in place.	Updated risks to be bought back to the Committee when work completed. Committee assured that focussed work continues to be undertaken and improved outcomes are showing. This item remains red due to need to keep focus on retention and those areas which remain hard to fill and result in high-cost agency usage.
Staff Survey	Summary of embargoed staff survey results provided. Further details to be provided including comparison with 62 acute trusts. Three workstreams underway: - • teamwork and leadership • anti-discrimination • building a safe speaking up culture. Next steps included service line results being cascaded with support for Tri's/Quads around three workstream priorities and reporting through service line performance meetings and interdivisional boards. Encouraging to see engagement programme developing but disappointing that less than half of staff would not recommend the organisation as a place to work or receive care.	Committee to be provided with comparison against 62 acute trusts along with how results were received by managers and wider workforce. Details to be provided around what support was being given to Divisions on data relating to their own teams so they could develop focussed plans and Committee could be assured that necessary actions at team level were being taken. Committee keen to receive assurance that focus and actions was on right things from an operational and staff perspective and asked to see evidence to support this. Given significance of survey feeding into wider staff

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

	Further detail to be received once detailed analysis was compiled including key themes coming out of free text.	engagement, retention and experience item is rated red. Committee asked for update around previous year's workstreams with focus on lessons learnt around what could have worked better.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Culture, Experience & Retention	Highlights included: • Continued improvements across staff engagement; floor walking, availability of hot food which was well received. • Expectations that an improved response rate on the NQPS (National Quarterly Pulse Survey). • New CEO would be holding staff forum starting the following week to improve engagement. • Social media policy strengthened, new media policy produced along with a branding policy. • Community Engagement & Involvement Manager shortlisted and won several awards for her work in the community and now a substantive member of staff. • BBC broadcasting an episode of Panorama based on the organisation Monday 29 January at 20:00 in relation to maternity services. • Progress was noted in respect of leadership development programmes with activities due to commence after Easter.	The Committee were assured that good progress is being made. The overall theme remains amber until outcomes from various initiatives being planned are embedded and positive impacts visible and shown to be sustainable. Committee requested update on actions to mitigate harassment and bullying faced by Black and Minority Ethnic (BME) staff disproportionately and in relation to bullying and harassment and evidence of the trust being culturally specific to support individual needs. Feedback on how staff were being supported after Panaroma programme including impact on morale was requested.
Workforce Sustainability Programme (WSP)	WSP Q4 position presented. The Committee welcomed improved time to hire data. Benchmarking should be a focus and resourcing team seek shared good practice but not all Trust's calculate their KPIs in same way. GHFT and Gloucestershire Health and Care (GHC) aspiration to mirror Key Performance Indicators (KPIs_ across end-to-end recruitment process to achieve a consistent comparison within Gloucestershire. Increased confidence with current target position of 49 working days and work to sustain/improve this provided.	Time to hire – confirmation of revised target and comparison around best practice in the south west region. Committee asked for further update on increase in nurse funded establishment. The Committee asked for all milestones rated red (delayed) to be brought back with detail on how performance would be improved.

	Framework agency performance when compared to other Trusts in the South West showed agreed locally negotiated bank rates helped performance and reduced off framework agency use/reliance. Committee commended significant progress made with recruitment including improvement to consultant recruitment and noted executive representatives would require further training as part of the overall improvements. Committee commended partnership working between HR and the Digital team with the medical e-rostering plans.	
Performance Appraisals	Overview of findings of non-medical appraisals review due to decline in completion rates presented. Organisation was consistently 10-15% below 90% target. A consistent problem of staff reporting poor-quality experience with regular comments including – *how do they improve my job; it's just a tick box exercise; an 'annoying piece of work that we have to do'*. Barriers identified included time, space, technology, attitude of the trust/leadership, attitude of the appraiser/appraisee and the appraisal paperwork. Next steps in review included paperwork review, training for appraisers and appraisees, with long term goals for improvement including sustained improvement with the compliance target.	The Committee reflected it was disappointing appraisees saw appraisals as target driven rather than for development. This review is important and welcomed with the focus on how to get the best out of an appraisal and how to undertake an appraisal well welcomed. Committee requested further detail around the way managers approaching appraisals could be improved, particularly during times of operational pressure and how appraisals could be linked to celebrating success as good practice and more work around helping staff to feel more positive around the value of the appraisal process. Suggestions around consideration of other routes such as continuous conversations be considered.
HSE Inspection and fire safety update	Summary provided in respect of on-going HSE inspection – areas such as violence and aggression (V&A) and musculoskeletal disorders (MSD) in scope along with relationship with Gloucestershire Managed Services (GMS) around non-compliance and pending security proposal.	Committee asked for this item to come back to future committee with a focussed update on the key issues the Committee needed assurance on. A lot of detail narrative was provided but due to time constraints the Committee

	Several risks around fire safety were reported and a fire safety plan was being prepared.	requested critical items be addressed outside of the meeting and be bought back to a future meeting with an action plan.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Items not Rated		

Risk Register

Three new emerging risks;

- Historical staff immunisation records being held within the resourcing team impacting on Occupational Health having correct immunisation information for staff;
- Increasing number of international nurses requiring visa extensions creating a financial and clinical risk to the organisation
- Staff requiring Oliver McGowan training causing a financial impact to the Trust and constraints on capacity levels, and compliance of this statutory training requirement.

Impact on Board Assurance Framework (BAF)

People and Organisational Development Performance Dashboard

January 2024

Deborah Tunnell
Deputy Director for People & Organisational Development

the Best Care for Everyone
care / listen / excel

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Executive Summary

Performance Indicator	Target	Jan-23	Feb-23	Mar-23	April-23	May-23	June-23	July-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23
Turnover	13%	13.60%	13.70%	12.92%	13.05%	12.62%	12.23%	12.12%	11.65%	11.56%	11.38%	11.37%	11.27%
Vacancy	8%	8.69%	7.58%	7.16%	7.61%	7.67%	7.40%	7.05%	7.05%	6.31%	6.43%	5.86%	6.54%
Sickness	5%	5.66%	5.34%	5.08%	4.67%	4.58%	4.52%	4.40%	4.27%	4.34%	4.36%	4.36%	4.31%
Appraisal	90%	78%	79%	81%	81%	80%	80%	79%	79%	79%	79%	79%	80%
Essential Training	90%	86%	85%	86%	87%	88%	88%	87%	87%	87%	86%	86%	85%
Agency (FTE & % of workforce)	2%	195 (2.44%)	190 (2.32%)	211 (2.55%)	144 (1.78%)	144 (1.79%)	176 (2.16%)	177 (2.50%)	167 (2.34%)	160 (2.20%)	122 (1.65%)	111 (1.51%)	103.51 (1.41%)
Bank (FTE & % of workforce)	6.5%	517 (6.47%)	649 (7.93%)	726 (8.78%)	598 (7.39%)	575 (7.15%)	555 (6.79)	571 (8.07%)	585 (8.20%)	589 (8.09%)	550 (7.03%)	589.85 (8.03%)	587.01 (8.00%)

Red: (10% over target) | **Amber:** (within 10% of target) | **Green:** (achieved/better than target)

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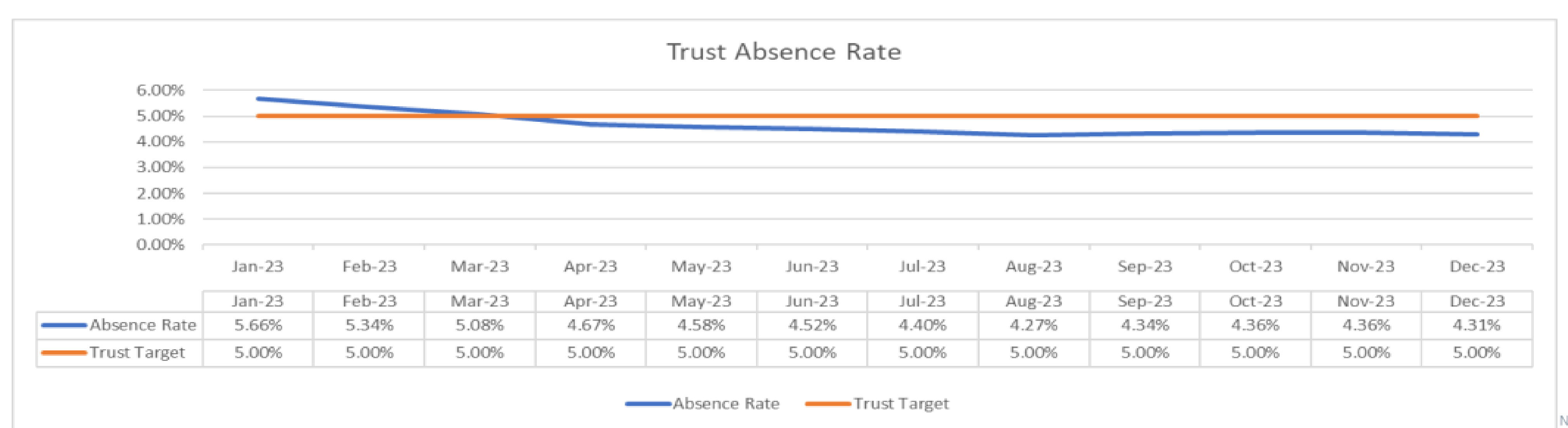
Absence: Sickness (BAF SR3 Workforce - Culture, Experience and Retention)

Key Points To Date
Sickness absence has seen a 0.05% decrease from Nov 23 to Dec 23, to 4.31%.
Dec 23 is the ninth consecutive month that sickness absence has been recorded under the Trust target of 5%.
Dec 23 sickness is currently 0.69% under the Trust target.

Improvement actions	Due Date	RAG
Focus continues on reducing sickness absence particularly through the sickness absence project under the Workforce Sustainability Programme. In addition through the work being delivered by the Health and Wellbeing Team to identify and expand on synergies.	May 2024	
The People Advisory Team continue to work closely with Line Managers supporting the sickness absence management process	Jan 2024	
Review of staff survey data to identify any trends/issues related to sickness absence	April 2024	



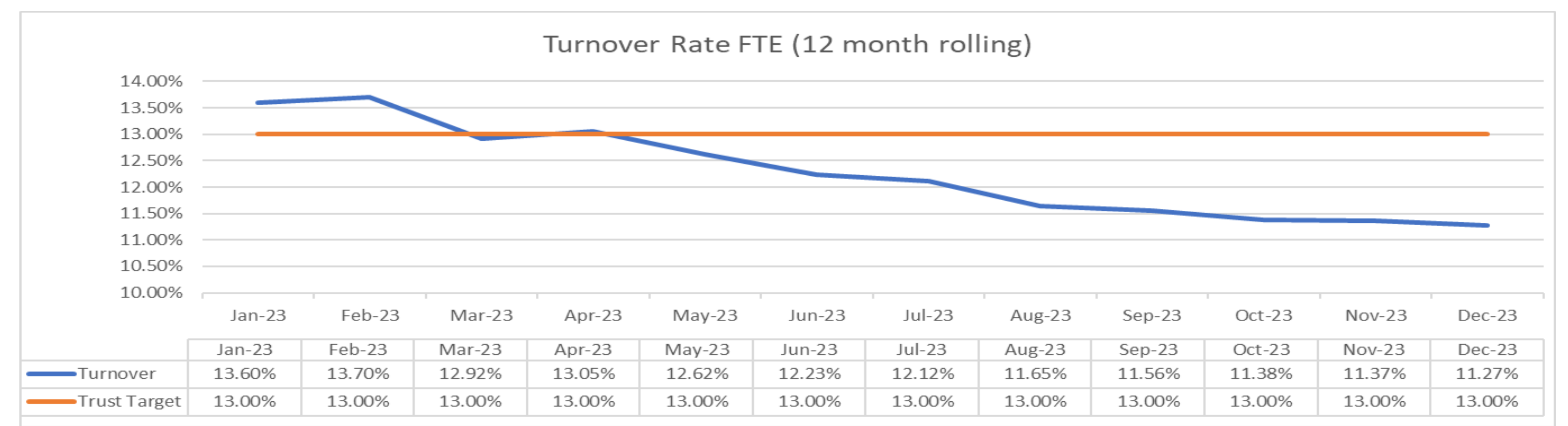
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Absence Rate	5.66%	5.34%	5.08%	4.67%	4.58%	4.52%	4.40%	4.27%	4.34%	4.36%	4.36%	4.31%
Trust Target	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%

NHS Foundation Trust

Turnover (BAF SR3 Workforce - Culture, Experience and Retention)

Key Points To Date
Turnover has seen a 0.10% decrease from Nov 23 to Dec 23 to 11.27% in Dec 23.
Dec 23 is the eighth consecutive month that has seen a month on month decrease in Turnover and also the eight consecutive month that Turnover is under the trust target of 13%.
Dec 23 Turnover is currently 1.73% under the Trust target.

Improvement Actions	Due Date	RAG
Following the successful New Leaders Welcome Event in Oct 23, this event is to run every 2 months from February 24	Completed	
Staff Experience Improvement Programme continues with its focus across the four core workstreams.	Ongoing, with specific action target dates	
The Retention Group has identified three projects on which it will initially focus: • Improving the exit process • Flexible retirement policy • Transition from substantive to bank	Q4 23/24	



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Turnover	13.60%	13.70%	12.92%	13.05%	12.62%	12.23%	12.12%	11.65%	11.56%	11.38%	11.37%	11.27%
Trust Target	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%

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Statutory & Mandatory Training (BAF SR3 Workforce - Culture, Experience and Retention)

KPI - 90% compliance target

Division	31-Dec-23	30-Nov-23
Corporate Division	91%	91%
Diagnostic & Specialty Division	88%	88%
Medicine Division	85%	84%
Non-Division	81%	83%
Surgery Division	84%	86%
Women & Children Division	78%	79%
GHT Total	85%	86%

Training Compliance % by Date : Breakdown by Subject

Subject	31-Dec-23	30-Nov-23
318|LOCAL|Moving and Handling Level 2 (2yr)|	84%	83%
318|LOCAL|Safeguarding Adults Level 2|	41%	43%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	93%	94%
NHS|CSTF|Fire Safety - 1 Year|	87%	87%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	94%	94%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	96%	95%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	83%	83%
NHS|CSTF|Information Governance and Data Security - 1 Year|	86%	86%
NHS|CSTF|Moving and Handling - Level 1 - 1 Year|	89%	90%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	92%	91%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	88%	87%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	90%	89%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	88%	88%
NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - 3 Years|	85%	86%
GHT Total	85%	86%

Key Points To Date

The Trust has seen a 1% decrease in overall compliance to 85% in Dec 23.

Medicine is the only division to see an improvement (1%) from Nov 23 to Dec 23.

Safeguarding Adults L2 has seen the greatest decrease in compliance (2%) from Nov 23 to Dec 23. However, Safeguarding Adults L1 is the only module to improve compliance levels from Nov 23 to Dec 23.

Improvement Actions	Due Date	RAG
Head of Corporate Learning & Development, Head of Education Learning & Development and Head of Prof Education & Apprenticeships are now appointed to, offering the capacity to commence a full Stat/Man review, working with stakeholders to review the numbers of programmes, relevancy and ability to undertake the requirements.	Review commencing Jan 2024 to March 2024	
Task and Finish Groups established to review training Passporting (Organisation and System	April 2024	
6 pre-tests are now live, the remaining 2 currently with the Subject Matter Experts. One being Information Governance the second Safety Awareness.	March 2024	
Other Trusts contacted regarding Safeguarding training compliance. Meeting with SME as to options to increase compliance, and review plans in relation to the intercollegiate document.	March 2024	

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Appraisal (BAF SR3 Workforce - Culture, Experience and Retention)

KPI - 90% compliance target

Appraisal Compliance % by Date : Breakdown by Division

Division	31-Dec-23	30-Nov-23
Corporate Division	75%	74%
Diagnostic & Specialty Division	78%	76%
Medicine Division	84%	83%
Non-Division	81%	81%
Surgery Division	88%	87%
Women & Children Division	70%	69%
GHT Total	80%	79%

Appraisal Compliance % by Date : Breakdown by Staff Group

Staff Group	31-Dec-23	30-Nov-23
Add Prof Scientific and Technic	62%	60%
Additional Clinical Services	84%	81%
Administrative and Clerical	76%	74%
Allied Health Professionals	76%	72%
Estates and Ancillary	77%	80%
Healthcare Scientists	81%	81%
Medical Staff - Consultants	93%	91%
Medical Staff - SAS	81%	78%
All Medical Staff	91%	89%
Nursing and Midwifery Registered	83%	82%
GHT Total	80%	79%

Key Points To Date

The Trust has seen a 1% increase in overall compliance to 80% in Dec 23.

All divisions have seen an improvement in compliance from in Dec 23, excluding Non Division which has remained consistent.

Apart from two groups, all staff groups saw an increase in compliance to Dec 23. Allied Health Professionals saw the greatest increase of 4%.

Of the two groups that did not see an improvement in compliance, Healthcare Scientists remained consistent at 81% in Dec 23 and Estates and Ancillary saw a 3% decrease in Dec 23.

Improvement Actions	Due Date	RAG
Report on stakeholder engagement finalised and presented to ELD, Staff-Side and PODG. Recommendations are now being taken forward	Completed	
Review and rewrite of non-medical appraisal policy, procedures and paperwork underway	March 2024	
Review of training support for appraisers and appraisees to be developed, alongside refreshed policy and paperwork	April 2024	

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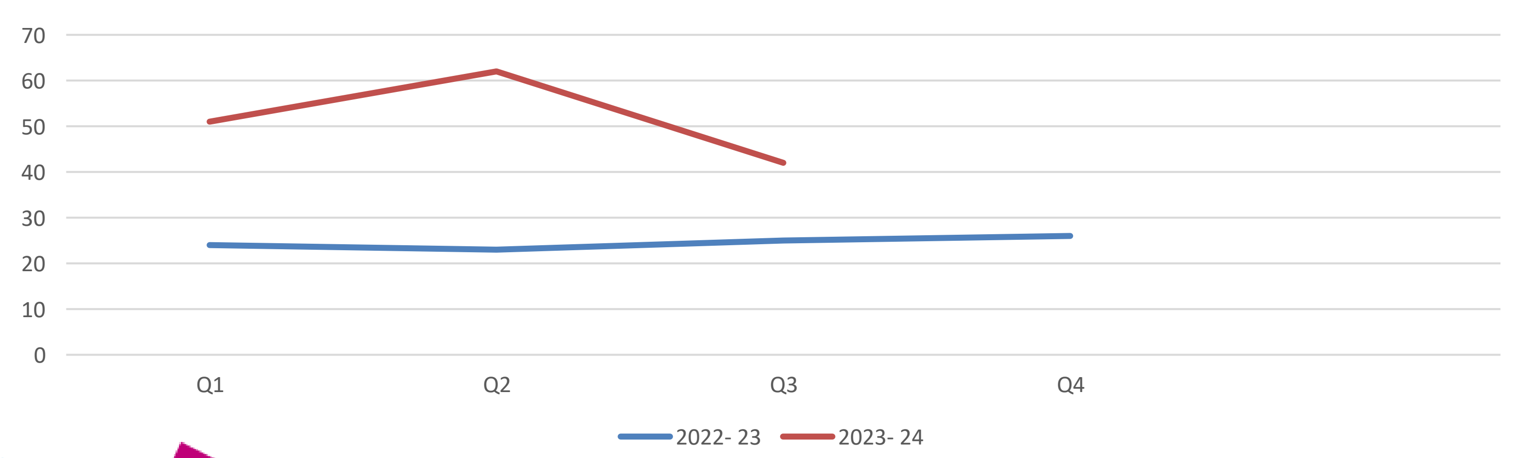
Freedom to Speak Up (BAF SR3 Workforce - Culture, Experience and Retention)

Key Points to Date
Freedom to Speak up cases have reduced this last quarter. Anonymous reporting (recorded by NGO as %) has stayed at 13% in Q2 compared with the overall 37% last year. This continues to bring reassurance that staff are increasing their trust in the service and speaking up options across the organisation.
Staff continue to speak up widely about behaviours and working relationships. A series of listening events have been supported in children's services during December.
To date, there are 47 open FTSU cases.

Improvement Actions	Date Due	RAG
Review of patient safety concerns raised to FTSU. Terms of Reference set Jan 2024	March 2024	
Review model of service with recruitment of additional FTSU Guardian	Feb 2024	



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Staff Engagement and Experience (BAF SR3 Workforce - Culture, Experience and Retention)

Key Points to Date	Date Due	RAG
Staff Experience Improvement Programme KPIs will be further developed in addition to the 23/24 Staff Survey and January 24 NQPS results in order to monitor full impact of the programme.	March 24	
Initial review of Staff Survey results appear positive, with alignment to the Staff Experience Improvement Programme being evident. A mapping exercise will be completed to identify key areas that still require improvement and whether there are any gaps that the programme is not addressing.	March 2024	
A reporting system for Discrimination events is required in order to manage cases appropriately. A review of systems is underway, with the aim of developing a paper to inform decisions	March 24	

Improvement Actions

The Leadership and Teamwork workstream continues to progress with the 6 cohorts of wave 1 of teams across all 5 divisions being mapped to have sessions with The Wellbeing Collective.

Bi-weekly meetings with The Wellbeing Collective are established to maintain relationships, share updates and address any concerns as they may arise.

2023 Staff Survey results will be used to inform the wave 2 of teams to attend development with The Wellbeing Collective.

The Discrimination workstream has been re-named to Anti-Discrimination

Agreed areas of focus are now:

- Reviewing and updating information on the intranet page
- Review the current reporting process and develop a appropriate reporting system and process for staff to staff discrimination.
- Review and update the Mutual Respect Policy and develop an anti-discrimination action plan
- Align activity into the Trust’s EDI Development Plan
- Align activity to the NHSE EDI High Impact Actions
- Co-Design and produce with the Inclusion Network

The Taskforce has formally completed, however there are some project closure elements to complete based on final recommendations. These are being progressed by the Staff Experience Improvement Programme team.

The Restorative Just and Learning Culture paper is in development.

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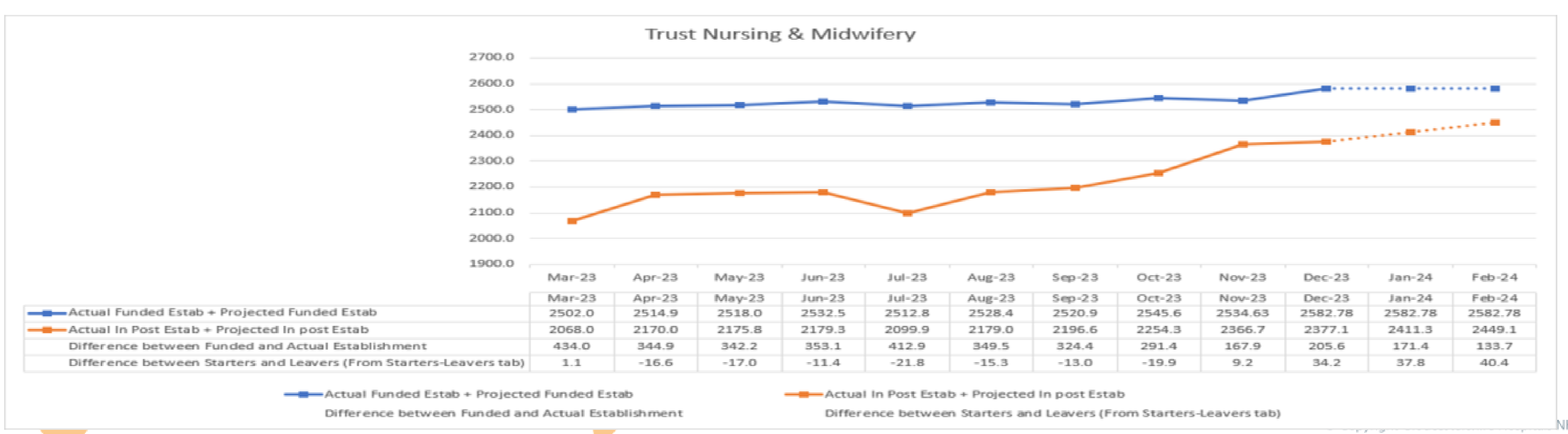
Recruitment Pipeline (BAF SR2 Workforce - Recruitment & Attraction)

Key Points to Date
There has been a further increase of staff in post of 10.4 FTE from Nov 23 to Dec 23.
The gap between in post and funded establishment for nursing and midwifery for Dec 23 currently sits at 205.68 FTE. Funded establishment has increased by 48.15 FTE.
Current projections from the staff in the recruitment pipeline, taking into account forecast leavers, indicate that by Feb 24, the vacancy for Nursing and Midwifery will have reduced to 133.68 FTE.

Improvement Actions	Date Due	RAG
International Educated Nurses (IEN) recruitment has been a big contributor to the gap reducing in the establishment. Planning for 2024/25 remains ongoing; however the lack of NHSE funding to support International recruitment will see a reduction in activity compared to previous years.	March 2024	
Last two cohorts of the 2023/24 IENs (60 nurses) will be completing their OSCE exams and will convert to B5 registered nurses to support the establishment gap over the next couple of months.	April 2024	
The Trust continues to recruit domestically, with a generic recruitment event held in December 2023. This saw a successful outcome of 14 Newly Qualified RNs and 3 experienced RNs. Ongoing recruitment events being planned for 24/25	Ongoing	

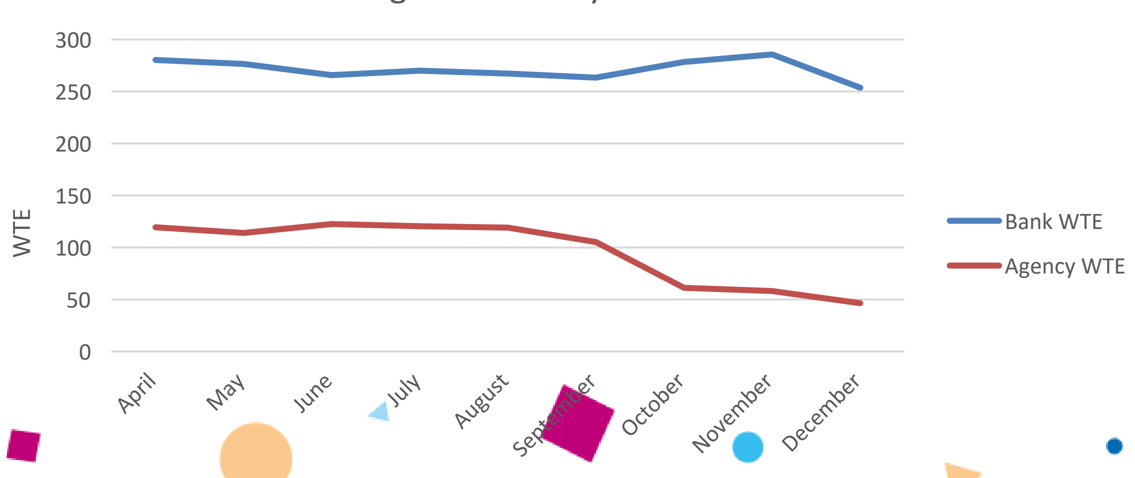


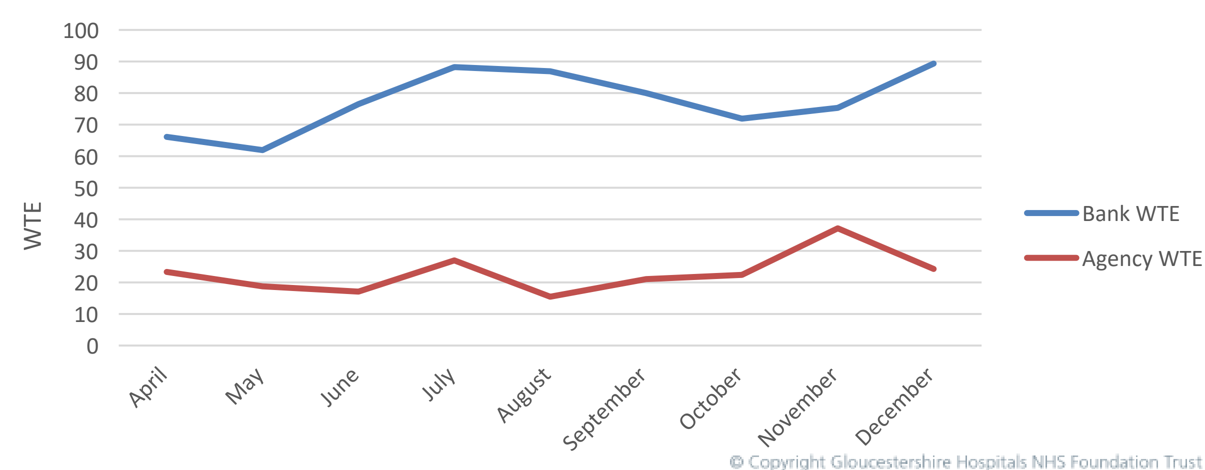
	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24
Actual Funded Estab + Projected Funded Estab	2502.0	2514.9	2518.0	2532.5	2512.8	2528.4	2520.9	2545.6	2534.63	2582.78	2582.78	2582.78
Actual In Post Estab + Projected In post Estab	2068.0	2170.0	2175.8	2179.3	2099.9	2179.0	2196.6	2254.3	2366.7	2377.1	2411.3	2449.1
Difference between Funded and Actual Establishment	434.0	344.9	342.2	353.1	412.9	349.5	324.4	291.4	167.9	205.6	171.4	133.7
Difference between Starters and Leavers (From Starters-Leavers tab)	1.1	-16.6	-17.0	-11.4	-21.8	-15.3	-13.0	-19.9	9.2	34.2	37.8	40.4

Bank and Agency WTE (BAF SR3 Workforce - Recruitment & Attraction)

Key Points to Date
Bank spend for Medics in M9 -- £1,557,824 Agency spend for Medics in M9 -- £397,411
Bank spend for Nursing & Midwifery in M9 -- £2,716,123 Agency spend for Nursing & Midwifery in M9 -- £373,618
Agency spend for Nursing continues to decrease as a result of the monthly roster reviews and template changes, bringing them in line with the budgeted establishment.
All Consultant locum claims have been paid via Locums Nest since 1st November. This has had an impact on reporting and is showing as an increase in overall spend and hours.

Improvement Actions	Date Due	RAG
The non-clinical bank coordinator starts in post in January 24 and will begin to work on rolling out the non-clinical Bank Service across the Trust. All bank and agency bookings will be recorded on HealthRoster from April 2024.	Full roll - March 2024	Amber
The Medical Grip & Control Group successfully launched Locums Nest with Consultants from 1st November 2023. A new T&F group has now been set up to review medical locum enhancements, with the first meeting scheduled for the middle of January 24.	March 2024	Green
The BI project for automated temporary staffing reports has been delayed due to external system requirements.	March 2024	Amber





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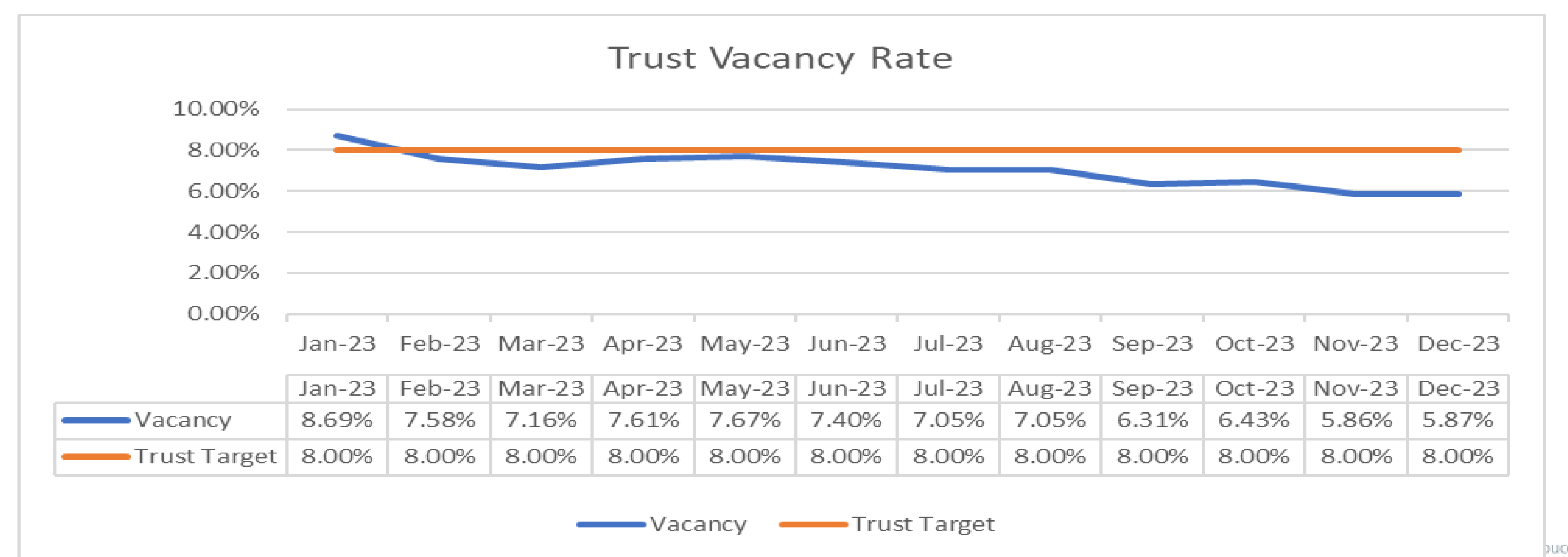
Vacancies (BAF SR2 Workforce - Recruitment & Attraction)

Key Points to Date
Trust vacancies have seen a slight increase of 0.01% from Nov 23 to Dec 23, now reported at 5.87%.
Dec 23 is the eleventh month that vacancies have been under the Trust target of 8%.
In Dec 23, the Vacancy is 2.13% under the Trust target.

Improvement Actions	Date Due	RAG
Improvements in Time To Hire, are realising a positive impact on vacancy reduction.	Ongoing focus	
There is ongoing recruitment activity, with drives across some hard to fill roles. This currently includes the Trust's Nurseries, Dietitians, Stroke and Vascular Consultants, and Maternity. There will be a further targeted focus across 2024/25 with the Trust's new marketing brand in place and a range of innovative attraction solutions.	March 2024	
A review of existing Golden Hellos is to take place to evaluate the effectiveness of these incentives.	April 2024	

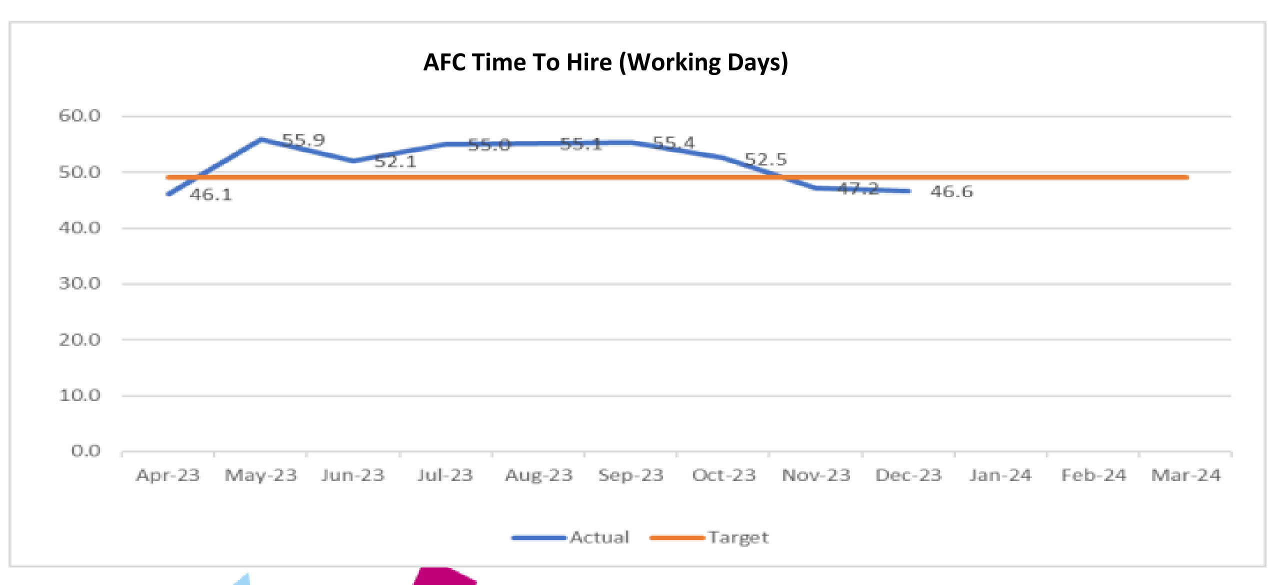


	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Vacancy	8.69%	7.58%	7.16%	7.61%	7.67%	7.40%	7.05%	7.05%	6.31%	6.43%	5.86%	5.87%
Trust Target	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%

Time to Hire (BAF SR2 Workforce - Recruitment & Attraction)

Key Points to Date
Month on month improvements are being seen with Time to Hire against target.
Divisional breakdown of KPIs has allowed a deep dive in to specific stages of the end to end recruitment process with informed discussion/support.

Improvement Actions	Date Due	RAG
Roll-out of TRAC VCP completed in November 2023 for Medicine Division. Early effectiveness is being monitored. Surgical Division was delayed until January 2024 due to additional training required.	January 2024	
Corporate TRAC VCP training completed in December 2023. Currently reviewing approval process for separate directorates within division, where a phased roll-out will be delivered	February 2024	
User surveys for both Recruiting Managers and Candidates will close in January to provide essential feedback on the experience received during recruitment to inform future interventions and activities	February 2024	



Month	Actual	Target
Apr-23	46.1	49.0
May-23	55.9	49.0
Jun-23	52.1	49.0
Jul-23	55.0	49.0
Aug-23	55.1	49.0
Sep-23	55.4	49.0
Oct-23	52.5	49.0
Nov-23	47.2	49.0
Dec-23	46.6	49.0

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Attrition (BAF SR2 Workforce - Recruitment & Attraction)

Key Points to Date
Highest attrition rate during recruitment is still at the Interview Process stage with the main reason given by candidates as having received another job offer and decided to withdraw from GHFT.
The Admin and Clerical staff group still remain with the highest attrition through the recruitment process
Overall, 191 candidates withdrew their applications during the recruitment stages shown below in December 2023

Improvement Actions	Date Due	RAG
Attrition data continues to be reviewed to understand candidates reasons for withdrawal. This ongoing deep dive is needed to help inform appropriate action. The data suggests applicants are applying for multiple posts and accepting one job, resulting in candidates retracting their application.	Ongoing monitoring	

Recruitment Attrition at each stage of the recruitment process (December 2023)

Recruitment Stage	Additional Clinical Services	Additional Professional Scientific and Technical	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Nursing and Midwifery Registered	(blank)	Grand Total
Interview	33	1	54	6	13	4	33		144
Longlisting	1	2	8	2	1	1	5		20
Offer	5	1	2	3	2		8	1	22
Shortlisting	1		2				1		4
Starting	1								1
Grand Total	**41**	**4**	**66**	**11**	**16**	**5**	**47**	**1**	**191**

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Key:

RAG Rating	RAG Definition
Blue	Completed
Green	On track to be delivered within planned timeframes
Amber	Delays to delivery within planned timeframes
Red	Risk to achievement

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Report to Public Board	
Date	14 March 2024
Title	**Staff Survey 2023 Results**
Author / **Sponsoring Director/ Presenter**	Abigail Hopewell, Head of Leadership OD and Staff Engagement Claire Radley, Director for People & OD

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 annual NHS Staff Survey results for 2023 were published nationally on 7 March 2024.

Due to taking a very proactive approach to engagement and promotion of the survey including the offer of incentives, we have seen a dramatic increase in the response rate - from 50% in 2022 to 68% in 2023, which is just below the highest response rate nationally of 69.5%.

Overall, the Trust remains considerably below the average for Acute Trusts for all People Promise scores. Equally, all People Promise elements have seen a statistically significant improvement in their score. Of the 100 questions which can be positively scored and compared to the 2022 results, 90 questions have improved. Of these one third of the questions (30) have witnessed year-on-year improvements since 2021. Another third (35 questions) have improved and exceeded the 2021 score despite a deterioration in 2022. There are just three questions where scores remain unchanged from 2022, and four question scores which have dropped by only a small percentage.

Of the three 'net promoter' questions, two of these have seen an improvement (this is in line with the national average trend). The question 'Care of patients/service users is my organisation's top priority' has dropped by 0.5% compared to 2022, and this bucks the national average trend.

The Staff Experience Improvement Programme is using the latest results to inform the focus of our activity around the three workstream priorities which are each linked to the NHS People Promises. We have also identified additional priorities for each division to concentrate on based on division-level analysis of the results. Divisions will report throughout the year on their progress at Divisional Board, monthly Executive Performance Review meetings. At Trust level progress is monitored via the Trust Leadership Team meeting and People & OD Committee.

Recommendation

To ACCEPT the published NHS Staff Survey results and associated plans for delivery and monitoring of improvements through stated governance processes.

Enclosures

Public Board – Staff Survey Results Summary March 2024 (under embargo until 7 March 2024 at 9.30am)
The Trust's Benchmark report will be published on the NHS staff survey website on Thursday 7 March 2024 at 9.30am (which is when the embargo is lifted).

Gloucestershire Hospitals
NHS Foundation Trust

NHS Staff Survey 2023

Summary of results for Public Board

Gloucestershire Hospitals NHS Foundation Trust

March 2024

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Gloucestershire Hospitals NHS Foundation Trust

2023 NHS Staff Surve

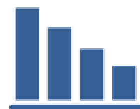
Organisation details

Completed questionnaires: 5475

2023 response rate: 68%

This organisation is benchmarked

Acute and Acute & Community Trusts



2023 benchmarking group details

Organisations in group: 122

Median response rate: 45%

No. of completed questionnaires: 477643

Survey details

Survey mode: Mixed

For more information on benchmarking group definitions please see the Technical document.

Appendix A: Response rate

Response rate

	2019	2020	2021	2022	2023
Your org	49.53%	47.64%	50.34%	50.06%	67.53%
Highest	75.96%	79.77%	79.95%	68.69%	69.45%
Average	46.93%	45.43%	46.38%	44.46%	45.23%
Lowest	27.20%	28.09%	29.47%	26.17%	23.03%
Responses	3403	3519	3897	4232	5475

People Promise elements and themes: Overview

People Promise elements, themes and sub-scores are scored on a 0-10 scale, **where a higher score is more positive than a lower score**.

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.95	5.64	6.30	-	5.26	5.88	6.50	6.45	5.62
Best result	7.71	6.37	7.16	-	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	-	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	-	5.05	5.60	6.35	6.34	5.54
Responses	5462	5458	5425	-	5145	5438	5454	5468	5469

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

Appendix B: Significance testing – 2022 vs 2023

Statistical significance helps quantify whether a result is likely due to chance or to some factor of interest. The table below presents the results of significance testing conducted on the theme scores calculated in both 2022 and 2023*. For more details please see the technical document.

