Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETING HELD IN PUBLIC

Thursday 9 May 2024 at 13:00

Room 3, Sandford Education Centre, Cheltenham General Hospital

AGENDA

REF	ITEM	PURPOSE	REPORT	TIME
1	**Apologies for absence**	Information		13:00
2	**Declarations of interest**	Approval		
3	**Minutes of previous meeting**	Approval	Yes	13:05
4	**Matters arising**	Assurance		
5	**Public questions**	Information		
6	**Staff story** *Claire Radley, Director for People & OD*	Information		13:15
7	**Chief Executive's Report** *Kevin McNamara, Chief Executive*	Information	Yes	13:30
8	**Board Assurance Framework** *Sim Foreman, Interim Trust Secretary*	Assurance	Yes	13:45
9	**Trust Risk Register** *Mark Pietroni, Medical Director & Director of Safety*	Assurance	Yes	13:50
PEOPLE AND ORGANISATIONAL DEVELOPMENT				
10	**Freedom To Speak Up Guardian (FTSU) Update** *Louisa Hopkins*	Information	Yes	14:00
11	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director* • ***PODC Dashboard***	Assurance	Yes	14:15
	Break			14:25
FINANCE AND RESOURCES				
12	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director*	Assurance	Yes	14:35
13	**Financial Performance Report** *Karen Johnson, Director of Finance*	Assurance	Yes	14:45
QUALITY AND PERFORMANCE				
14	**Maternity update** *Lisa Stephens, Director of Midwifery*	Assurance	Yes	15:00
15	**Safer staffing report** *Matt Holdaway, Director of Quality and Chief Nurse*	Information	Yes	15:20
16	**Quality and Performance Committee Report** *Sam Foster, Non-Executive Director*	Assurance	Yes	15:30
17	**Integrated Performance Report (Operational Performance)** *Al Sheward, Chief Operating Officer, Mark Pietroni, Medical Director & Director of Safety and Matt Holdaway, Director of Quality and Chief Nurse*	Assurance	Yes	15:40

STANDING ITEMS				
18	**Any other business and questions on consent items**	Information		15:50
19	**Governor observations**	Information		15:55
20	**Date and time of next meeting** Thursday 11 July 2024 at 11:15 (Museum of Gloucester, Gloucester)	Information		16:00
CONSENT ITEMS				
21	**Annual Equality Report 2022/23** *Claire Radley, Director for People & OD*	Approval	Yes	
22	**Health and Safety Executive – Letter of Contravention** *Claire Radley, Director for People & OD*	Information	Yes	
Close by 16:00				

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST DRAFT Minutes of the Board meeting held in public on 14 March 2024 13:45 in Sandford Education Centre, Cheltenham General Hospital		
Chair	Deborah Evans	Chair
Present	Helen Ainsbury	Interim Chief Digital Information Officer
	Vareta Bryan	Non-Executive Director
	John Cappock	Non-Executive Director
	Marie-Annick Gournet	Non-Executive Director
	Balvinder Heran	Non-Executive Director
	Karen Johnson	Director of Finance
	Kevin McNamara	Chief Executive Officer
	Jaki Meekings-Davis	Non-Executive Director
	Alison Moon	Non-Executive Director and Vice Chair
	Sally Moyle	Associate Non-Executive Director
	Mike Napier	Non-Executive Director
	Mark Pietroni	Medical Director and Director of Safety / Deputy Chief Executive Officer
	Ian Quinnell	Interim Director of Strategy and Transformation
	Al Sheward	Chief Operating Officer
Attending	Craig Bradley	Deputy Chief Nurse and Director of Infection Prevention and Control
	Sim Foreman	Interim Trust Secretary (minutes)
	Sam Foster	Incoming Non-Executive Director
	Katherine Holland	Head of Patient Experience (Item 7)
	Susan Hughes	Consultant Midwife (Item 7)
	Raj Kakar-Clayton	Non-Executive Director INSIGHT programme
	Steve Perkins	Director of Operational Finance (from Item 15)
	Debbie Tunnell	Deputy Director for People and Organisational Development
Observers	Three members of the public and two governors observed the meeting.	
Apologies	Matt Holdaway	Chief Nurse and Director of Quality
	Kaye Law-Fox	Gloucestershire Managed Services Chair / Associate Non-Executive Director
	Claire Radley	Director for People and Organisational Development

REF	ITEM
1	**CHAIR'S WELCOME AND INTRODUCTION**
	The Chair welcomed everyone, especially Sam Foster and Raj Kakar-Clayton and those observers in attendance. The Chair advised it was Alison Moon's last Board meeting and recorded thanks for the huge input and contribution from Alison over her six-year term and recognised her as a role model for non-executive directors.
2	**APOLOGIES FOR ABSENCE**
	Apologies were NOTED from Matt Holdaway, Claire Radley and Kaye Law-Fox.
3	**DECLARATIONS OF INTEREST**
	There were no declarations of interest.
4	**MINUTES OF PREVIOUS MEETING**
	RESOLVED: The minutes of the meeting held on 11 January 2023 were **APPROVED**.

5	**MATTERS ARISING**
	It was confirmed that a discussion on the Board Assurance Framework focused on discomfort related to the risk profile had been scheduled into the board strategy and development and it was AGREED to close the action. Feedback on the areas of focus for the refreshed Quality and Performance report could be provided until April 2024 and the action remained open. **RESOLVED:** The Board **NOTED** the update on matters arising and **APPROVED** the CLOSED items.
6	**PUBLIC QUESTIONS**
	Keith Smith of Bishops Cleeve had submitted three public questions and when available the response to these would be shared with the Board. **RESOLVED:** The Board **NOTED** the update and actions related to public questions.
7	**PATIENT STORY**
	Katherine Holland presented two patient stories of woman, Hollie and Beth, who had been in contact with Trust following the BBC Panorama programme as one of the women was unable to attend due to timings and the other did not want to attend. The Board heard both of their stories from 2022 and Susan Hughes provided the response from the service as to how these were dealt and subsequent learning and actions. The Board heard the services was focused on listening and responding to feedback, specifically in relation to induction of labour and delays to discharge, and agreed it was helpful to understand this engagement. Discussion took place on how feedback from teams and ideas were acted upon and implemented and it was confirmed this was taking place. The example of staff breaks was provided and these were being audited to ensure they happened. Craig Bradley stated he was saddened that the experience had led one of the women to not. want to have more children as a result of her experience, but reinforced that changes within the maternity service were happening and there was a real willingness within the service to listen and make changes. Alison Moon endorsed and supported the use of real time feedback, to effect those instant changes and those that do not require investment, but recognising the size of the Maternity Unit (34-36 beds) questioned whether it was the right model over the longer term. **RESOLVED:** The Board **NOTED** the two maternity patient stories as presented by Katherine Holland and requested thanks be passed on to the women who shared them.
8	**CHIEF EXECUTIVE OFFICER'S REPORT**
	Kevin McNamara highlighted the following matters and updates from his report: • **Maternity** - It was confirmed that the Board had held a development session earlier in the day to focus on the Panorama programme and maternity. The Board heard that the national experts in maternal and neonatal deaths at Oxford University (MBRRACE) and the Local Maternity and Neonatal System, had issued a statement setting out the way data should be used appropriately such as benchmarking and that the Trust data did not show it being out of line with the national average and not statistically significantly different from the UK rate. The Trust had committed to undertake a review of all neonatal and maternal deaths over the past five years and terms of reference were finalised for this work led by the Chief Nurse and Director of Midwifery. Stroud Maternity unit had been subject to inspection in December 2023 and the report was expected in the next week. • **Staff Survey** - The Trust must be one of most highly ranked in country with a 68% response rate, especially as Kevin's former organisation, Great Western Hospital in Swindon was second with 69%. • **Annual Plan** – This has been discussed and approved in an earlier confidential Board meeting.