People Promise elements	2022 score	2022 respondents	2023 score	2023 respondents	Statistically significant change?
We are compassionate and inclusive	6.83	4222	6.95	5462	Significantly higher
We are recognised and rewarded	5.39	4225	5.64	5458	Significantly higher
We each have a voice that counts	6.16	4203	6.30	5425	Significantly higher
We are safe and healthy	5.63	4208	-	-	-
We are always learning	4.97	4086	5.26	5145	Significantly higher
We work flexibly	5.63	4217	5.88	5438	Significantly higher
We are a team	6.33	4216	6.50	5454	Significantly higher
Themes					
Staff Engagement	6.32	4227	6.45	5468	Significantly higher
Morale	5.31	4226	5.62	5469	Significantly higher

Note. 2023 results for 'We are safe and healthy' have not been reported due to an issue with the data. Please see https://www.nhsstaffsurveys.com/survey-documents/ for more details.

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Question summary

56 out of 87 questions (64%), which are directly linked to the People Promises/theme, have seen a **statistically significant improvement**.

The remaining questions show a modest improvement or have remained the same as 2022, with the exception of two questions which show a modest deterioration:

Q16a – not experienced discrimination from patients/public: **2023: 91%** (2022: 92%)

Q24a – organisation offers me challenging work: **2023: 69%** (2022: 71%)

Another question, not attached to the Promises/themes, has shown a modest deterioration:

Q31b - Disability: organisation made reasonable adjustments to enable me to carry out work: **2023: 71%** (2022: 72%)

Whilst movement of this nature is minor and may be no more than random fluctuation in the data, we will monitor these questions in future surveys

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League table: historic positive score

Gloucestershire Hospitals
NHS Foundation Trust

The historical league table for Trusts which administered their survey with PICKER shows how your overall positive score changed from the previous survey, and how this change compares to other organisations Acute and Acute Community Trusts who ran the NHS Staff Survey with Picker.

NHS Staff Survey 2023: Overall Positive Score Change (12/62)

5%
4%
4%
3%
3%
2%
2%
1%
1%
0%

#12

All Trusts
Gloucestershire Hospitals NHS Foundation Trust

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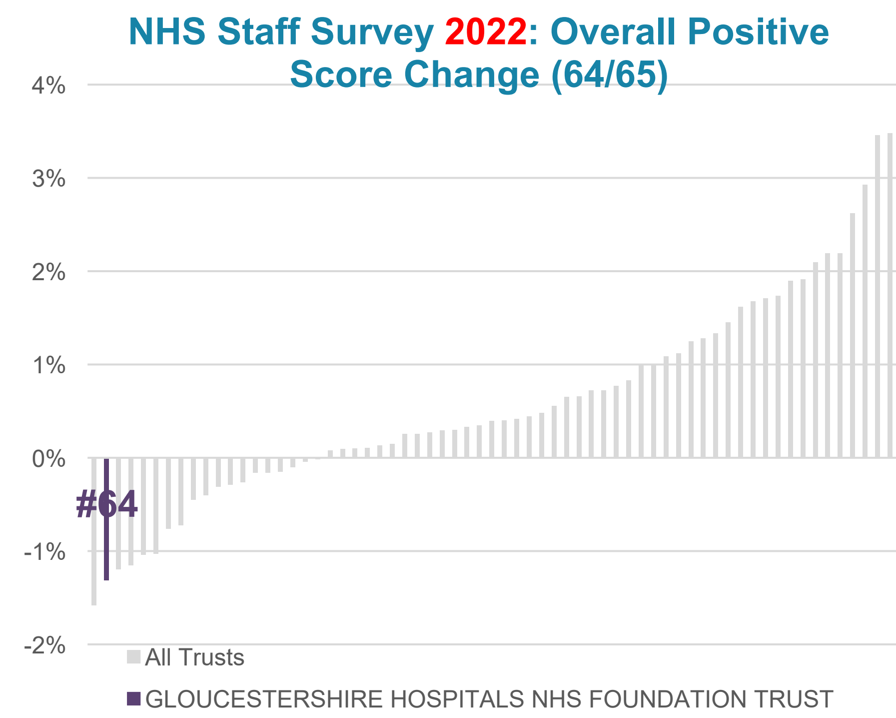
NHS Staff Survey 2022: Overall Positive Score Change (64/65)



Net Promoter Questions

- Care of patients/service users is my organisation's top priority

- I would recommend my organisation as a place to work

- If a friend of relative needed treatment I would be happy with the standard of care provided by this organisation

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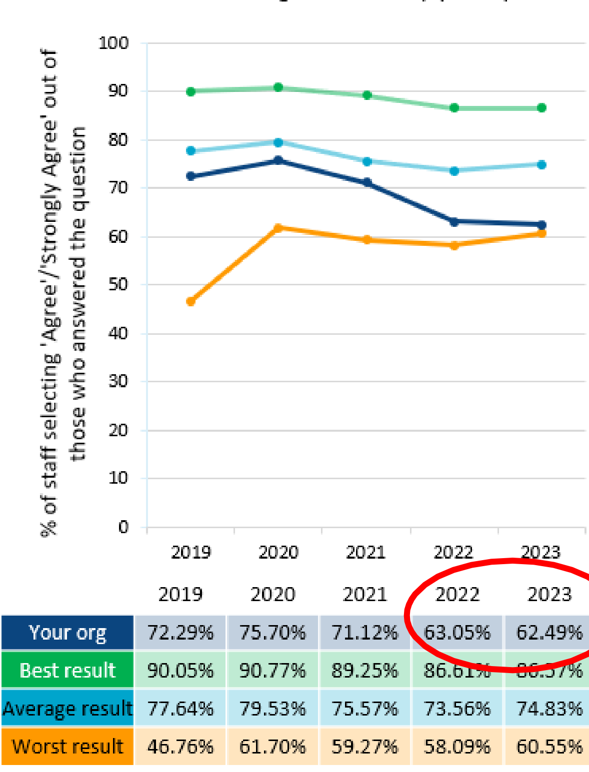
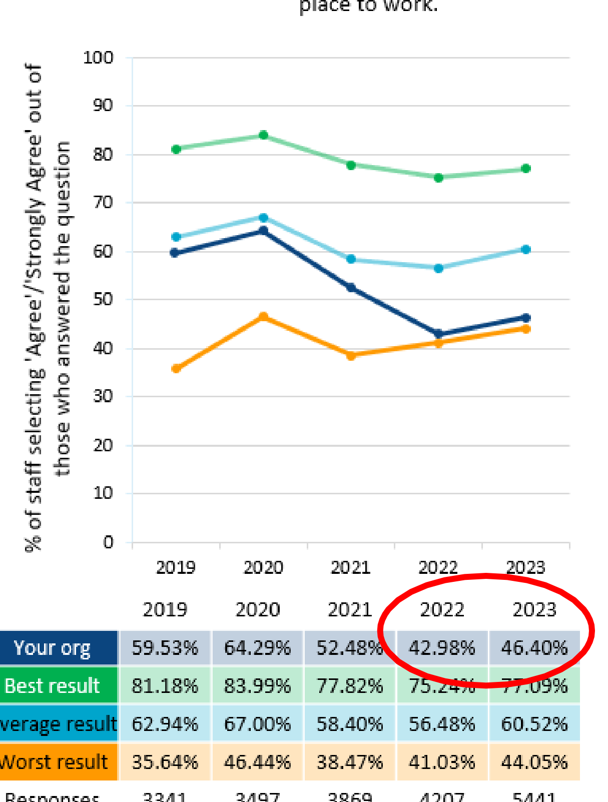
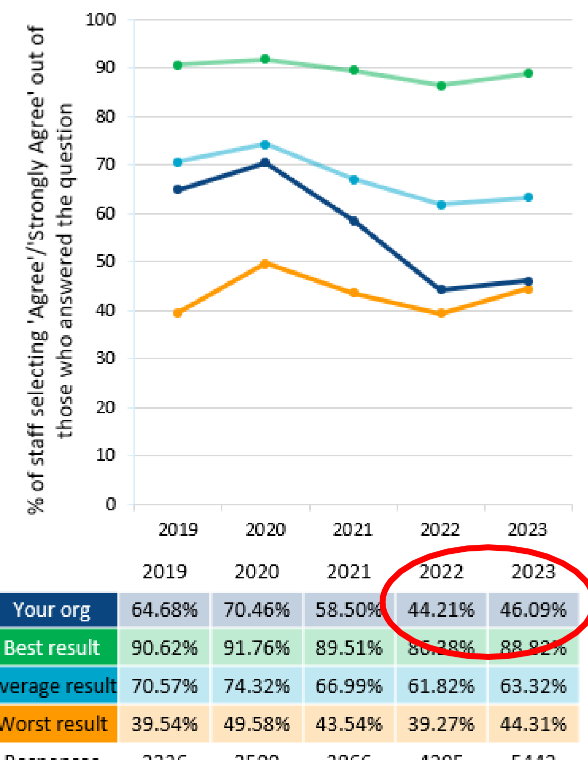


	2019	2020	2021	2022	2023
Your org	72.29%	75.70%	71.12%	63.05%	62.49%
Best result	90.05%	90.77%	89.25%	86.61%	86.57%
Average result	77.64%	79.53%	75.57%	73.56%	74.83%
Worst result	46.76%	61.70%	59.27%	58.09%	60.55%
Responses	3346	3499	3873	4208	5442



	2019	2020	2021	2022	2023
Your org	59.53%	64.29%	52.48%	42.98%	46.40%
Best result	81.18%	83.99%	77.82%	75.24%	77.09%
Average result	62.94%	67.00%	58.40%	56.48%	60.52%
Worst result	35.64%	46.44%	38.47%	41.03%	44.05%
Responses	3341	3497	3869	4207	5441



	2019	2020	2021	2022	2023
Your org	64.68%	70.46%	58.50%	44.21%	46.09%
Best result	90.62%	91.76%	89.51%	86.28%	88.82%
Average result	70.57%	74.32%	66.99%	61.82%	63.32%
Worst result	39.54%	49.58%	43.54%	39.27%	44.31%
Responses	3326	3500	3866	4205	5442

Staff Experience Improvement Programme – workstream priorities

Teamwork and leadership workstream

Building a safe speaking up culture

Anti-discrimination

Priorities identified from staff survey results alongside other key data sources/ intelligence

Teamwork & Leadership workstream
NHS People Promise 7: We are a team

Anti-discrimination workstream
NHS People Promise 1 sub-score: Diversity & Inclusion

Building a safe speaking up culture workstream
NHS People Promise 7: We each have a voice that counts

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Report to Board of Directors			
Date	14 March 2024		
Title	**Gender Pay Gap Report**		
Author / Sponsoring Director/ Presenter	Coral Boston		
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 report shares information due to be published on 30 March 2024 as part of our requirement to participate in national Gender Pay Gap reporting. This data set used for this report, as determined by national reporting requirements, is data extracted from March 2023. Please note, the data excludes GMS who are required to submit their own report during March 2024.

The measured position on the Gender Pay Gap for GHNHSFT at 31 March 2023 is as follows:

- The mean pay for men is 25.7% higher than for women. Compared to the 28.2% in 2022, this is a decrease of 2.5%.
- The median pay for men is 19.1% higher than for women. Compared to the 21.7% in 2022, this is a decrease of 2.6%.

The report further explores the Gender Pay Gap information for all GHNHSFT staff, as well as excluding, and isolating Medical Staff.

The dominant theme is that if the medical workforce and their Clinical Excellence Award (CEA) are excluded, the median pay gap is nullified. Analysing pay across all staff except medical staff creates a mean gender pay gap of 1.89% in favour of males, but a median gap of -4.85%. The clear implication is that the pay gap across the medical workforce is sufficient to nullify the female zero gender pay gap across the remainder of the Trust's workforce, and generate the overall results set out in the bullet points above.

It is important to note that the Gender Pay Gap can be objectively explained when we consider the application of terms and conditions which are set nationally and reward length of service. Furthermore, there is no significant Gender Pay Gap reported across our Non-Medical workforce, which accounts for approximately 81.9% of the total workforce.

The report details actions to ensure we address specific issues identified through the more detailed analysis, and maintain the positive overall position.

Risks or Concerns

N/A

Financial Implications

N/A

Recommendation

The Board is asked to **NOTE** the contents of the report as a source of information and assurance. In line with reporting requirements, this report will also be made available via the Trust intranet and Internet following receipt from the Board.

Enclosures

Gender Pay Gap Report.

GENDER PAY GAP REPORT

Data reported as at 31 March 2023, unless otherwise indicated.

1. Summary

This is Gloucestershire Hospitals NHS Foundation Trust's (GHFT) seventh Gender Pay Gap report. It is based on a snapshot of all GHFT staff on 31 March 2023. On that date, GHFT's permanent workforce head count was made up of **8830 (approx. 79.3% female and 20.7% male)**.

The analysis used to prepare this report identifies a 'mean' and 'median' gender pay gap.

The measured position on the gender pay gap at 31 March 2023 is as follows:

- **The mean gender pay gap is the difference between mean pay for men and women in the organisation. In GHFT, the mean pay for men is 25.7% higher than for women. Compared to the 28.2% in 2022, this is a decrease of 2.5%.**
- **The median gender pay gap is the difference between median pay for men and women in the organisation. In GHFT, the median pay for men is 19.1% higher than for women. Compared to the 21.7% in 2022, this is a decrease of 2.6%.**

It is critical to emphasise that this does not mean that a male and a female employee member doing equal work receive different levels of pay. Rather, the above statistics are driven largely by:

(i) The pay of the medical workforce which has an amplified effect on statistics relating to the total workforce.
(ii) The distribution of males and females within different parts of the workforce.

The primary focus lies in the exclusion of the medical workforce and their Clinical Excellence Awards (CEA), which effectively cancels out the median gender pay gap. When examining pay across all staff except medical personnel, there is a mean gender pay gap of 1.89% favouring males, but a median gap of -4.85%. This suggests that the pay gap within the medical workforce is significant enough to balance out the absence of a gender pay gap among female employees across the rest of the Trust's workforce. Addressing the gender based pay disparities highlighted in the table below requires a multifaceted approach aimed at promoting equity and fairness within the organisation.

2. Introduction

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (***the Regulations***) require public sector organisations with over 250 staff to report on and

publish their gender pay gap on a yearly basis. This is based on a snapshot from 31 March of each year, and each organisation is duty bound to publish information on their website. This report captures data as at 31 March 2023.

GHFT employs circa. 8830 staff in a number of Staff Groups, including: administrative; nursing; allied health; and medical roles. All staff except for medical and Very Senior Managers (VSMs) are on Agenda for Change pay-scales, which provide a clear process of paying staff equally, irrespective of their gender or ethnicity.

What is the gender pay gap?

The gender pay gap shows the difference in the average pay between all males and females in the Trust. If there is a particularly high gender pay gap, it can indicate there may be several issues with which to deal, and the individual calculations may help to identify what those issues are.

The gender pay gap is different to equal pay. Equal pay deals with pay difference between males and females who carry out the same job, similar jobs or work of equal value. It is unlawful to pay people unequally because they are male or female.

What do we have to report on?

The statutory requirements of the Gender Pay Gap legislation is that each public sector organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payment.

Definitions of pay gap

The **mean pay gap** is the difference between the pay of all male and all female Staff when added up and divided respectively by the total number of males, and the total number of females in the workforce.

The **median pay gap** is the difference between the pay of the middle male and the middle female, when all male Staff and then all female Staff are listed from the highest to the lowest paid.

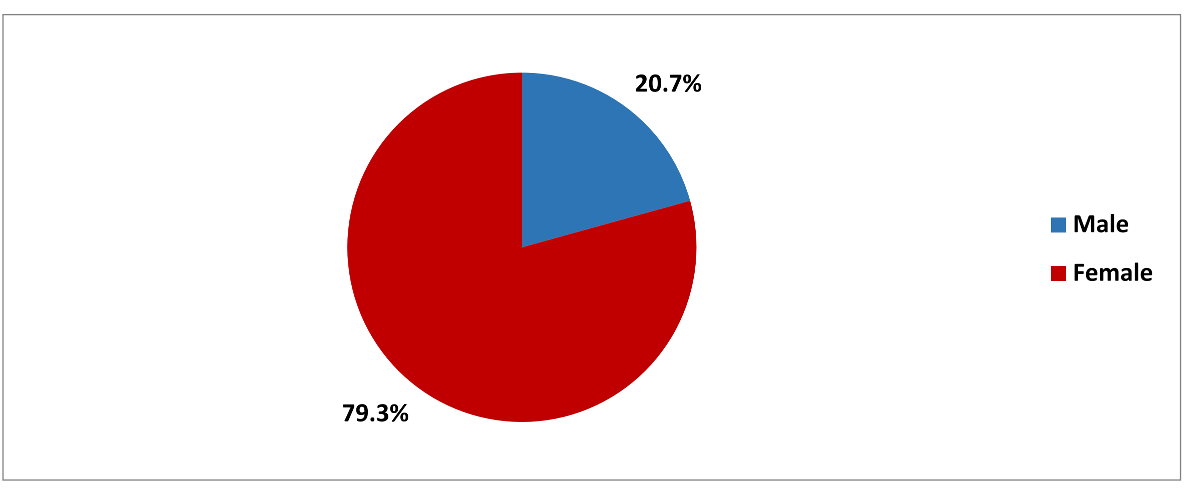
Who is included?

All staff who were employed by GHFT and on full pay on the snapshot date (31 March 2022) are included. Bank staff who worked a shift on that date are also included. Staff who are on half or nil absence, less than full pay maternity leave and agency staff are not included.

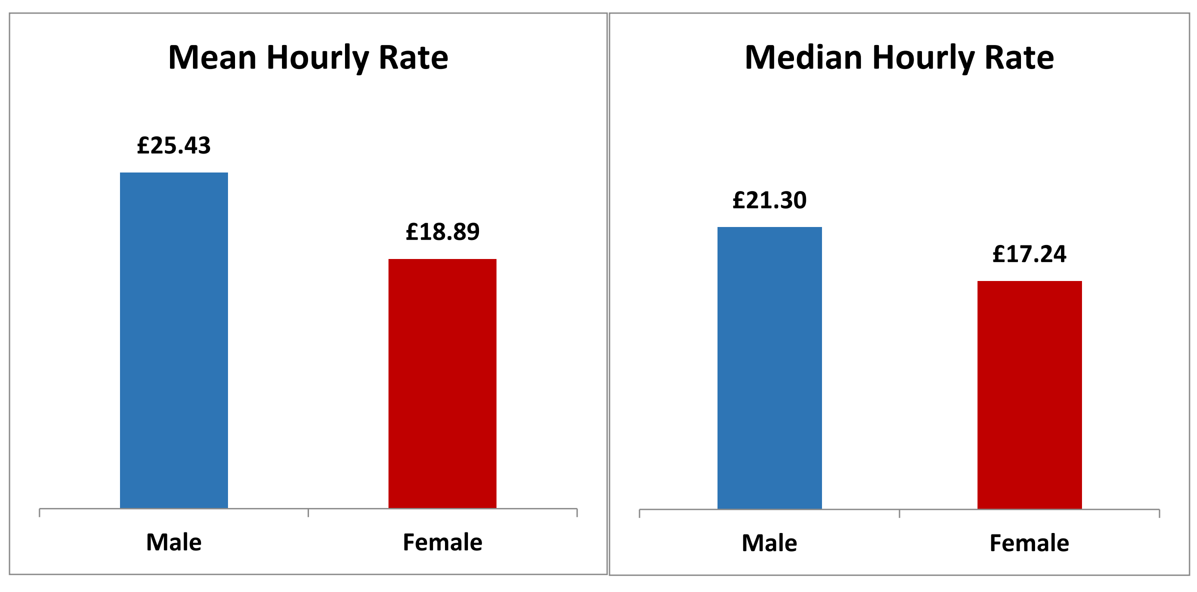
3. Results for Gloucestershire Hospitals NHS Foundation Trust

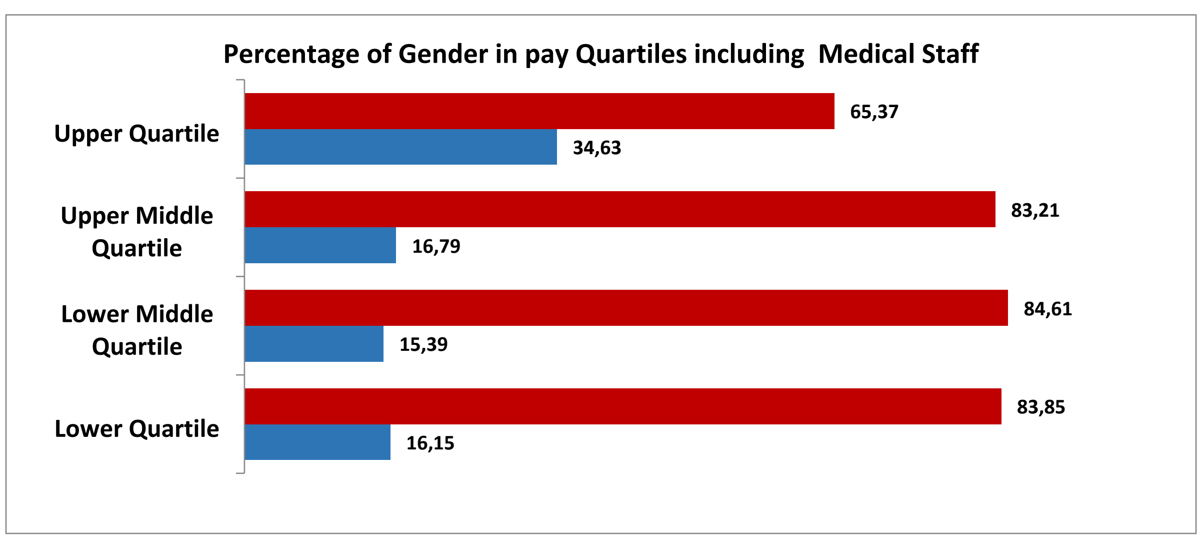
Trust Gender Profile (based on headcount)

GHFT, as is typical of the NHS, has a higher proportion of females to males in its workforce – of the 8830 staff counted as part of the gender pay gap reporting, 6999 female Staff compared to 1831 male staff.



Gender Pay Gap GHFT Including Medical Staff





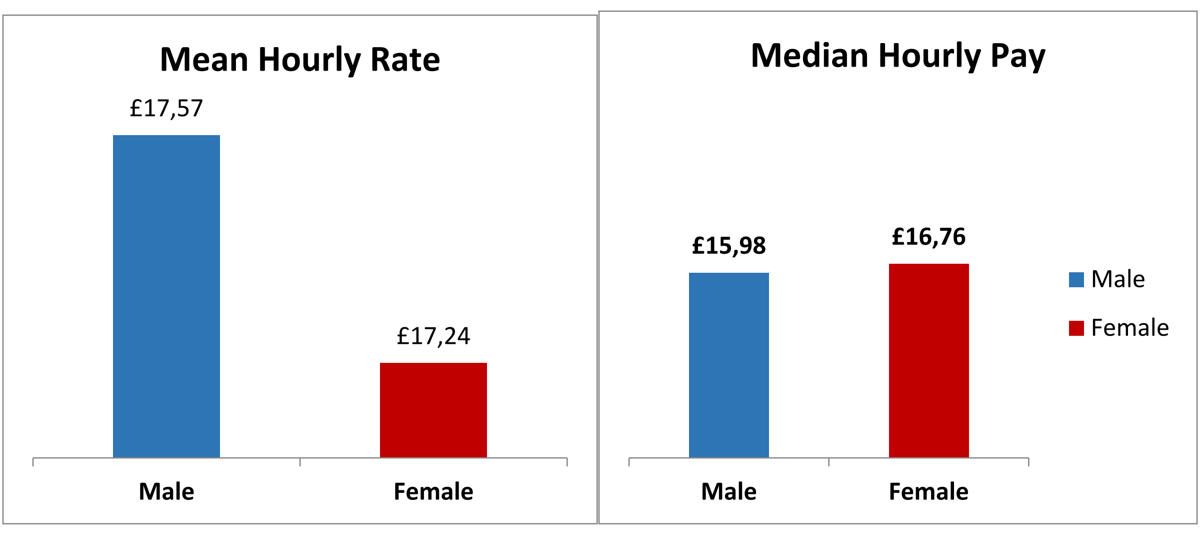
The above charts show that the mean hourly pay for males is £6.54 higher than that of females, a gender pay gap of 25.7%.

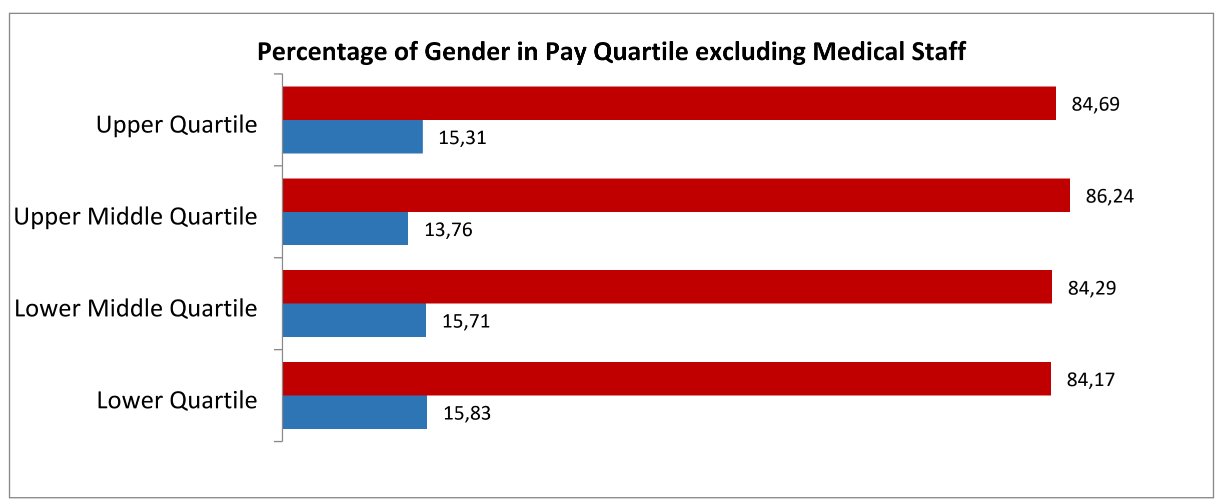
They also show that median pay for males is £4.07 higher than females, a gender pay gap of 19.1%. We are also required to split the workforce into quartiles (blocks of 25%) split by pay and show the proportions of males and females in each quartile. The results of this split are shown below. Even though females make up the majority of the workforce at 79.3% and males 20.7%, there continues to be more males in the highest pay quartile (34.6%).

As explained in the introduction, the inclusion of medical staff with the rest of the workforce has a significant effect on the GPG figures.

Gender Pay Gap GHFT Excluding Medical Staff

When removing Medical Staff from the equation, GHFT has an even higher percentage of females than males in its workforce – of the 7231 staff counted as part of the gender pay gap reporting, 84.9% were female (**from 79.3%** when Medical Staff were included). The Gender Pay Gap is much smaller as an average, and is -4.85% for the median.

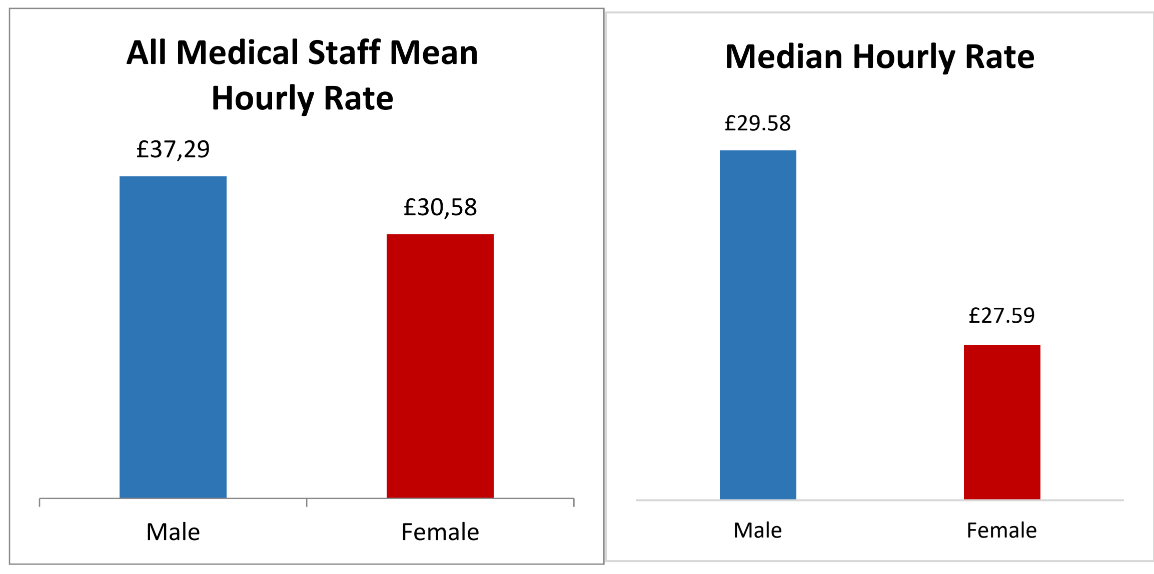


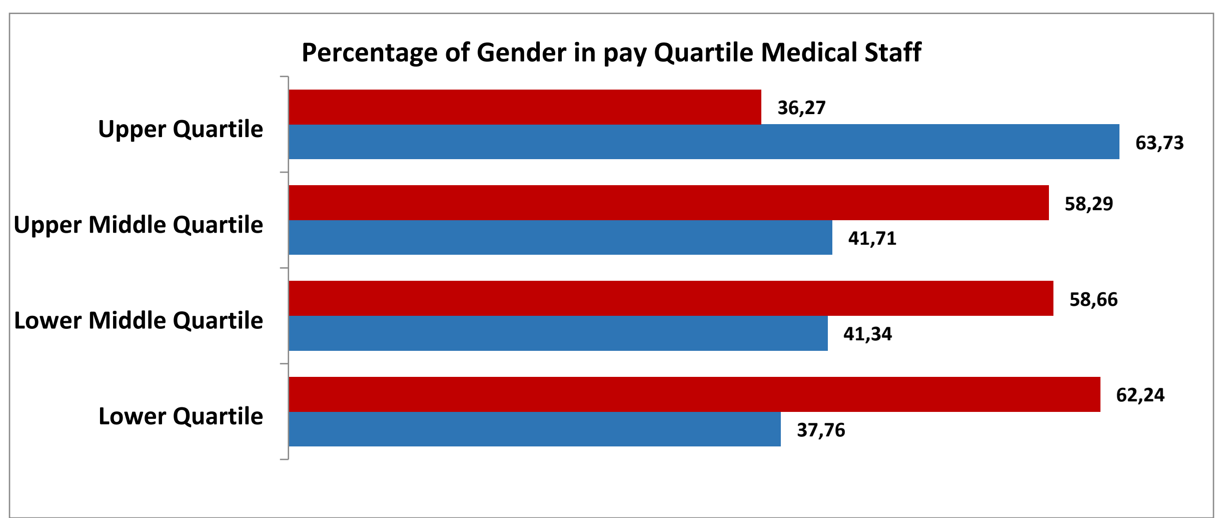


The above charts show that the mean hourly pay for males is **£0.33** higher than that of females, a gender pay gap of **1.89%**. The quartile split also show a higher proportion of females in all pay quartiles.

Gender Pay Gap GHFT Medical Staff Only

When including only Medical Staff, the Trust still has a higher percentage of females than males overall in its workforce, but the difference isn't so great. Of the **1586 (based on this assignment Category)** Medical Staff counted as part of the gender pay gap reporting (including General Practitioner Trainees), 53.8% were female (from 79.3% when non-Medical staff included).





The above charts show that the mean hourly pay for males is **£6.71** higher than that of females, a gender pay gap of **18.0%**. The above chart also shows that median pay for males is **£2.00** higher than females, a gender pay gap of **6.75%**. The quartile split shows that the lower quartile is **62.24%** female, while in the upper quartile this is completely reversed and **63.73%** are male.

What does this mean?

The figure for the median pay gap is usually considered to be more representative of gender pay gap across the workforce. However, that still does not take account of the small number of higher paid staff (Senior Medical staff) that are skewing the data when combined with non-medical staff. The effect is simply more extreme when using the mean.

The gender composition and pay gaps in each individual band are examined below; for ease of reference, we have highlighted in green where the higher average pay is to be found (male or female cohort).

Grade	No. of Male Staff	Male Average Hourly Rate*	No. of Female Staff	Female Average Hourly Rate*	Difference	Gap
Apprentice	5	£5.49	28	£5.67	0.18	-3.27%
Band 1	2	£10.63	3	£10.54	0.09	0.84%
Band 2	288	£12.79	1395	£12.74	0.05	0.38%
Band 3	94	£12.00	714	£11.90	0.10	0.80%
Band 4	89	£12.99	507	£13.31	0.32	-2.44%
Band 5	242	£17.50	1576	£18.83	1.32	-7.56%
Band 6	158	£19.20	1082	£20.50	1.29	-6.72%
Band 7	104	£22.92	555	£23.27	0.35	-1.54%
Band 8a	48	£25.98	164	£26.12	0.14	-0.53%
Band 8b	29	£30.12	55	£29.90	0.22	0.74%
Band 8c	14	£32.86	21	£36.28	3.42	-10.41%
Band 8d	9	£40.96	21	£32.73	8.23	20.09%
Band 9	3	£51.32	4	£42.45	8.86	17.27%
Career Grade	50	£37.16	44	£34.55	2.61	7.02%
Consultant	264	£55.82	157	£53.08	2.74	4.91%
Misc	24	£31.52	36	£26.32	5.19	16.47%
NED	1	£7.58	8	£10.15	2.56	-33.82%
Trainee Grade	403	£25.14	626	£24.87	0.27	1.06%
VSM	4	£75.65	3	£88.36	12.71	-16.80%

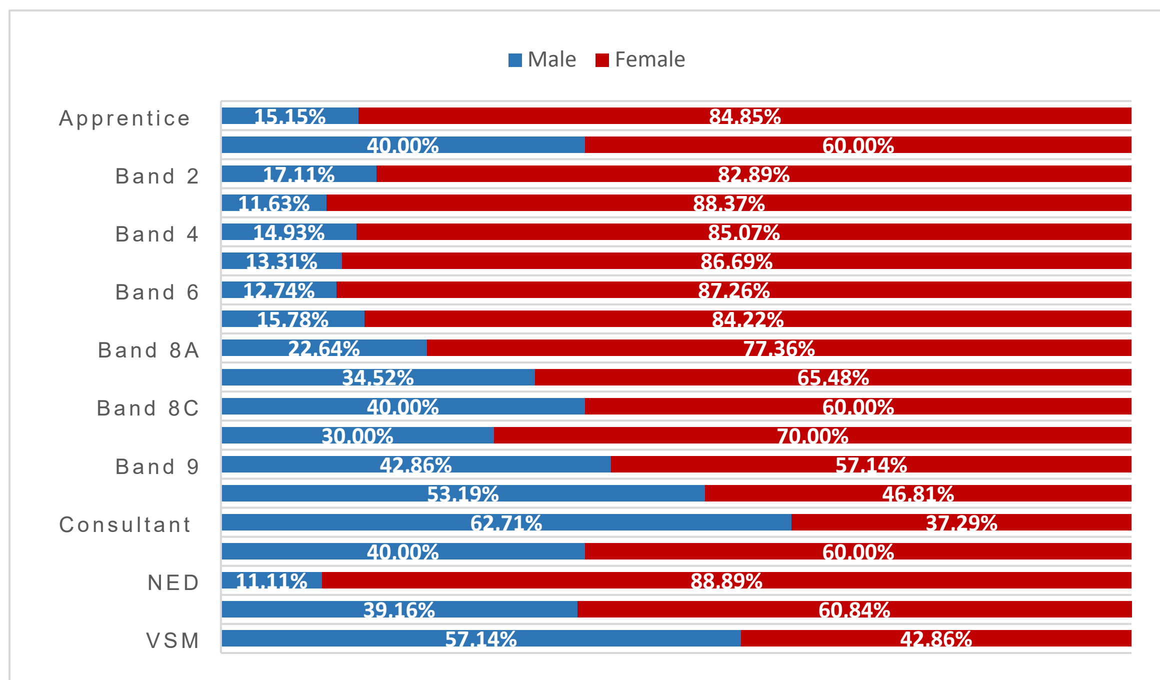
***Refers to the mean hourly rate**

ⁱnegative values mean that the difference and the gap are favourable to females.

The above table shows that, on average, females earn more in almost half of the pay bands than males – the band where males earn more are Bands 1, 2, 3, 8b, 8d, 9 and medical roles.

We have also analysed the proportion of males and females across each of the above bands, and the results of this are shown in the bar chart below.

Gender split by band – based on headcount



4. Specific Focus Areas

Medical Staff

The most significant feature of the data at 31 March 2023 is that if Medical Staff were to be removed from the calculations, then the median gap is nullified and the mean is reduced to **1.89%** from **25.7%**.

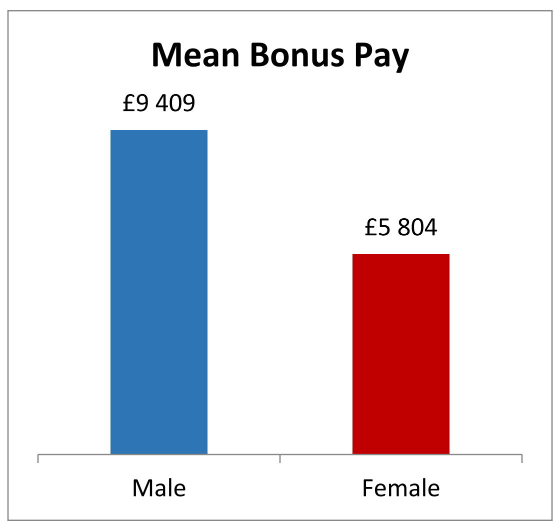
Medical staff group compromises a large group, from Foundation level doctors in their first-year post qualifications to consultants. The pay gap for Medical staff as a whole is **18.0%** - males get paid on average **£37.29** per hour whereas females are paid **£30.58** per hour.

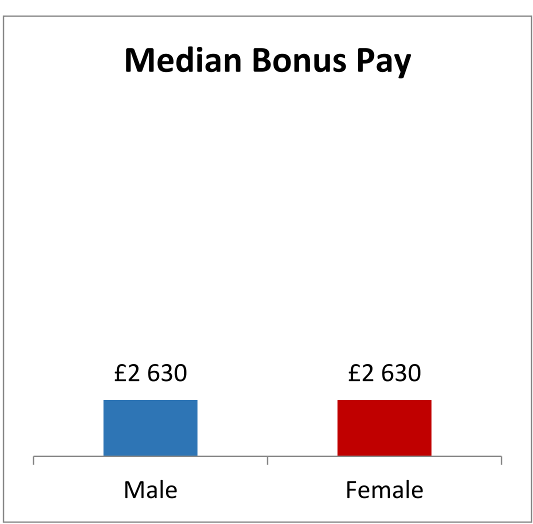
Please note National Clinical Excellence Awards have been excluded from the Medical Pay Calculations in this document. The Bonus section will address the Awards.

5. Bonuses

In the specified period, a total of **382** bonuses were awarded. **136** to female consultants and **246** to male consultants. When compared to the ratio pf male to female consultants, **64.40%** of bonuses were paid to male consultants, who represent **62.71%** of all consultant's positions. While **35.60%** were given to female consultant's, who represent **37.29%** of all consultants' positions. This data is encouraging as it reflects a decrease compared to the previous report, with the GPG dropping from 45.36% to **38.31%** last year.

NHS Employers acknowledge that the current local CEA system is flawed and worsens inequalities for women and BME colleagues, and part time workers.





Mean gender pay gap, bonus 38.31% **Median gender pay gap bonus 0.00**

Following the 2021 consultation on reform of the National Clinical Excellence Awards, the Department of Health and Social Care (DHSC) and the Welsh Government have agreed the following changes will be implemented in a revised scheme as the National Clinical Impact Awards.

The awards have been re-branded as the National Clinical Excellence Awards to reflect to applicants and scorers that the primary focus of the awards is the output of activities, rather than undertaking activities in the absence of describing their impact and results. (More Information can be found: https://www.gov.uk/government/publications/clinical-excellence-awards-application-guidance/guide-for-applicants-national-clinical-excellence-awards-2021-awards-round

6. Recommendations and Actions

The gap in our mean and median pay and particularly bonus pay, shows there is more work to be done. We will continue to take steps to reduce our pay gap and explore best practice, to support the integration and learning from these findings, the following steps are proposed:

Aim	Objective	Action	Time-scale
Implement the recommendations outlined in the Mend the gap review for medical staff and extend these suggestions to both Senior and non-medical workforce	Collate specific actions to reduce and work to eliminate the existing gender pay gap	Create a culture of accountability and commitment to gender at all levels of the organisation Promotion of coaching and mentoring opportunities	2024-2026

Support the development of our female leaders	Through the promotion of Senior Leadership Development Programmes Talent pipelines designed to ensure that opportunities foster the growth of career aspirations of women	Review current development and talent programmes that supports the development of women	2024 - 2025
Determine if there is an interest in establishing a Woman's network	Offer networking and support opportunities through the development of a woman's network Raise awareness and promote initiatives that support women in the workplace.	Promote through the Inclusion Newsletter/Comms Planned webinars throughout the year Promote International woman day As part of international woman's day EDI nominate a female role model from within the Trust	March 2025

Actions are aligned with High Impact 3 of the NHS Equality, Diversity, and Inclusion (EDI) Improvement Plan.

7. Conclusion

The Gloucestershire Hospitals NHS Foundation Trust gender pay gap at **31 March 2023** is reported at:

- **Median gender pay gap, 19.1% in favour of male staff (21.7% in 2022)**
- **Mean gender pay gap is 25.7% in favour of male staff (28.2% in 2022)**

The figures reflect the **combined** gender pay gap of both medical and non-medical staff.

The People and OD Committee are asked to **NOTE** that the gender pay gap can be objectively explained, when we consider the application of terms and conditions which are set nationally and reward length of service. Furthermore, there is no significant **(1.89%)** Gender Pay Gap reported across out Non-Medical workforce, which accounts for approximately **81.9%** of the total workforce as a result of the agenda for change framework.

The gender pay report continues to evidence the assumption that the overarching

pay gap is associated with length of service of a number of senior male Doctors; with further analysis demonstrating that the number of females both entering the Medical workforce and existing staff within pay quartiles 1-3 will lead to a reverse in this pay gap in future years. The Committee are therefore advised that as such, the current pay gap is a consequence of the application nationally driven terms and conditions and Clinical Excellence Awards.

Author: EDI Team
Presenter: Circulated for Approval

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee 24th January 2024		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Regulatory Update	NHS Review of Paediatric Hearing Services received a 'Red' rating – serious risk	Action plan in development. Full report to Committee February '24, monitored via QDG. Escalation routes to be reviewed.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Regulatory Update	Section 29a warning notice issued for Urgent and Emergency Care (UEC).	Action plan in development to be monitored through QDG.
	NHSE - Annual Peer Review of Trauma Units highlighted concerns about high rates of unexpected deaths.	Action plan in development. Governance via QDG.
	HSE Inspection – Phase 1 took place December '23	Phase 2 planned for February '24
Board Assurance Framework - SR1	The Trust will be moved to Tier 2 for Urgent and Emergency Care, which was anticipated.	The Trust would receive support from the Emergency Care Intensive Support Team and GIRFT (Getting it Right First Time) team. The risk score is under review.
SR5	Ambulance Improvement Plan. The trust is one of the five worst in terms of handover delays in the South West.	The trust has been in conversation with the Secretary of State. Key actions have been implemented including an ambulance cohort area in the Emergency Department resulting in improved performance in January.
Quality and Performance Report	Revised Quality and Performance report in development to provide greater clarity in reporting to committee.	Revised report to February committee. Maintaining performance continues to be challenging, particularly in light of on-going industrial action. Focus remains on improving pathways and

		working collaboratively to improve performance.
Trust Risk Register	One new Never Event reported related to the misplacement of naso-gastric tube.	Investigations on-going.
	One new referral to Health Services Safety Investigations Body (HSSIB)	Investigations on-going. Weekly meetings taking place to address action plans.
	Nine Serious Incidents reported including several maternity declarations	Work on-going relating to recording data quality recording.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Patient Safety and Risk Assurance Report	Draft Patient Safety Incident Response Framework (PSIRF)	Plan and Policy approved pending recommended changers. Committee to receive updates on implementation.
	Falls	No longer reported on QPR as performance is now in range
	Maternity Incentive Scheme	Compliance achieved on all standards
	Learning from Deaths Report – Q1 (April – June '23)	Hospital Mortality Group review completed. Mortality indicators remain as expected except for weekend admissions which remain high.
	Maintenance backlog – significant estates issues noted across some divisions.	Clarity re escalation routes to be provided. Backlog maintenance to be raised nationally and with ICB.
	The Committee were advised that the BBC Panorama programme was to focus on the Trusts maternity service	Post programme learning and development planned
Discharges	Ian Sturgess work	Committee to receive briefing on outcomes of February workshop.
Human Tissue Authority (HTA)	Compliance and action plan	Action plan closed. All actions signed off.
Items not Rated		

SYSTEM FEEDBACK No further business to note, key issues picked up in various reports.

GOVERNOR OBSERVATION There were no governor in attendance

Investments

Case	Comments	Approval	Actions

Glossary:

H1/H2= first/second half of the financial year

ERF: Elective Recovery Fund

CIP: Cost Improvement Programme

ICS = Integrated Care System

Impact on Board Assurance Framework (BAF)
All strategic risks discussed. Challenge given on current and target risk scores

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

Glossary:
H1/H2= first/second half of the financial year
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KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee 4 January (extraordinary) and 28 February 2024		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Water safety	Several areas of focus remain within the Group including Trust and Gloucestershire Managed Services (GMS). Evidence of much work underway to ensure/ maintain safety including audits. Pressure of time commitment on Infection Precentral and Control (IPC) team and impact on other responsibilities they have. Chief Executive outlined external resource to support Internal Audit results, progress against actions and ensuring cohesiveness and supporting transformation across the Group.	Agreed to continue with monthly reporting for assurance.
PACs clinical systems	Update provided, backlog stated to be resolving, mitigations in place by continued outsourcing, team morale noted as affected by the disruption. Business as usual should resume when the planned upgrade to PACs has been successfully achieved.	Further report to Committee
Maternity Services	Dashboard and comprehensive report presented. Questions included areas regarding the stillbirth rate for December, declining FFT score and plateaued appraisal rates. Reassurance given that these areas are high focus within the service. Safeguarding training rate shows improvement. The recent Panorama programme was noted and Trust actions to be shared. External review of maternity services requested by Chief Executive and supported by Committee.	Maternity services continue to be reported monthly to Committee. Detail to March Committee.
Quality and Performance Report	Quality and Performance report received covering areas of urgent and emergency care, elective and cancer activity. Deep tissue injuries and numbers of falls with harm. Both had increased over winter months and thought to be linked with issues of flow. VTE assessment now 'mandatory and improvements expected in reporting. Emerging issue with potential JAG re-accreditation for Endoscopy and coding of screening patients.	Detailed work timelines to return to committee and contemporaneous data. Report to March Committee.
Regulatory Report	Current action plan updates provided and closure of HTA inspection and Early Inflammatory Arthritis Audit both expected soon. Recent Health and Safety Executive visit focussing on violence and aggression noted, awaiting feedback.	

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

	Paediatric hearing service rated red for consistency of care within current clinical guidelines, no safety or governance concerns described to committee.	Detailed report to March Committee for assurance on delivery of improvements.
Safety, Risk and Incident reports	Risk escalated to Corporate Risk Register concerning risk of harm due to violence and aggression involving staff/patients. Importance of Trust and GMS working well together clear and work to establish if current model is most effective. Two Never Events reported, high levels of complaints continued and new model of divisional 'tri' ownership working with corporate team noted. First patient safety panel held with patient safety champions.	Assurance route for violence and aggression is through People and OD committee.
Director of Infection Prevention and Control (DIPC) Report	Quarterly report received. Much work and some significant improvements in year/ comparisons in SW. MRSA and MSSA low, E Coli lowest in SW. Areas needing continued focus include hand hygiene standards, surgical site infection. National cleaning standards of 2021 being implemented now by GMS, approach questioned and assurance requested on current cleaning standards. Verbal reassurance that cleanliness in general was 'good' Noted that the Infection Control Committee has oversight of this but a request for this committee to see more of the detail.	Quarterly update to Committee from DIPC
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Fractured Neck of Femur update positively received by Committee and ambition, detail and improvements noted. Final report to go to Hospital Mortality Group and by exception to Committee and then to return to business as usual.		
Items not Rated		
Operational Plan shared with Committee enroute to Finance and Resources Committee		
Impact on Board Assurance Framework (BAF)		
Discussion on status of Strategic Risks (SR) 1, 2 and 5 indicating some good momentum in SR1 and recent Flow workshop. Support regarding discharges noted from national lead who is due to visit. SR5 regarding national patient safety strategy implementation noted the importance of capacity to deliver fully, remains a work in progress. SR6 not available to review- due in March.		

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
ICS = Integrated Care System
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Quality and Performance Report
Statistical Process Control Reporting

Reporting Period January 2024

Executive Summary

URGENT & EMERGENCY CARE
The total level of attendances across our EDs increased by just under 1% in January (from 12,100 to 12,225); note that this partly reflects the lower level of attendances across the Christmas break. A lot of energy and effort went into improving the Trust's performance in terms of ambulance handovers (which had deteriorated consistently through the autumn and early winter, and average 117 minutes in December). This had reduced to 56 minutes in January – a reduction of 52%. The performance improvement may largely reflect the change of use of the Courtyard space to create additional Majors capacity.

It's probably fair to say that, this switch of focus has had a detrimental impact on some of our other metrics. So four-hour compliance (overall) has fallen from 59.3% to 56.3%, and twelve-hour performance has also fallen back from 85.2% in December to 84.6% in January.

The number of SDEC attendances has increased by ~ 10% month-on-month in January. This may partially reflect the larger number of normal working days in the month and the closure of AEC for the duration of the IA in December. A quarter of these patients arrived via ED (this is down from 28% in December) and 93% of these patients were discharged directly from SDEC (which is a significant improvement from the 89 – 90% being achiever during the latter months of 2023.

ELECTIVE CARE
January data is still undergoing validation prior to submission on 19th February. Although the Trust has not met the 78 week standard, progress has been made with a reduction seen in number of breaches. Final position for January is a total of 5 breaches across 3 specialties- ENT (2) Oral Surgery (2) and Cardiology (1). The part- validated RTT position for January is also showing signs of improvement with an anticipated month end position of 65% and a reduction in the over 52 week cohort with final position likely to be in the region of 2950-2990. Achievement of zero patients waiting 65 weeks at year end continues to be the focus and numbers in the cohort have reduced however as with last month services still face significant challenges. There are currently 1884 patients at risk of being a 65 week breach by the end of March this consists of 623 admitted patients and 1261 non-admitted. Services at greatest risk remain Oral Surgery, ENT, Upper GI, Cardiology and Neurology.

CANCER

Jan-24 performance shows we missed delivery on all 3 of the new national operational standards – However please note, this is an UNVALIDATED POSITON and MAY CHANGE.
The Trust is MAY MEET the 28d FDS standard in Jan. Current performance of 73.7% and could increase with validation
The Trust WILL NOT MEET the 31d FDT standard in Jan with data showing performance of 92.8%.
The Trust WILL NOT MEET the 62d Standard at 54.8% with 116.5 breaches for 257.5 treatments. The number of both treatments and breaches is expected to increase as validation occurs.
The Trust back-log has seen a marked increase with an end of Jan reportable position of 223; Of the GHFT backlog, Colorectal and Urology due to complex pathways and diagnostic capacity. Industrial impact and Winter Pressures is continuing to have an impact on performance and patients' pathways and this is being monitored and recorded for understanding and analysis.

QUALITY
The Quality Delivery Group monitor and review all the exception reports generated for the quality metrics and this is reported in the Quality Delivery Exception Report each month.
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Demand and Activity

The table below shows monthly activity for key areas. The columns to the right show the percentage change in activity from:
1) The same month in the previous year
2) The same year to date (YTD) period in the previous year

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24
All electives (including day cases)	5,933	5,786	6,560	5,087	6,175	6,183	5,898	6,301	5,842	6,255	6,471	5,592	6,704
Day cases	5,133	4,939	5,656	4,348	5,278	5,272	5,009	5,439	5,007	5,148	5,501	4,725	5,761
ED attendances	10,947	10,710	12,511	11,616	12,993	13,176	12,764	12,300	12,813	13,111	12,422	12,142	12,278
FUP outpatient attendances	37,387	33,602	38,510	30,822	34,947	36,692	34,746	35,289	34,716	37,346	38,412	31,545	39,228
GP referrals	10,495	9,773	11,928	9,357	10,638	11,190	10,504	10,750	10,496	11,245	10,644	8,825	11,122
New outpatient attendances	18,394	16,977	18,872	14,918	17,280	18,322	17,679	17,527	17,841	19,568	20,157	15,200	19,192
Non elective (Incl. Assessment)	5,273	5,039	5,728	5,318	5,610	5,708	5,466	5,299	5,656	6,101	6,032	5,655	5,868
Outpatient attendances	55,781	50,579	57,382	45,740	52,227	55,014	52,425	52,816	52,557	56,914	58,569	46,745	58,420

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Guidance

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

How to interpret variation results:

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

How to interpret assurance results:

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

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Source: NHSI Making Data Count

Access Dashboard

This dashboard shows the most recent performance of metrics in the Access category. Exception reports are shown on the following pages.

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation	
Cancer	Cancer - 2 week wait breast symptomatic referrals	≥ 93.0%	Jan-24	26.8%
	Cancer - 28 day FDS (all routes)	≥ 75.0%	Jan-24	71.6%
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%	Jan-24	90.9%
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%	Jan-24	98.2%
	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	≥ 94.0%	Jan-24	97.9%
	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	≥ 94.0%	Jan-24	72.5%
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%	Jan-24	61.4%
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%	Jan-24	77.4%
	Cancer - 62 day referral to treatment (urgent GP referral)	≥ 85.0%	Jan-24	55.0%
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%	Jan-24	65.4%
	Number of patients waiting over 104 days with a TCI date	No Target	Jan-24	12
	Number of patients waiting over 104 days without a TCI date	No Target	Jan-24	57
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%	Jan-24	24.69%
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600	Jan-24	627
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%	Jan-24	95.2%
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%	Jan-24	21.47%
	% of ambulance handovers < 15 minutes	No Target	Jan-24	22.48%
	% of ambulance handovers < 30 minutes	No Target	Jan-24	56.55%
	% of ambulance handovers over 60 minutes	≤ 1.00%	Jan-24	27.50%
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%	Jan-24	46.1%

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation	
Emergency Department	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%	Jan-24	40.9%
	ED: % total time in department - under 4 hours (type 1)	≥ 95.00%	Jan-24	55.86%
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0	Jan-24	967
	Number of ambulance handovers 30-60 minutes	↓ Lower	Jan-24	638
	Number of ambulance handovers over 60 minutes	= 0	Jan-24	817
Maternity	% of women booked by 12 weeks gestation	> 90.0%	Jan-24	92.3%
Operational Efficiency	% day cases of all electives	> 80.00%	Jan-24	85.93%
	Average length of stay (spell)	≤ 5.06	Jan-24	7.34
	Average patients with discharge ready date	≤ 100	Jan-24	144
	Cancelled operations re-admitted within 28 days	No Target	Jan-24	68.57%
	Intra-session theatre utilisation rate	> 85.00%	Jan-24	89.91%
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40	Jan-24	2.31
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65	Jan-24	8.45
	Number of patients stable for discharge	≤ 70	Jan-24	196
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380	Jan-24	498
	Urgent cancelled operations	↓ Lower	Jan-24	0
Outpatient	Did not attend (DNA) rates	≤ 7.60%	Jan-24	6.24%
	Outpatient new to follow up ratio's	≤ 1.90	Jan-24	1.94
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%	Dec-23	9.07%
Research	Research accruals	No Target	Feb-23	141

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Access Dashboard

This dashboard shows the most recent performance of metrics in the Access category. Exception reports are shown on the following pages.

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower	F	Jan-24	325	
	Referral to treatment ongoing pathways 35+ Weeks (number)	No Target		Jan-24	10,812	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target		Jan-24	5,638	
	Referral to treatment ongoing pathways over 52 weeks (number)	= 0	F	Jan-24	2,983	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%	F	Jan-24	65.49%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	No Target		Jan-24	76.10%	H
	% patients receiving a swallow screen within 4 hours of arrival	No Target		Jan-24	77.50%	H
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target		Jan-24	78.9%	
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%	?	Dec-23	99.0%	H
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	≥ 65.00%	?	Jan-24	0.00%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%	?	Jan-24	100.0%	

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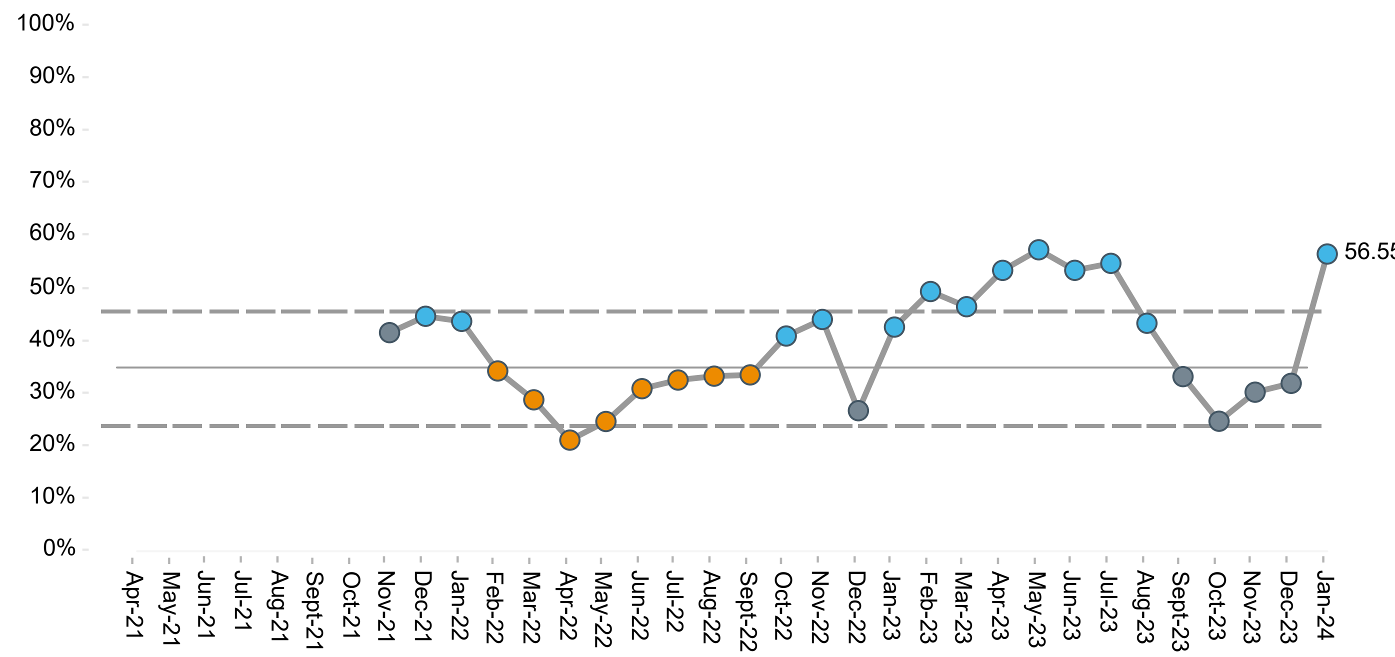
Access

SPC - Special Cause Variation

[595] % of ambulance handovers < 30 minutes

Target: No Target



Data Observations

[1] SINGLE POINT

Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.

[2] SHIFT

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

[3] RUN

When there is a run of 7 increasing or decreasing sequential points, this may indicate a significant change in the process. This process is not in control.

[4] 2 OF 3

When 2 out of 3 points lie near the Lower Control Limit (LCL) and Upper Control Limit (UCL), this is a warning that the process may be changing.

Commentary

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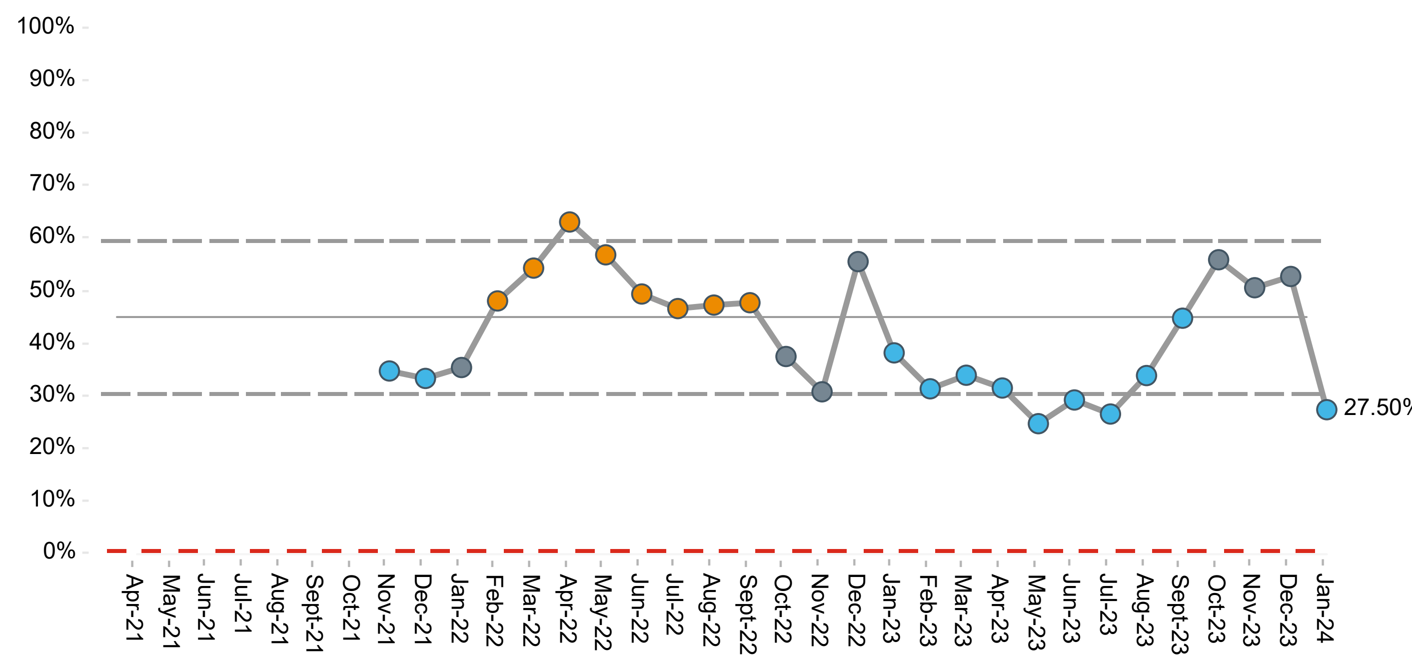
Access

SPC - Special Cause Variation

[482] % of ambulance handovers over 60 minutes

Target: ≤ 1.00%



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Commentary

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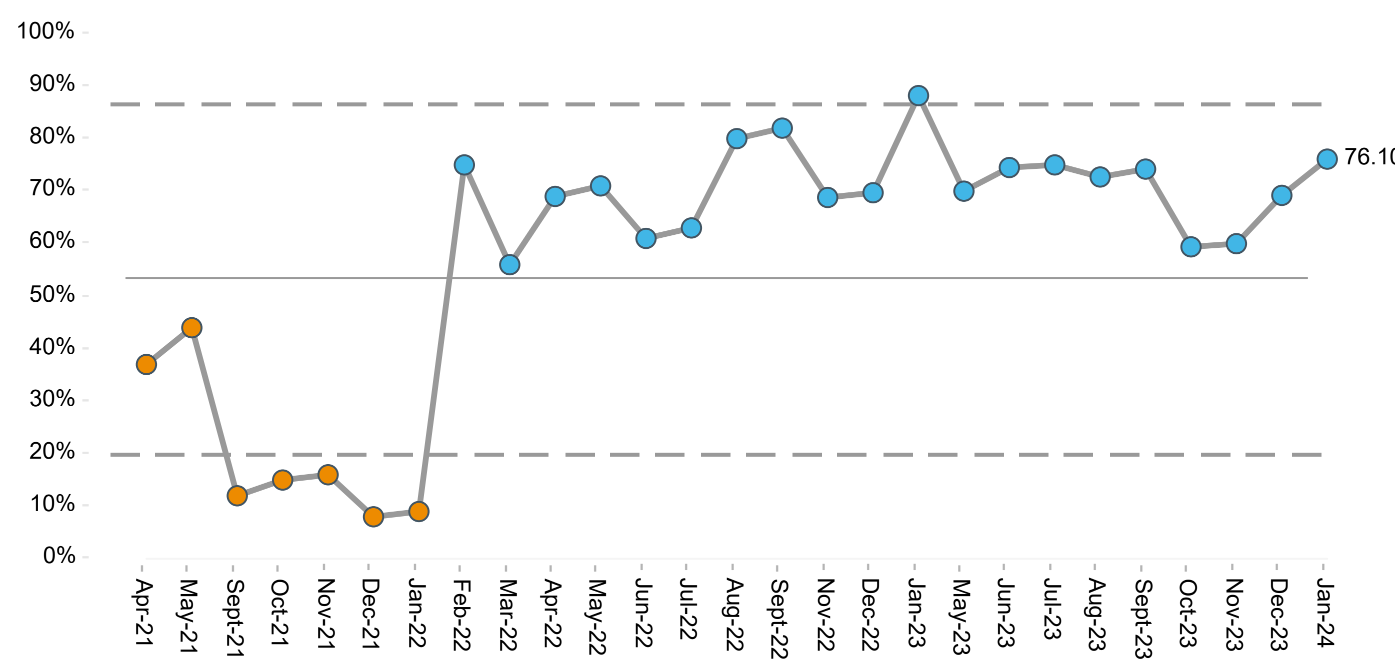
Access

SPC - Special Cause Variation

[473] % of patients admitted directly to the stroke unit in 4 hours

Target: No Target



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Commentary

General Manager - COTE, Neuro and Stroke

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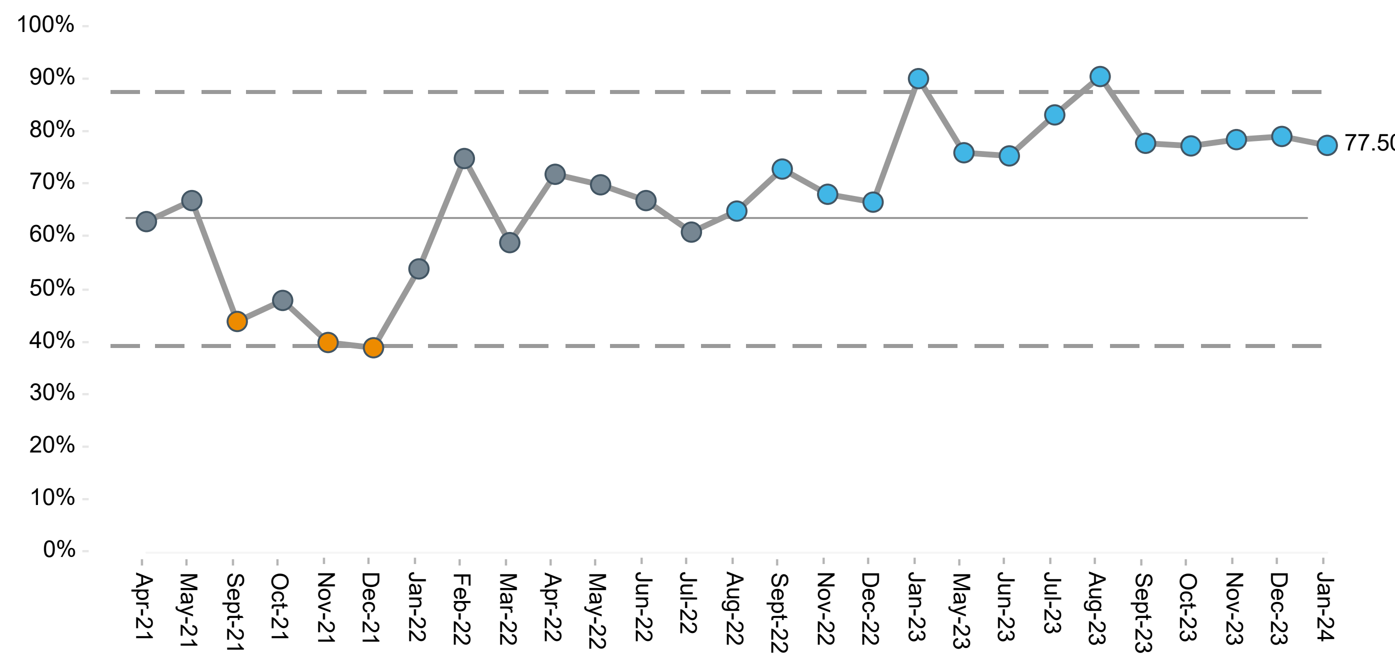
Access

SPC - Special Cause Variation

[474] % patients receiving a swallow screen within 4 hours of arrival

- - - Target: No Target



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Commentary

General Manager - COTE, Neuro and Stroke

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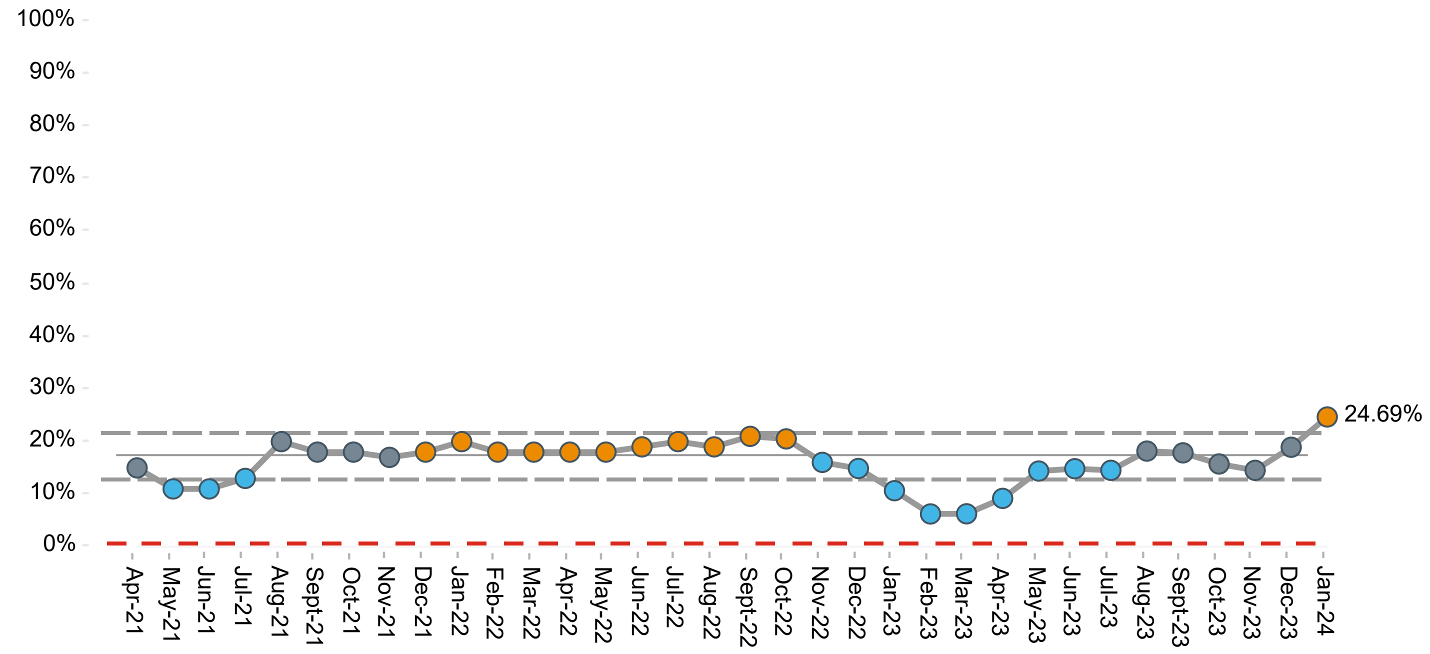
SPC - Special Cause Variation

[183] % waiting for diagnostics 6 week wait and over (15 key tests)

Target: ≤ 1.00%



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Commentary

Associate Director of Elective Care

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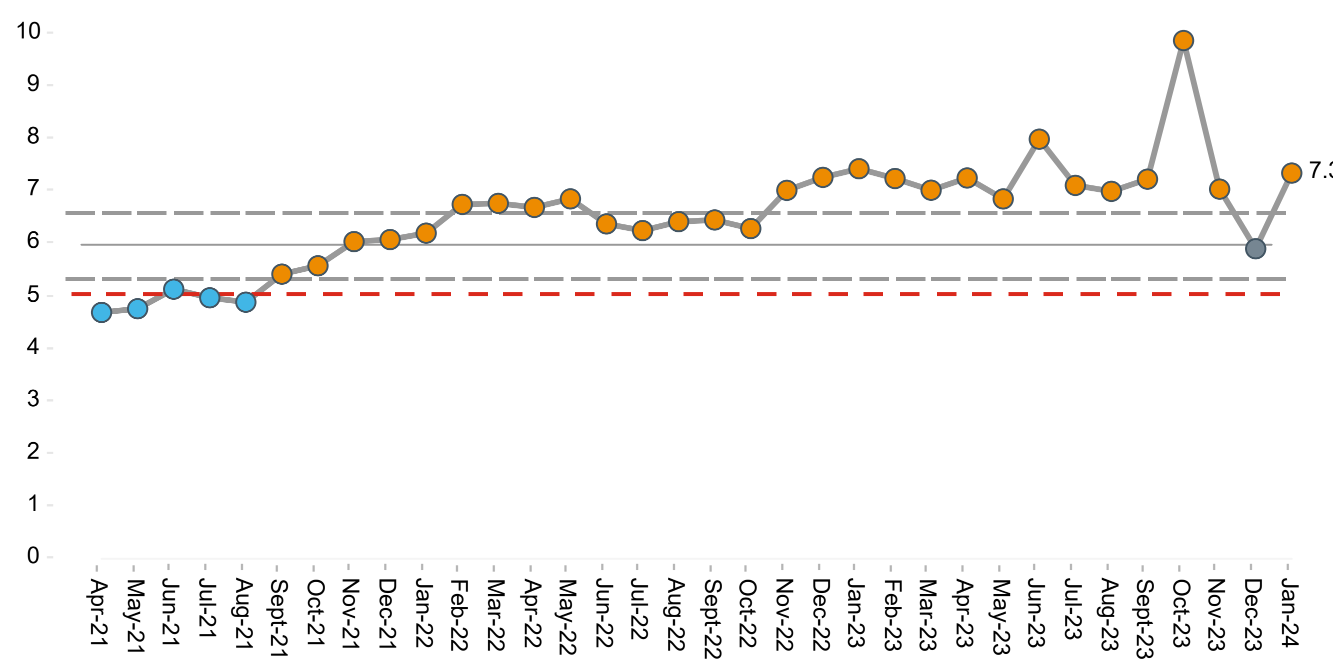
SPC - Special Cause Variation

[188] Average length of stay (spell)

Target: ≤ 5.06



Commentary

Overall average length of stay shows a continued downward trajectory linked to all the work underway to drive internal actions such as red to green and the next steps processes. This is increasing the number of discharges on a daily basis as well as reducing the overall LOS to a now 5.9 average. This is the lowest it has been since Jan 22.
Deputy Chief Operating Officer

Data Observations

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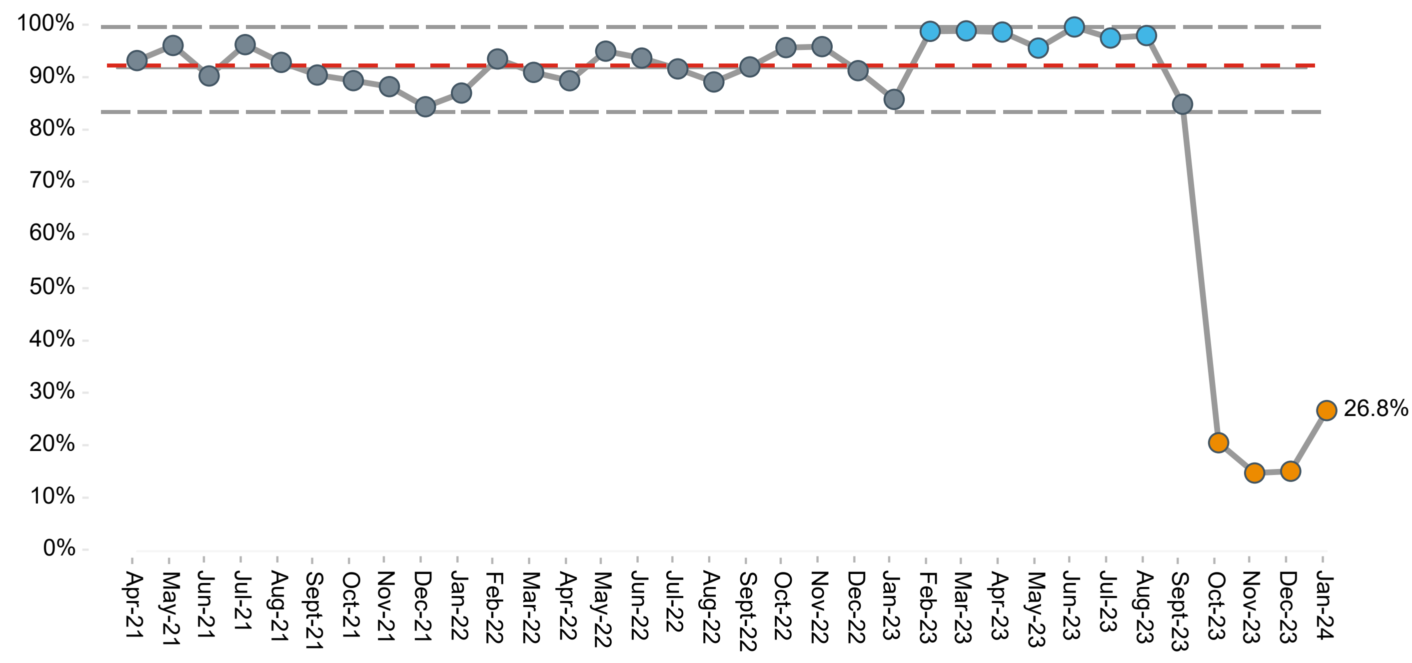
Access

SPC - Special Cause Variation

[170] Cancer - 2 week wait breast symptomatic referrals

Target: ≥ 93.0%



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Commentary

Unvalidated Jan performance of 26.8 - Decline in performance due to staffing issues within Breast Service. Recovery plan for Breast has been generated and supported by ICB
Divisional Director of Operations

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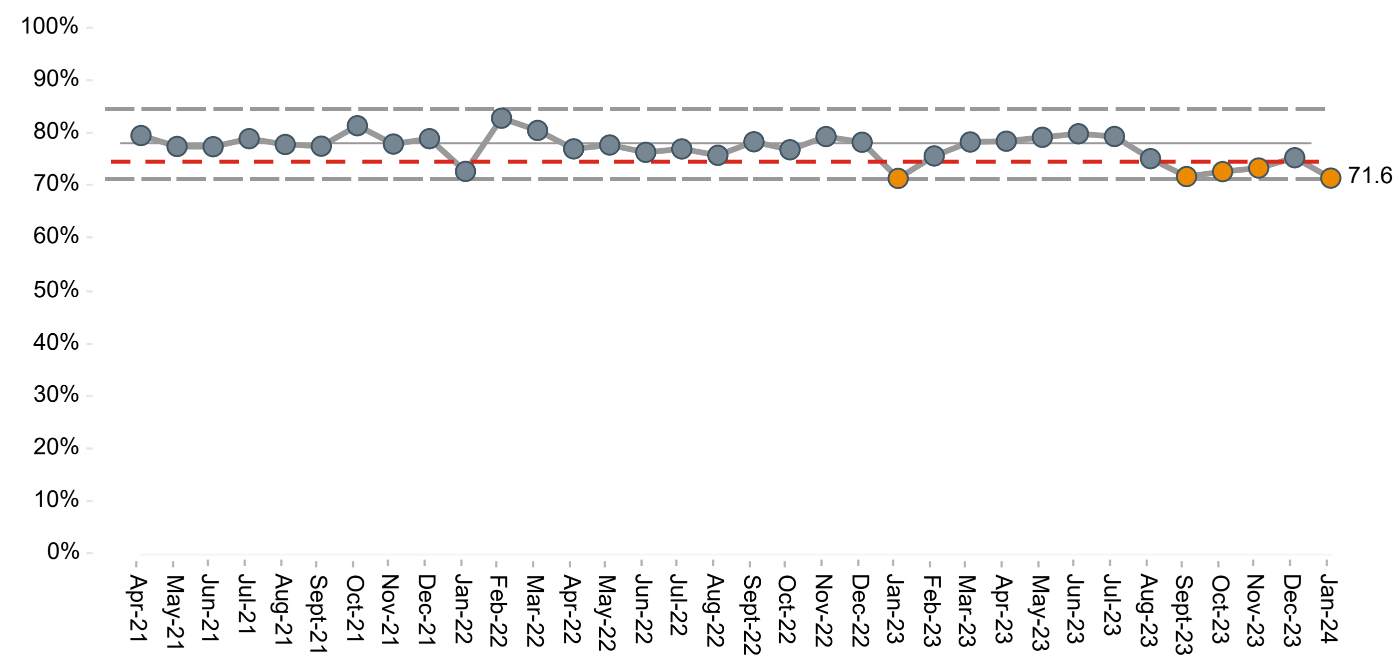
Access

SPC - Special Cause Variation

[593] Cancer - 28 day FDS (all routes)

Target: ≥ 75.0%



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Commentary

Divisional Director of Operations

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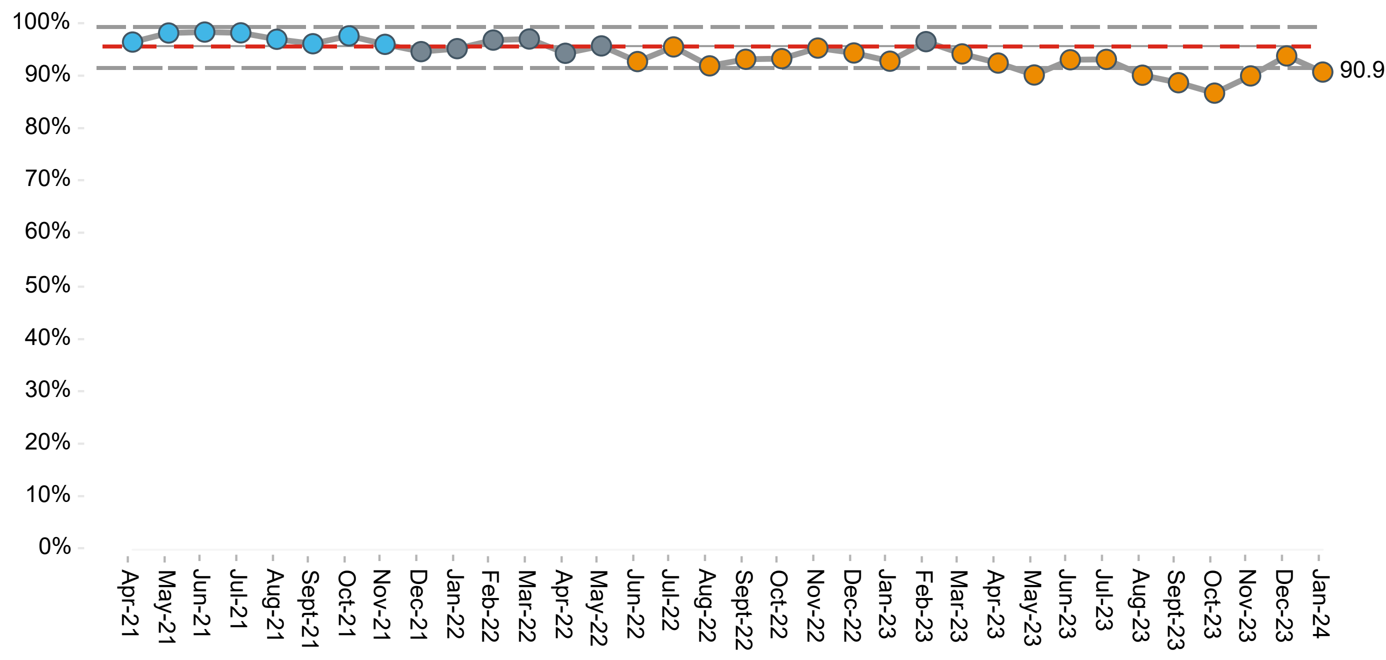
Access

SPC - Special Cause Variation

[171] Cancer - 31 day diagnosis to treatment (first treatments)

Target: ≥ 96.0%



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Commentary

Unvalidated Jan performance of 91 % with 33 out of 357 patients breaching. Note - This is likely to decrease due to additional treatments being added once pathology is received

Divisional Director of Operations

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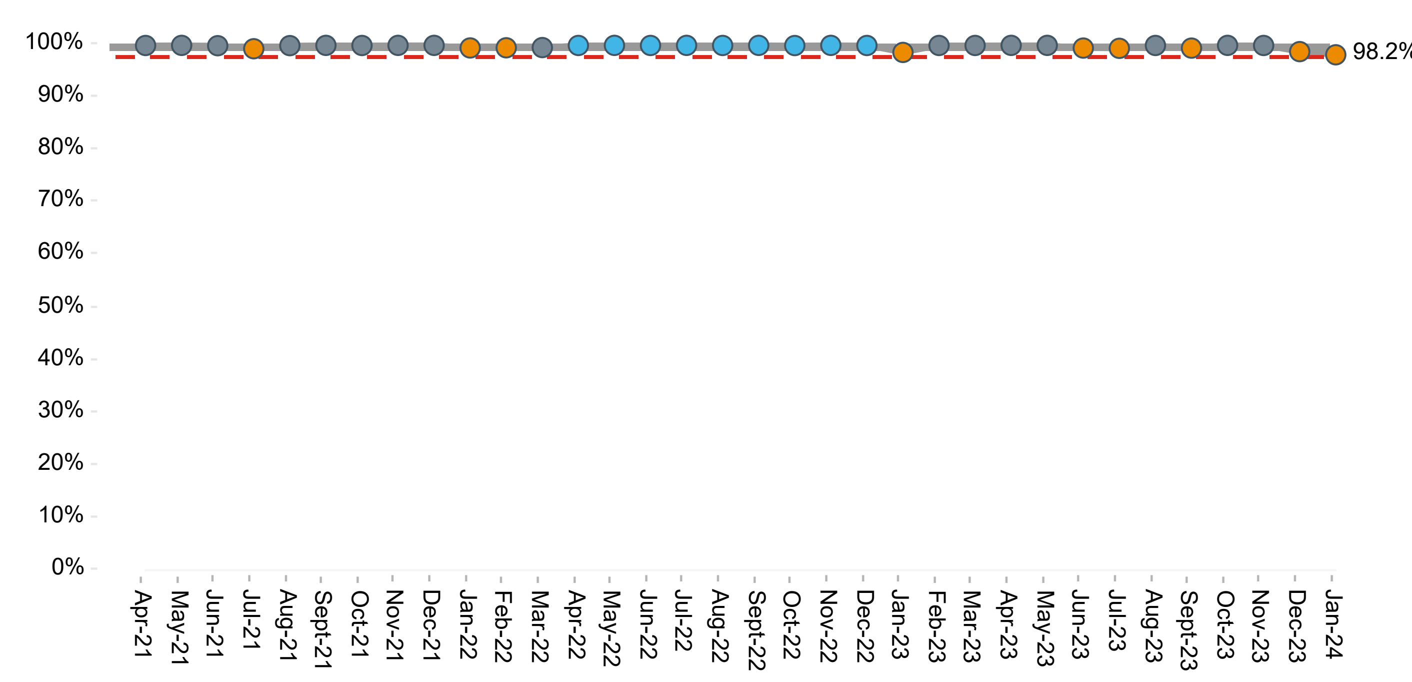
SPC - Special Cause Variation

[172] Cancer - 31 day diagnosis to treatment (subsequent – drug)

- - - Target: ≥ 98.0%



Data Observations

[1] SINGLE POINT

Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.