	• **Reducing waiting times Emergency Department** – On 1 March 2024 all trusts were given 12 hours of notice of a directive to achieve 76% performance throughout the month. Work related to this was focused on validation of data related to minor breaches and working to stream non-urgent activity away from Emergency Department into other services. The importance of flow in achieving this was highlighted and the Board heard that the national discharge lead was due to visit the Trust). • **Service developments** – The new £15m Community Diagnostic Centre had opened at Gloucester Quays following impressive teamwork, whilst on the hospital sites, the cardiac catheter laboratories had moved into the new Image Guided Interventional Surgery (IGIS) Hub Gloucestershire Royal Hospital, with a third laboratory going live in the Autumn. • **NHS Oversight Framework** – Quarter 3 position confirmed the Trust remained in Segment 3 as per the letter appended to the report. The reasons for this were explained and highlighted the need for complex further conversations on mortality and the Standardised Hospital Mortality Index (SHMI). This would be added to the Board forward planner. **ACTION (SF).** **RESOLVED:** The Board **NOTED** the report.
9	**BOARD ASSURANCE FRAMEWORK (BAF)**
	RESOLVED: The Board **NOTED** the Board Assurance Framework.
10	**TRUST RISK REGISTER (TRR)**
	Mark Pietroni presented the Trust Risk Register included three new risks; two related to workforce and one related to mortality (Fractured Neck of Femur). This mortality risk had been tracked closely in quarter one and although Fractured Neck of Femur was back within the expected range, the Risk Management Group felt that further work was required which warranted its promotion to the Trust Risk Register. The Risk Management Strategy had also been approved but performance had been mixed in relation to the transfer from Datix to Datix Cloud The Chair queried the time lag on the Fractured Neck of Femur being added to the Trust Risk Register so late in the process, especially when the papers confirmed patients to theatre in 36 hours was almost 100% and therefore challenged if this risk would be subject to early review. This was supported by Alison Moon who confirmed the Quality and Performance Committee had been assured on this and noted performance had almost returned to pre-pandemic levels. Mark Pietroni would provide the Board's feedback to the Risk Management Group. In relation to workforce risks, discussion took place on whether staff inclusion felt any different especially for Black and Minority Ethnic (BME) and staff with protected characteristics. It was explained that the staff networks had chairs in place and they were being provided with time to do the role alongside their jobs. Although there had been challenges in getting people to come forward (and be released), they would be supported so they stay and ongoing checks to manage the risk. The scoring on the physical and psychological harm risk was queried and challenged whether the consequence should be higher than 3 due to the potential of harm from knives and needles. On a related point, an update on the proposed security consultant was requested. Ian Quinnell confirmed the Trust was awaiting Gloucestershire Managed Service (GMS) to respond to the security proposals. GMS recognised it was not a specialist in this field and had used a security consultant with experience of working with London trusts to identify and review hotspots and options. There was discussion on whether available key controls were being used in the right way and noted that there were some historic incidences where staff had not been supported and had pursued their own legal actions for redress. Security had been an area of focus within the Care Quality Commission inspection of the Emergency Department

	and referenced the use of body cameras etc. The Board NOTED there was lots to do to make places feel safer and there was an openness to ideas in which to do this. Jaki Meekings Davis referred to the closed risks related to ineffective care and prolonged care for children and having visited that department was aware these were system risk, rather than Trust risks. Assurance was sought that these (and other) risks were raised with the Integrated Cre Board and an action was agreed to check the Trust Risk Register against the Integrated Care Board's risk register. **ACTION (MP).** **RESOLVED:** The Board **NOTED** and **RECEIVED** the Trust Risk Register.
AUDIT AND ASSURANCE	
11	**COMMITTEE (AAC) REPORT**
	John Cappock reported from the meeting held on 29 February 2024 and confirmed there were no RED items. AMBER items were justified with reasons and supporting evidence and GREEN items were NOTED. Once again, the Committee had received high quality papers, circulated in good time and noted demonstrable progress on follow up actions. Audits had been focused on non-traditional areas such as Mental Health Act and organisational readiness (culture). There were some long standing actions related to internal audit that were being followed up for closure to avoid a negative impact on the Head of Internal Audit opinion and it was reported collegiate work was underway with the external auditors in respect of the financial year-end and planned audit programme. **RESOLVED:** The Board **NOTED** the Audit and Assurance Committee report.
PEOPLE AND ORGANISATIONAL DEVELOPMENT	
12	**PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE (PODC) REPORT**
	Balvinder Heran presented the report from the meeting held on 25 January 2024 advising that good, timely papers had delivered focused outcomes. There were two RED rated items, not due to any lack of progress, but due to their importance. These were time to hire which was being reduced, and progress on agency posts. AMBER items related to culture and workforce sustainability (linked to reduction in time to hire) and the Committee had been assured on continued focus on these by the team prevented then being escalated to RED. Kevin McNamara confirmed that executives would be discussing what it would take to firmly reduce time to hire from the 49 days and scrutinise those hard to recruit and high-risk roles that night require a more bespoke approach. Al Sheward echoed this and flagged that whilst time to hire could be rated GREEN, there was a link to locum and agency spend which was huge. Discussion took place on differentiating those roles that been vacant over three months and/or where recruitment processes had been run twice and it was agreed the executive would provide an update to the next committee meeting. **RESOLVED:** The Board **RECEIVED** the update from the People and OD Committee.
13	**STAFF SURVEY RESULTS 2023**
	Debbie Tunnell presented a high level of the staff survey results for 2023 and reminded that initial results had been embargoed until the data for all 122 trusts was published. It was confirmed that the Board had received the initial results presented at the confidential session in January 2023 which showed performance compared to 66 trusts using Picker as the survey provider. Key areas of the results were highlighted as follows: • 68% response rate increased from 50% last time reflects significant work in the Trust to achieve this through giving staff time and space to complete the survey. The response rate also demonstrates an increased confidence from staff that the Trust will listen to what they say. The score showed great progress compared to others. • 87 questions linked to the People Promise (15 duplicated across themes). • National issues on the Health and Safety pillar were revisited.