[2] SHIFT

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

Commentary

Achievement of 31 day subsequent treatment anti-cancer drugs at 98%
Divisional Director of Operations

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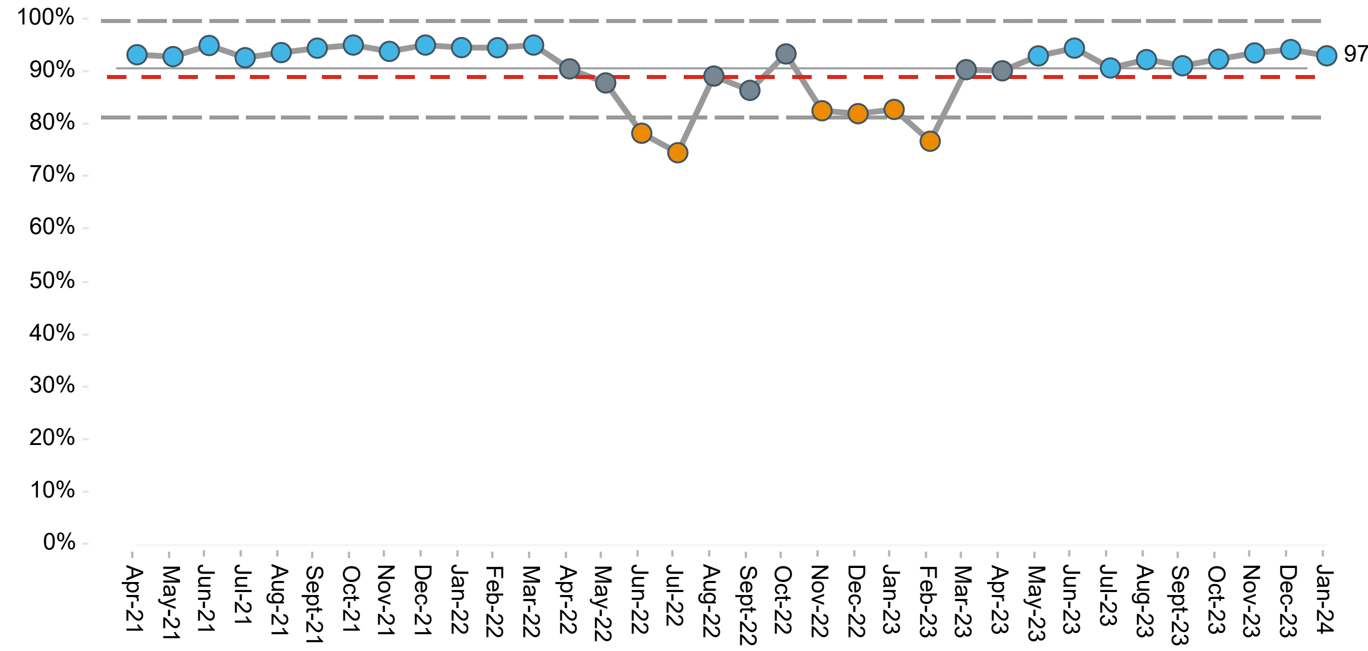
SPC - Special Cause Variation

[174] Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)

Target: ≥ 94.0%



Data Observations

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[4] 2 OF 3

When 2 out of 3 points lie near the Lower Control Limit (LCL) and Upper Control Limit (UCL), this is a warning that the process may be changing.

Commentary

Achievement of 31 day subsequent treatment Radiotherapy at 98%
Divisional Director of Operations

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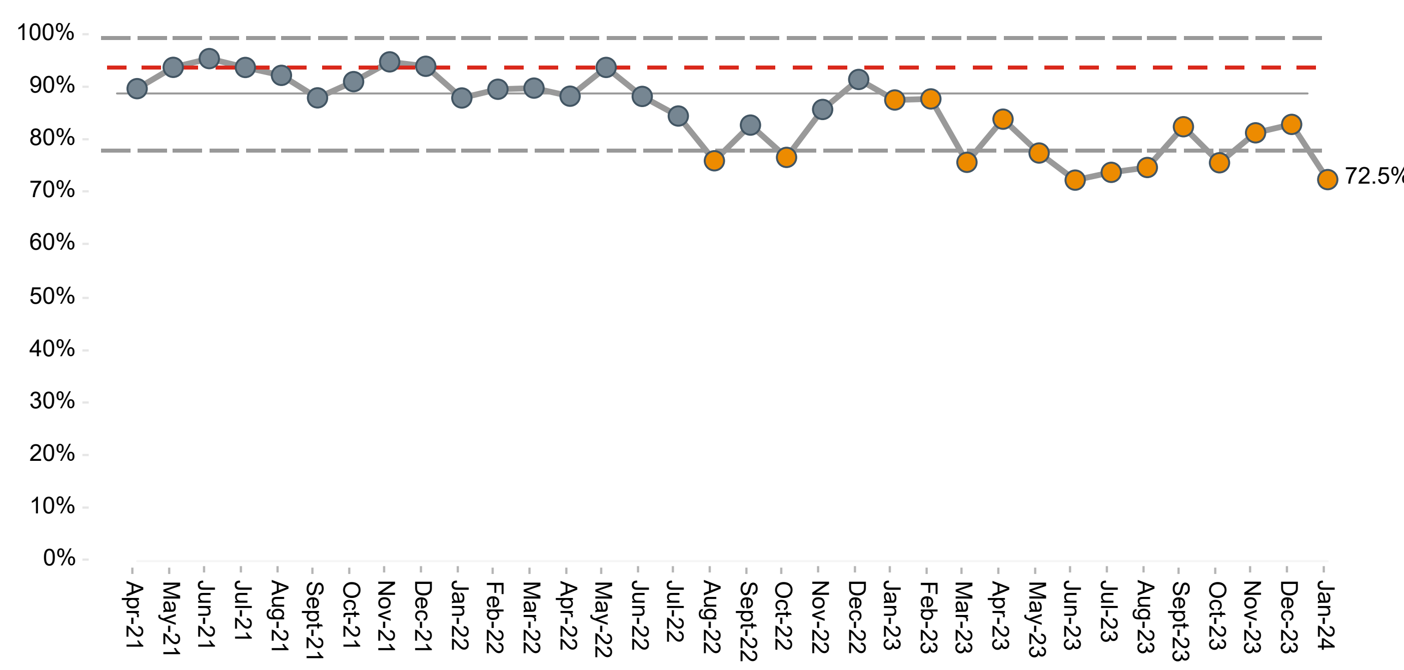
SPC - Special Cause Variation

[173] Cancer - 31 day diagnosis to treatment (subsequent – surgery)

Target: ≥ 94.0%



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Commentary

Divisional Director of Operations

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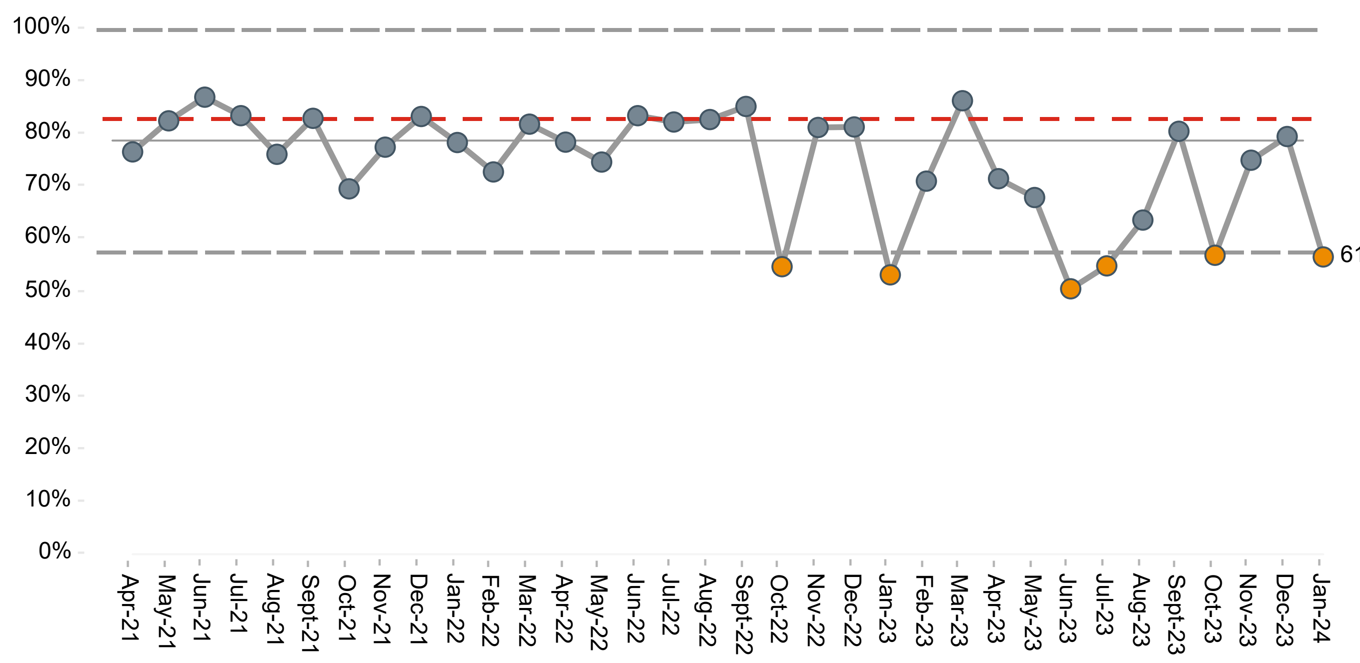
SPC - Special Cause Variation

[176] Cancer - 62 day referral to treatment (screenings)

Target: ≥ 90.0%



Data Observations

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Commentary

Divisional Director of Operations

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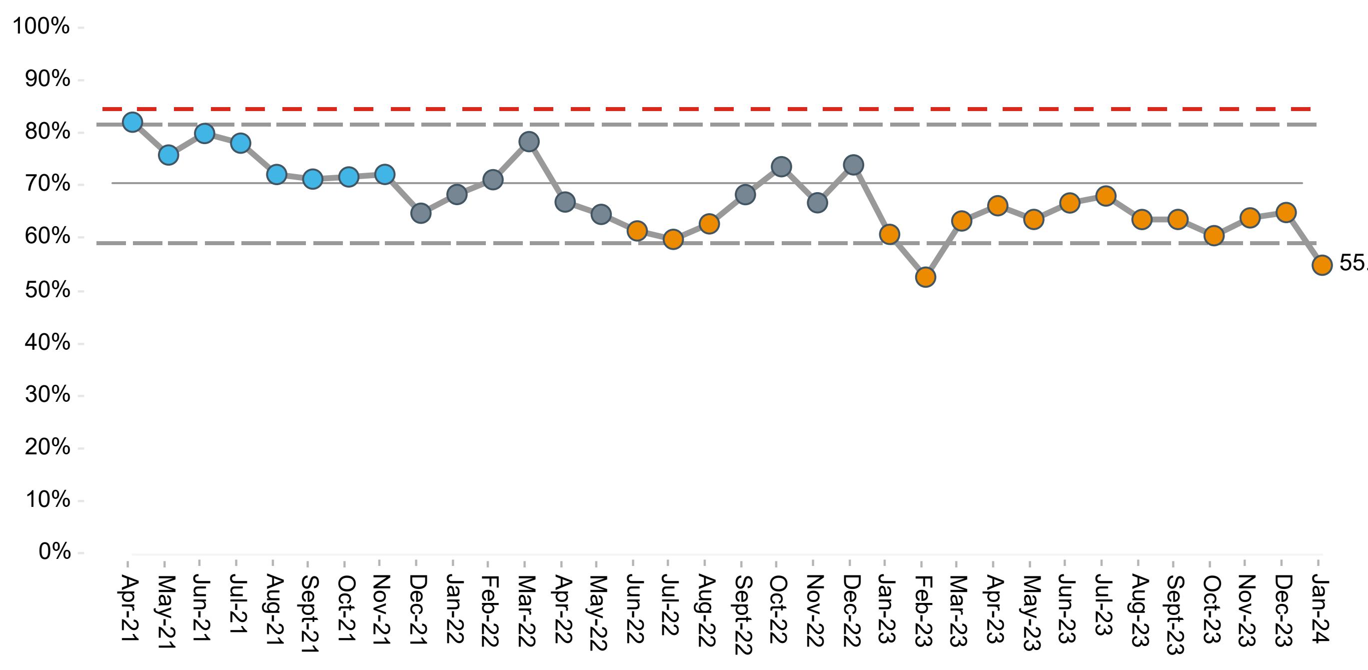
SPC - Special Cause Variation

[175] Cancer - 62 day referral to treatment (urgent GP referral)

Target: ≥ 85.0%



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[4] 2 OF 3

When 2 out of 3 points lie near the Lower Control Limit (LCL) and Upper Control Limit (UCL), this is a warning that the process may be changing.

Commentary

Divisional Director of Operations

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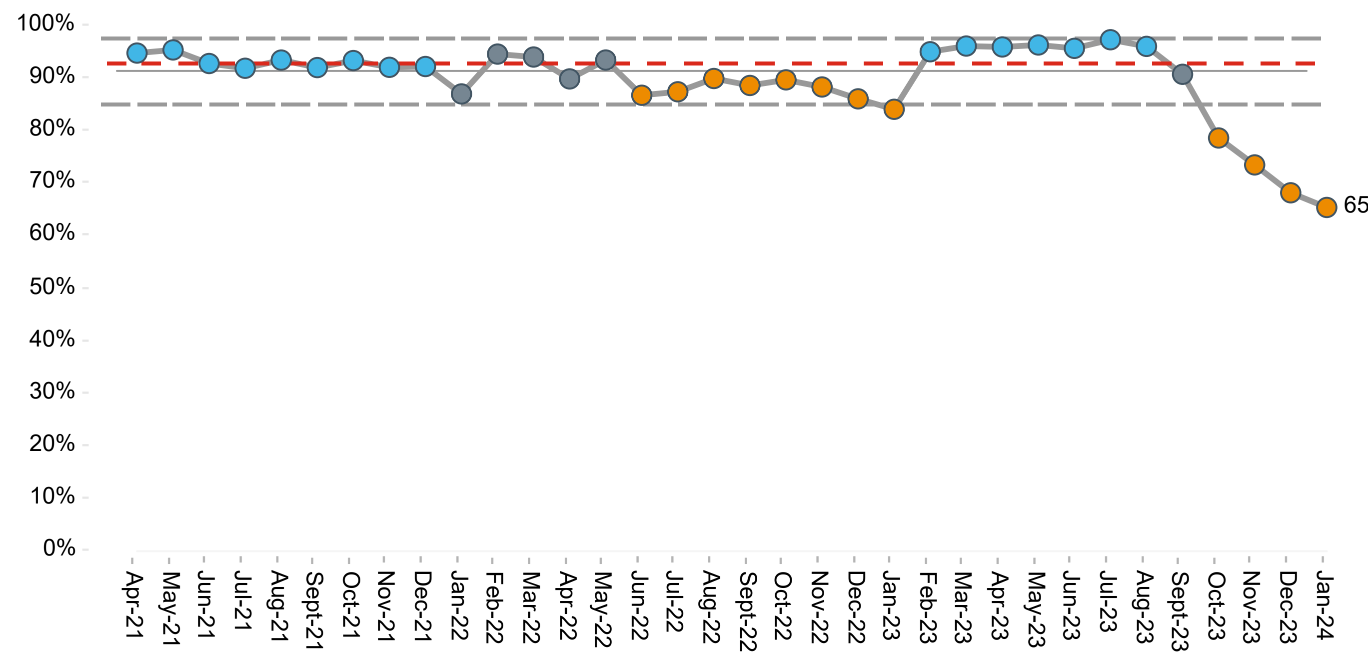
SPC - Special Cause Variation

[169] Cancer - urgent referrals seen in under 2 weeks from GP

Target: ≥ 93.0%



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[4] 2 OF 3

When 2 out of 3 points lie near the Lower Control Limit (LCL) and Upper Control Limit (UCL), this is a warning that the process may be changing.

Commentary

January continues to see a decline in 2WW Performance, achieving 65% in Dec. This has been due to staffing issues and capacity within the Breast service; A recovery plan has been agreed with additional support provided. Endoscopy straight to test capacity is also impacting ability to see Colorectal patients within 2 weeks.

Divisional Director of Operations

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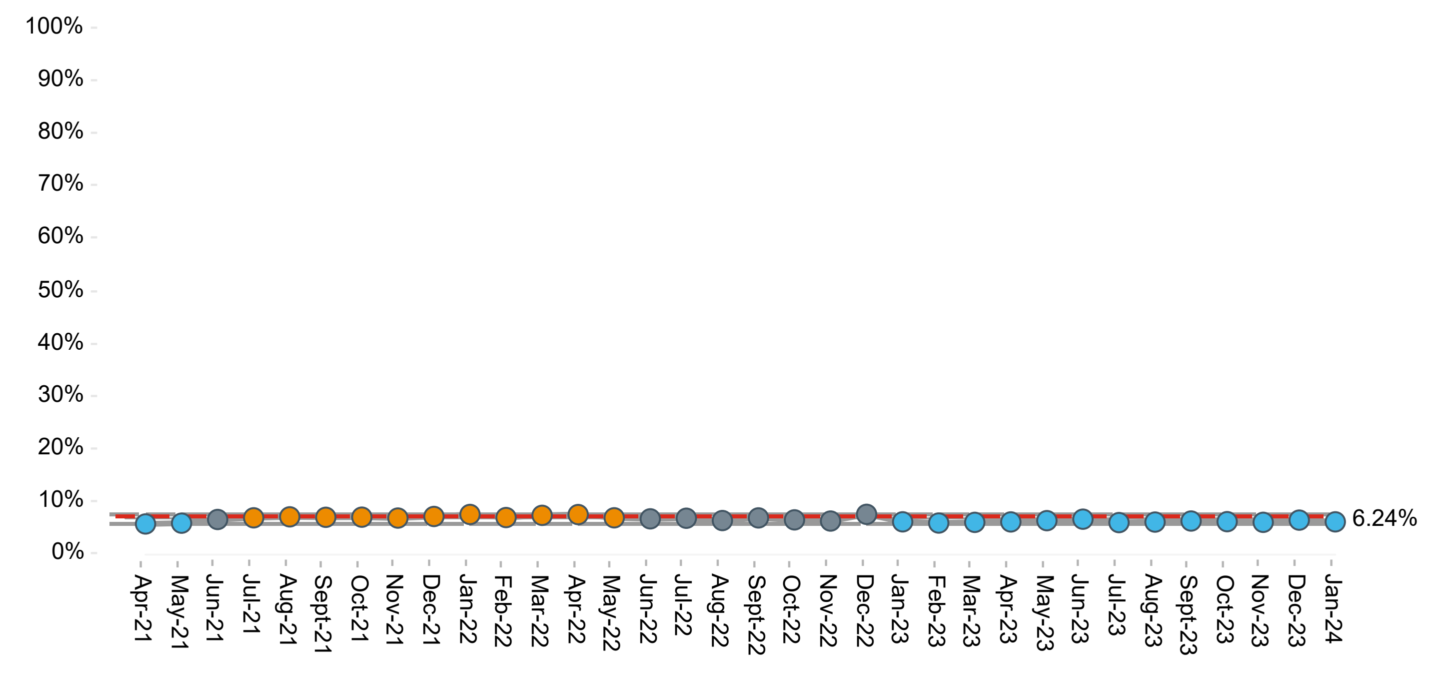
SPC - Special Cause Variation

[491] Did not attend (DNA) rates

- - - Target: ≤ 7.60%



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Commentary

Associate Director of Elective Care

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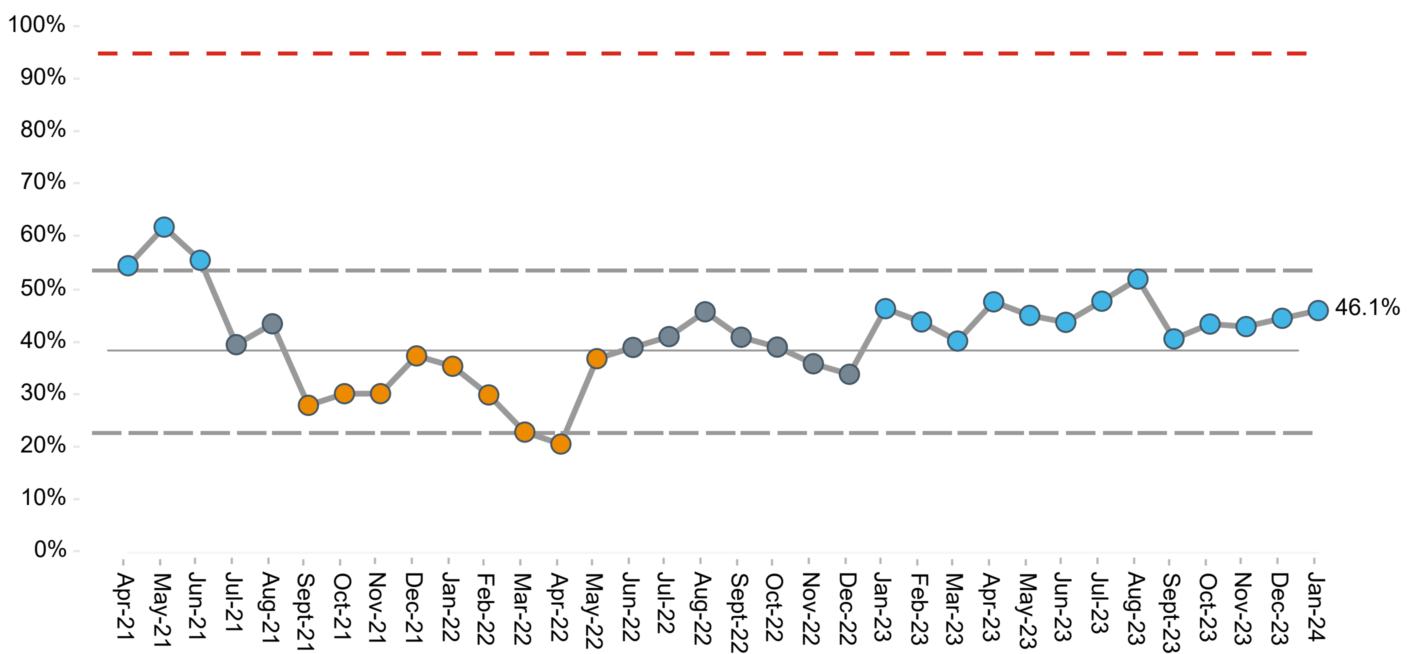
SPC - Special Cause Variation

[195] ED: % of time to initial assessment - under 15 minutes

Target: ≥ 95.0%



Data Observations

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Commentary

General Manager of Unscheduled Care

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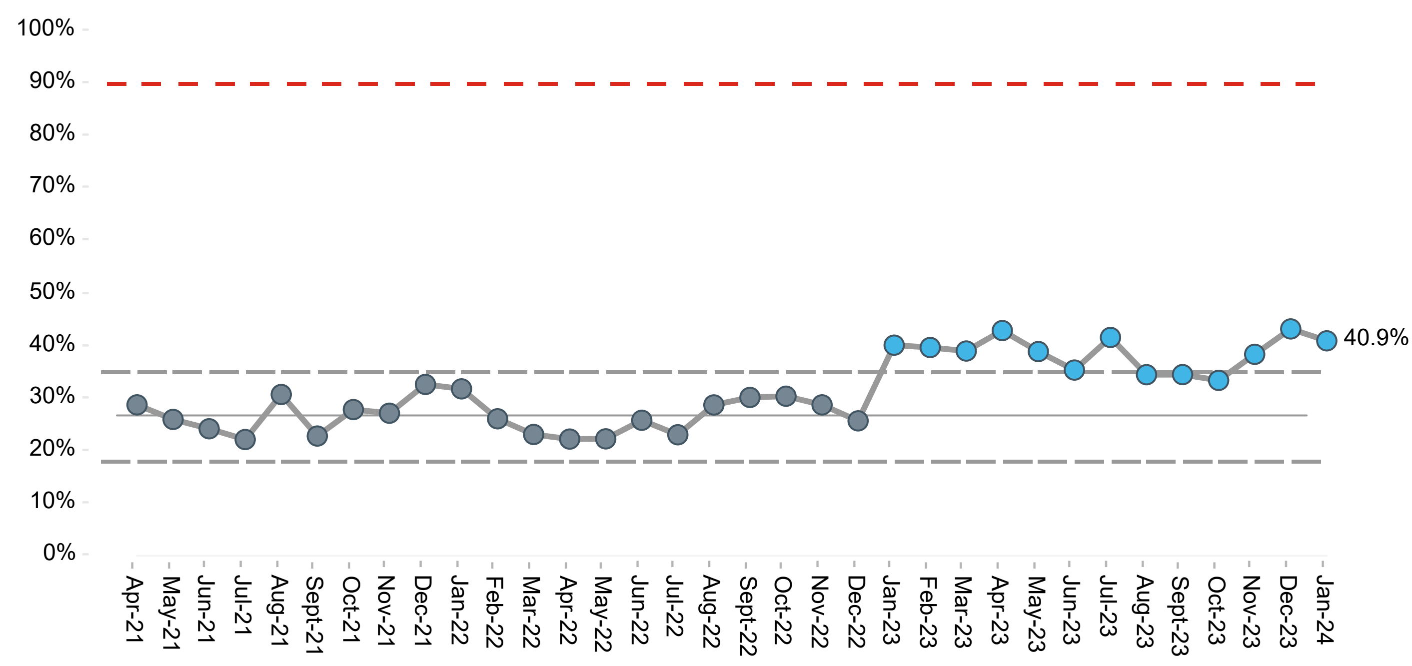
SPC - Special Cause Variation

[196] ED: % of time to start of treatment - under 60 minutes

Target: ≥ 90.0%



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Commentary

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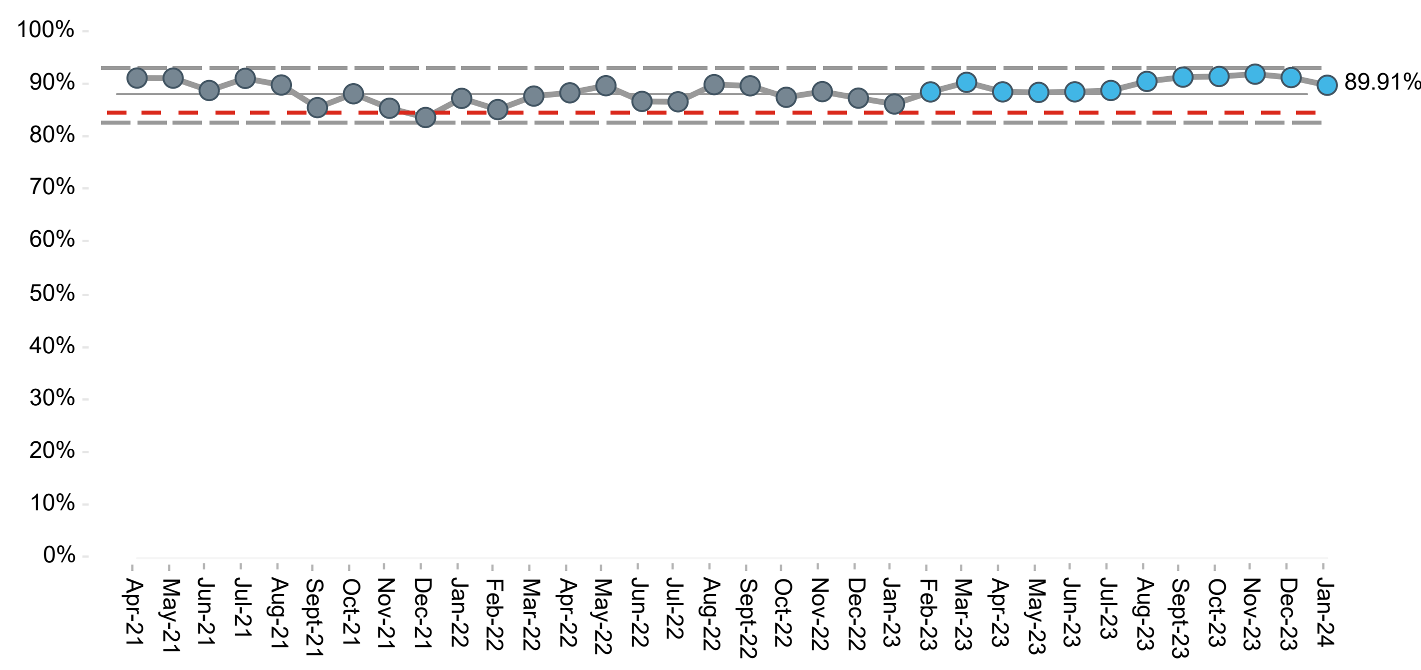
SPC - Special Cause Variation

[488] Intra-session theatre utilisation rate

Target: > 85.00%



Data Observations

[2] SHIFT

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Commentary

Overall GHFT capped utilisation achieved 79% in December 2023, a deterioration of 2% on the previous month. Uncapped utilisation rate for emergency theatre lists across all sites in the same period is 83%, also a deterioriation of 2% from the previous reporting period.

Director of Operations - Surgery

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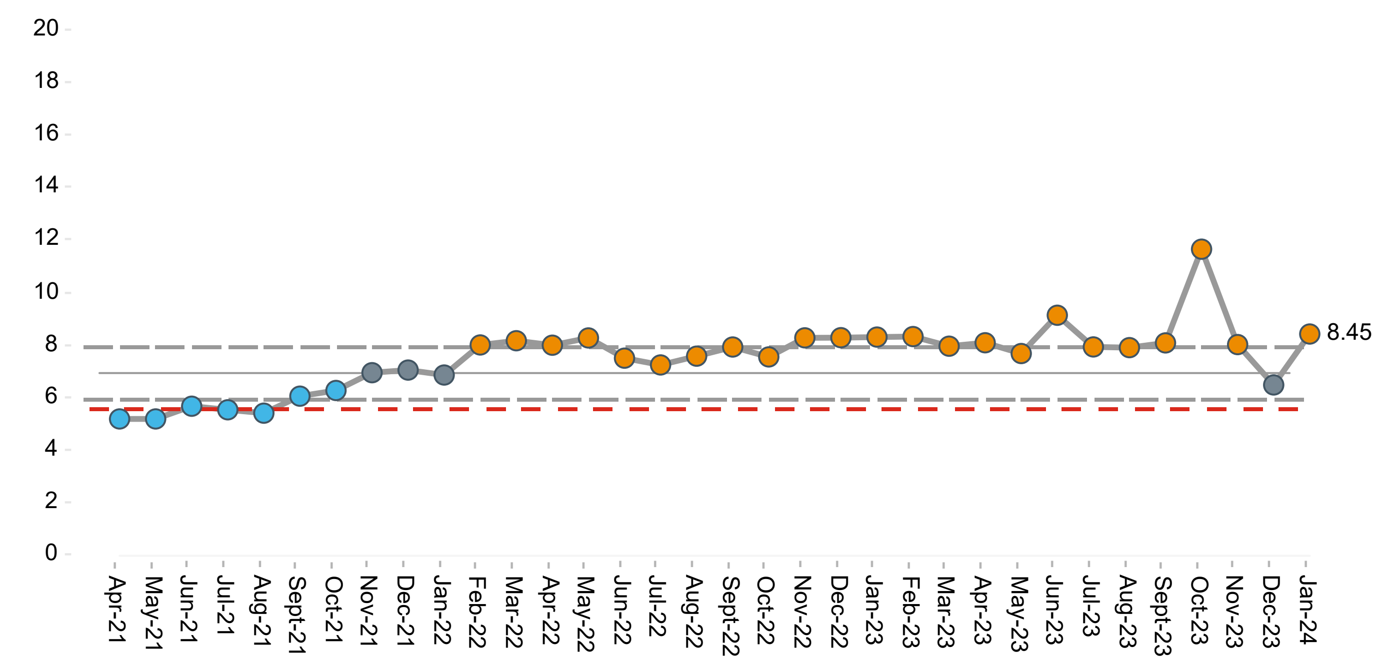
SPC - Special Cause Variation

[189] Length of stay for general and acute non-elective (occupied bed days) spells

- - - Target: ≤ 5.65



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Commentary

Similar to the overall LOS, the LOS within non elective is where the significant reduction in LOS have been realised. Now at 6.25 days, this represents the lowest level since Jan 22, supporting the impact of the work that has been underway for several months around driving hospital flow.
Deputy Chief Operating Officer

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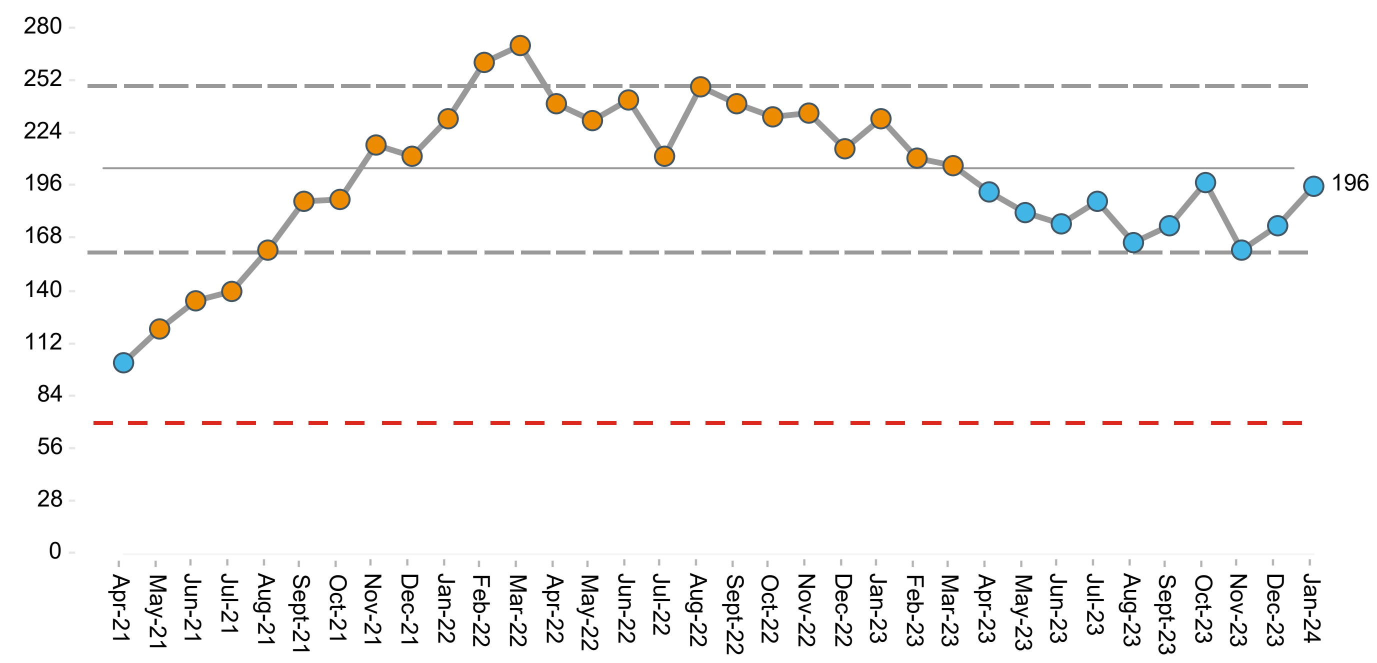
SPC - Special Cause Variation

[186] Number of patients stable for discharge

Target: ≤ 70



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[3] RUN

When there is a run of 7 increasing or decreasing sequential points, this may indicate a significant change in the process. This process is not in control.

[4] 2 OF 3

When 2 out of 3 points lie near the Lower Control Limit (LCL) and Upper Control Limit (UCL), this is a warning that the process may be changing.

Commentary

The number of nCTR patients remains much higher than the target set within the system of 120 by the end of the year. Ongoing discussions and drive to improve the flow within P1-3 to enable better flow out of the acute hospital. Additional work being undertaken internally to drive down the number of P2 discharges, enabling more P0 and P1 pathways.
Head of Therapy & OCT

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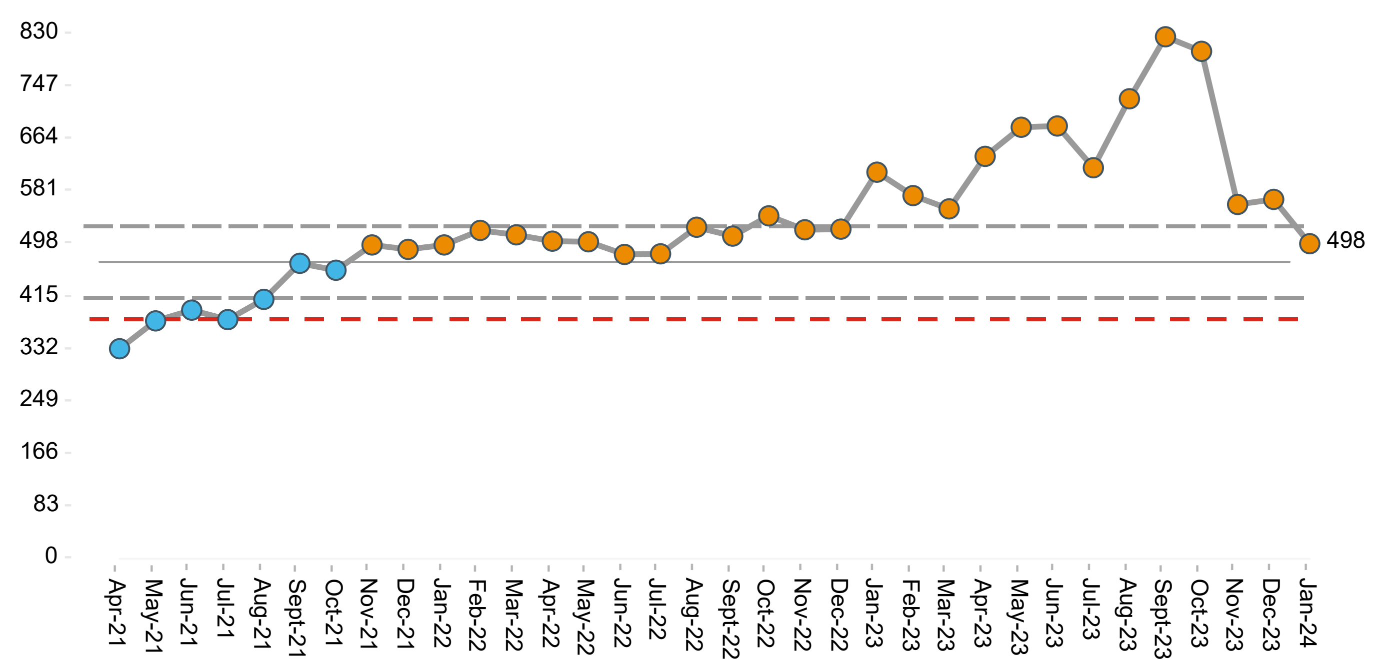
SPC - Special Cause Variation

[288] Number of stranded patients with a length of stay of greater than 7 days

Target: ≤ 380



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Commentary

Stranded patients over 7 days has reduced alongside the LOS work, but still remains much higher than would be ideal, linked to the overall issues around the number of nCTR patients currently within the hospital.
Deputy Chief Operating Officer

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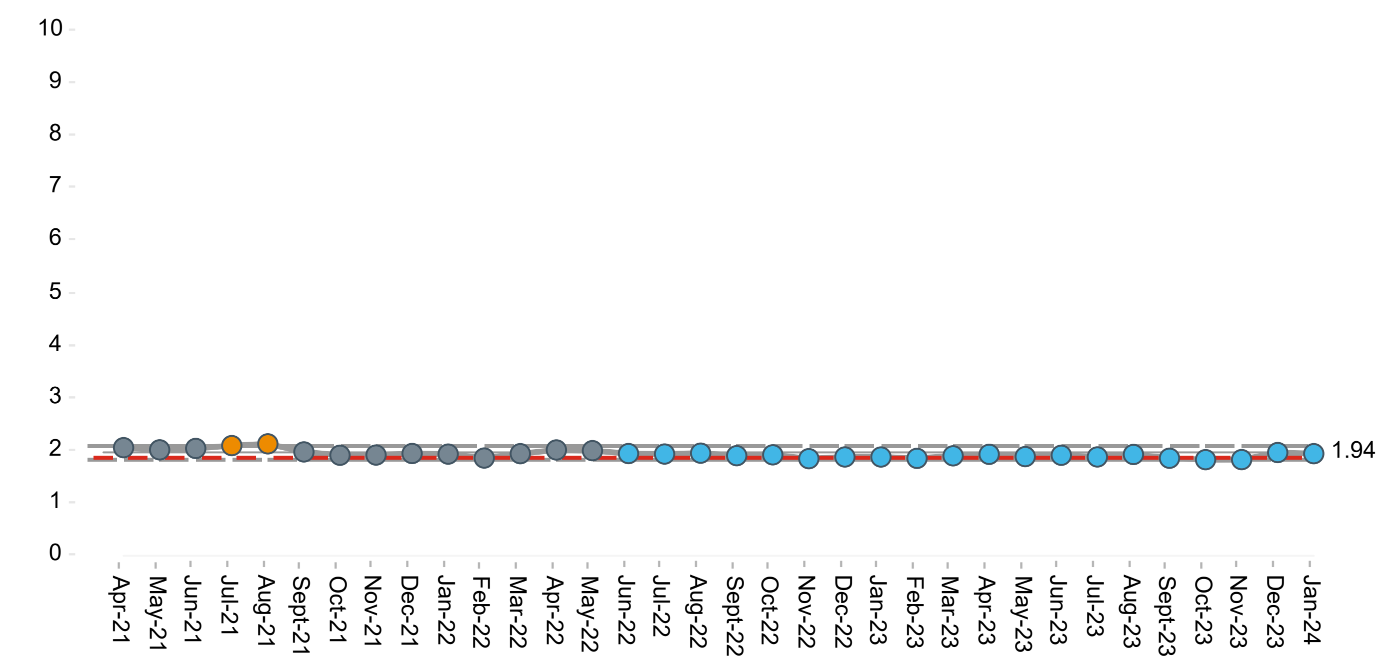
SPC - Special Cause Variation

[490] Outpatient new to follow up ratio's

Target: ≤ 1.90



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Commentary

Associate Director of Elective Care

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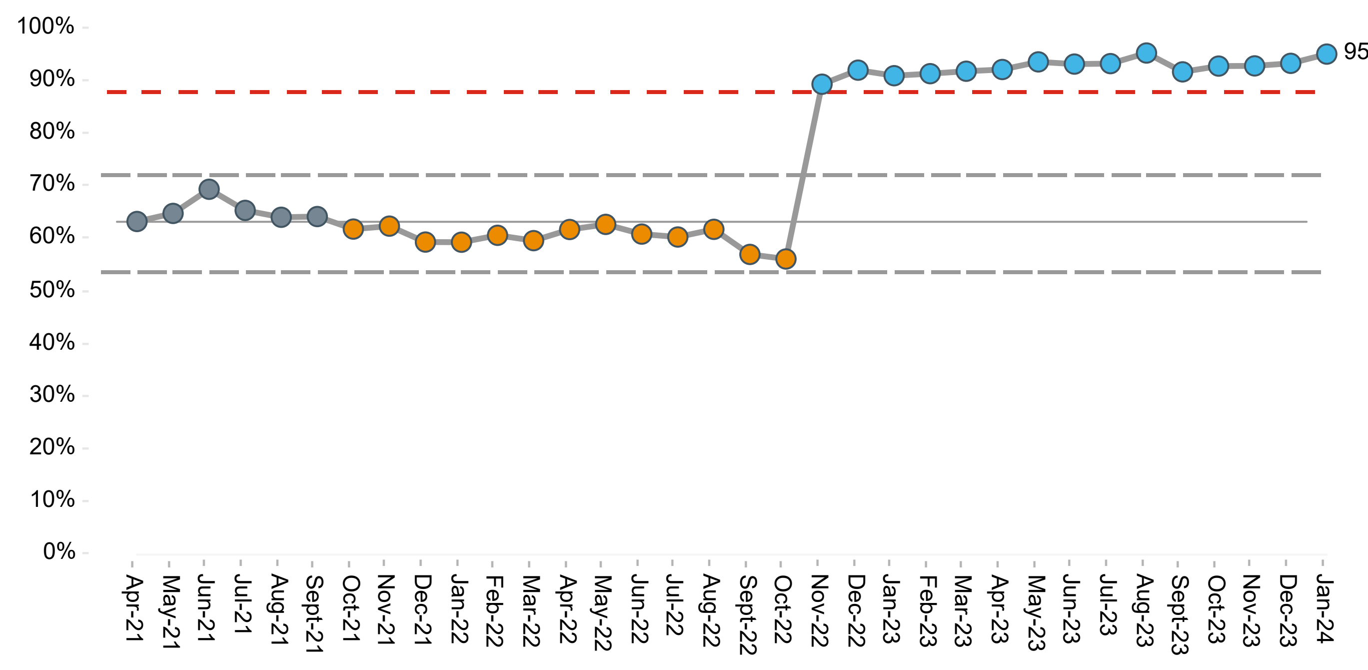
SPC - Special Cause Variation

[301] Patient discharge summaries sent to GP within 24 hours

Target: ≥ 88.0%



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Commentary

Medical Director

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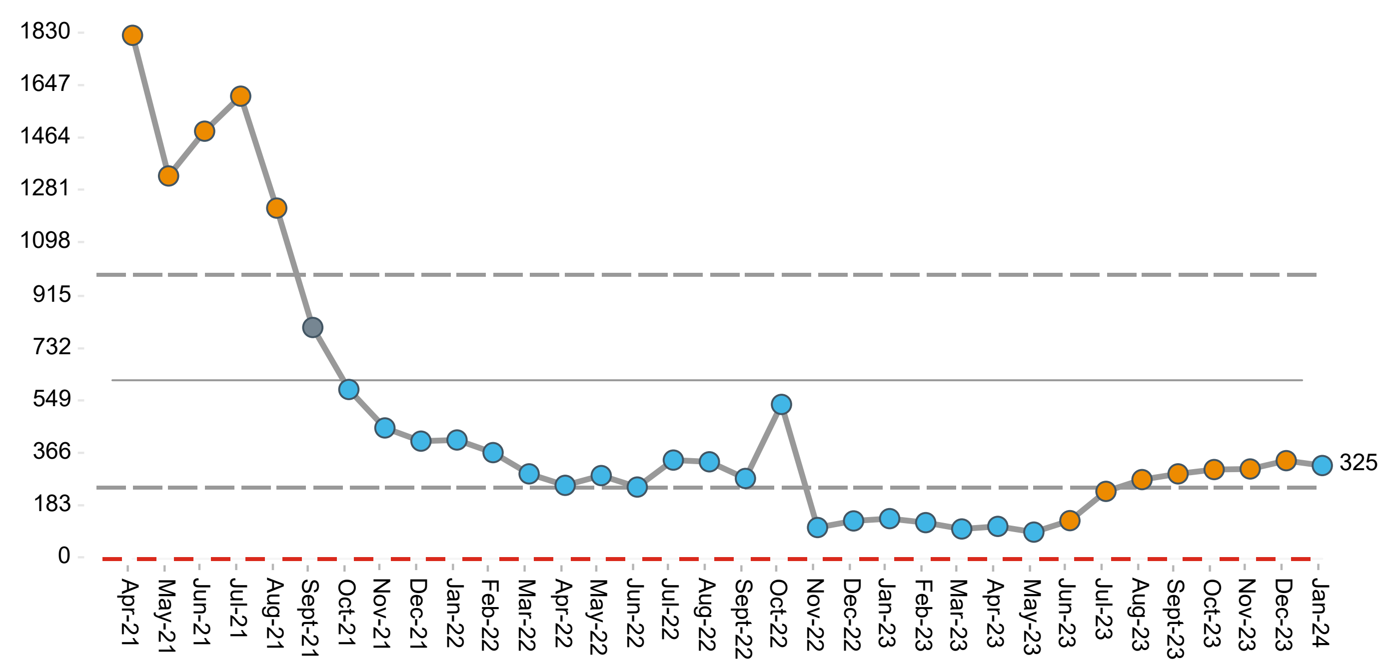
SPC - Special Cause Variation

[567] Referral to treatment ongoing pathway over 70 Weeks (number)

Target: ↓ Lower



Commentary

The over 70week category has started to reduce. December final position was 342 patients waiting over 70 weeks. Although still being validated the January position is anticipated to be around 326. A decrease of 16.
Associate Director of Elective Care

Data Observations

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[2] SHIFT

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[4] 2 OF 3

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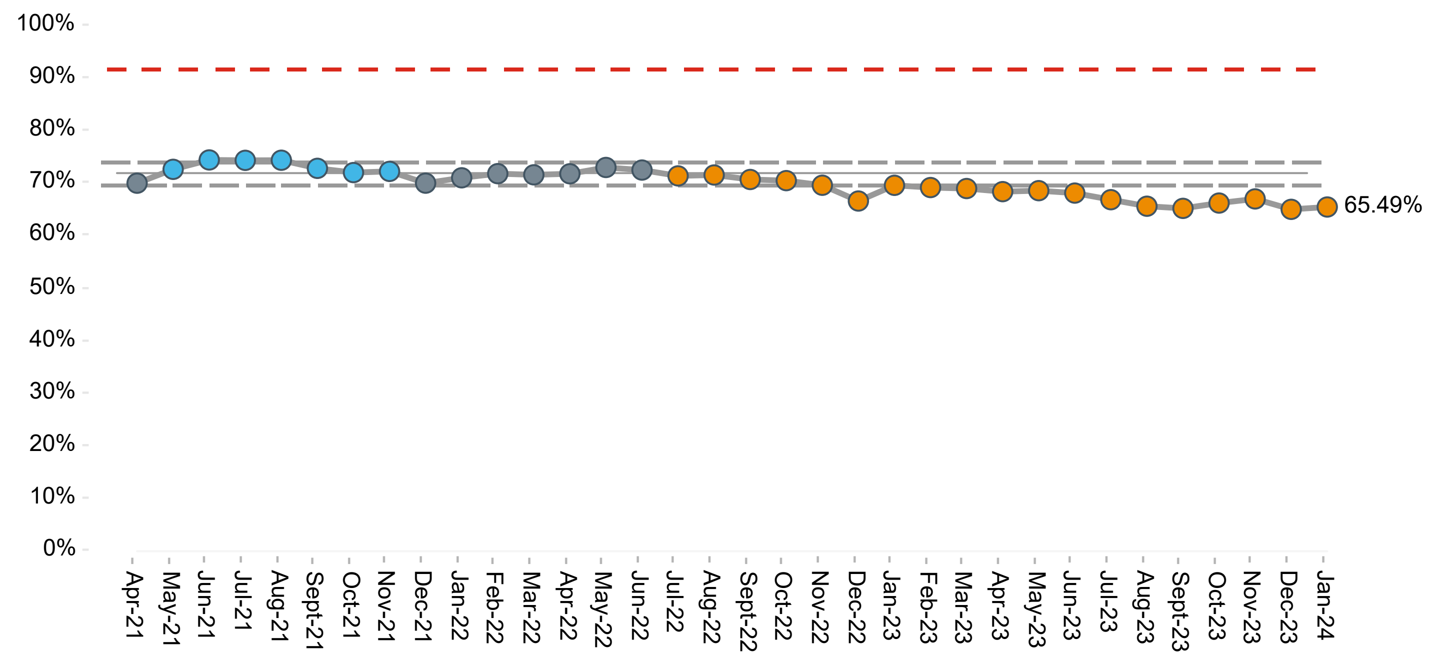
SPC - Special Cause Variation

[164] Referral to treatment ongoing pathways under 18 weeks (%)

Target: ≥ 92.00%



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Commentary

Following deterioration due to Xmas/New Year and Industrial Action in December the RTT January month- end position is showing signs of improvement with an anticipated month end position of 65% (up from 64.42% in December). January data is still undergoing validation prior to submission with early figures demonstrating a reduction in total incomplete pathways. Currently there are a total of 74,658 total incomplete pathways, this is down by 475 on Decembers submitted total of 75,133. Total incomplete figure is anticipated to reduce further as validation continues.

Associate Director of Elective Care

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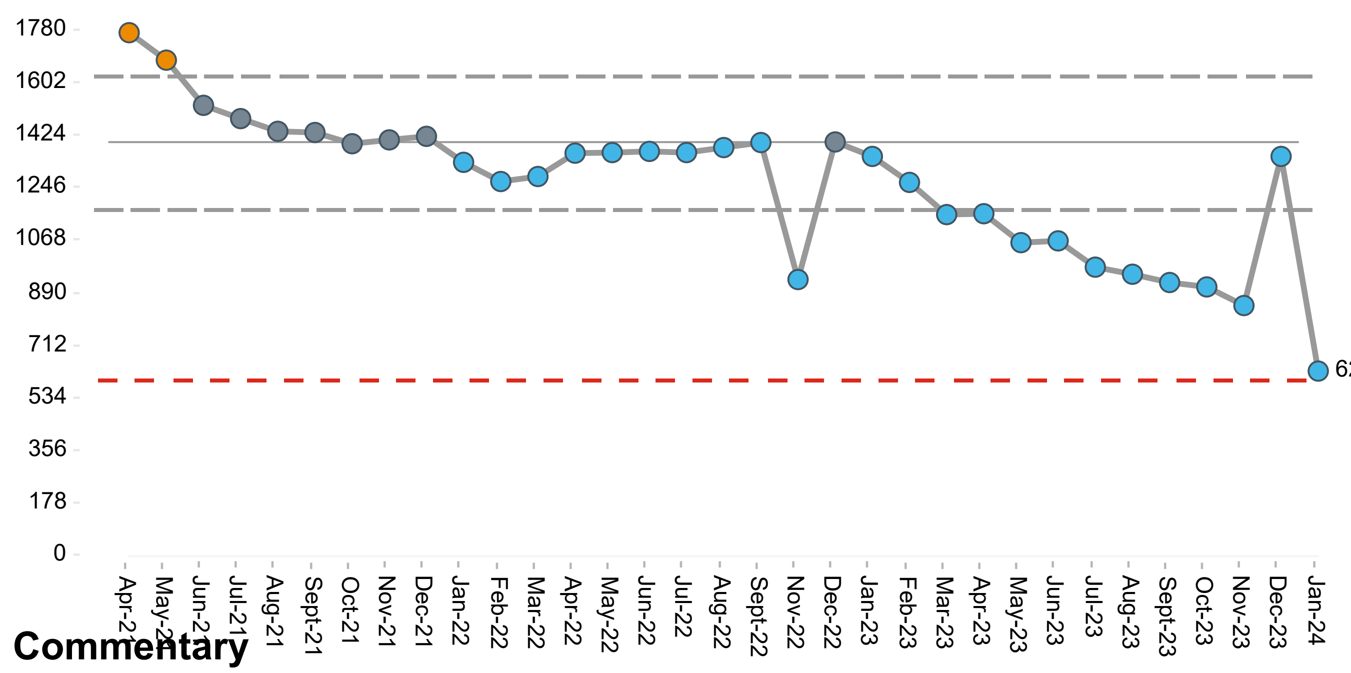
SPC - Special Cause Variation

[184] The number of planned/surveillance endoscopy patients waiting at month end

- - - Target: ≤ 600



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Commentary

Commentary

Due to DM01 and Surveillance waiting list and performance issues – JAG accreditation is at risk. NHSE has advised that we withdraw from JAG and an executive response to JAG is required by end of Jan 24. - With the Tri.
Endoscopy Delivery Group chaired by Deputy COO is in place - Action plan in place
NHSE Support visit took place 14/12/23 - Key takeaways:
Visibility of Executive support - lack of
Data quality discrepancy surrounding surveillance patients - now resolved which will result in nearly doubling of DM01 waiting list
Demand and Capacity unknown - to be complete by middle of Jan
Estates and facilities available are not sufficient
Low Wait list initiative payments - unattractive
Equipment replenishment - not undertaken for 3 years or more
Cost associated with desired service delivery model are unknown

General Manager of Endoscopy

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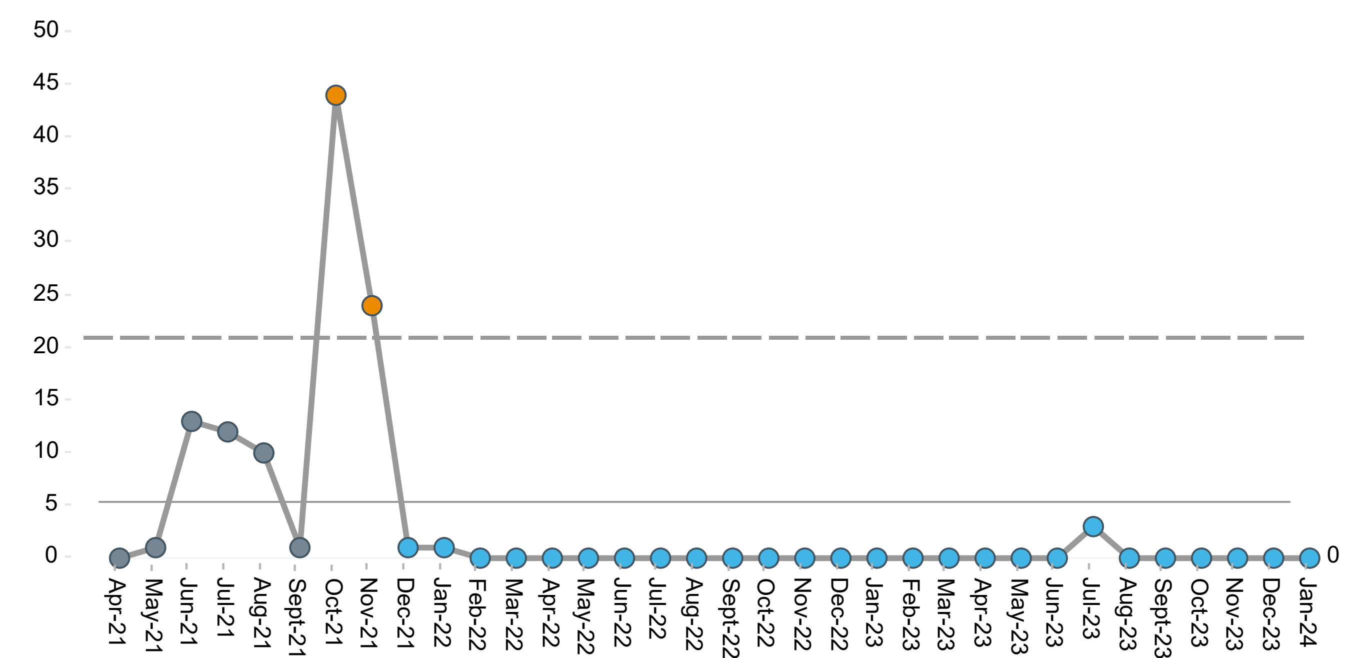
SPC - Special Cause Variation

[552] Urgent cancelled operations

- - - Target: ↓ Lower



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Commentary

Not given

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Quality Dashboard

This dashboard shows the most recent performance of metrics in the Quality category. Exception reports are shown on the following pages.

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation	
Friends & Family Test	ED % positive	No Target	Jan-24	78.3%
	Inpatients % positive	No Target	Jan-24	92.2%
	Maternity % positive	No Target	Jan-24	81.0%
	Outpatients % positive	No Target	Jan-24	94.8%
	Total % positive	No Target	Jan-24	92.2%
Health Inequalities	Smoking Status Compliance	No Target	Jan-24	84%
Infection Control	C. difficile - infection rate per 100,000 bed days	↓ Lower	Jan-24	38.3
	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target	Jan-24	79
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target	Jan-24	322
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target	Jan-24	119
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target	Jan-24	223
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower	Jan-24	0.0
	MSSA - infection rate per 100,000 bed days	≤ 12.7	Jan-24	4.3
	Number of E. coli bacteraemia cases	No Target	Jan-24	8
	Number of Klebsiella bacteraemia cases	No Target	Jan-24	2
	Number of MSSA bacteraemia cases	≤ 8	Jan-24	1
	Number of Pseudomonas bacteraemia cases	No Target	Jan-24	0
	Number of bed days lost due to infection outbreaks	↓ Lower	Jan-24	23
	Number of community-onset healthcare-associated C. difficile cases per month	≤ 5	Jan-24	2
	Number of hospital-onset healthcare-associated C. difficile cases per month	≤ 5	Jan-24	7

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation	
Infection Control	Number of trust apportioned C. difficile cases per month	< 10	Jan-24	9
	Number of trust apportioned MRSA bacteraemia	= 0	Jan-24	0
Maternity	% PPH >1.5 litres	< 2.00%	Jan-24	4.65%
	% breastfeeding (discharge to CMW)	= 0.0%	Jan-24	0.0%
	% breastfeeding (initiation)	≥ 81.00%	Jan-24	75.88%
	% of women smoking at delivery	< 7.00%	Jan-24	8.67%
	% of women that have an induced labour	≤ 33.00%	Jan-24	28.10%
	% stillbirths as percentage of all pregnancies	< 0.200%	Jan-24	0.218%
	Number of births less than 27 weeks	No Target	Jan-24	1
	Number of births less than 34 weeks	No Target	Jan-24	4
	Number of births less than 37 weeks	No Target	Jan-24	32
	Number of maternal deaths	No Target	Jan-24	0
	Percentage of babies <3rd centile born > 37+6 weeks	No Target	Jan-24	1.7%
	Total births	No Target	Jan-24	459
Mortality	Number of deaths of patients with a learning disability	No Target	Jan-24	2
	Number of inpatient deaths	No Target	Jan-24	199
	Summary hospital mortality indicator (SHMI) - national data	No Target	Sept-23	1.103
MSA	Number of breaches of mixed sex accommodation	≤ 10	Jan-24	18
Operational Efficiency	Daily Average of Boarded Patients	No Target	Jan-24	11
Patient Advice and ..	% of PALS concerns closed in 5 days	No Target	Jan-24	87%

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Quality Dashboard

This dashboard shows the most recent performance of metrics in the Quality category. Exception reports are shown on the following pages.

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Patient Advice and ..	Number of PALS concerns logged	↓ Lower		Jan-24	350	
Patient Safety Incidents	Medication error resulting in moderate harm	↓ Lower		Jan-24	1	
	Medication error resulting in severe harm	↓ Lower		Jan-24	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower		Jan-24	41	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower		Jan-24	1	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower		Jan-24	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower		Jan-24	20	
	Number of falls per 1,000 bed days	↓ Lower		Jan-24	8.30	
	Number of falls resulting in harm (moderate/severe)	↓ Lower		Jan-24	3	
	Number of patient safety incidents - severe harm (major/death)	No Target		Jan-24	7	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower		Jan-24	7	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target		Oct-23	58.08%	
	Number of DoLs applied for	No Target		Jan-24	140	
	Total ED attendances aged 0-18 with DSH	↓ Lower		Jan-24	82	
	Total admissions aged 0-17 with DSH	↓ Lower		Jan-24	24	
	Total admissions aged 0-17 with an eating disorder	↓ Lower		Dec-23	9	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower		Jan-24	0	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower		Aug-23	0	
	Total number of maternity social concerns forms completed	No Target		Jan-24	71	
Serious Incidents	Number of never events reported	= 0		Jan-24	2	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Serious Incidents	Number of serious incidents reported	↓ Lower		Jan-24	8	
	Percentage of serious incident investigations completed within contract timescale	> 80%		Jan-24	10,000%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%		Jan-24	10,000.0%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target		Jan-24	73.4%	

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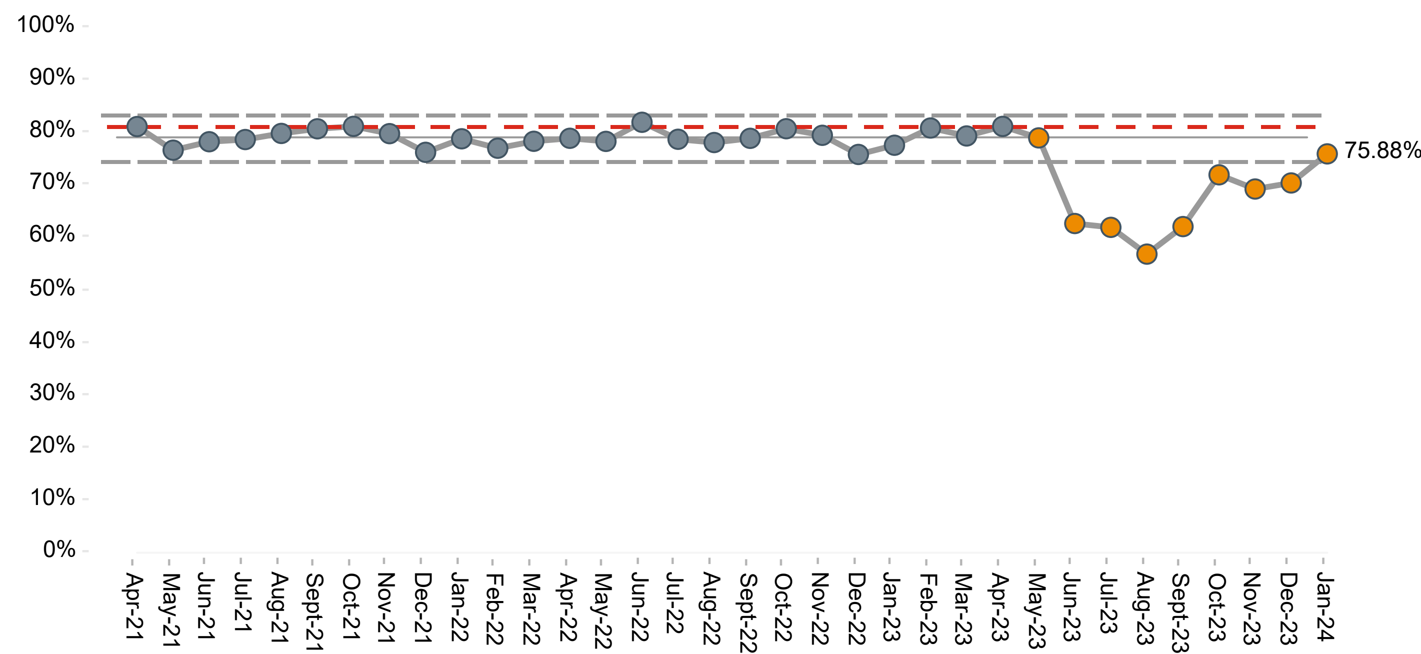
Quality

SPC - Special Cause Variation

[573] % breastfeeding (initiation)

Target: ≥ 81.00%



Data Observations

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[2] SHIFT

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Commentary

Divisional Director of Quality and Nursing and Chief Midwife

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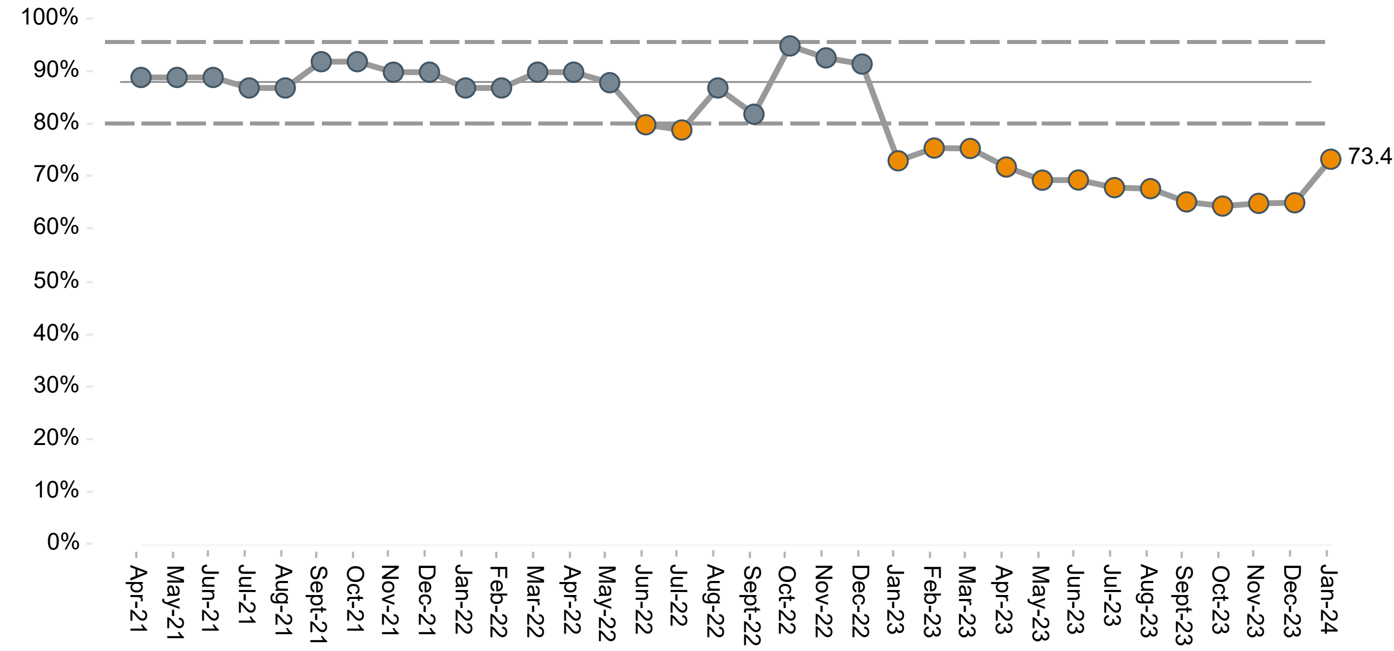
Quality

SPC - Special Cause Variation

[125] % of adult inpatients who have received a VTE risk assessment

- - - Target: No Target



Data Observations

[1] SINGLE POINT

Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control.

[2] SHIFT

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

Commentary

Quality Improvement & Safety Director

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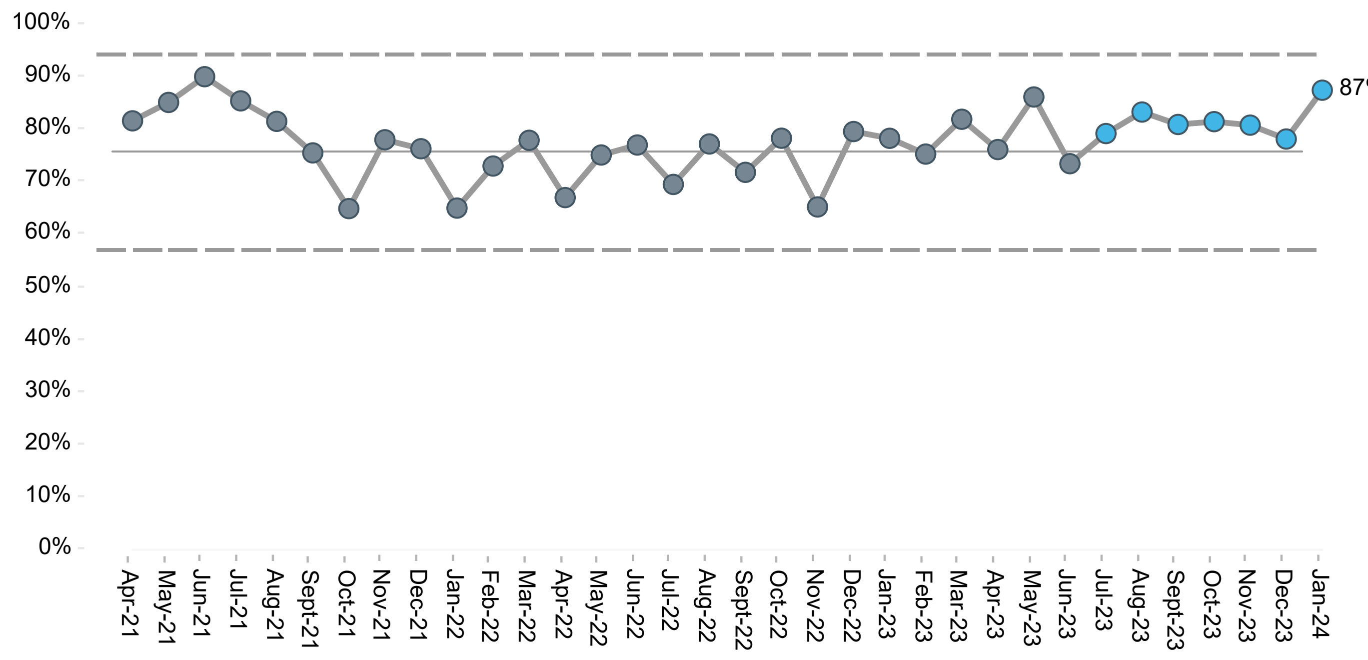
Quality

SPC - Special Cause Variation

[569] % of PALS concerns closed in 5 days

- - - Target: No Target



Data Observations

[2] SHIFT

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

Commentary

The % of PALS Concerns closed within 5 working days is 87%, a increase from 78% in December. The number of new concerns received in January was 350 (above average) and up from 215 in December (below average). This is the highest number of concerns received since October 2022. The improved position of response is in part due to the return of a member of staff following sickness, the start of a new member of staff within the team and improved links with teams in order to respond more promptly. Complexity of cases remains high, however, with the main areas receiving concerns being Elective Orthopaedic and ENT and relating to cancellations and waiting times of appointments .

Head of Quality

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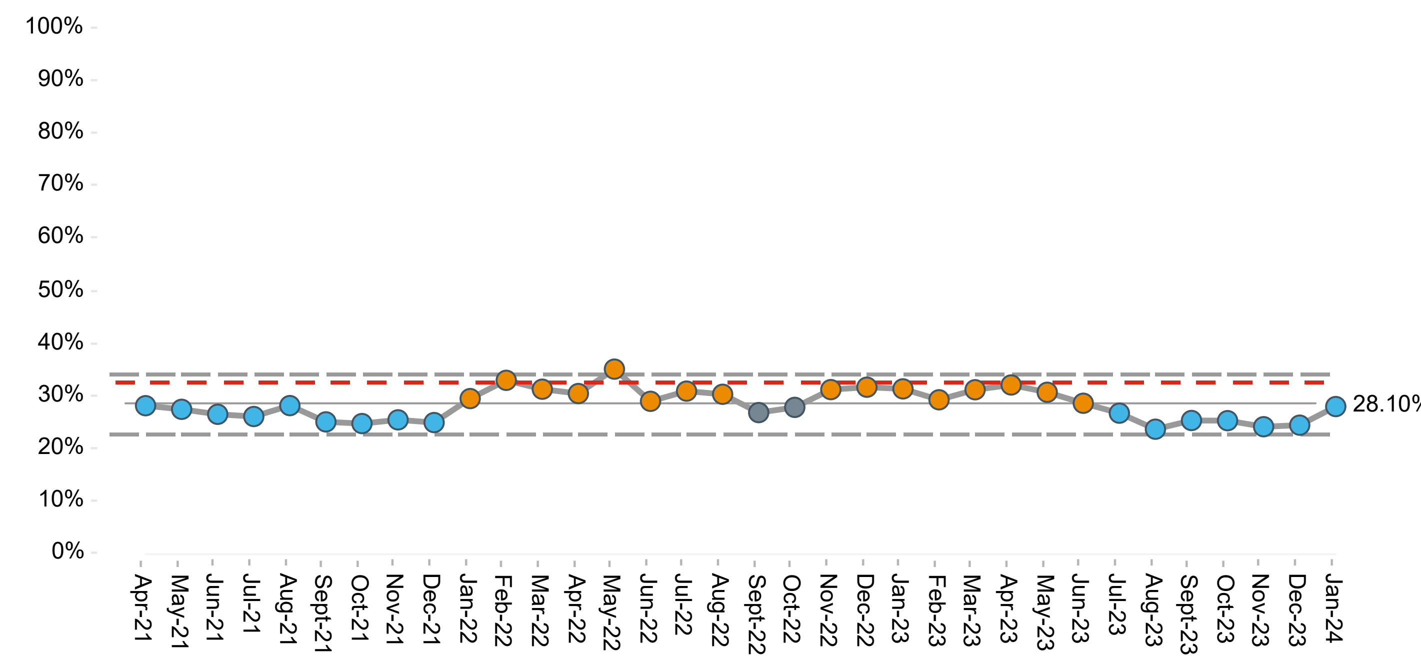
Quality

SPC - Special Cause Variation

[479] % of women that have an induced labour

- - - Target: ≤ 33.00%



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[4] 2 OF 3

When 2 out of 3 points lie near the Lower Control Limit (LCL) and Upper Control Limit (UCL), this is a warning that the process may be changing.