- Staff engagement and morale results suggest movement in the right direction but still a way to go.
- Statistically significant improvements in 57/87 questions.
- Some modest deteriorations had occurred but the team were not taking the foot off the pedal and expected to see progress in future staff survey or the pulse surveys between full surveys.
- The Trust was 12th most improved in the country (12/66) and in the top 20% overall.
- Net Promoter questions focused on 25 questions related to recommending the Trust as a place to work / place for treatment had improved in line with national trends and made significant improvement.

The Board discussed what is meant in relation to "So what" and "and" challenges and noted three key workstreams had been identified as priorities. The increased percentage scores were welcomed however the gap compared to national average had remained the same and the question was posed on how the Trust could reach or exceed this. In response it was acknowledged and recognised that there was still a long way to go and the team needed to unpick the findings from the data to understand the "what and where" staff elements and triangulate it against other people metrics. Debbie Tunnell reinforced the key positive message from the results was that staff were confident to respond as they believed the organisation was listening. Discussion took place on how the results might impact on workforce and how the Board could receive assurance on this, especially when it felt like the work was not central to everyone's agendas. This was acknowledged as a valid point and it was challenging to balance operational delivery, finances and workforce issues but the executive would maintain focus and tension to improve. Kevin McNamara added that the survey had taken place at a time when car parking arrangements had changed and became an issue for a number of staff, however the Trust needed to move past gimmicks to ensure real change on the ground to build trust and support well-being initiatives. It was explained that it would not be possible to break even if the Trust did everything to resolve issues coming from the survey that had arisen, but there were real opportunities to make this "everyone's responsibility" rather than "someone else's responsibility". This would be achieved by getting out and meeting with people.

The Chair raised points that supported the previous points and queried whether the free text comments had been able to identify themes in the way the 2022 results had done and asked what was the Trust's manifesto – standards to achieve and commit to deliver for colleagues for this. It had previously been stated that the Trust would work with all teams on culture over three years, but it seemed to be suggesting his was now going to take longer. Executives confirmed that wave one of this work was in train and reaffirmed that three-year programme still stood and all teams would go through the initiative in waves.

Mark Pietroni noted that it was positive to improve on 2022 results but the Trust was some distance from the 2020 position and shared a view that this was in part related to the flow through the hospitals and improving and facilitating discharges would have a greater impact than a Human Resources led initiative alone. The link between happy staff and improved performance was noted and prompted a question on whether the right offer was being promoted which linked into discussions that were taking place with leaders across the Trust. The Board would receive the plans to address the issues raised from the staff survey results through the coming year.

RESOLVED: The Board **ACCEPTED** the published NHS Staff Survey results and associated plans for delivery and monitoring of improvements through stated governance processes.

14	**GENDER PAY GAP REPORT**
	Debbie Tunnell reported that overall, there were no specific issues of concern, but the extrapolation of Medical Director data had shown whilst no issues linked to terms and conditions existed, the senior higher paid roles were often male dominated. There could more attention given to Clinical Excellent Awards for more females. An equality, diversity and inclusion action plan was in place to monitor progress. Discussion took place on whether issues were generational and any plans to change the awards and it was confirmed that over 50% of the current medical school students were female but there would be a time lag (30-40 years) for them to filter through into the senior roles. It was explained that there had been no competitive awards for three years and instead these had gone to clinicians equally. Women were less likely to apply but if they did there was no difference in the decision to award. The Trust would pay a bronze, silver or gold award to the clinician and seek reimbursement for the cost. However, it was explained that the awards were due to be abolished to fund the consultant pay awards. **RESOLVED:** The Board **NOTED** 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. *Break from 15:03 until 15:20 when Karen Johnson left and was replaced by Steve Perkins.*
QUALITY AND PERFORMANCE	
15	**QUALITY AND PERFORMANCE COMMITTEE (QPC) REPORT**
	Alison Moon presented reports from the January and February meetings. There had been significant focus on paediatrics in January with a follow up coming to the March meeting (not February as stated in report). Maternity discussions had been covered at board level through board development earlier in the day but the Committee had looked at data issues from December 2023 and been assured they were areas of high focus. There were no RED items from an assurance basis. Water safety was an area of focus across the Group (Trust and Gloucestershire Managed Services) with lots of work underway and the Committee had welcomed the external resource to bring cohesion towards water safety, as well as the input from Craig Bradley, as the Director of Infection Prevention and Control (DIPC) and his team. Craig had also provided an update on cleaning standards in his capacity as the DIPC. The PACS clinical systems backlog was resolving and normal service when the PACS upgrade was completed. Helen Ainsbury added harm reviews would still happen once business as usual was in place. Helen also flagged a live update on PACS downtime earlier in the day, following a stable phase. The team were looking differently at the management of the issue from last time and had introduced live testing. Nothing had been cancelled and although there had been 100% capacity for some time, it was disappointing have instability. In response to a query on the impact of backlogs, it was confirmed that the Trust was exceeding a number of targets but this could drop as performance moved back closer to the planned target, and although radiology backlog increased, this was managed through increased outsourcing. Venous thromboembolism (VTE) assessments now 'mandatory and improvements expected in reporting. There was an emerging issue related to the reaccreditation of the endoscopy service with an update on this planned for the March meeting. Fractured Neck of Femur was rated GREEN by the Committee and the Committee had received assurance from a good presentation by the Divisional Leadership Team. **RESOLVED:** The Board **RECEIVED** the Quality and Performance Committee report for assurance.

16	**QUALITY AND PERFORMANCE REPORT**
	Al Sheward presented the report and focused on three key areas. **Diagnostic waiting times (DM01)** • These were challenged but the Trust remained well positioned in the region. • Key challenges related to endoscopy and lower gastro intestinal (GI) and it was confirmed a recovery plan was in place. • Surveillance patients had been added back into lists leading to a performance dip and national advice had been requested. **Cancer** • 91 patients waiting over 104 days (60 of these were in urology) and • 62-day performance was 57% (with most of the breaches occurring in Lower GI and Urology) and this was likely to get worse before it got better as the Trust was about to clear some long waiters. • Insourcing weekend lists would continue until March 2024 and would clear 100 patients • 28-day faster diagnosis data showed more patients being seen and diagnosed more quickly. **Referral To Treatment (RTT)** • 104-weeks - There were no breaches. • 78-weeks – Six breaches were declared in February 2024 (down from 14 in December 2023) and the target was to reach zero. It was explained that many of the last few breaches related to patients having procedures elsewhere such as Bath. • Posts were vacant despite three rounds of recruitment. • 65-weeks – 200 patients to clear by the end of March but it was still likely to have some waiting for Lower GI and urology with the aim to have all cleared by September 2024. The Trust was ranked first in the region for the fewest patients waiting over 65-weeks with some having over 2000. • During financial year 204/25 the Trust aims to clear all 52-week patients by 31 March 2025. Balvinder Heran asked how indicators without a target were assessed and measured and it was explained that greyed out indicators did not have national targets, but these might be set locally and data may not be available during this reporting period. Al Sheward was looking reporting periods over the year and would link this into the work to develop the integrated performance report. Kevin McNamara flagged the missing commentary missing from some sections of the report e.g. the specialty information related to Emergency Department performance would be addressed next time. **RESOLVED:** The Board **NOTED** the Quality and Performance Report and update from the executive triumvirate.
17	**LEARNING FROM DEATHS**
	Mark Pietroni presented the report which had been considered in detail by the Quality and Performance Committee and advised the number of appendices provided had been reduced for the Board meeting held in public. The report included patient family feedback and LeDeR[1] reviews. It was confirmed that the Standard Hospital Mortality Index (SHMI) had decreased and was now within the expected range overall, but the range for patients admitted at weekends remained outside of the expected range and the Trust was looking at the main drivers for this in conjunction with the Gloucestershire system mortality group.