Commentary

Divisional Director of Quality and Nursing and Chief Midwife

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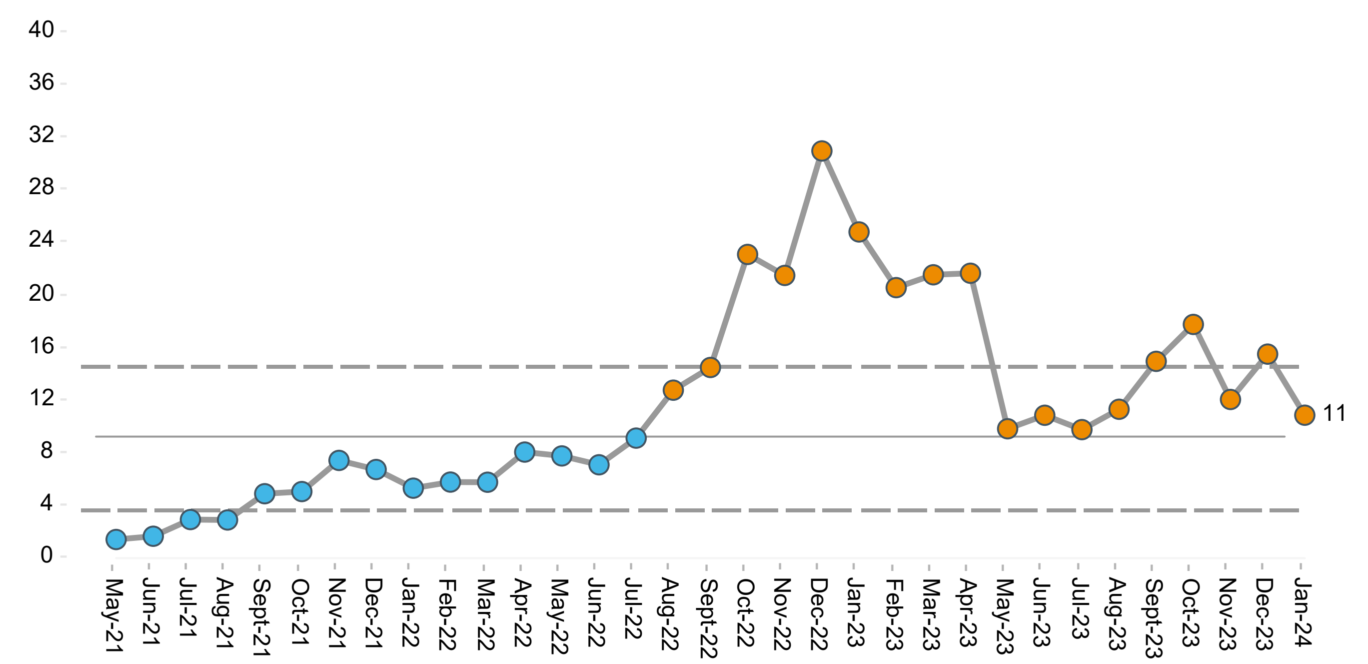
Quality

SPC - Special Cause Variation

[607] Daily Average of Boarded Patients

- - - Target: No Target



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Commentary

This number remains fairly steady with the majority being associated with pre empting practice, rather than boarding. January saw a return to challenges around flow in terms of high levels of attendance and acuity leading to greater admissions. This saw a return to boarding practices to balance risk, but still at a low rate than when at the peak of our flow challenges.
Director of Operations for Hospital Flow

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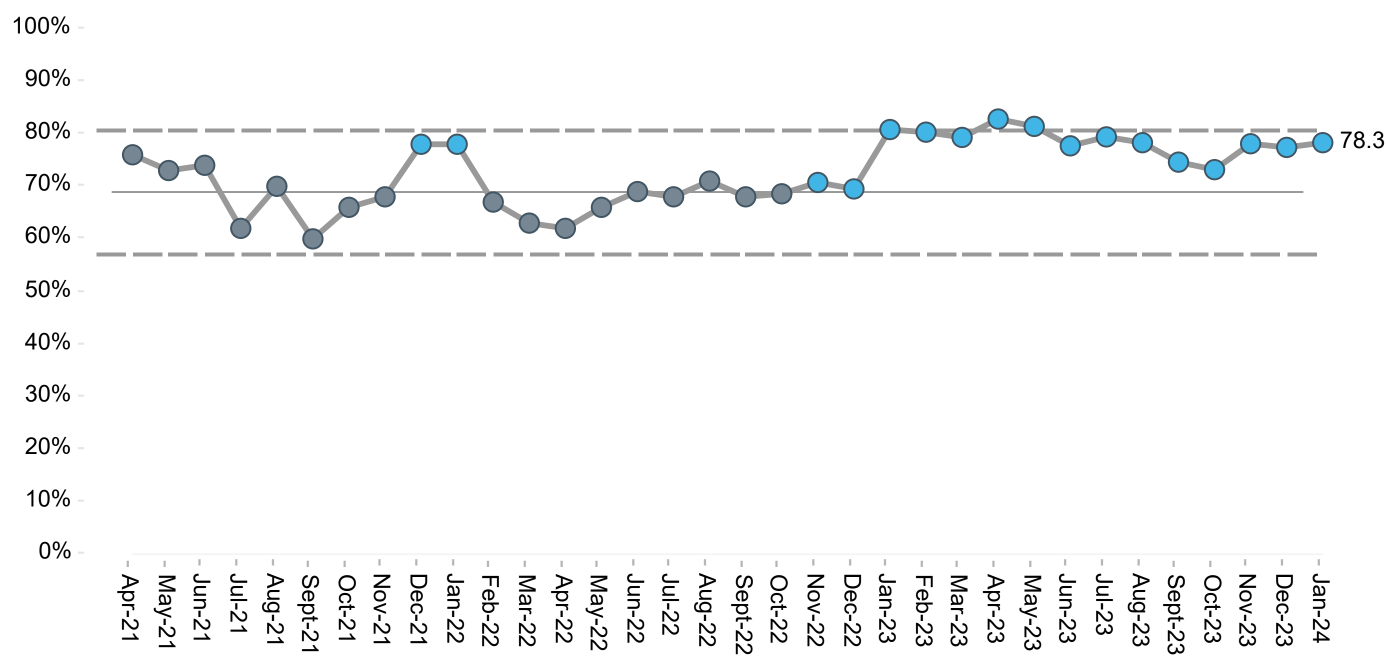
Quality

SPC - Special Cause Variation

[154] ED % positive

Target: No Target



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[4] 2 OF 3

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Commentary

The current positive FFT score for ED is at 78.3% across both sites, an increase from 77.4% in December 2023.
The score has remained
above average for over a year.
The main theme remains focused on wait times, the information provided while waiting, basic care and the environment, particularly for those being treated in minors.
Updates and monitoring is through to QDG.
Head of Quality

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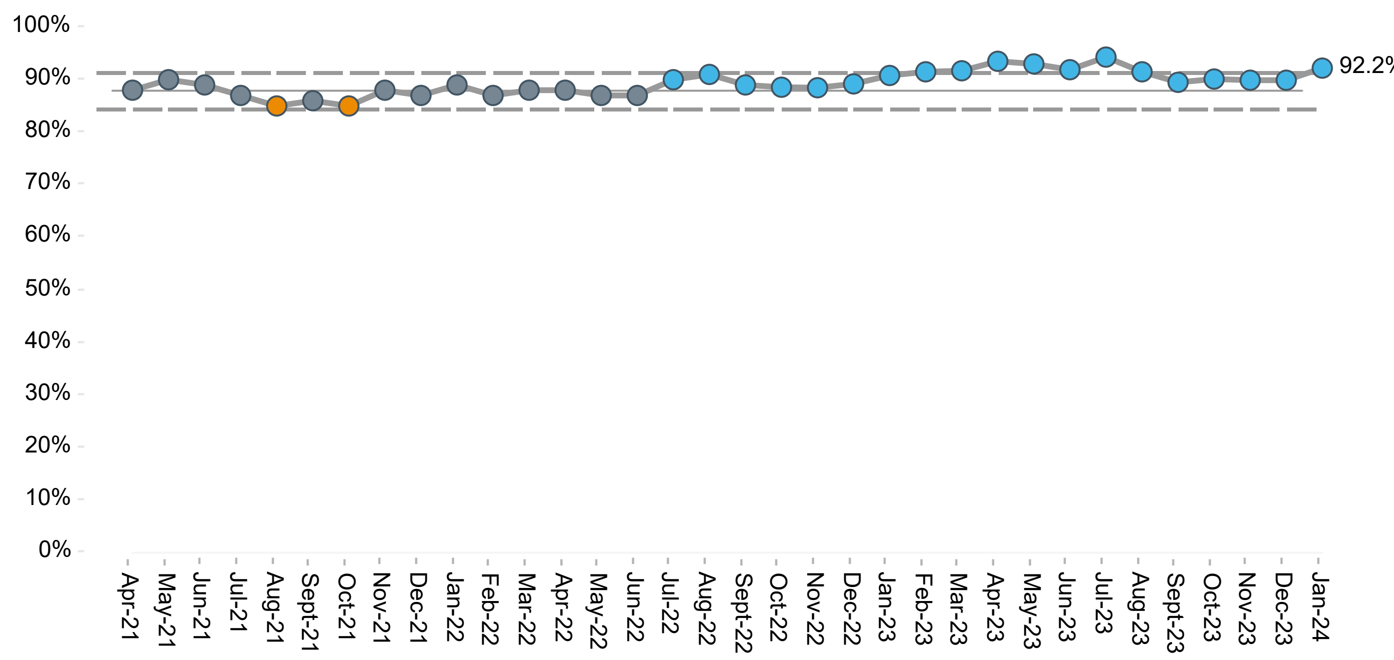
Quality

SPC - Special Cause Variation

[153] Inpatients % positive

Target: No Target



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Commentary

The current positive FFT score for Inpatient and Daycase is at 92.2%, which is an increase from 89.9% in November. The score is above the upper control limit.
The scores for inpatient areas (86.2%) and acute care areas (87.9%) are less positive than for daycase (97.5%) and are affected by the challenges in flow leading to the need to reintroduce boarding which is affecting patients experiences. Patients report that staff are overall kind and caring with acknowledgement that there are significant pressures due to staffing and resources.
Updates and monitoring will be reported through Quality Delivery Group via divisional reports and the monthly Patient Experience Report.
Head of Quality

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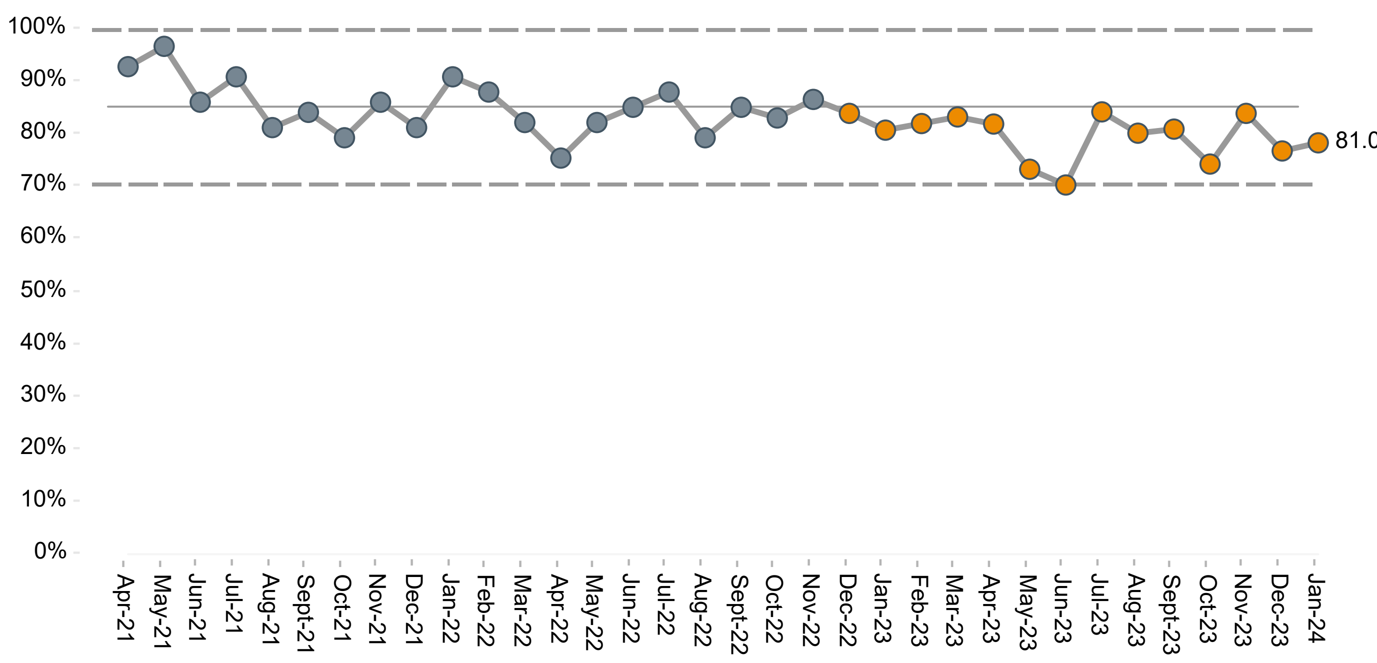
Quality

SPC - Special Cause Variation

[155] Maternity % positive

- - - Target: No Target



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[2] SHIFT

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Commentary

The current positive FFT score for Maternity services is 81.0%, which is an increase from November 2023 (79.4%). The positive score has remained below the average (88%) for a more than a year. The feedback for the maternity ward (74.7%) was poorer than the birth units and delivery suite (86.8%).

The division are undertaking significant improvement work on the Maternity Ward as identified as part of collaborative working event. The new Maternity and Neonatal Patient Experience Group is monitoring insight data and improvement projects.
Head of Quality

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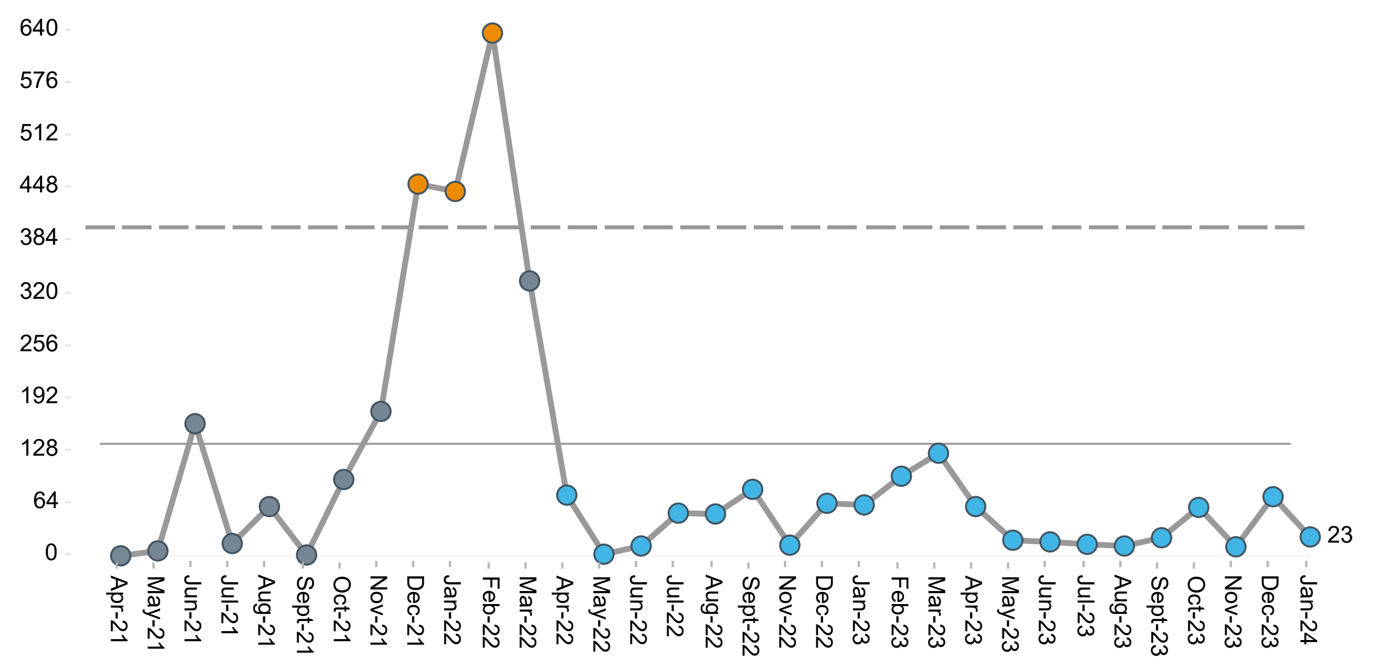
Quality

SPC - Special Cause Variation

[455] Number of bed days lost due to infection outbreaks

Target: ↓ Lower



Data Observations

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Commentary

During January 2024, 23 bed days were lost due to outbreaks associated with transmission of COVID-19 and Flu (this is down from 72 bed days lost in December). This has included one full ward closure due to COVID-19. The IPCT reviewed all outbreak affected areas and supported use of empty beds where possible for patients who were deemed safe to use them which significantly reduced the number of empty beds in closed areas. The IPCT continued to also support with ensuring implementation of effective IPC practices to minimise risk of transmission including use of single room isolation, testing and cleaning. Global staff communications on Flu has been sent and public facing comms have been created also. Additional on-call IPCT support is being provided over the weekend and weekend plans provided to site.
Director of Infection Prevention & Control

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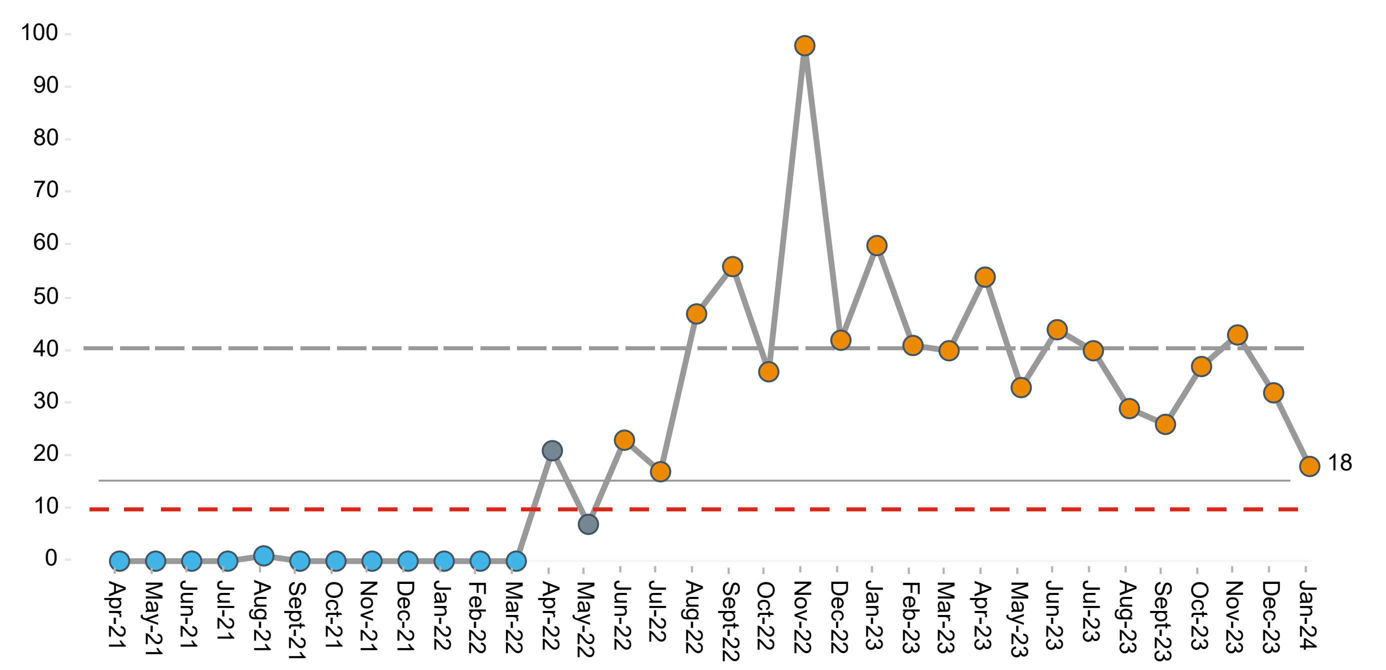
Quality

SPC - Special Cause Variation

[148] Number of breaches of mixed sex accommodation

Target: ≤ 10



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[4] 2 OF 3

When 2 out of 3 points lie near the Lower Control Limit (LCL) and Upper Control Limit (UCL), this is a warning that the process may be changing.

Commentary

Mixed-sex accommodation breaches are recorded manually each day. These are due to operational pressures when patients can be placed into wards from assessment areas and recovery within a 4-hour window. Breaches for clinical reasons are reported to the Gold director on-call and action is taken to resolve the issue as soon as possible.
Deputy Chief Nurse

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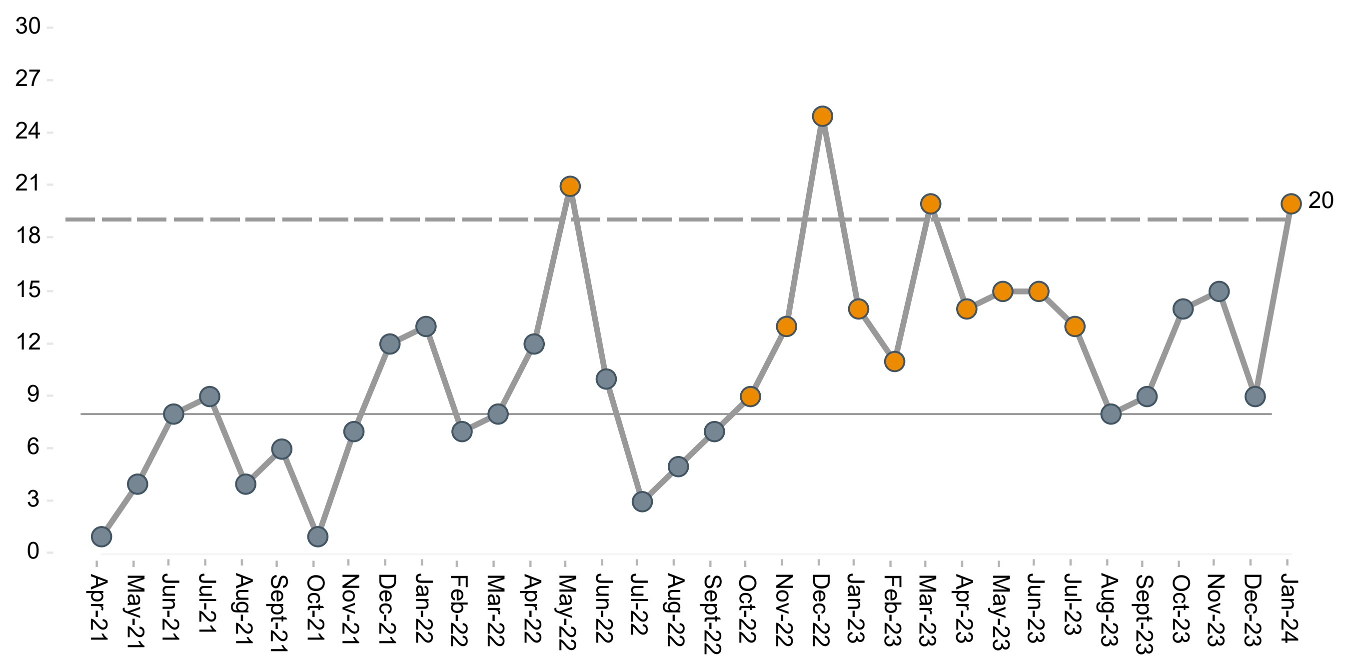
Quality

SPC - Special Cause Variation

[462] Number of deep tissue injury pressure ulcers acquired as in-patient

- - - Target: ↓ Lower



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Commentary

Each of these are reviewed with the ward team as part of the Preventing Harm Hub. Risk factors include prolonged immobility in the ED and periods spent in hospital corridors.
Deputy Chief Nurse

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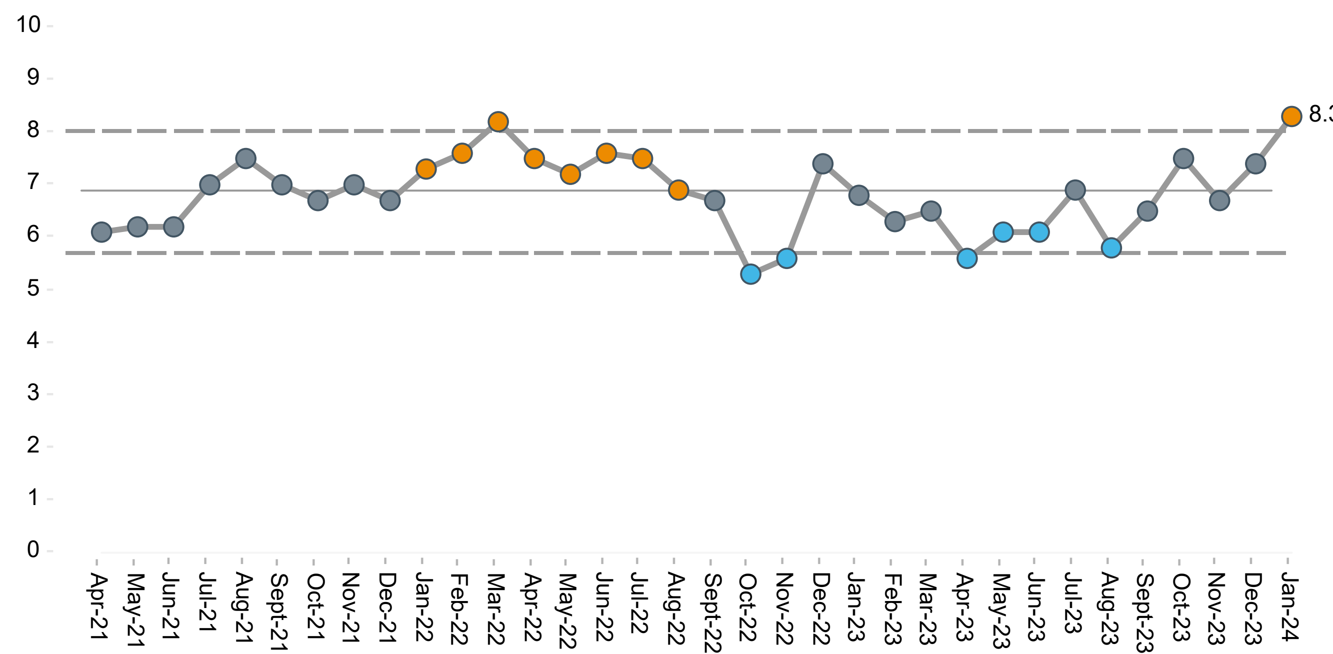
Quality

SPC - Special Cause Variation

[112] Number of falls per 1,000 bed days

Target: ↓ Lower



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Commentary

Falls per 1000 bed days has spiked to 8.3. All falls with harm are reviewed at the prevention harm hub
Deputy Chief Nurse

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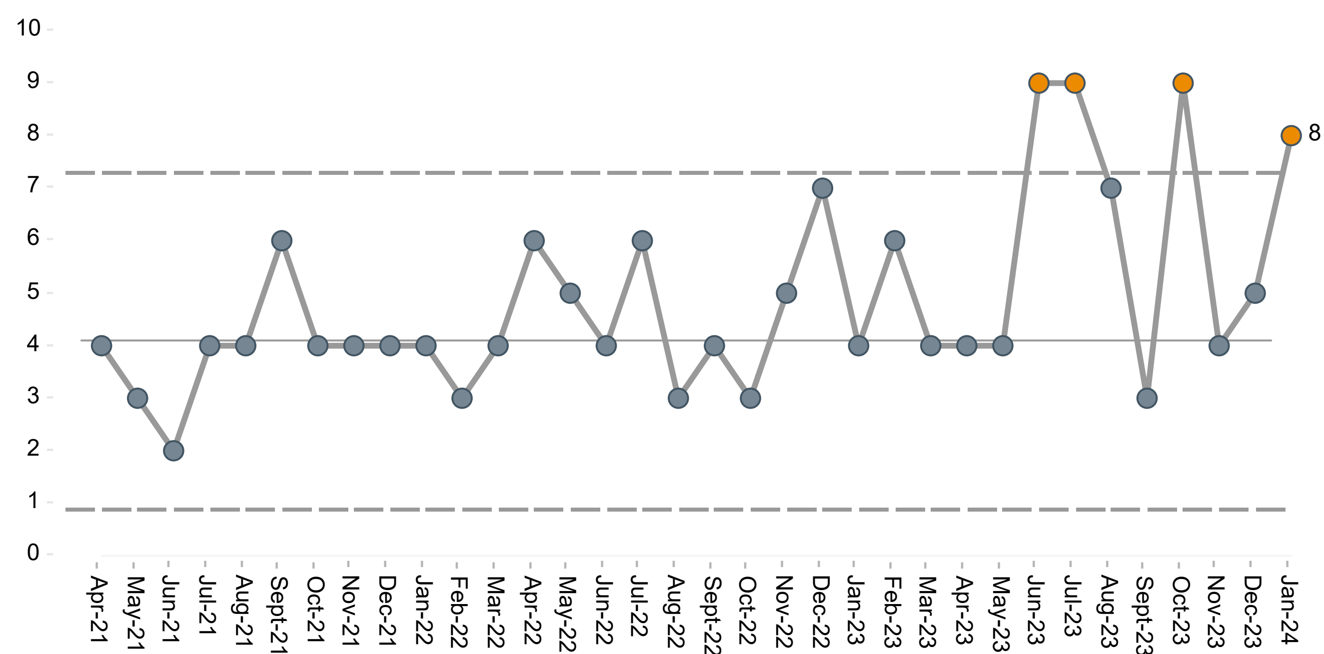
Quality

SPC - Special Cause Variation

[103] Number of serious incidents reported

- - - Target: ↓ Lower



Data Observations

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Commentary

Quality Improvement & Safety Director

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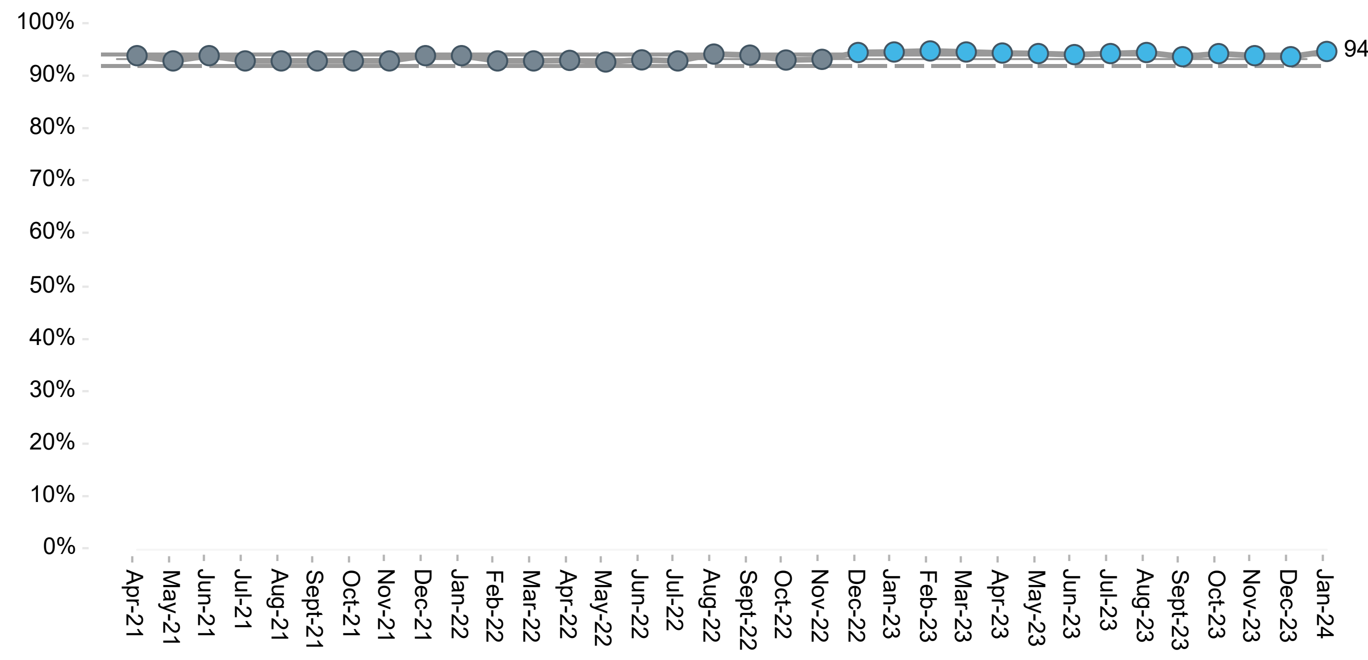
Quality

SPC - Special Cause Variation

[291] Outpatients % positive

- - - Target: No Target



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Commentary

The current positive FFT score for Outpatients is 94.8%, an increase from 93.8% in December. The score is above the UCL and remains above average where it has been for over a year.

Larger outpatient departments saw increases in their score including Physiotherapy, ENT and Trauma/T&O. This will have impacted the overall score. Comments remain positive overall with many saying 'thank you', however, the main themes for improvement continue to be waits for appointments, waits in the outpatient departments, patients not feeling they have enough time when in their appointment and patients not feeling listened to.
Head of Quality

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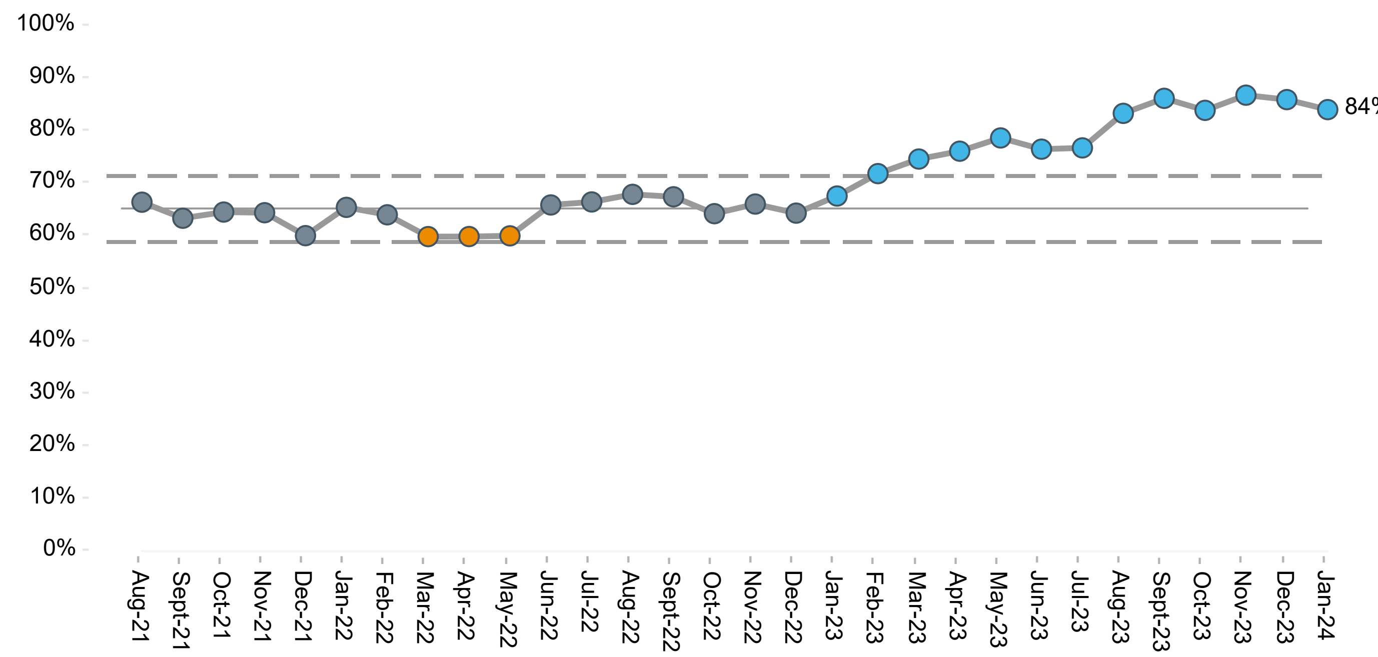
Quality

SPC - Special Cause Variation

[610] Smoking Status Compliance

- - - Target: No Target



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Commentary

Recording smoking status compliance is at 82% in Jan. New member of staff appointed in team.
Head of Inequalities, Health Improvement

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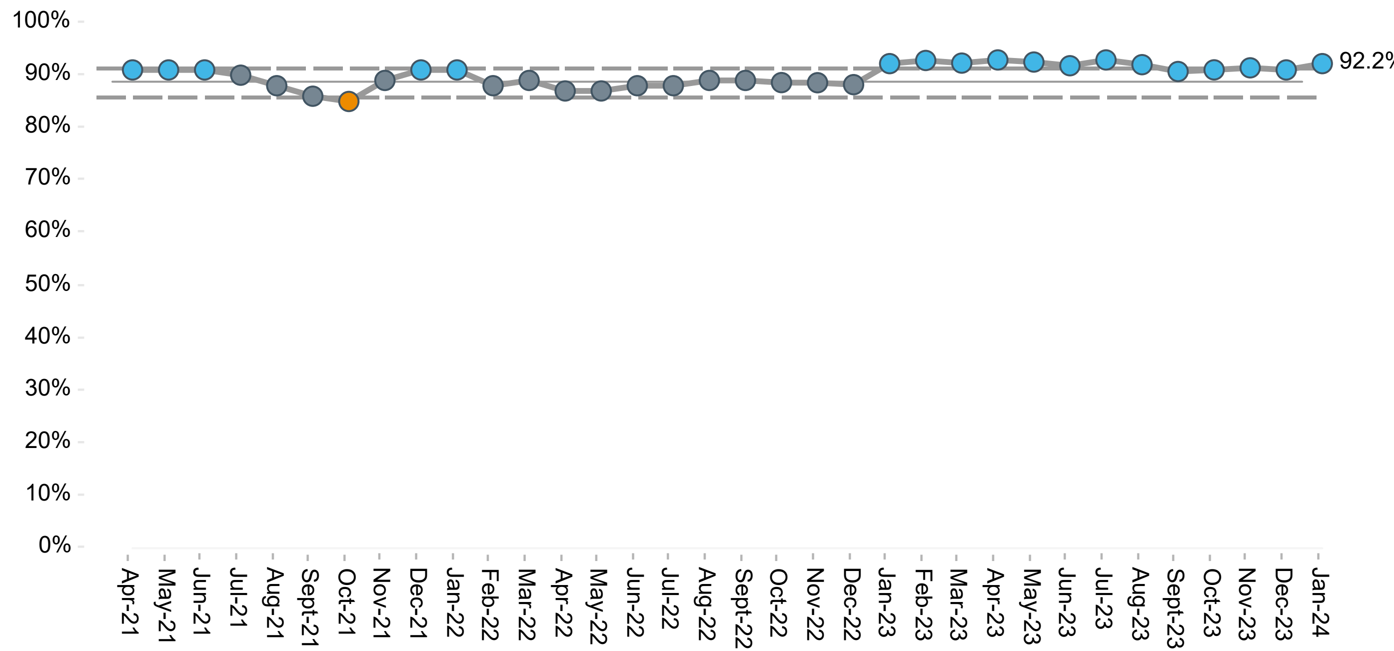
Quality

SPC - Special Cause Variation

[156] Total % positive

- - - Target: No Target



Commentary

The overall Trust FFT positive score has seen an increase this month to 92.2% compared to 91.0% in December.

Our overall score sees us
remain above average (89%) and the upper control (92%). The increase is as a result of increases in positive score across all four care types namely Emergency Department and Maternity. .
Head of Quality

Data Observations

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Financial Dashboard

This dashboard shows the most recent performance of metrics in the Financial category. Exception reports are shown on the following pages.

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People & OD Dashboard

This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Exception reports are shown on the following pages.

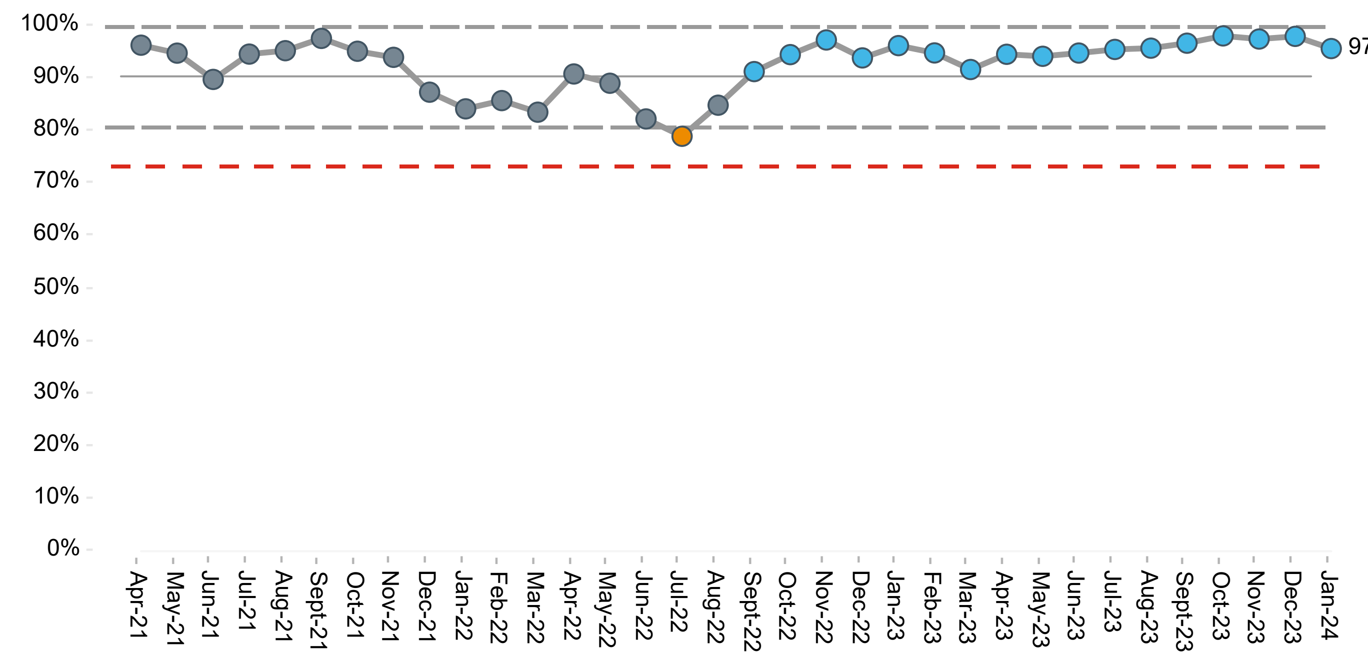
Metric Topic	Metric	Target & Assurance	Latest Performance & Variation	
Appraisal and Mandatory Training	Trust total % appraisal completion	≥ 90.0%	Dec-23	80.0%
	Trust total % mandatory training completion	≥ 90%	Dec-23	85%
Safe Nurse Staffing	% registered nurse day	≥ 90.00%	Jan-24	97.80%
	% registered nurse night	≥ 90.00%	Jan-24	97.34%
	% unregistered care staff day	≥ 90.00%	Jan-24	94.61%
	% unregistered care staff night	≥ 90.00%	Jan-24	102.45%
	Care hours per patient day HCA	≥ 3.0	Jan-24	3.3
	Care hours per patient day RN	≥ 5.0	Jan-24	5.4
	Care hours per patient day total	≥ 8.0	Jan-24	8.6
	Overall % of nursing shifts filled with substantive staff	≥ 75.00%	Jan-24	97.63%
Vacancy and WTE	Trust total % agency usage	≤ 2.00%	Dec-23	112.00%
	Trust total % bank usage	≤ 6.50%	Nov-23	106.92%
	Trust total % vacancy rate	< 8.00%	Oct-23	6.43%
Workforce Expenditure and Efficiency	Trust total % sickness rate	≤ 5.0%	Sept-23	4.3%
	Trust total % turnover rate	≤ 13.00%	Feb-23	14.14%

People & OD

SPC - Special Cause Variation

[508] Overall % of nursing shifts filled with substantive staff

Target: ≥ 75.00%



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Commentary

Deputy Chief Nurse

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Trust Board – March 2024

LEARNING FROM DEATHS REPORT – Q1, April 2023 to June 2023

1. **Aim**

1.1 To provide assurance of the governance systems in place for reviewing deaths and in addition demonstrate compliance with the National Guidance on Learning from Deaths.

1.2 This report covers the period April to June 2023 and is an update from the previous report.

2. Learning From Deaths

2.1 The main processes to review and learn from deaths are:

a. Review by the Medical Examiners and family feedback collected by the bereavement team on all deaths and provided to wards.

b. Structured judgment reviews (SJR) for deaths that meet identified triggers completed by clinical teams, providing learning through presentation and discussion within specialties. (Appendix 1)

c. Serious incident review and implementation of action plans.

d. National reviews including Learning Disability Reviews, Child Death Reviews, Perinatal Deaths and associated learning reports and national audits.

2.2 All deaths in the Trust have a first review by the Trust Bereavement Team and the Trust Medical Examiners. These deaths are entered on to the Datix system to support the SJR process.

2.3 All families are given the opportunity to provide feedback to the bereavement team on the quality of care. The feedback is overwhelmingly positive and is routinely shared with the relevant ward area via datix. (Appendix 2)

2.4 The family feedback analysis from Bereavement is analysed through to the End of Life meeting and triangulated with the national end of life survey data.

2.4 The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings. Completion of structure reviews sits around 39% within this reporting period. Performance and feedback of learning is presented to HMG on a rolling basis from Divisions. Themed issues are being tracked in nine areas over time through datix reporting.

2.5 All serious incidents have action plans based on the identified learning which are monitored to completion. High level learning themes are fed into expert Trust groups.

3. **Mortality Data** - SHMI

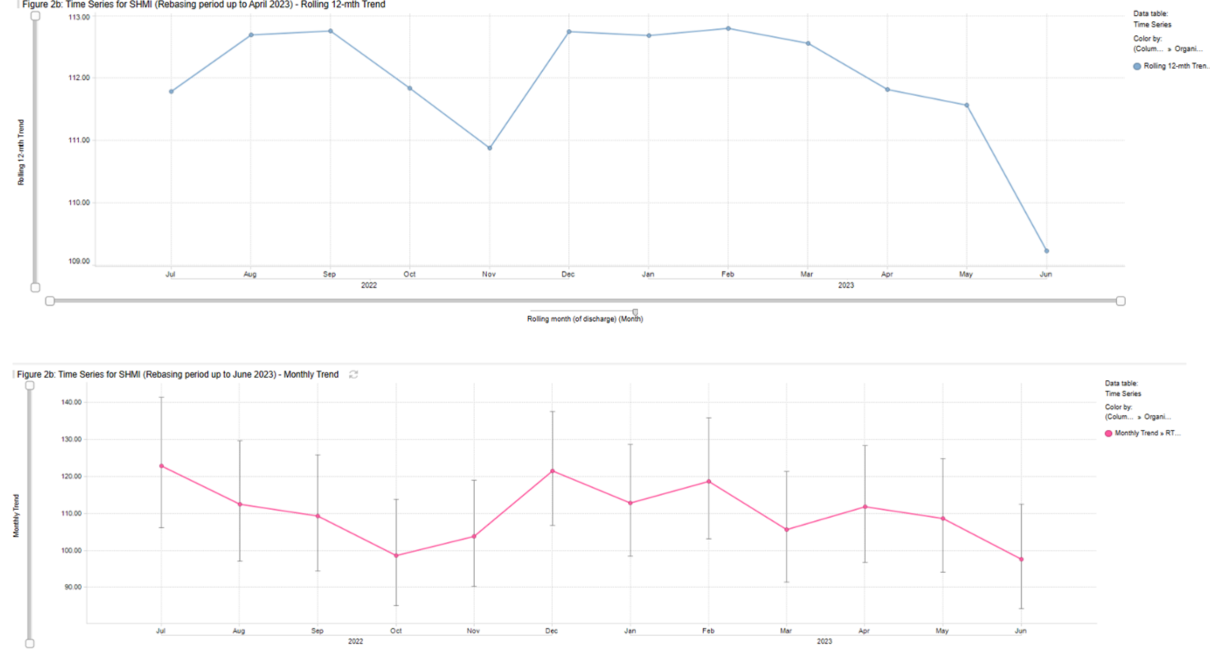
3.1 We have prioritised SHMI (Standardised Hospital Mortality Index) over HSMR for board reporting and driving analysis at HMG. Other organisations, including NHSI, are also moving towards SHMI over HSMR.