[1] LeDeR is a service improvement programme for people with a learning disability and autistic people.

	The time delay for patients with Fractured Neck of Femur (FNOF) had shown an encouraging return to national averages. Discussion took place on whether the decrease in diagnosis of dementia was a county or national issue and whether it was a temporary or systemic concern and in response it was confirmed that it was a temporary issue affecting a number of trusts. The Trust was co-operating with hospitals with a lower SHMI (including the Bristol Royal Infirmary and Royal United Hospital in Bath) and this had identified similar data issues related to coding, primarily in primary care where most dementia diagnoses occurred. The Trust would continue to challenge and question the data. Further questions related to why the Trust appeared to be more affected than others and the NHS England Oversight Framework focus on this suggested more work was needed to provide assurance to the Board. **ACTION (MP).** Mark Pietroni noted the request and advised three main areas would be data, Fractured Neck of Femur and excess mortality arising from delays in the Emergency Department and long lengths of stay in hospital. It was also confirmed that delays in Structured Judgement Reviews **RESOLVED:** The Board **NOTED** the Learning From Deaths report for assurance.
FINANCE AND RESOURCES	
18	**FINANCE AND RESOURCES COMMITTEE REPORT**
	Jaki Meekings Davis presented the reports from both January and February meetings. The capital programme had been rated RED in January but reduced to AMBER in February following confirmation of additional resources to International Financial Reporting System (IFRS) accounting standard 16 risks. The new finance system approval had moved to the next stage of the process with a report due at the March 2024 meeting to update on the latest position. A review of Gloucestershire Managed Service (GMS) service and contract management, including governance arrangements, was taking place led by Tracy Cotterill and initial findings would be presented to the March 2024 meeting. The February meeting had also focused on the delivering the 2023/24 plan on target. In addition, the capital plan for 2024/25 had been rated AMBER despite a higher allocation for backlog maintenance, there would still be a high number of unfunded schemes and work continued to reduce to deficit. Jaki Meekings Davis also flagged new Cabinet Office spend controls which introduced additional processes to protect organisations, but could impact on Standing Orders and Standing Financial Instructions and the general resources to deliver this needed reviewing. The risk related to the potential delay to spending plans as result of the additional planning and checks. The Digital Transformation report had shown remarkable progress against the Healthcare Information and Management Systems Society (HIMSS) measure of digital maturity over the past five years from Level 0.2 to Level 6. **RESOLVED:** The Board **RECEIVED** the update from the Finance and Resources Committee
19	**FINANCIAL PERFORMANCE REPORT (MONTH 10)**
	Steve Perkins confirmed the Trust continued to monitor IFRS16 issues and presented the report for Month 10. The Gloucestershire Integrated Care System had a deficit of £700k which included the Trust deficit position of £3.3m. The Trust's position was improved on what had originally been agreed for the second half of the year (H2) and was due to best case scenarios being realised and income adjustments. The Board heard this would be a further presentational change following the Integrated Care System risk share agreement to mitigate external factors being applied and linked to prepare for financial year-end close down. The Month 10 capital position was £48m year to date which was £7m adrift from plan. The Trust had been informed of the need to absorb IFRS 16 costs but it had been confirmed that

	the matter would now be addressed centrally by NHS England in February 2024. 2024/25 expenditure was being brought forward where possible to achieve balance and use all capital resource. The next report would reflect and incorporate feedback from board members on strengthening reporting and assurance. **RESOLVED:** The Board **RECEIVED** the contents of the Financial Performance Report at Month 10 as a source of assurance that the financial position was understood.
STANDING ITEMS	
20	**ANY OTHER BUSINESS**
	There were no items of any other business.
21	**GOVERNOR OBSERVATIONS**
	Observations and comments from Mike Ellis (Public Governor – Cheltenham) and Maggie Powell (Appointed Governor – Healthwatch Gloucestershire) included echoing thanks from Governors to Alison Moon for her work and welcoming the listening and communications that were referenced in the patients' stories and this had been evidenced first hand on a governor and non-executive visit to the maternity department. Staff survey improvements were welcomed but the Trust was still some way from other organisations. Questions related to urology and cancer would be submitted via the governors' log.
22	**DATE AND TIME OF NEXT MEETING**
	The next meeting will be held at 13:00 on Thursday 9 May 2024 at 13:00 in Room 3 Sandford Education Centre, Cheltenham General Hospital.
Close 16:03	

MATTERS ARISING (MAIN BOARD)

ACTIONS/DECISIONS			
Item	**Action**	**Owner / Due Date**	**Update**
January 2024			
12. Quality and Performance Report	Board members provide feedback on areas of focus for refreshed Quality and Performance Report	All / Apr 2024	Papers include new Integrated Performance Report to supplement Quality and Performance Report **CLOSED.**
March 2024			
8. Chief Executive's Report	Item on mortality and the Standardised Hospital Mortality Index (SHMI) to be added to Board forward planner.	Sim Foreman / May 2024	Board development session in May 2024. **CLOSED**
10. Trust Risk Register	Check and cross reference the Trust Risk Register against the Integrate Care Board's risk register.	Mark Pietroni / May 2024	ICB contacted and discussion in progress. **OPEN**
17. Quality and Performance Report	Provide more assurance to the Board on why the Trust was more affected than others on by dementia coding data issues.	Mark Pietroni / May 2024	Board development session in May 2024. **CLOSED**

Chief Executive Report to the Board of Directors - May 2024

1. People and Culture

1.1 Prime Minister visits Cheltenham

On Thursday 14 March 2024, The Prime Minister, Rishi Sunak, and the Lord Chancellor and Secretary of State for Justice, Alex Chalk, visited Cheltenham General Hospital's Chedworth Surgical Unit and the two new theatres that opened that week.

They toured of the new facilities and took the opportunity to meet staff and patients, and listened to how the dedicated units would help improve the quality of care.

The two new theatres (theatre 7 and 8) opened on Monday 11 March and combined with Chedworth Surgical Unit means that the Cheltenham Hospital now benefits from new and dedicated day surgery facilities. The new theatres will be used for urology, GI and orthopaedic surgery bringing the total number of theatres on the Cheltenham site to 14. They adjoin a modern state-of-the-art day surgery unit, Chedworth Surgical Suite, Combined these will help us treat up to 1,600 more day-surgery patients per year.

1.2 Princess Royal Visit

On 22 March 2024, HRH The Princess Royal visited the Stroud Maternity Unit at Stroud Hospital. The visit was organised by Stroud Hospitals League of Friends, for which HRH is a Patron, and she spent time getting a tour of the unit and meeting mothers, babies and staff who benefit from the League's support.

The League of Friends has been a supporter of Stroud Maternity for decades, funding refurbishment projects and additional equipment. More recently, from 2017, the League support has extended to free singing and yoga for mothers and babies at the Hospital and more recently other groups have been initiated to give practical and emotional support, as well as companionship to new mothers.

1.3 Richard Graham Visit

On 9 April 2024 Richard Graham, MP for Gloucester, visited Maternity Services at GRH and met staff and families. This was in part on the back of the Panorama documentary and during the visit, he toured the facilities, meeting colleagues in Triage, Delivery Suite, Birth Unit, Maternity Ward, Neonatal Unit and taking time to learn more about ongoing service developments.

1.4 Health Care Support Workers re-banding

As part of ongoing discussions nationally, and representations from UNISON, NHS England has set out national guidance to Trusts to ensure the banding of Health Care Support Workers (HCSWs) aligns with the work undertaken and the Trust recognises that many of our Band 2 HCSWs have been carrying out work and task at a Band 3 level.

The Trust support that colleagues should be paid fairly and in line with evolving job evaluation criteria for the work undertaken. As a result, we have been working with our Trade Unions to develop a proposed re-banding offer and there is an agreement in principle with most of our recognised unions, however UNISON will ballot their members on the offer.

The proposed changes will apply to eligible Band 2 HCSWs, irrespective of any union membership status.

The Trust has written to all individuals affected and also recognise that other staff groups at Band 2 in our hospitals have raised questions if their roles are being looked at nationally or locally. We continue to work with our Staff Side partners to support all staff.

1.5 Body Warn Cameras

On 10 April the Trust introduced a 12-week trial for using body warn cameras in our Emergency Department (ED) in Gloucestershire Royal Hospital, with the aim to increase security and safety for patients, staff and the public.

The trial has been initiated in response to increasing incidents of abuse and aggression both within ED and across our hospitals more widely. This forms part of our commitment to the health, safety and welfare of our staff, patients and visitors, which the Trust takes very seriously. We are taking this step to support the de-escalation of incidents and support action that is taken following safety incidents in terms of identifying and prosecuting any offenders.

The cameras will be worn by key staff in ED and also by the GRH security response team and would be activated during an incident of abuse, violence, aggression or security risk. Individuals who are being aggressive or violent will be informed that the camera is recording and the body cameras will not be switched on during normal clinical activities.

There are stringent controls in place for the trial, where only our Risk, Health & Safety team can access any footage captured. All aspects of the trial will be compliant with Data Protection Impact Assessment (DPIA) requirements. Notices will be displayed in ED to confirm body worn cameras are present and may be in use during an adverse event. An evaluation will take place at the end of the trial.

We know there is more we can do to ensure everyone feels safe at work and a review is currently underway using an external provider to help us understand what actions we should be taking.

1.6 Sexual Safety Charter

There has been national focus on safety in the workplace, including sexual safety, and in September 2023 the Royal College of Surgeons produced a report that showed the shocking level of abuse and harassment many staff were experiencing.

The Trust has set out its commitment to sign up to the Sexual Safety Charter by the end of May 2024 and are working with staff and partners to ensure the principles of the charter are achievable and, if not, how to make them achievable.

We have established a Sexual Safety working group and their work in aligned to the Safe Learning Environment Charter (SLEC) we will also be signing up to. A Sexual Safety Policy is also currently being developed and will be going through all the relevant governance routes shortly.

We will be engaging with staff, through Schwartz rounds and other routes, so that staff can be involved on both charters, and also understand the results of the Staff Survey and NETS. We are extremely grateful to individuals who have given feedback about their personal experiences and we are clear what more we must and should do to ensure no one is subject to any form of sexual harassment or violence.

1.7 'Go and See' Service Visits

Since the beginning of March, I have visited almost 30 wards and services across both hospitals and continue to be impressed with the pride teams have in the care they provide for our patients, and the honesty in sharing where things need to be improved. I am grateful for colleagues who have been able to take time to walk myself and others through their service area, discussing their experiences, their patient journey and what they may need in driving forward any further changes.

Over the last eight weeks I have spent time with our Allied Health Professional Services, visited ED in Cheltenham, walked around the new Chedworth Suite and Theatres, met with the SACT Team who had relocated to Avening Ward (which had been their eighth move in just over three years). I have also met staff across Tivoli, Bibury, Snowshill and Dixton Wards and spent time on the Critical Care Units at both hosptials. In addition, I spent time with surgery and medicine leadership, visiting every ward from 2a to 5b, theatres on both sites, Oncology, Radiology, Pathology, Outpatients and our Mortuary Teams.

These visits are absolutely essential in being able to learn and listen to staff, what matters to them and what they are doing to care for our patients, and I look forward to more visits over the next few weeks.

2. Operational context

2.1 Performance

The Integrated Flow Hub has improved patients' experiences since it launched in February. An integrated, multi-disciplinary and co-located trial Hub including Community, Social Care, Virtual Wards and System Partners was set up to support patient flow from Gloucestershire's acute hospitals.

It has improved patients' experiences based on the initial two aims:

- Ensuring Patients don't spend any longer in hospital than needed
- Ensuring Patients get their most independent outcomes

We will continue to monitor the success of the Integrated Flow up and the positive impact it is having.

The Trust has also been working closely as a system with partners from Newton Europe to help improve our flow position and 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.

We have reduced No Criteria To Reside (NCTR) patient numbers from a high of 216 on 4 January 2024 to 151 on 25 February, although we have risen slightly to 171 on 12 April. We know there is a correlation between lower No Criteria To Reside and better flow and reduced delays for patients.

Four-hour performance across the Trust improved by 2% to 58% compared to February's position. The UEC team have also completed validation of all four hours breaches on a daily basis and are implementing live validation in April.

Handover delays deteriorated very marginally in March and April, from 66 mins to 79 mins. Dialogue with SWAST in place to address anomalies with XCAD system underway

The number of patients waiting more than 78 weeks at the end of March was five patients, which consisted of two Oral Surgery; one Cardiology; one Surgical Endoscopy and one Upper GI. The Trust has a focus on predicting patients who may get to 78 weeks and combined with the review of patients at 65 weeks, will drive fewer patients getting to 78 weeks.