3.2 SHMI Review

The picture shows seasonal rise in winter as seen in previous years, dropping monthly since February. SHMI remains within expected range. At June 2023, SHMI is 109.23. Rolling 12 month trend gives a more accurate picture of seasonal variations.

The initial analysis approach is described below.

SHMI Monthly Trend



Comparison with Model Hospital peers shows that 1 peer Trust remains above expected limits for SHMI with GHFT showing as amber (on the 90% upper control limit) alongside 3 others from the Model Hospital Peer Group.

Rolling 12month SHMI-Model Hospital Peers

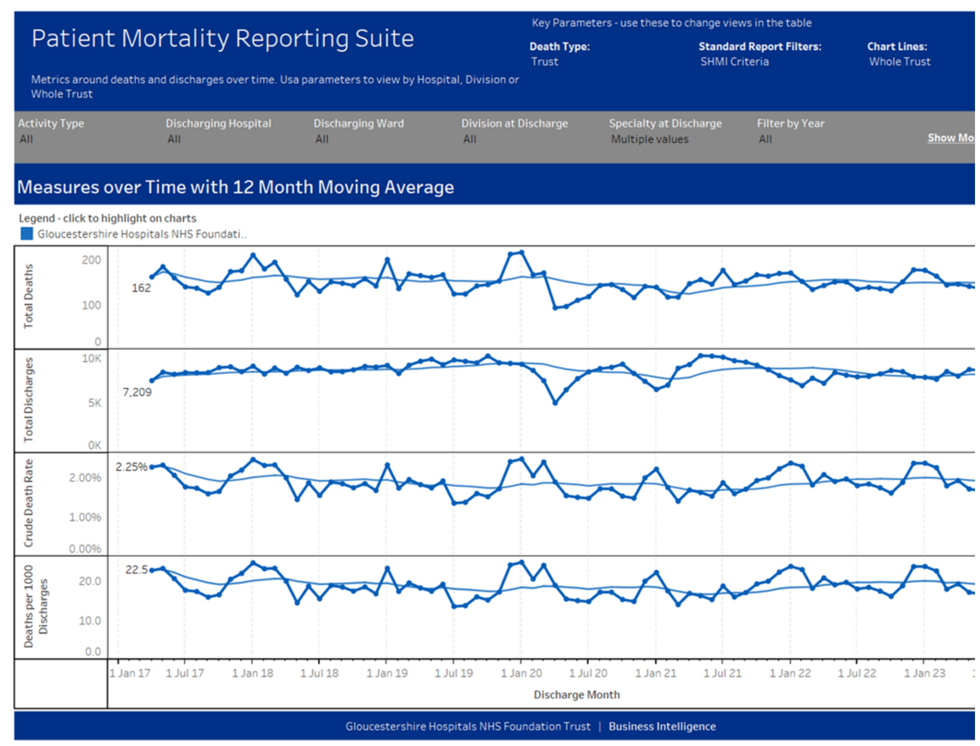
Methodology:

- Patient classifications of day case, regular attenders, and regular night attenders, were excluded.
- Spells with a discharge method of still birth were excluded, as well as patients with a diagnosis indicating COVID.

Current SHMI position:

- The trust remains within the “as expected” range in the last 2 complications.

- Local data shown below confirms a rise in observed deaths in December 2022 which is broadly in line with winter peaks seen in the period 2018 onwards. In Jan-June 2023 there has been a decline in observed deaths and in crude mortality rate.



Conclusion:

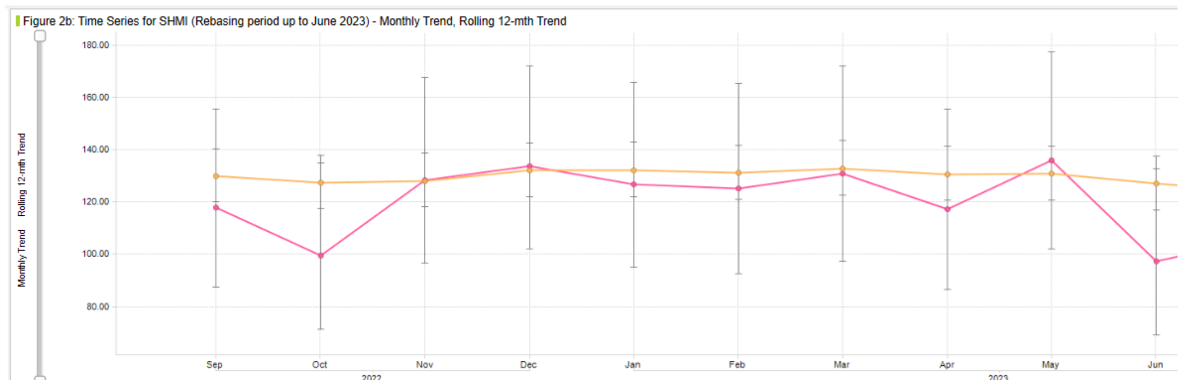
- SHMI for the Trust remains "As Expected"

3.3 Weekend Mortality

Weekend Mortality indicators include deaths in patients **admitted** on a Saturday or Sunday. SHMI in this group is significantly higher than for patients admitted Monday -Friday. Weekend SHMI for the period April to June 2023 was:

- April 117.44
- May 136.07
- June 97.14

Rolling 12 month SHMI (yellow line) irons out some of the monthly variations, see graph below. It is showing a downward trend.



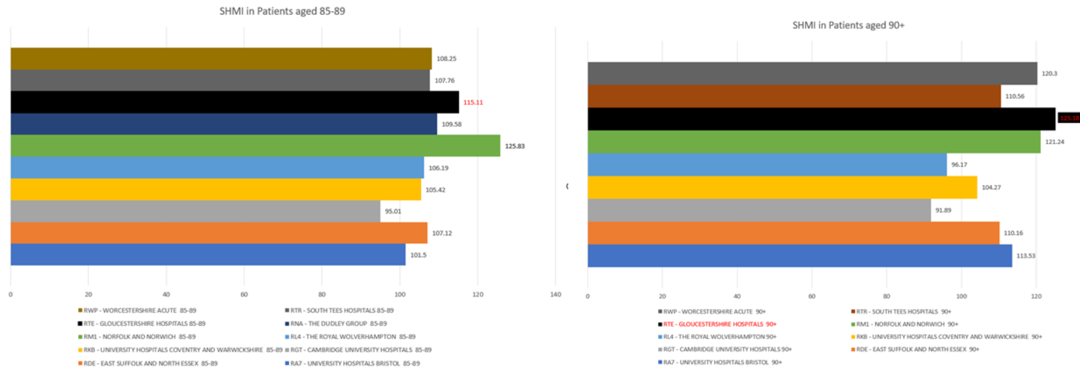
Other peer hospitals also show weekend mortality indicators higher than weekday but in terms of significance, only 2 show higher than expected (see below).

A system-wide project to clinically review a sample of notes from patients aged 85 and older admitted on a weekend is being planned. It is hoped this will identify some themes in terms of both care and data accuracy to shed light on the differential mortality in this group. It is hoped this will be completed in the final quarter of 2023/24 and a report produced in quarter 1 of 2024/25.

3.4 Age bands

Business Intelligence have analysed SHMI by age band and shown that our oldest patients are tending to show a higher SHMI within GHT compared to Model Hospital Peers. Most apparent in those aged 90 years and older. This may be driven, at least in part, by the reduction in dementia diagnoses discussed in the previous report impacting

on the "expected deaths" calculation. Also trolley waits, multiple ward moves and delays to care packages extending length of stay are likely to have a disproportionate impact on care in older patients. Deconditioning both physically and mentally will exert a toll on recovery and discharge options.



3.5 Sepsis

The Trust remains within normal distribution and therefore not outlying. SHMI of 96.57 compared to national mean of 99.11.

3.6 Fractured Neck of Femur Mortality

a) In July 2023, a report was presented to Quality & Performance Committee which summarised the key performance issues that are contributing to performance of the Trauma Service against the key Fractured Neck of Femur (#NOF) targets set nationally, and recommended required steps to improvement.

b) In addition, in September 2023, additional analysis was provided to the Hospital Mortality Group.

   This item is now reported to Quality & Performance Committee in a separate quarterly report so will no longer form part of the Learning from Deaths Report.

4. Structured Judgement Review Process

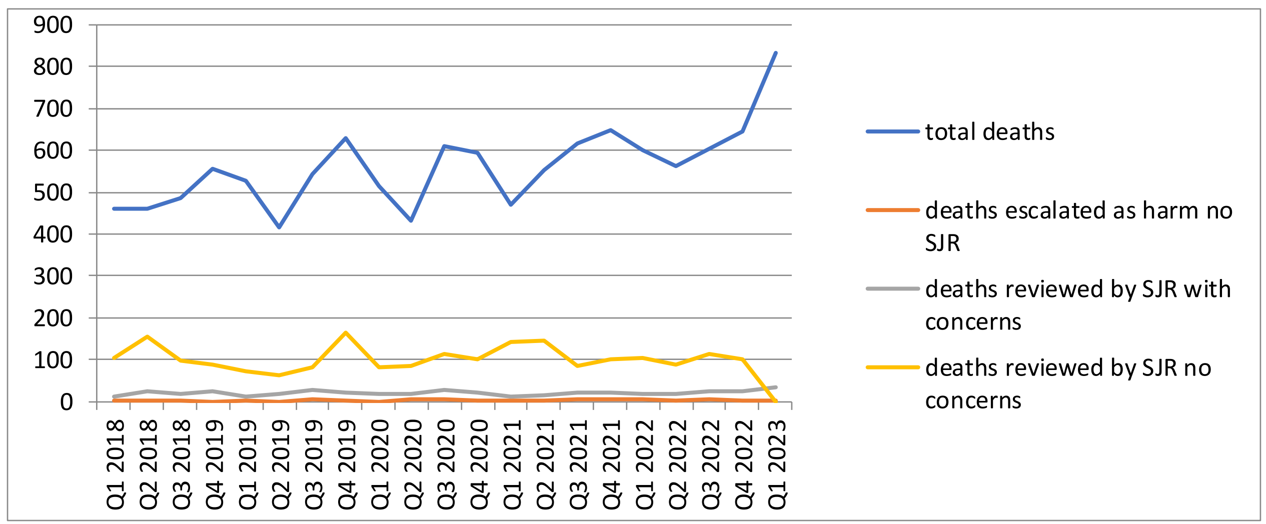
4.1 The input of the Bereavement Team continues to add huge value to our process. It is the model on which other Trusts will be expected to base their service. They continue to ensure all deaths are recorded in real time.

4.2 Deaths identified for review (next page)

Mortality Quarterly Dashboard: Quarter 1 (April to June 2023)

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
***832**	644	**3**	6	**33**	24	**102**	102	128 (15%)	127 (20%)	**6**	1
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
832	2409	**3**	19	**33**	77	**102**	408	128 (15%)	489 (20%)	**6**	4

***Total deaths for Q1 taken from Healthcare Evaluation Data (HED). This is a change as not all deaths are now recorded on Datix from 31/05/2023. Also relates to figures denoted with a * in Divisional data (Appendix One). Data will be taken from BI Mortality Dashboard going forward.**



Assessment Scores

Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		Score 2 – Poor Care		Score 3 – Adequate Care		Score 4 – Good Care		Score 5 – Excellent Care		Deaths escalated to harm review panel following SJR	
This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)
0	0	8	8	19	19	39	35	20	18	6	6

Problems identified in care and care record									
Problem in assessment, investigation or diagnosis		Problem with medication /IV fluids /electrolytes /oxygen		Problem related to treatment/management plan		Problem with infection control		Problem related to operation/ invasive procedure	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
3	3	0	0	1	1	0	0	0	0
Problems identified in care and care record									
Problem in clinical monitoring		**Problem in resuscitation following a cardiac or respiratory arrest**		**Other Problem**		**Quality of Patient Record Poor or very poor**			
This Quarter	**This Year (YTD)**	**This Quarter**	**This Year (YTD)**	**This Quarter**	**This Year (YTD)**	**This Quarter**	**This Year (YTD)**		
2	2	0	0	2	2	0	0		

System Indicators

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
50 (39%)	**83(66%)**	**3(2%)**	**14 (66%)**	**48(37%)**	**75 (54%)**	**70 (54%)**	**27 (19%)**
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
50(39%)	327(66%)	**3(2%)**	14 (66%)	**48(37%)**	194 (36%)	**70 (54%)**	29 (5%)

4.3 Feedback on progress is provided to the Hospital Mortality Group. The SJR approach continues to embed within all divisions; deaths are identified through Datix and then identified for review using the agreed triggers. Some areas review all deaths because of small numbers of deaths in the specialty.

4.4 The Performance against standard tables above illustrates the general performance of 39% in the first quarter of 2023/2024. There has been a decrease in performance when comparing against the annual, average performance in 2022/2023; which was around 66%. Timeliness and completion rate has been impacted by high clinical workload with the added pressures from continued industrial action

5. **Family Feedback from Bereavement team**

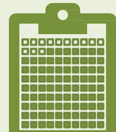
5.1 Following a review of family feedback mechanism with the End of Life lead, a new set of indicators and themed reporting has been developed. The themed reporting is based on the national End of Life audit categories which allowed triangulation of feedback with the findings of the annual audit. This data is presented at the End of meeting Life (as the expert group) as part of their meetings and informs discussion on assurance and improvement work with highlights (for 2022/2023) can be seen in Appendix 5. The following represent key findings and summary scores at a glance:

National Audit of Care at the End of Life 2022/23
Key findings at a glance

NC183 - Gloucestershire Hospitals NHS Foundation Trust

*UK refers to the findings for England and Wales

(CNR – Cat 1)



92%
UK 87%

Case notes recorded that the patient might die within hours or days

(CNR– Cat 1)

100%
UK 95%

Case notes, with an individualised plan of care, recorded a discussion (or reason why not) with the patient regarding the plan of care

(CNR – Cat 1)

93%
UK 98%

Case notes recorded a discussion (or reason why not) with families/carers regarding the possibility the patient may die

(CNR – Cat 1)

98%
UK 87%

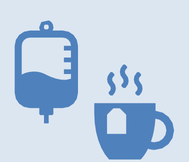
Case notes recorded extent patient wished to be involved in care decisions, or a reason why not

(CNR – Cat 1)

76%
UK 76%

Case notes recorded an individualised plan of care

(CNR – Cat 1)



88%
UK 79%

Case notes recorded patient's hydration status assessed daily once dying phase recognised

(QS)

52%
UK 54%

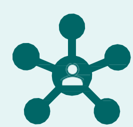
Families/carers were asked about their needs

(QS)

71%
UK 71%

Families/carers felt the quality of care provided to the patient was good, excellent or outstanding

(H/S)



No
UK 60%

Hospitals have face-to-face specialist palliative care service available 8 hours a day, 7 days a week

(SRM)

89%
UK 85%

Staff feel confident they can recognise when a patient might be dying imminently

88%
UK 82%

Staff feel supported by their specialist palliative care team

80%
UK 83%

Staff feel they work in a culture that prioritises care, compassion, respect and dignity

National Audit of Care at the End of Life 2022/23
Summary scores at a glance

214 Hospital/site overviews (H/S)	7,620 Case Note Reviews (CNR)	3,600 Quality Surveys (QS)	11,143 Staff Reported Measures (SRM)

NC183

50	111	195
Case Note Reviews (CNR)	Staff Reported Measures (SRM)	Quality Surveys (QS)

*UK refers to the findings for England and Wales

Measure	NC183	UK
Communication with the dying person (CNR)	8.5	8.0
Communication with the families and others (CNR)	6.8	7.1
Involvement in decision making (CNR)	9.7	9.2
Individualised plan of care (CNR)	7.6	7.6
Needs of families and others (QS)	5.4	5.5
Families' and others' experience of care (QS)	6.1	6.3
Workforce/Specialist Palliative Care (H/S)	6.9	8.1
Staff confidence (SRM)	7.2	7.5
Staff support (SRM)	6.7	7.1
Care and culture (SRM)	7.2	

5.2 Themes of Feedback – Q1 2023/2024 - April to June 2023.

There were 10 negative and 56 positive comments received.

5.3 Communication with the dying person

Comments re communication were generic and not specific to the dying person.

5.4 Communication with families and others

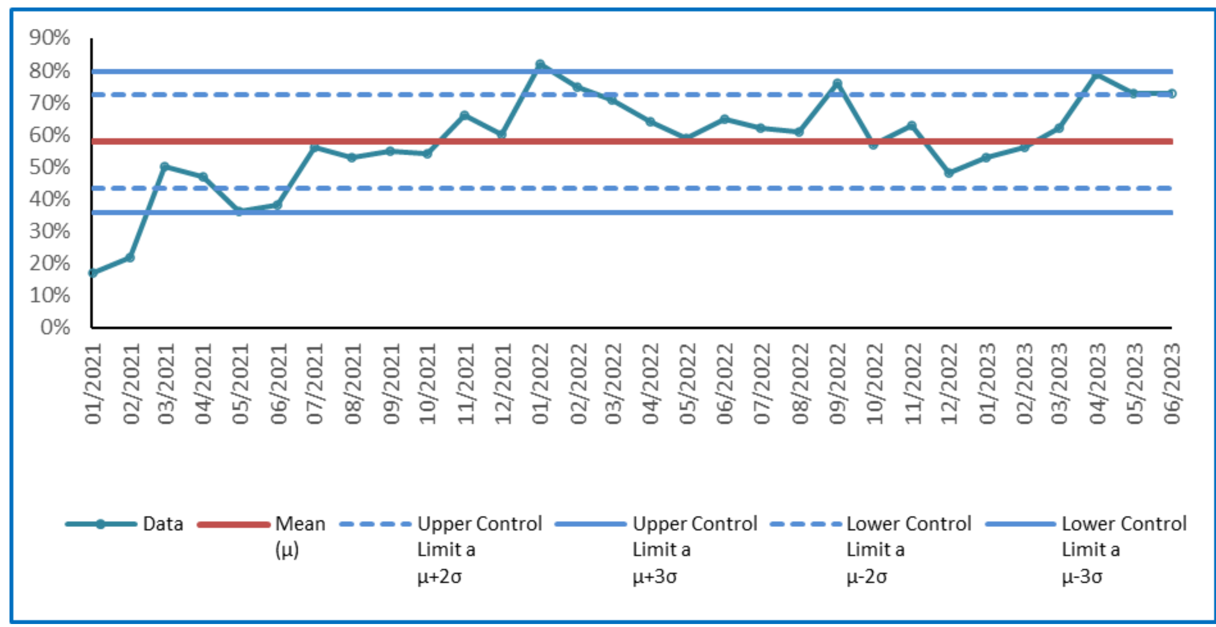
The 10 negative comments relate largely to communication including no clear diagnosis), discharge and concerns with care.

Themes around the negative communication lack of clarity on diagnosis, communication re admission, ward moves, mixed messages, getting through to hospital and being informed re death.

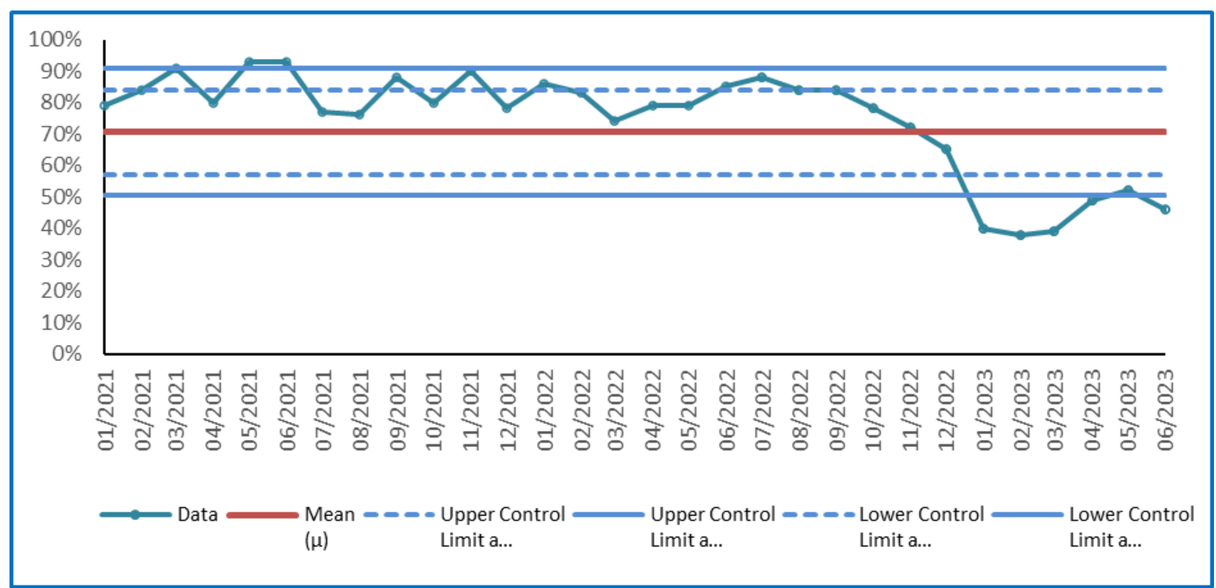
5.5 **Positive Feedback: ED and DCC**

There were 21 positive comments of care in the ED and 19 positive comments on care in DCC.

5.7 Percentage of feedback received of all deaths



5.8 Percentage of Positive Feedback received (all deaths where feedback received)



5.8 Conclusion

Family feedback has increased in the Q1 (April to June 2023) and hit the upper control limit of 80%. This will progress to an adjustment in mean by the next report. The positive feedback remains a concern although has improved in the last quarter.

6. Learning from Deaths

6.1 All mortality reviews are reported through Speciality mortality and morbidity (M&M) meetings. Actions are developed within the speciality and monitored through individual speciality and divisional processes.

All specialties now receive individual monthly data on SJR performance and report to HMG on a rolling basis where performance is reviewed. Most SJRs are undertaken within 2 months.

6.2 The main learning from structure reviews is through the feedback and discussion in local clinical meetings at Specialty level. Some themes continue to be identified which are in common with known areas of quality.

6.3 Serious incidents that result in death all have action plans.

6.4 Feedback from bereaved families has come up with several themes both positive and negative which are included in Appendix 2. Recurrent themes include negative communication regarding being unprepared for the death, lack of clarity on diagnosis, communication re-admission.

6.5 Deaths outside the SJR process are included in the table below:

Deaths by Special Type –	Oct-Dec 2021	Jan-Mar 2022	Apr- June 2022	Jul-Sept 22	Oct – Dec 2022	Jan- Mar 2023	April-May 2023	June – July 2023
Type	*Number*	*Number*	*Number*	*Number*				
Maternal Deaths (MBRRACE)	1	0	0	2	1	0	0	0
Serious Incident Deaths	2	4	7	9	7	6	0	0
Learning Difficulties Mortality Review (Inpatient deaths)	6	3	9	8	7	5		
Perinatal Mortality								
Neonatal <8 days	4	4	4	4	4	2	0	0
Stillbirth>24/40	1	5	2	4	2	3	5	1

7. LeDeR Report

7.1 On average there are 1 – 2 deaths per month of a person with a Learning Disability. These are all reported to LeDeR. The Learning Disability Team also contribute time to assisting reviewers with interpretation of notes of people who had been in hospital, but died elsewhere.

7.2 Deaths of people with LD or autism are not usually evenly spread throughout the year, but have been over the last 5 quarters. This is a bit unusual, but there is no theme which would give rise to concern.

7.3 **Activity and Performance**

7.4 LeDeR reviews usually do not reach the QA panel until at least 6 months after the person has died, as it takes that long for the reviewers to be able to interview family and carers and to review professionals' notes and then write their report.

7.5 Feedback on deaths of people with LD or autism will therefore not reach staff involved for at least 6 months. Even then, feedback can only be shared if family have given permission for this, and whether they give this consent or not is variable. (Further detail can be seen in Appendix 3).

For comparison:

Quarter	Total number of LD deaths	Number of COVID deaths within total	LeDeR QAs concluded for in-hospital deaths
2 2022/2023	6	2	6
3 2022/2023	8	0	8
4 2022/2023	5	0	1
1 2023/2024	5	0	0
2 2023/2024	5	0	0

7.6 A request was received to look at whether there was any difference around day of death. In summary, there is not. Over 2022/2023 and 2023/2024 (to date) that more LD inpatients died on a Friday than any other day of the week, but the place of death, cause of death and length of stay were so varied that nothing can be inferred from this finding.

7.7 **Improvements needed**

7.8 A very recent learning point is that ReSPECT plans need to be legible, as well as to-the-point, reflective of the patient's (or their representative's) wishes and that the patient's mental capacity to state their wishes has been considered. It would be appreciated if that could be cascaded to medical staff from HMG.

7.9 LeDeR reviewers have again highlighted episodes in hospital, not necessarily leading to the death of the individual, where incorrect food or fluid consistencies

were given to the patient. A project will be commencing later this month to pilot a solution to this and will be led by the Chief AHP

8. **Appendices**

8.1 The Trust reporting requirements can be found below:

Appendix 1 - Mortality Quarterly Dashboard & Divisional Performance – Q1 2023/24

Appendix 2: Bereavement Feedback Report

Appendix 3: **LeDeR Report to Hospital Mortality Group – January 2024**

9. **Conclusions**

9.1 All deaths are reviewed within the Trust via the independent Medical Examiner Service.

9.2 There is good local learning from problems in care and ensuring these are being reflected within specialties.

9.3 Learning from serious incidents is monitored through SERG.

9.4 Timeliness and completion rate has been impacted by high clinical workload with the added pressures from continued industrial action.

9.5 Family feedback shows good satisfaction, analysis is reported under the national end of life clinical audit themes and will be interpreted by the End of life group to identify areas for improvement. Family feedback has increased in the Q1 (April to June 2023) and hit the upper control limit of 80%. This will progress to an adjustment in mean by the next report. The positive feedback remains a concern although has improved in the last quarter.

9.6 Mortality indicators across most parameters for SHIMI remain "as expected" with the exception of SHMI for Weekend Admissions. Data analysis confirms that the greatest differential between weekday and weekend admission SHMI occurs in our very elderly patients (>85y) and a number of factors are being investigated for themes which may explain this. It is clear that a decrease in diagnosis of dementia in the population affects the risk profile (expected deaths calculation) and adversely affects overall SHIMI

10. **Recommendations**

10.1 The Committee is asked to note the Learning from Deaths Quarterly Report and approve in advance of it going to Trust Main Board.

Authors: Jo Mason-Higgins, Acting Associate Director of Safety (Investigation and Family Support)
Pam Adams, Trust Mortality Co-ordinator

Presenter: Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO

January 2024

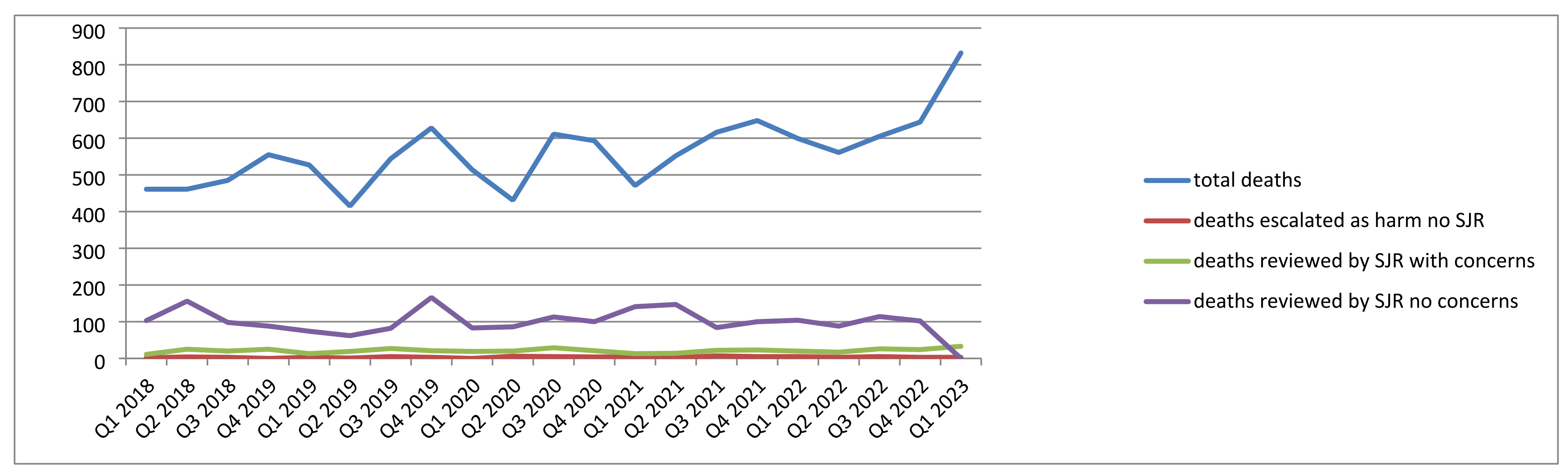
Mortality Quarterly Dashboard: Quarter 1 (April – June)

Mortality Data Quality Assured till Mar 2023

Trust wide

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
832*	644	**3**	6	**33**	24	**102**	102	128(15%)	127 (20%)	**6**	1
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
832	2409	**3**	19	**33**	77	**102**	408	128(15%)	489 (20%)	**6**	4

****Total deaths for Q1 taken from Healthcare Evaluation Data (HED). This is a change as not all deaths are now recorded on Datix from 31/05/2023. Also relates to figures denoted with a * in Divisional data (Appendix One). Data will be taken from BI Mortality Dashboard going forward**



Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		Score 2 – Poor Care		Score 3 – Adequate Care		Score 4 – Good Care		Score 5 – Excellent Care		Deaths escalated to harm review panel following SJR	
This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)
0	0	**8**	8	**19**	19	**39**	35	**20**	18	**6**	6

Problems identified in care and care record									
Problem in assessment, investigation or diagnosis		Problem with medication /IV fluids /electrolytes /oxygen		Problem related to treatment/management plan		Problem with infection control		Problem related to operation/ invasive procedure	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
3	**3**	**0**	**0**	**1**	**1**	**0**	**0**	**0**	**0**
Problems identified in care and care record									
Problem in clinical monitoring		**Problem in resuscitation following a cardiac or respiratory arrest**		**Other Problem**		**Quality of Patient Record Poor or very poor**			
This Quarter	**This Year (YTD)**	**This Quarter**	**This Year (YTD)**	**This Quarter**	**This Year (YTD)**	**This Quarter**	**This Year (YTD)**		
2	**2**	**0**	**0**	**2**	**2**	**0**	**0**		

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)		Completion of Key Learning Message (% of total requiring review)		Deaths selected for review but not reviewed to date (% of total requiring review)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
50 (39%)	**83(66%)**	**3(2%)**	**14 (66%)**	**48(37%)**	**75 (54%)**	**70 (54%)**	**27 (19%)**
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
50(39%)	327(66%)	**3(2%)**	14 (66%)	**48(37%)**	194 (36%)	**70 (54%)**	29 (5%)

Surgical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
153*	99	**0**	3	**6**	4	**12**	8	**15(9.8%)**	**13 (11%)**	**1**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
153	312	**0**	2	**6**	19	**12**	37	**15(9.8%)**	**61 (20%)**	**1**	0

	Total number of deaths	**Deaths presented to harm review panel (No SJR undertaken)**	**Total number of deaths selected for review under SJR methodology (% of total death)**	**Deaths investigated as serious or moderate harm incidents. Following SJR**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Critical care	31	0	7 (22%)	0	0	0
T&O	50	0	5 (10%)	2	2	0
Upper GI	19	0	0 (0%)	0	0	0
Lower GI	15	0	1(6%)	0	0	0
Vascular	6	0	0 (0%)	0	0	0
Urology	8	0	1 (12%)	N/A	N/A	N/A
Breast	0	N/A	N/A	N.A	N/A	N/A
ENT	0	0	0 (0%)	N/A	N/A	N/A
OMF	0	N/A	N/A	N/A	N/A	N/A
Ophthalmology	1	N/A	0(0%)	0	0	0

Performance against standards for review			
Deaths reviewed within 3 months of request (% of total requiring review)	**2nd reviews (where indicated) within 1 month**	**Completion of Key Learning Message (% of total requiring review)**	**Deaths selected for review but not reviewed to date**

		of intial review (% of total requiring review)				(% of total requiring review)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
5 (33%)	**10 (45%)**	**0**	0	**10 (66%)**	**18 (82%)**	**10 (66%)**	**1 (4.6%)**
This Year (YTD)	Last Year	**This Year(YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
5 (33%)	**38 (46%)**	**0**	**5 (83%)**	**10 (66%)**	**64 (88%)**	**10 (66%)**	**7 (10%)**

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**0**	**0**

Medical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
566*	514	**2**	3	**24**	18	**66**	92	**86(15%)**	**110 (%)**	**0**	2
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
566	**1246**	**2**	11	**24**	40	**66**	261	**86(15%)**	**318**	**0**	3

	Total number of deaths	Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)	Total number of deaths selected for review under SJR methodology	Deaths investigated as serious or moderate harm incidents. Following SJR (total)	Number of SJRs with very poor or poor care	Number of SJRs with excellent care
Lead Specialty						
Acute medicine	**297**	0	4(1%)	**0**	**0**	**0**
Cardiology	**11**	0	11 (100 %)	**0**	**0**	**0**
Emergency Department	**51***	0	53	**3**	**6**	**0**
Gastroenterology	**9**	0	1 (11%)	**0**	**0**	**0**
Neurology	**3**	0	0(0%)	**0**	**0**	**0**

Renal	10	0	5(50%)	0	0	0
Respiratory	53	2	11(20%)	0	0	0
Rheumatology	0	N/A	N/A	N/A	N/A	N/A
Stroke	33	0	1 (3%)	0	0	0
COTE	127	1	8 (6%)	0	1	2
Diabetology	20	0	1 (5%)	0	0	0
Endoscopy	0	0	N/A	N/A	N/A	N/A

***HED total number of deaths for ED does not correlate with SJR figure. Possible issue with the way deaths in ED are coded as they may come under Acute Medicine.**

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)		Completion of Key Learning Message (% of total requiring review)		Deaths selected for review but not reviewed to date (% of total requiring review)	
This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter
44 (51%)	72 (66%)	3 (3.4%)	3 (37.5%)	37	73 (66%)	57	17 (15%)
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
44 (51%)	265 (70%)	3 (3.4%)	12 (66%)	37	220 (62%)	57	55 (13%)

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	0	0

Diagnostic and Specialties

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
103*	29	**0**	0	**1**	1	**2**	7	**3**	8	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
103	104	**0**	1	**5**	1	**10**	7	**16**	9 (10%)	**0**	0

	Total number of deaths	Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)	Total number of deaths selected for review under SJR methodology	Deaths investigated as serious or moderate harm incidents. Following SJR (total)	Number of SJRs with very poor or poor care	Number of SJRs with excellent care
Lead Specialty						
Oncology	**81**	**0**	**1**	**0**	**0**	**0**
Clinical haematology	**18**	**0**	**1**	**0**	**0**	**0**

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
3 (100%)	**1 (50%)**	**0**	0	**1**	**1 (50%)**	**3**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
3 (100%)	**8 (50%)**	**0**	1 (100%)	**1**	**11 (69%)**	**3**	**2 (12%)**

Reason for SJR not being undertaken	This Quarter	Last Quarter
Notes unavailability	**0**	**0**

Maternity and Gynaecology

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of in hospital deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
1	0	**0**	0	**0**	0	**0**	0	0	0	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
0	3	**0**	0	**0**	0	**0**	0	0	1	**0**	0

	Total number of deaths	Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)	Total number of deaths selected for review under SJR methodology	Deaths investigated as serious or moderate harm incidents. Following SJR (total)	Number of SJRs with very poor or poor care	Number of SJRs with excellent care

Lead Specialty						
Gynaecology	**1**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Maternity	**0**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
N/A	N/A	**N/A**	N/A	**N/A**	N/A	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
N/A	Measurement amended	**N/A**	**N/A**	**N/A**	1 (100%)	**0**	0

Date report compiled: 07/10/2023

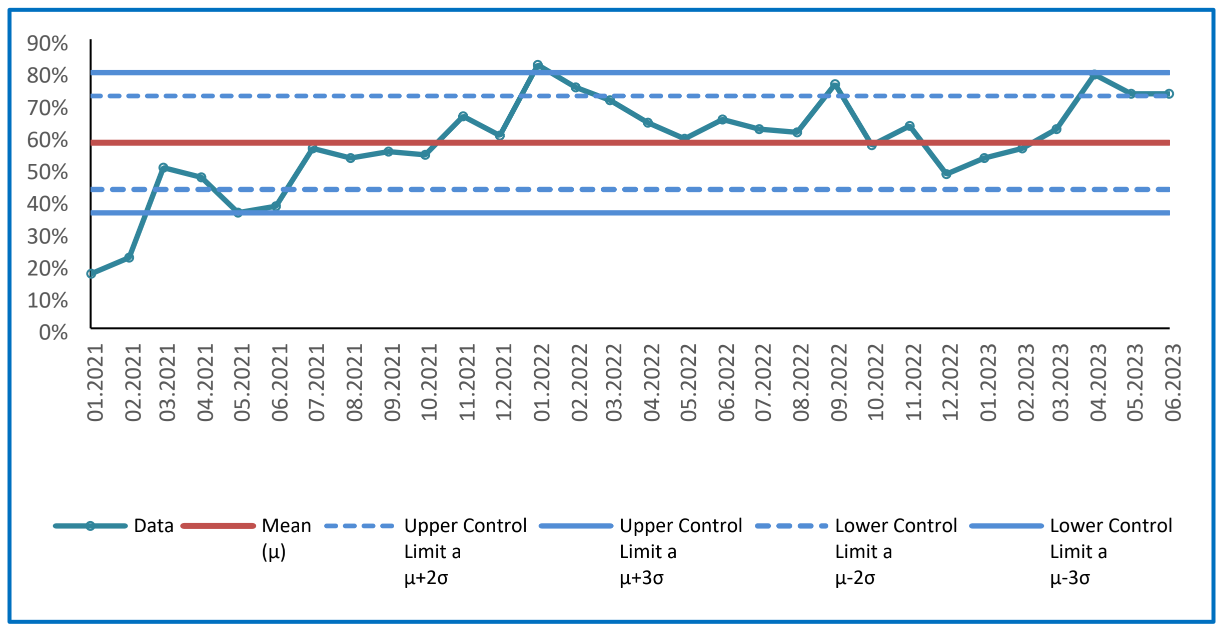
Author: Julia Hande

Feedback from families and others to bereavement team

April -June 2023

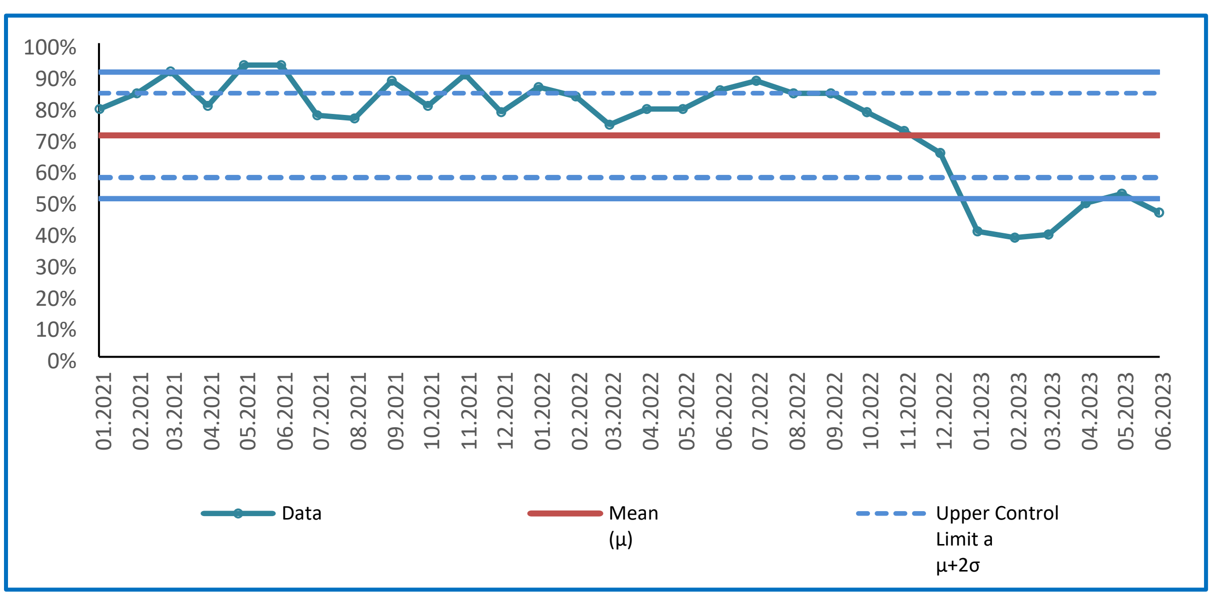
1.0 Trustwide

1.1. % of deaths where feedback received.



Family feedback has increased in the Q1 (April to June 2023) by 5 points and hit the upper control limit of 80%. This will progress to an adjustment in mean by the next report. The positive feedback remains a concern although has improved in the last quarter. This is reflected in the divisions.

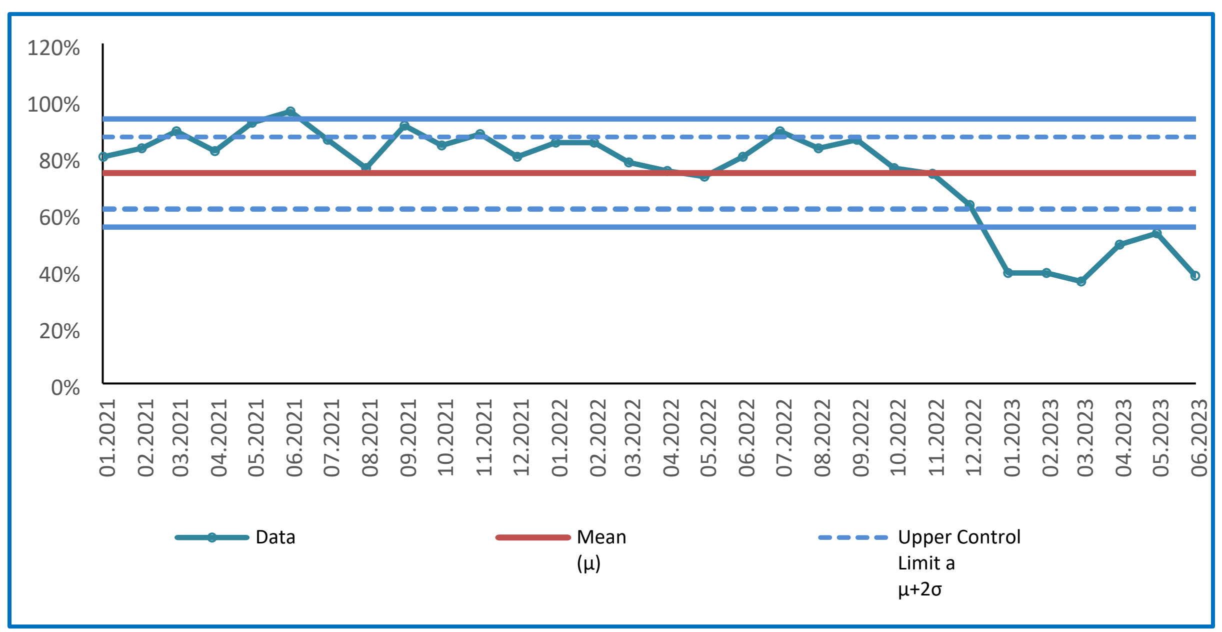
1.2 % of positive feedback received (all deaths where feedback received)



There are 6 consecutive points below the mean from 01/23 to 06/23, although an increase in positive feedback is noted between April and June 2023.