Cancer performance against the 28-day faster diagnosis target has started to improve with 75% of people in March receiving a diagnosis or all clear following a suspected cancer referral against the 75% target. In order to maintain this standard of 75% and achieve the new target of 77% Faster Diagnosis Standard (FDS), some planned actions include: a new escalation policy to support earlier identification of bottlenecks and concerns; Review of 2WW booking date and aim to bring this in line with seven days or less.

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.

2.2 The Perfect 12 days of Spring

Between 15–26 April, clinical teams audited and tested several initiatives to help improve flow across the system, which was called The Perfect 12 days of Spring.

The 12 Days is part of our work on developing the clinical vision of flow. It was to create space and capacity to see the patients who need us in the *right place first time*, and reduce ambulance waits, eliminate crowding in the Emergency Departments and SDECs, stop boarding and improve the overall experience and outcomes for our patients and staff.

Despite seeing significant pressure during the fortnight, front line staff were directly involved and able to influence how the initiatives ran and assess whether they improve patient flow. Throughout the 12 Days were daily huddles in the Incident Control Room (ICC) at GRH setting out the actions at the beginning of the day and review progress.

Clinical teams were supported by Business Intelligence (BI), Quality Improvement (QI) and the Strategy and Transformation teams, and daily communications with lessons learned and progress were shared with all staff. Focus on Frailty initiatives allowed record numbers of discharges to be realised across the period. Surgery established the Head & Neck Assessment facility meaning patients we seen more quickly by the specialty and spent less time in ED.

Initiatives tested included The Model Ward and the Integrated Flow Hub, protected AMU beds and launch of the new single discharge form. In addition, as part of the Clinical Vision of Flow (CVoF) Programme, four clinically-led workstreams were established: Emergency Departments; Assessment and Short Stay; General/ Specialty; and Frailty.

Over the next six months, these workstreams will be working to improve flow, supported by staff from across the Trust.

2.3 Industrial Action – British Medical Association (BMA) Pay Offer

The BMA's consultants committee has accepted the Government's offer on pay for consultants in England and reform to the pay review body, the DDRB. This brings to an end the current dispute with the Government that has continued for over a year, during which consultants have taken unprecedented industrial action.

The deal represents an improvement on a previous offer that was rejected by consultants in January and follows intensive negotiations between the BMA and the Government since then.

However, presently no resolution has been agreed between Junior Doctors and the Government and Junior Doctors have balloted in favour for more industrial action, extending the existing mandate into the autumn. No new dates for industrial action have been announced at this stage, but these are expected shortly.

In addition, NHS England has written to all NHS organisations setting out how it expects them to help in '*Improving the working lives of doctors in training*'. The aim is to ensure doctors are valued and involved in decisions that impact on them and their families, some of which has been exacerbated by the cost-of-living crisis. NHS England have outlined the need for better rota management and deployment and a focus on reducing duplicative inductions and pay errors by streamlining and improve the quality of HR support.

3. Quality & performance

3.1 Young Influencers

In January 2024, the Trust undertook a review of our Young Influencer Group, with the aim of better realigning the work of programme to the Engagement and Involvement Strategy 2020-2024.

The Communications and Engagement Team met with a number of external organisations who also lead on similar projects, and held a focus group with young people to establish the new direction for our Young Influencers.

The Trust has recently recruited more members and currently have seventeen Young Influencers from a range of local communities. They have been meeting monthly with the aim of:

- improving quality of care and services
- improving patient safety
- improving patient experiences
- shaping services around what matter most to young people

In April 2024 the Young Influencers carried out the NHS 15 Step Challenge in Children's ED and have provided meaningful feedback, which is currently being pulled together to present to the department and Patient Experience team. They made some excellent observations and recommendations, including the lack of wheelchair spaces in the waiting room, and an idea to use country flags on name tags to identify if a member of staff can speak another language.

The group is currently working together to produce an information and wellbeing leaflet aimed at young people accessing the Children's ED and will update the Council of Governors in June.

4. Strategy

4.1 Patient Engagement Portal

The Trust launched a Patient Engagement Portal (PEP) in April, which, over the next two years, will improve how we communicate with our patients. The purpose of a 'PEP' is to enable direct communication with patients, through the NHS App, and help patients access more of their hospital information and improving accessibility to services.

Similar programmes have been implemented across most Trust and it is expected that the new portal will free up some clinical and operational time, as patients will be able to accept of decline appointments in real time.

The Trust has partnered with DrDoctor to provide our portal, where patients will be able to view their letters, manage their appointments, complete clinical assessments and establish a means of communication with our outpatient services.

It is expected that the full functionality will be phased in over the next two years, and in the initial phase, patients will be able to view their outpatient appointment letters digitally, via an SMS link and also be able to view their upcoming appointments.

Patients will also receive reminders on SMS of when their appointment is approaching to reduce Did Not Attends (DNAs) across our services.

4.2 Aquablation robotic technology

The Trust has treated its first patients using a new robotic procedure, designed to improve the outcomes of individuals with an enlarged prostate.

Aquablation therapy, designed to treat benign prostatic hyperplasia (BPH), is a robotically-assisted water-jet treatment which involves injecting a high-speed jet of water into the prostate to precisely destroy some of the prostate tissue and widen the urethra.

Living with an enlarged prostate can have a detrimental impact on a person's quality-of-life, including difficulty passing urine, a frequent need to urinate and difficulty fully emptying their bladder. If left untreated, it can lead to more severe symptoms such as acute urinary retention and infections.

The private provider suppling the equipment, Procept Bio-robotics, say it is the first and only image-guided robotically-assisted therapy for the treatment of BPH. The new equipment forms part of the Trust's wider centres of excellence vision. Patients will receive pre as well as post-operative care at the new Chedworth Surgical Unit.

The urology team treated the Trust's first day case patient on Thursday 18 April at Cheltenham General Hospital using the state-of-the-art equipment and the plan is to scale up the caseload over two years.

5 Regulators

5.1 CQC Report - Stroud Maternity Unit

On 20 March the Care Quality Commission's (CQC) published its report following their Inspection in December 2023 of Stroud Maternity Unit (SMU), which resulted in a rating of 'Requires Improvement.' The full report can be viewed on the CQC's website.

The CQC inspected the maternity service at Stroud as part of their national maternity inspection programme. Stroud Maternity Unit (SMU) includes a birth centre, antenatal clinic, and conservatory area where additional support services were provided. The focused inspection of the maternity service examined only at the safe and well-led domains within the regulator's framework.

Stroud was previously inspected under the maternity and gynaecology framework in 2015, however this was changed in 2018 and as a result the historical rating and inspection is not comparable. This means that the resulting rating for Safe and Well-led from this inspection will be the first rating of maternity services for the location and does not affect the overall Trust level rating.

The CQC rated Stroud Maternity Unit as requires improvement because:

- Compliance for safeguarding training was low, staff did not always ensure equipment was safe and ready for use and medicine management was poor;
- Staff did not always complete risk assessments or follow policy to ensure women and birthing people were suitable for care and birth, and documentation was not always contemporaneous;
- There was ineffective governance process and oversight, and leaders did not always manage risk and manage safety incidents well;
- Leaders did not always use reliable information to evaluate and run the service;
- There was limited engagement with the team and community to review and develop the model of care and services provided.

However, the CQC noted that:

- Staff had training in key skills and controlled infection risk well;
- The team at Stroud Maternity Unit worked well together for the benefit of women and birthing people and were passionate about the philosophy of the unit.

Following the CQC inspection, the team have strengthened processes around medicines and the checking of equipment. They have also ensured that routine data collection is in place for the 36-week place of birth assessment, helping mums to be guided to the best place of care for them and their baby.

The Trust expects the CQC to re-inspect the service in the near future and will be working with colleagues and partners to obtain an improved overall rating.

5.2 Gloucestershire Maternity Inspection

The CQC also visited Maternity at GRH to carry out inspection on 26 March 2024 and the assessment of our service included the following CQC quality statements:

Safe

- Learning culture
- Safe and effective staffing
- Medicines optimisation

Well led

- Freedom to speak up
- Governance, management, and sustainability

The initial feedback was that there were no immediate safety concerns. Some areas of good practice were identified and some areas for improvement. The CQC interviewed key leaders and made 57 data requests following the inspection. The inspection report is due later in May 2024.

5.3 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.

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 and after the birth of their baby

The full results for England are available on the CQC website.

5.4 Care Quality Commission ICS Reviews on Hold

The Care Quality Commission's (CQC) assessments of integrated care systems has been put on hold, as the government paused the final approval to review some key elements.

They were due to begin in April 2024, following pilots in Birmingham and Solihull and Dorset ICSs, and the CQC has suspended planned assessments until it receives government approval.

Under the legislation brought in when ICSs were set up in 2022, the CQC can review and assess systems, but ministers must approve its methodology. The CQC has written to all ICB Boards to confirm that there is a short delay to the introduction of the new reviews to allow for further refinements to the approach.

5.5 Tobacco and Vapes Bill

The government have set out their new Tobacco and Vapes Bill, with the aim of making the UK smokefree. The bill will mean anyone turning 15 from 2024, or younger, will be banned from buying cigarettes, and aims to make vapes less appealing to children.

Although the legislation will not ban smoking outright, it will make it illegal to sell tobacco products to anyone born after 1 January 2009, meaning the legal age someone can purchase tobacco will rise by one year every year, with the aim of stopping young people from ever taking up smoking.

Richard Graham, MP for Gloucester has written to both Trusts outlining his support for the new legislation and the impact it will have on NHS services and local communities into the future.

Kevin McNamara
Chief Executive

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	Apr 2024	Apr 2024	CNO/MD/COO	QPC	3x3=9	N/A	5x5=25
SR2	Failure to implement the quality governance framework	Dec 2022	Apr 2024	Apr 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. **(Culture and Retention)**	Feb 2024	Feb 2024	Mar 2024	DFP	PODC	3x4=12	N/A	5x4=20
SR17	Inability to attract a skilful, compassionate workforce that is representative of the communities we serve **(Recruitment and attraction)**	May 2024	Mar 2024	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	Apr 2024	Apr 2024	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	Apr 2024	Apr 2024	COO/DST	QPC	2x3=6	N/A	4x3=12
5.	**Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services**								
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	Apr 2024	Apr 2024	DOF	FRC	2x4 = 8	4x4=16	5 x 1 = 5
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	July 2019	Apr 2024	Apr 2024	DST	FRC	4x4=16	N/A	4x4=16

Board Assurance Framework Summary

	sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.								
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Dec 2022	Apr 2024	Apr 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	Apr 2024	Apr 2024	CDIO	FRC	5x3=15	N/A	5x4=20
SR13	Inability to maximise digital systems functionality	Dec 2022	Apr 2024	Apr 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	Apr 2024	Feb 2024	MD	CIRG	2x3=6	N/A	3x4=12

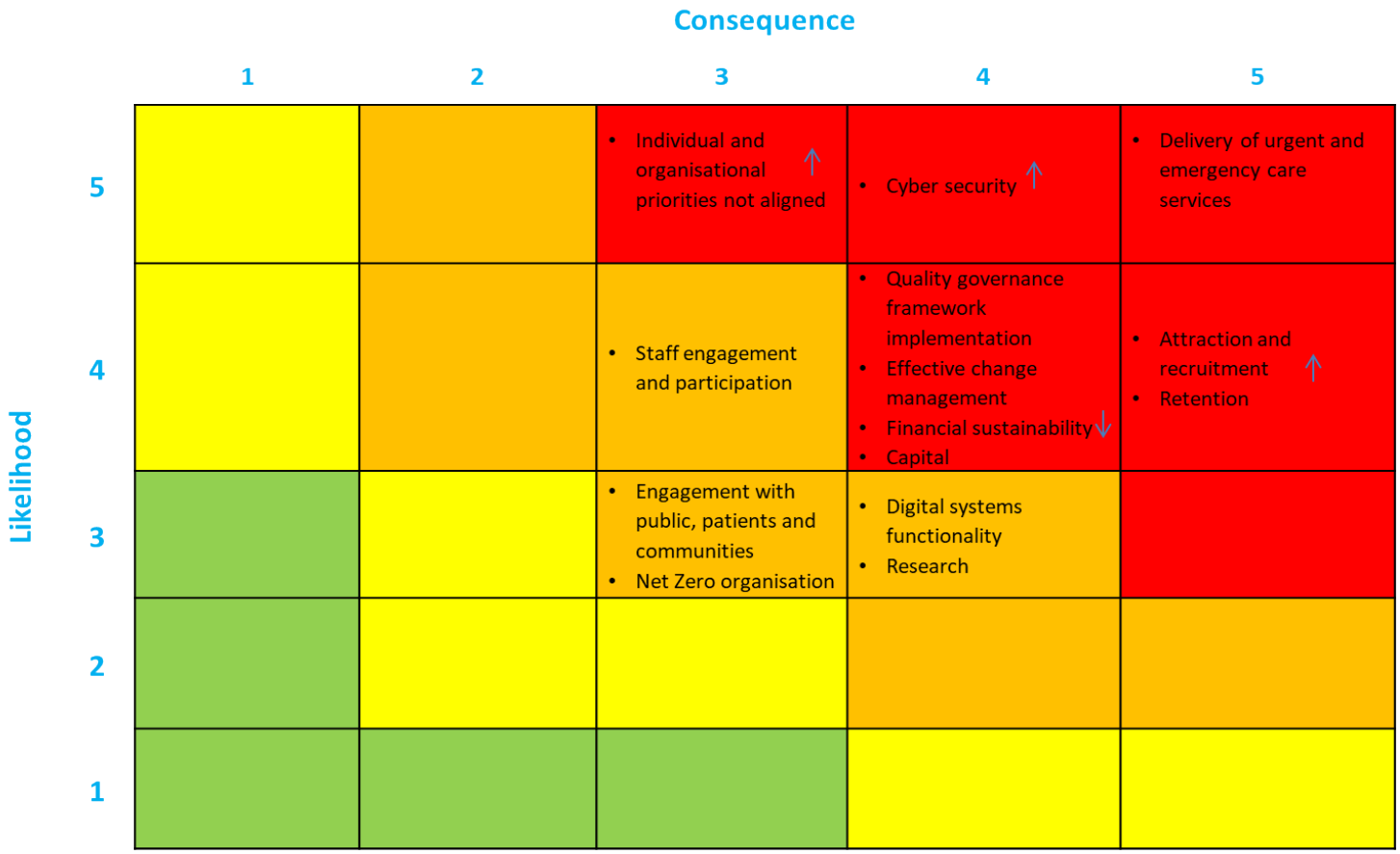
SR17 has been added under a new reference (as there had been a previous version incorrectly labelled as SR02 which duplicated the quality rrisk above).