2.0 Medical Division

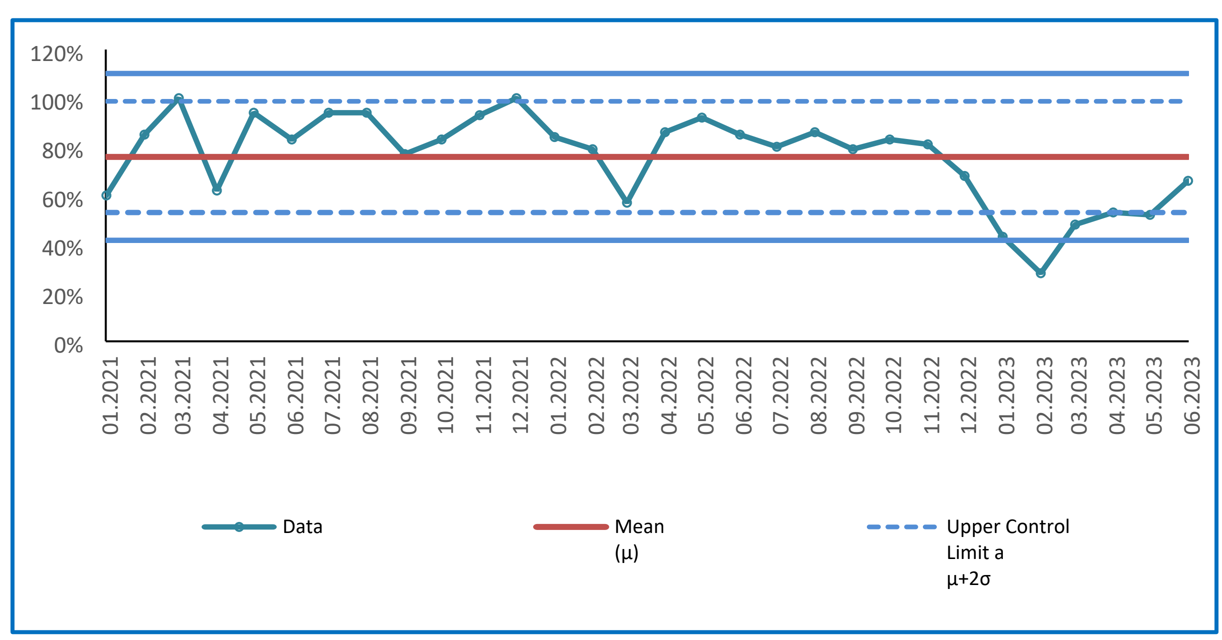
2.1 % of positive feedback received (all deaths where feedback received)



6 consecutive points below the mean and lower control limit between 01/23-06/23. Special cause variation in Q4 (22/23) and Q1 (23/24)

3.0 Surgical Division

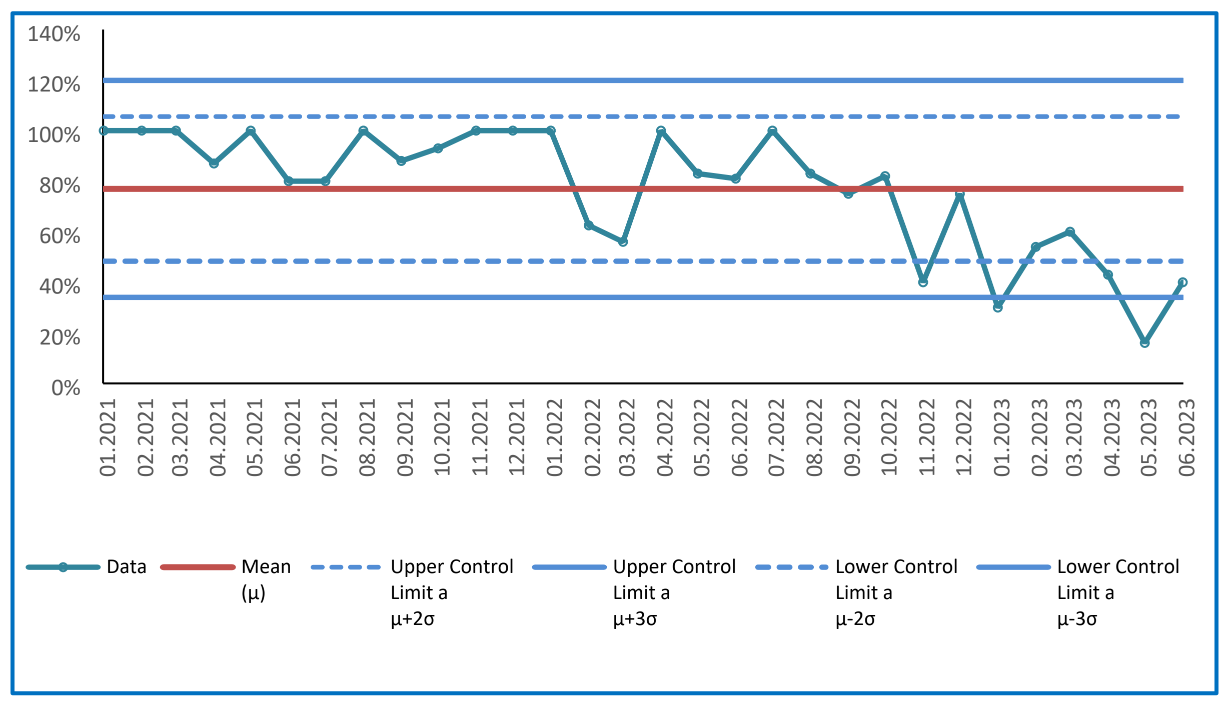
3.1 % of positive feedback received



Special cause variation in Q4 (22/23) 1 point below lower control limit but slowly increasing over Q1 (23/24)

4.0 Diagnostics and Specialties Division

4.1 % of positive feedback received



2 points below lower control limit; 1 in Q4(22/23) and 1 in Q1 (23/24)

5.0 Themes of Feedback (April -June 2023) for triggered incidents.

There were 166 Datix on the Mortality feedback report;

There were 10 negative comments and 56 positive comments recorded with the remainder recorded as no feedback given.

5.1 Negative Feedback

Negative comments were related to communication (including no clear diagnosis), discharge and concerns with care.

'' Daughter (speaking on behalf of family) very unhappy with communication on the ward. Was not informed that her father had had a stroke. Previous concerns regarding his admission. Referred to PALS.''

'' Concerns about care and the events immediately prior to her death, as well as coning surrounding care of the catheter, her recurrent hospital admissions with no clear diagnosis and communication by nursing staff. Family reported being very unhappy with the care. They feel that she was discharged from hospital in December without a conclusive unifying diagnosis.''

'' Family concerns around poor communication explaining mum's care and change to EOL. Concerns with care of pressure sore and collapsed lung. Son feels ward were negligent with medication.''

There were 14 mixed feedback reports;

’’The care was mainly good. Some elements were frustrating and the pt was an 'after thought'. An example provided: discussions were held around feeding through a tube but the actions weren't always followed through until the following day due to availability of doctors.
Pals number provided to NOK’’.

’’ Overall care from nurses and doctors was good or brilliant. Family concerns and questions regarding time taken for him to be seen after triage and actually be treated.’’

’’ Doctor who called from CGH was horrible and abrupt. ACUC was diabolical. Ryeworth was not good. Concerns with mouth care, his bed was cold and wet, skin on bum was split. Daughter felt he was left to die.
Care in A&E was first class.’’

’’ Family felt care was good but had concerns regarding previous discharge ’’

5.2 Positive feedback

Comments were generic and related to how fantastic the staff were.

21 comments were relating to ED care;

’’ staff were very good in Ed obviously busy but no concerns at all’’

’’ Everyone was nice and helpful. Everybody was very busy, but they weren't kept waiting. Care was excellent, appreciative of being given a side room.’’

’’ Exceptional care, it was a hard time but they couldn’t have done more’’

’’ Family impressed and happy with the care, would like to express their thanks to everyone’’

19 related to care in DCC;

’’ The doctors and nurses were wonderful and communication was outstanding. The care was amazing and couldn't be faulted.’’

’’ Everyone was wonderful - did their best - nurses were amazing ’’

Other comments

’’The nurses were so kind and all the staff were so very caring. The care was wonderful and to be praised.’’
‘The care was amazing and the staff cared for both patient and family, staff couldn't be faulted!!’’ ’’Care was exemplary throughout time at GRH, especially in 3a.Upset pt was on trolley for 24hours on 2a’’

’’ Lovely care especially nurse Linda in recovery and eating specialist, Lorraine. Everyone so professional’’

Report author: Julia Hande

Hospital Mortality Group
January 2024

Learning Disability Deaths Report (LeDeR)

1. Purpose of Report

1.1. Regular update to HMG on in-hospital Learning Disability deaths

2. Executive Summary

2.1. On average there are 1 – 2 deaths per month of a person with a Learning Disability. These are all reported to LeDeR. The Learning Disability Team also contribute time to assisting reviewers with interpretation of notes of people who had been in hospital, but died elsewhere.

2.2. Deaths of people with LD or autism are not evenly spread throughout the year, but have been over the last 5 quarters. This is a bit unusual, but there is no theme which would give rise to concern.

3. Activity and Performance

3.1. LeDeR reviews usually do not reach the QA panel until at least 6 months after the person has died, as it takes that long for the reviewers to be able to interview family and carers and to review professionals' notes and then write their report.

3.2. Feedback on deaths of people with LD or autism will therefore not reach staff involved for at least 6 months. Even then, feedback can only be shared if family have given permission for this, and whether they give this consent or not is variable.

3.3. For comparison:

Quarter	Total number of LD deaths	Number of COVID deaths within total	LeDeR QAs concluded for in-hospital deaths
3 2022/2023	8	0	8
4 2022/2023	5	0	3
1 2023/2024	5	0	2
2 2023/2024	5	0	0
3 2023/2024	4	0	0

3.3 Reminder of LeDeR grading of care

Grading of care by LeDeR has to be balanced across Primary Care, Secondary Care and Social Care. Only one grade can be given per individual. Deficits in any area will bring down the overall grading.

Grade	Descriptor
6	Excellent care, exceeding expected good practice
5	Good care, meeting expected good practice
4	Satisfactory care, fell short of expected good practice in some areas, but this did not significantly impact on the person's wellbeing
3	Care fell short of expected good practice but did not contribute to the cause of death
2	Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death
1	Care fell far short of expected good practice and this has contributed to the cause of death

3.4 Of the completed LeDeR reviews in Q3 of 2022/2023, 7 were graded at least 'good'. One in-hospital death was graded 'inadequate'. This patient was presented at the previous HMG meeting. The difficulty was due to staff really struggling to manage the presenting acute condition on top of the underlying learning disability, which is not an easy condition to manage. We are exploring ways to assist existing staff to understand this condition, but have already included it in induction teaching for nursing staff new to the organisation. We also have an independent supporter challenging decision-making processes after LeDeR graded that case as 5 (met expected good practice).

3.6 A request was received to look at whether there was any difference around day of death. In summary, there is not. Over 2022/2023 and 2023/2024 (to date) that more LD inpatients died on a Friday than any other day of the week, but the place of death, cause of death and length of stay were so varied that nothing can be inferred from this finding.

2022/2023

Day of death	Total
Monday	6
Tuesday	0
Wednesday	3
Thursday	5
Friday	6
Saturday	3
Sunday	3

2023/2024 (to date)

Day of week	Total
Monday	0
Tuesday	1
Wednesday	5
Thursday	1
Friday	5
Saturday	2
Sunday	0

4 Improvements needed

4.1 A very recent learning point is that ReSPECT plans need to be legible, as well as to-the-point, reflective of the patient's (or their representative's) wishes and that the patient's mental capacity to state their wishes has been considered. It would be appreciated if that could be cascaded to medical staff from HMG.

4.2 LeDeR reviewers have again highlighted episodes in hospital, not necessarily leading to the death of the individual, where incorrect food or fluid consistencies were given to the patient. A project will be commencing later this month to pilot a solution to this and will be led by the Chief AHP.

Author: Jeanette Welsh, Lead for Safeguarding Adults
Presenter: Jeanette Welsh, Lead for Safeguarding Adults

KEY ISSUES AND ASSURANCE REPORT (KIAR) FINANCE AND RESOURCES COMMITTEE – JANUARY 2024		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Capital Programme	At the end of month 9 capital expenditure was £38m against a plan of £45m - £7m behind plan. Despite this underspend to date, the forecast outturn is an overspend due to changes in accounting standards International Financial Standard (IFRS) 16. The impact of delays in delivery of the fifth Orthopaedic Theatre remain to be agreed with Region. Failure to secure agreement to a carry forward of funds could lead to the scheme not being delivered as planned.	The Committee NOTED the seriousness of the position and received assurance that positive discussions were taking place with the Region.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Financial Performance Report	At Month 9 there was a small overspend of £1.14m which was favourable compared to plan. The drivers for this improved position include funding from NHS England to cover the costs of industrial action. The run rate in a number of staffing related areas remain encouraging. The forecast outturn position of an £8.9m deficit remains fluid with a number of items yet to be confirmed including the costs of Industrial Action. The overall direction of travel is a positive one. The Integrated Care System forecast is for breakeven – after excluding the impact of industrial action. A number of service pressures including patients with “No criteria to reside” or with low clinical need and unfunded additional nursing costs remain to be resolved for both this and future financial years.	The Committee NOTED the seriousness of the position and the risks remaining in the final quarter of the financial year.
Financial Sustainability Report	The Committee noted the position at the end of Month 9 – to date £21.2m of savings had been delivered (£6.9m non-recurrent) and £2.2m behind plan. Significant risk remains around delivery of “red” rated schemes during the remainder of the year. The pace towards greater pan Integrated Care System working e.g. on shared services and estates remained	The Committee NOTED the position, risks around delivery and mitigating actions. Early preparations had begun for 24/25 schemes with a view to achieving a rapid take off come April. Over £7m of schemes had been identified to date. In addition to Executive actions already underway, NEDs undertook to

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

	slow thereby impacting on the ability to generate savings.	highlight opportunities for greater collaboration at pan Integrated Care System meetings etc.
Five Year Financial Plan 2024/2029	Although planning guidance had yet to be published, systems and providers were preparing plans using consistent parameters etc. The baseline was to be the exit underlying position for 2023/24 – a £6.4m deficit (excluding the impact of Industrial Action) since the included a significant level of non-recurrent actions/income. The Trust was forecast to exit 2023/24 with a £61.9m underlying deficit.	The Committee NOTED the challenging targets and impact on the underlying deficit position which would need to be reflected in the Trust's longer term financial strategy.
Budget Setting Update	The process had begun in November 2023 and were moving towards sign off. Sustainability schemes continue to be identified and designed with an indicative target of 3.4% (£26m). Despite these measures, further reductions in outline budgets were required in order to meet 2024/5 targets and ensure no worsening of the underlying deficit position. Work would continue to resolve the position and a report made to the next meeting. Discussions around the GMS contract would continue, in particular the risks around achievement of National Cleaning Standards.	The Committee NOTED the update, the underlying position and the high level of sustainability schemes which would be required.
New Finance System	There was an urgent requirement to replace the current finance system which had been in place for thirty years and no longer fit for purpose. Approval to replace the system had been obtained in 2022. There had been only limited interest in the tender process and the projected costs were significantly higher than originally anticipated.	The Committee APPROVED the process taken to date, supported Elmbridge as the preferred supplier and urged the Finance team to work to review the specification in order to make the scheme more affordable.
Gloucestershire Managed Services KIAR and Contract Management Group Overview Exception Report	KIARs for October, November and December were considered along with a verbal update from the January meeting. The most recent Contract Management Group exception report – which monitors the contract between the two organisations was considered alongside since they reflect each side of the contractual relationship. Recruitment to key posts remains challenging and achievement of National Cleaning Standards is an amber risk. Financial pressures within GMS were significant and mitigating actions were under active discussion. Progress against a range of measures was noted and the hard work undertaken in pursuit of these improvements noted.	The Committee NOTED the various strands of work around Governance processes between and within the two organisations currently underway and looked forward to receiving an update on progress at the next meeting

Glossary:

H1/H2= first/second half of the financial year

ERF: Elective Recovery Fund

CIP: Cost Improvement Programme

ICS = Integrated Care System

	The process by which GMS Board received assurances around water and safety compliance issues (and then onto the Trust) was explored.	
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Productivity Dashboard (including Outpatients Transformation Programme and Theatres Improvement Programme)	The Committee received encouraging reports on all fronts with much work underway. Significant improvements had been made in Productivity ratios overall, Theatre and Outpatient Clinic Utilisation and DNAs.	
National Costing Collection update	The Committee received the NCC submission for the Trust which had been significantly delayed due to national level system changes. Comparisons to national benchmarks/averages and potential explanations were noted. The work undertaken by the Trust was of a very high standard and the Committee encouraged an application be made for a national costing award.	
Matters Arising	All matters either resolved or in hand with the exception of the Wye Valley Linac agreement which has been outstanding for four years.	To be escalated and reported to next meeting.
Items not Rated		
Finance and Resources Committee workplan 2024/25		
Integrated Care System (ICS) Update		

Investments			
Case	**Comments**	**Approval**	**Actions**
None			.

Impact on Board Assurance Framework (BAF)
SR 9: Failure to deliver recurrent financial sustainability and SR 11: Sustainable Healthcare had been reviewed by Executive Leads and an update provided – it was agreed to incorporate a longer-term perspective to the next iteration of SR 9.

Glossary:

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KEY ISSUES AND ASSURANCE REPORT (KIAR)
FINANCE AND RESOURCES COMMITTEE – FEBRUARY 2024

The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Capital Programme 2023/24	At the end of month 10 capital expenditure was £41.2m against a plan of £48.3m - £7m behind plan. Despite this underspend to date, the forecast outturn is for a break even position due to additional funding for the impact of International Financial Reporting Standard (IFRS) 16. The impact of delays in delivery of the fifth Orthopaedic Theatre remain to be agreed with Region. Failure to secure agreement to a carry forward of funds could lead to the scheme not being delivered as planned.	The Committee **NOTED** the M10 capital position and the risk with the current forecast outturn.
Capital Plan 2024/25	Although the Integrated Care System has identified additional funds to assist the Trust in tackling its backlog maintenance problems, there remain a number of unfunded high-risk schemes. Many of these involve long delivery and planning periods and cannot be resolved in any one financial year. The current Trust plan of £33.1m is unaffordable – the entire Integrated Care System allocation is £36.1m – work continues to reduce this figure.	The Committee **APPROVED** the draft Capital plan ahead of the 29 February submission. The March Board meeting would receive an update including an assessment of the impact of the plan on risks and assurance mechanisms over the short and medium term.
Financial Sustainability Report 2023/24	The Committee noted the position at the end of Month 10 – to date £24m of savings had been delivered (£6.9m non-recurrent) and this was £3.2m behind plan. Significant risk remains around delivery of "red" rated schemes during the remainder of the year. As the Trust focusses on its underlying financial position, a greater proportion of schemes need to be of a recurring nature in future years.	The Committee **NOTED** the report and the improvements taking place.
Operational Plan 2024/2029 and Planning and Budget Setting 2024/25	Although planning guidance has yet to be published, systems and providers are preparing plans using consistent parameters etc. A high-level submission was made on 29 February showing a £45.5m deficit position. Work continues to identify further efficiencies but the size of the challenge should not be underestimated. In addition to Acute sector pressures, the ICB faces cost pressures in relation to continuing healthcare. The next submission will be presented to the Board on 14 March.	The Committee **NOTED** the updated financial plan and supported the 29 February high level financial submission.

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

Digital Transformation Report	This is the final year of the Digital strategy – 39 projects are currently active and due for delivery in coming months. In addition to delivery, there was to be a focus on resilience. The five programmes are; Sunrise Electronic Patient Record (EPR), Clinical Systems Optimisation, Business Intelligence, Infrastructure, Cyber Security and Information Governance. The Virtual Ward work undertaken by the team had received plaudits from NHS England nationally.	Further work on EPR, infrastructure and configuration, and system health checks was underway. Improvements related to resilience were identified.
Cabinet Office Spend Controls Compliance	This was an update from Procurement on new rules relating to approval by the Cabinet Office of proposed procurement exercises. In effect, they require the introduction of pre-procurement authorisation within the Trust for proposed expenditure above certain thresholds and Cabinet Office involvement for some. In addition to understanding the impact of any delay on spending plans (especially capital) the committee were concerned about the staffing implications of these new measures, adequacy of our existing Standing Orders/Standing Financial Instructions and general appreciation of them across the organisation - including at Board level.	Head of Procurement will conduct a review of best practice elsewhere and develop a proposal for the Committee to consider.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Financial Performance Report 2023/24	At Month 10 the financial position was a surplus of £3,909k which was £6,288k favourable when compared to plan. The drivers for this improved position include funding from NHS England to cover the costs of industrial action. The forecast outturn position of an £4.4m deficit is an improvement on previous forecasts and the overall direction of travel is positive although there remain many variables at play. The Integrated Care System forecast is for a year end deficit of £675K.	The Committee **RECEIVED** the report as a source of assurance that the financial position was understood.
Productivity Deep Dive (including Outpatients Transformation Programme and Theatres Improvement Programme)	The Committee received encouraging reports on all fronts with much work underway. Significant improvements had been made in Productivity ratios overall, Theatre and Outpatient Clinic Utilisation and Did Not Attends (DNAs). Productivity Champions are being identified throughout the organisation.	
Digital Clinical Systems Report	The Committee received updates on the large number of new systems as well as software and process enhancements which had taken place in recent years. The focus is now on embedding the benefits of these into operational working and budgets.	The Committee received the report as assurance of the delivery of competent systems and congratulated the IM&T

Glossary:

H1/H2= first/second half of the financial year

CIP: Cost Improvement Programme

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ERF: Elective Recovery Fund

	Over the past five years the Trust has been focussed on achieving HIMSS Level 6 – based on 2018 standards. HIMSS is a measure of digital maturity. To date it has progressed from level 0.2 (one of the lowest ever recorded in the NHS) to near Level 6 – a remarkable achievement.	team on achievement of the HIMSS standard.
Matters Arising		

Items not Rated

Financial Risk Register
Committee Terms of Reference
GMS Articles of Association
Integrated Care System Digital Strategy
Digital Investment Review

Investments

Case	Comments	Approval	Actions
Fire Alarm Panel Tender Approval	Preferred supplier appointed.	YES	

Impact on Board Assurance Framework (BAF)

SR 13: Digital Systems Functionality and SR 9: Financial Sustainability had been reviewed by Executive Leads and an update provided. SR10: Condition of the Estate was reported to be work in progress as there was further work to be done on risk, compliance and backlog maintenance.

Glossary:
H1/H2= first/second half of the financial year
ERF: Elective Recovery Fund
CIP: Cost Improvement Programme
ICS = Integrated Care System

<table>
<tr><th colspan="4">Report to Board</th></tr>
<tr><td>Date</td><td colspan="3">14 March 2024</td></tr>
<tr><td>Title</td><td colspan="3">Financial Performance Report (Month 10 – Ended 31 January 2024)</td></tr>
<tr><td>Author /Sponsoring Director/Presenter</td><td colspan="3">Hollie Day, Caroline Parker, Craig Marshall
Karen Johnson</td></tr>
<tr><td colspan="3">Purpose of Report</td><td>Tick all that apply ✓</td></tr>
<tr><td>To provide assurance</td><td>✓</td><td>To obtain approval</td><td></td></tr>
<tr><td>Regulatory requirement</td><td></td><td>To highlight an emerging risk or issue</td><td></td></tr>
<tr><td>To canvas opinion</td><td></td><td>For information</td><td></td></tr>
<tr><td>To provide advice</td><td></td><td>To highlight patient or staff experience</td><td></td></tr>
<tr><td colspan="4">Summary of Report</td></tr>
<tr><td colspan="4">Purpose

This purpose of this report is to present the financial position of the Trust at Month 10.

Revenue

The Trust is reporting a year to date (YTD) surplus of £3.9m which is £6.3m favourable to plan. This is the position after adjusting for donated assets impact and Salix grant.

The Integrated Care System year to date surplus position of £8m which is £10.4m favourable to plan. This is the result of a £6.3m favourable to plan position from GHFT, a £3.2m year to date favourable position at Gloucestershire Health and Care NHS Foundation Trust and a £0.9m favourable position at Gloucestershire Integrated Care Board.

Capital

The Trust is reporting a year to date position of £41.2m against a planned spend of £48.3m which is a variance of £7.1m. The Trust has reported a System capital breakeven position and a national programme underspend of £1.3m against community diagnostic centre project and £7.5m against the 5th Orthopaedic Project</td></tr>
<tr><td colspan="4">Recommendation</td></tr>
<tr><td colspan="4">The Board is asked to RECEIVE the contents of the report as a source of assurance that the financial position is understood.</td></tr>
<tr><td colspan="4">Enclosures</td></tr>
<tr><td colspan="4">Finance report</td></tr>
</table>

Report to Trust Board

Financial Performance Report
Month Ended 31st January 2024

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Revenue & Balance Sheet

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Director of Finance Summary

Gloucestershire Hospitals
NHS Foundation Trust

System Overview

The Integrated Care System is reporting a forecast deficit of £675k. The forecast includes a £450k surplus position at Gloucestershire Integrated Care Board, a £3.3m surplus position at Gloucestershire Health and Care and a £4.4m deficit position at Gloucestershire Hospitals.

The ICS year-to-date (year to date) surplus position is £8,097k which is £10,407k favourable to plan. This is the result of a £6,288k favourable position at Gloucestershire Hospitals, £3,182 favourable position at Gloucestershire Health and Care and a £937k favourable position at Gloucestershire Integrated Care Board.

Month 10

M10 year to date Financial position is reporting a surplus of £3,909k which is £6,288k favourable to plan. The position includes :

- Industrial Action costs £3,316k
- PFI indexation above planned inflation £620k and net impact of elective activity underperformance £1,210k
- Unfunded nursing for Courtyard (10-18 patients) and Acute Medical Unit (26 unfunded beds open) £2,225k
- Same Day Emergency Care open after 23:00 £246k
- Frailty Assessment Service - up to 8 additional patients £201k
- Guiting - 3 additional patients £433k
- Ward 4b - swing bay is open without funding (6 patients) £645k
- Ward 7b - 2 RNs providing care for one patient each day £482k
- Decision To Admit patients in ED - can be up to 50 (budget can cover 20) £2,388k
- Overseas Nursing Supernumerary costs £2,000k
- Divisional pay pressures in medical staffing and nursing £7,600k
- Interest receivable and payable lower than plan £3,800k benefit
- Reserves £13,000k benefit including release of remaining Health & Well Being accrual £1,000k and release of £4,000k NHS England Elective Recovery Fund accrual
- Release of prior year accruals (corporate) £2,000k
- Non recurrent funding from NHS England to support Industrial Action £6,600k

The Financial Sustainability Plan target for the Trust is £34.7m in 23/24 and year to date the programme has delivered £24m of savings (£15.9m recurrent; £8.1m non-recurrent). The programme is behind plan by £3.3m. There remains significant risk of delivery due to £6.1m red-rated schemes.

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Month 10 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
Revenue position year to date is £3.9m surplus which is £6.3m favourable to plan	↑	Revenue Position year to date is £3.9m deficit which is £6.3m favourable against the plan of £2.4m deficit.
Income is £646m year to date which is £37.6m favourable to plan	↑	M10 income position is £646m year to date which is £37.6m favourable to plan. This is driven by Gloucestershire Managed Service reporting additional income due to pay award funding and capital margin. It is also driven by overperformance of pass through drugs and Health Education England income which is netting off underperformance on elective contracts. Further information is on the Activity slide.
Pay costs are £393m year to date which is £23.6m adverse to plan	↓	Pay costs are £393m year to date which is £23.6m adverse to plan. Pressures include Industrial Action costs and covering escalation & vacancies within Emergency Department, Acute Medicine, theatres and trauma.
Non Pay costs are £241m year to date which is £7.7m adverse to plan.	↓	Non Pay costs (included non-operating costs) are £241m year to date which is £7.7m adverse to plan. This position includes overspends on clinical supplies within the Surgery Division, increased Private Finance Initiative costs due to indexation and undelivered Financial Sustainability Schemes.
Delivery against Financial Sustainability Schemes	↓	The Financial Sustainability Plan (FSP) target for the Trust is £34.7M. In Month 10, the Trust had planned efficiencies of £27.3M and achieved £24M.
The cash balance is £53.2m	↑	Cash has increased by £2.1m in month.

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Oversight Framework – Financial Matrix

The Framework is built around five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts and Integrated Care Boards:

- quality of care, access and outcomes
- preventing ill-health and reducing inequalities
- people
- finance and use of resources
- leadership and capability

The Financial Matrix used by the Trust to monitor the Finance and Use of Resources for Month 10 year to date position is below. The System is also required to monitor against these metrics plus achievement of Mental Health Standard.

Group Position	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Financial efficiency – variance from efficiency plan	27,321	24,014	(3,307)
Financial stability – variance from breakeven*	(2,378)	3,909	6,287
Agency spending against ledger budget	(6,533)	(15,403)	(8,870)
*adjusted position			

The Trust is adverse to plan for Financial Efficiency and Agency Spending. Financial Stability is favourable to plan this month due to £6.3m funding received from NHSE to support industrial action and financial recovery plans delivering. This favourable position is not expected to continue in M11-M12.

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M10 Group Position versus Plan

The financial position as at the end of January 2024 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity, and excludes the Hosted GP Trainees (which have equivalent income and cost) each month.

In January the Group's consolidated position shows a surplus of £3.9m which is £6.3m favourable to plan.

Statement of Comprehensive Income (Trust and Gloucestershire Managed Services (GMS))

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 10 Financial Position	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	564,920	572,351	7,431			0	564,920	572,351	7,431
PP, Overseas and RTA Income	3,648	4,587	939			0	3,648	4,587	939
Other Income from Patient Activities	10,931	19,342	8,411			0	10,931	19,342	8,411
Operating Income	41,312	45,313	4,001	59,460	74,822	15,362	29,005	49,858	20,853
Total Income	**620,812**	**641,594**	**20,782**	**59,460**	**74,822**	**15,362**	**608,505**	**646,139**	**37,634**
Pay	(358,447)	(371,317)	(12,870)	(20,187)	(22,618)	(2,430)	(369,990)	(393,599)	(23,608)
Non-Pay	(249,358)	(254,578)	(5,220)	(37,133)	(51,731)	(14,598)	(224,940)	(236,368)	(11,428)
Total Expenditure	**(607,805)**	**(625,895)**	**(18,090)**	**(57,320)**	**(74,349)**	**(17,029)**	**(594,931)**	**(629,967)**	**(35,036)**
EBITDA	**13,008**	**15,699**	**2,691**	**2,139**	**473**	**(1,666)**	**13,574**	**16,172**	**2,598**
EBITDA %age	**2.1%**	**2.4%**	**0.4%**	**3.6%**	**0.6%**	**(3.0%)**	**2.2%**	**2.5%**	**0.3%**
Non-Operating Costs	(8,343)	(4,746)	3,597	(2,139)	(473)	1,666	(8,909)	(5,219)	3,690
Surplus / (Deficit)	**4,665**	**10,953**	**6,288**	**0**	**(0)**	**(0)**	**4,665**	**10,953**	**6,288**
Dontated Asset, Impairment & Salix Grant Adjustment	(7,044)	(7,044)	0	0	0	0	(7,044)	(7,044)	0
Adjusted Surplus / (Deficit)	**(2,379)**	**3,909**	**6,288**	**0**	**(0)**	**(0)**	**(2,379)**	**3,909**	**6,288**

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

** Group position excludes £70m of inter-company transactions, including dividends

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Balance Sheet

	Group Closing Balance 31st March 2023 £000	GROUP Balance as at M10 £000	B/S movements from 31st March 2023 £000
Non-Current Assests			
Intangible Assets	16,483	13,071	(3,412)
Property, Plant and Equipment	357,717	375,934	18,217
Trade and Other Receivables	3,901	3,794	(107)
Total Non-Current Assets	**378,101**	**392,799**	**14,698**
Current Assets			
Inventories	12,312	12,657	345
Trade and Other Receivables	46,622	28,197	(18,425)
Cash and Cash Equivalents	49,193	53,243	4,050
Total Current Assets	**108,127**	**94,097**	**(14,030)**
Current Liabilities			
Trade and Other Payables	(104,686)	(89,272)	15,414
Other Liabilities	(11,160)	(14,572)	(3,412)
Borrowings	(5,904)	(10,422)	(4,518)
Provisions	(7,929)	(5,005)	2,924
Total Current Liabilities	**(129,679)**	**(119,271)**	**10,408**
Net Current Assets	**(21,552)**	**(25,174)**	**(3,622)**
Non-Current Liabilities			
Other Liabilities	(7,603)	(4,972)	2,631
Borrowings	(53,914)	(54,113)	(199)
Provisions	(2,824)	(2,085)	739
Total Non-Current Liabilities	**(64,341)**	**(61,170)**	**3,171**
Total Assets Employed	**292,208**	**306,455**	**14,247**
Financed by Taxpayers Equity			
Public Dividend Capital	397,288	403,732	6,444
Reserves	28,113	28,113	(0)
Retained Earnings	(133,194)	(125,390)	7,804
Total Taxpayers' Equity	**292,208**	**306,455**	**14,247**

The table shows the M10 balance sheet and movements from the 2022/23 closing balance sheet.

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Capital

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Capital

Director of Finance Summary

Funding

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m, of which £1.5m was in relation to IFRS 16 Right of Use CDEL, leaving a remaining programme of £55.8m. Year to date movements for additional national programme funding and agreement of the IFRS16 funding allocation have brought the forecast programme funding (including IFRS 16) to £59.2m.

The Trust are in dialogue with the region around the 5th Orthopaedic theatre project and at this time have reported a forecast based on the projected spend on the scheme to date. No final decision has been made with respects to the project including any returning of funds. The Trust have reported an underspend against the Community Diagnostic Centre lease capital of £1.3m. This could rise to £1.4m in M11 once the final lease has been assessed.

YTD Position

As of the end of January (M10), the Trust had goods delivered, works done or services received to the value of £41.2m, against a planned spend of £48.3m, equating to a variance of £7.1m behind plan.

On 9th February, the Region communicated that the assumption is that all systems will reflect a balanced system capital position (excluding IFRS16) and that the regional IFRS16 overspend will be managed without the need for further mitigations.

As a result of our current outturn position, the Trust will now not pursue some of those mitigations that had been previously agreed to ensure that the system capital (excluding IFRS16) does not underspend. Not all mitigations could be reversed and coupled with the latest system capital forecasts and brokerage to national funding allocations, the system capital is estimated to be heading for a £1.1m underspend.

As a result, the Capital Delivery Group on 21st February agreed to bring forward £1.3m of schemes from the 24/25 capital programme to mitigate. The decision to go over by £0.2m was to future proof any optimism remaining in programme delivery forecasts. This will be monitored throughout March and action taken should spend need to be slowed down.

The trust has reported a System capital breakeven position and a national programme underspend of £1.3m against community diagnostic centre project and £7.5m against the 5th Orthopaedic Project.

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23/24 Programme Funding Overview

Gloucestershire Hospitals
NHS Foundation Trust

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m, of which £1.5m was in relation to IFRS 16 Right of Use CDEL, leaving a remaining programme of £55.8m. Year to date movements for additional national programme funding and agreement of the IFRS16 funding allocation have brought the forecast programme funding (including IFRS 16) to £59.2m. The breakdown of secured funding is shown in the below.

in £000's		Plan	Forecast	Variance	Secured
DIGITAL	Digital	5,700	5,700	0	5,700
MEDICAL EQUIPMENT	Medical Equipment	5,996	4,851	1,145	4,851
ESTATES	Estates	14,192	14,207	(15)	14,207
CENTRAL CONTINGENCY	Central Contingency	0	1,416	(1,416)	1,416
Total Charge against Capital Allocation (excluding impact of IFRS 16)		25,888	26,174	(286)	26,174
RIGHT OF USE ASSET	Right Of Use Asset	1,478	729	749	729
Total Charge against Capital Allocation (including impact of IFRS 16)		27,366	26,903	463	26,903
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY	Image Sharing	326	174	152	174
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY	iRefer	0	152	(152)	152
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY	Digital Pathology	115	0	115	0
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Equipment 22/23	451	451	0	451
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Enabling works	4,185	4,185	0	4,185
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Digital	2,540	2,540	0	2,540
NAT PROG: ELECTIVE RECOVERY FUND	5th Orthopaedic Theatre	8,703	8,703	0	8,703
NAT PROG: RIGHT OF USE ASSET: NEW	Leases: Community Diagnostic Centre	4,098	4,098	0	4,098
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL	CT Scanner	0	954	(954)	954
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL	Endoscopic Retrograde Cholangiopancreatography (ERCP)	0	1,251	(1,251)	1,251
NAT PROG: CYBER IMPROVEMENT PROGRAMME	Cyber Improvement	0	100	(100)	100
NAT PROG: CONNECTING CARE RECORDS	Regional Integration Engine	0	175	(175)	175
STP PROGRAMME: GSSD	Strategic Site Development	561	561	0	561
IFRIC 12	PFI Lifecycle	1,126	1,126	0	1,126
DONATIONS VIA CHARITABLE FUNDS	Gamma Camera	1,075	1,061	14	816
GRANT	PSDS 3a Salix (Grant Funded)	6,724	6,724	0	6,724
Total Additional Capital		29,904	32,255	(2,351)	32,010
Gross Capital Funding Total (including IFRS 16)		57,270	59,158	(1,888)	58,913
Excluding IFRS16		(1,478)	(729)	(749)	(729)
Gross Capital Funding Total (excluding IFRS 16)		55,792	58,429	(2,637)	58,184

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23/24 Programme Spend Overview

As of the end of January (M10), the Trust had goods delivered, works done or services received to the value of £41.2m, against a planned spend of £48.3m, equating to a variance of £7.1m behind plan. In month, the Trust delivered a £3.1m gross capital spend.

The current internal forecast outturn position is showing a gross capital spend of £53m versus a gross funded position of £59m, a £6m underspend. This position comprises a £0.1m overspend within System capital, a £5m overspend on IFRS 16, and an £11m underspend in National Programme funded projects.

Capital Programme Year-to-Date expenditure and forecasts by programme area are shown below.

in £000's	In Month			Year to Date			Forecast		
	Last Forecast for this Month £000's	In Month Actual £000's	Variance to Last Month Forecast £000's	Plan £000's	Actual £000's	Variance to Plan £000's	Funding £000's	Forecast £000's	Variance
DIGITAL	349	219	130	4,269	2,838	1,451	5,700	3,801	1,899
MEDICAL EQUIPMENT	79	61	17	3,846	1,030	2,817	4,851	1,534	3,317
ESTATES	1,286	1,770	(484)	12,262	16,517	(4,255)	14,207	19,885	(5,678)
22/23 VAT RECLAIMS	(50)	(74)	24	0	(722)	722	0	(793)	793
RIGHT OF USE ASSET: NEW (FORMERLY FINANCE LEASE)	0	0	0	0	1,818	(1,818)	0	1,818	(1,818)
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**1,663**	**1,976**	**(313)**	**20,398**	**21,481**	**(1,082)**	**26,174**	**26,244**	**(70)**
RIGHT OF USE ASSET	987	44	943	1,091	4,973	(3,882)	729	5,689	(4,960)
Total Charge against Capital Allocation (including impact of IFRS 16)	**2,650**	**2,020**	**630**	**21,489**	**26,454**	**(4,964)**	**26,903**	**31,933**	**(5,030)**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	43	14	28	441	62	379	326	152	174
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	769	372	397	6,944	3,955	2,989	7,176	5,006	2,170
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	1,104	576	527	7,046	1,176	5,870	8,703	1,176	7,527
NAT PROG: RIGHT OF USE ASSET: NEW	0	0	0	4,098	375	3,723	4,098	2,799	1,299
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	513	(4)	517	0	344	(344)	2,205	2,205	0
NAT PROG: CYBER IMPROVEMENT PROGRAMME	0	0	0	0	0	0	100	100	0
NAT PROG: CONNECTING CARE RECORDS	0	0	0	0	0	0	175	175	0
STP PROGRAMME: GSSD	0	0	0	561	561	0	561	561	0
IFRIC 12	94	94	0	938	938	0	1,126	1,126	0
DONATIONS VIA CHARITABLE FUNDS	0	0	0	575	817	(242)	1,061	1,061	(0)
GRANT	120	60	60	6,209	6,491	(282)	6,724	6,724	0
Gross Capital Spend Total	**5,292**	**3,133**	**2,159**	**48,302**	**41,173**	**7,129**	**59,158**	**53,018**	**6,140**
Excluding IFRS16	(987)	(44)	(943)	(1,091)	(4,973)	3,882	(729)	(5,689)	4,960
Gross Capital Spend Total (excluding IFRS 16)	**4,305**	**3,089**	**1,216**	**47,211**	**36,200**	**11,011**	**58,429**	**47,329**	**11,100**

	Last Forecast for this Month £000's	In Month Actual £000's	Variance to Last Month Forecast £000's	Plan £000's	Actual £000's	Variance to Plan £000's	Funding £000's	Forecast £000's	Variance
Gross Capital Spend Total	**5,292**	**3,133**	**2,159**	**48,302**	**41,173**	**7,129**	**59,158**	**53,018**	**6,140**
Less Donations and Grants Received	(120)	(60)	(60)	(6,784)	(7,308)	524	(7,785)	(7,785)	0
Less PFI Capital (IFRIC12)	(94)	(94)	(0)	(938)	(938)	(0)	(1,126)	(1,126)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	28	28	0	280	280	0	335	335	0
Total Capital Departmental Expenditure Limit (CDEL)	**5,106**	**3,007**	**2,099**	**40,860**	**33,207**	**7,653**	**50,582**	**44,442**	**6,140**

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Recommendations

The Board is asked to:

- Note the Trust is reporting a surplus of £3,909k which is £6,288k favourable to plan.
- Note the Trust capital position as of the end of January 2024

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Date: **February 2024**

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