Work is underway with Executives to refresh and update all risks for the current financial year which may result in further new references being applied.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Board Assurance Framework Summary

Heat Map



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 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 30 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 patients to Wards. • Trust Flow and Escalation Policies currently under review. • Establishments of GP Assessment Space within AMU • 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 • Shortage of Medical Ward Rounds at weekends.

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 GHFT COO • Standardised Data set and Operational Dashboard now BAU • Quality & Performance Committee Report to Board. • Ambulance 6A Audit and associated QI Approach.	• Process and Flow issues resulting in patients leaving the Trust later than required. • No control over flow rate of Ambulance and "batching" resulting in overcrowding in ED • Cultural tolerances to fixed number of Decisions to Admit and Patients Housed in Corridors. • Non Criteria to Reside position above the required level of 13% of beds.

ACTIONS PLANNED

Action	Lead	Due date	Update
Initialisation and mobilisation of Newton Improvement programme across system	ICB	Ongoing	- Mobilisation and project establishment underway.
Roll out of the clinical vision of flow (CVOF) work.	COO	Ongoing	- Clinical Vision of Flow established. Team being led by Deputy Tri. Workstream leads currently being identified.
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 & Flow Improvement Board agreement with the PIP (Performance Improvement Plan)	COO	Ongoing	- PIP reaching final iteration and will be BAU for the UECIB - Include Reset weeks (create continuity with pb in right place)
Improvements required on the flow of patients out of the Trust into community-based services	Director of Flow ICB	June 2024	- NC2R expectation set as part of planning submission. - Escalation Triggers to be agreed - Weekend discharges to be focus of coming weeks.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Friends and Family scores continue to be positive • 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 (<70%% 4hr; Handover time greater than 15mins) Significant improvements earlier this year not sustained. • Patients awaiting Minors department treatment wait a very lengthy time. • Prolonged waits for patients >12 hours. • 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 2024-2025

Updated AS 15th April 2024.

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Quality governance framework

April 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 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 reviewed before implementation. CCQ inadequate ratings for maternity (2023) and surgery (2022). CQC "MUST DO" action to improve governance (2022). 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.	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 very unlikely that the Trust will receive an Outstanding rating by CQC in this financial year. The new CQC Inspection Framework is now being delivered which needs to be embedded into the organisation. We are awaiting inspection reports which may change the organisation's rating.

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	End Q1 2024/25	New proposed governance structures were presented to the December Board Development session and the next steps are to provide a more detailed plan by the end of Q1 2024/25. This plan is in development with the new CQC framework being implemented - The CQC "safe key question" with the new Patient Safety Plan and Policy are now being implemented (1 March 2024) with us moving into a transition phase as we close incidents/ investigations opened under the 'old policy' and move into delivering the new. - The CQC "caring key question" for experience continues to be developed with the Chief Nurse, Deputy Director of Quality and Head of Patient Experience. This month saw a deep dive into the Arts programme for the Trust. - The "effectiveness key question" will be developed next once the Executive portfolios are agreed.
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	End Q1 2024/5	The Trust has been served with 3 S9A warning notices in Urgent and Emergency Services GRH, Children and Young People Services GRH and Maternity GRH. The CQC meeting with Children and Young People's Service went ahead with the service being able to demonstrate significant improvement to the issues identified. The review meetings with CQC for maternity and ED have new dates set for April 2024.
Work to improve the ratings of the core services rated as inadequate to improve governance	CNO	End of Q4 2024/25	There was an unannounced inspection of GRH maternity service at the end of March 2024. A 57-item data request has been made and the response needs to be returned to CQC by 16 April 2024. MDG and QDG have oversight of the CQC improvement plan for all the S29a, Must do and Should do improvement action plans. The final report has been received for Stroud Maternity and the service was rated as "requires improvement" and an action plan is being development to return to CQC by 22 April 2024.

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

			We await the final reports for Urgent and Emergency Care (GRH) and Children and Young People Services (GRH).
Formal governance review, focusing on quality ward to Board processes	CNO	Date end of Q1 2024/25	Workshop held with Board in December 2023 with the Good Governance Institute (GGI). Proposed new meeting structures agreed in principle with a further developed plan to be approved by end of Q1. Director for integrated governance to commence in post Feb 2024 with reporting structures to be agreed by Board and then implemented.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
- Patient Safety and Risk Report - Regulatory Report – oversight of current position of action plans including the NHS Review Paediatric Hearing Services action plan - Unannounced inspection of Maternity GRH March 2024 with no immediate safety actions identified	Regulatory Report - CQC Section 29a Warning notices for ED, C&YP and maternity. Maternity - CQC rating of inadequate with NHSE Maternity Safety Support Improvement Programme continues until the service has met exit criteria. - L3 Children safeguarding training Urgent and Emergency Care - Continued pressure within the system with this impacting on quality (safety, experience and effectiveness). CQC - Awaiting the reports from 2 inspections (UEC, C&YP) - Maternity (Stroud) rated “requires improvement”	• 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.

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	Q3 2024/25	Progress delayed because of Trust wide governance review and arrival of new Director of Integrated Governance.
Introduction of PSIRF	MD	Q1 2024/25	Board and ICB approval agreed. Business case for additional resource sitting with ICB. Task and Finish Group established to develop, test and implement new processes.
Establish A3 thinking approach to establish a recognised planning and monitoring approach for improvement	CN\ MD\I Q	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. Closed

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

• Feedback from staff on safety huddles • Quality Account	• Staff Survey Results • CQC Well-Led Report • 2 services rated inadequate • QPR metrics	• Internal audit reviews 2022-25

Updated 17 April 24

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 April 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	
		Jan 2023	Jun 2023	Jan 2024			
4x3=12	Development of an Integrated Gloucestershire system (Completed)	4x3=12	4x3=12	2x3=6	Developed and embedded system working	Q2 2021/22	
						Q4 2021/22	

CONTROLS/MITIGATIONS

- System wide development and agreement of Operational Plan (2024/25)
- Systemwide STRATEGIC and TACTICAL escalation Groups (SEG, TEG) established as BAU
- System Quality and Performance Committee oversees progress of improvement plans in areas of significant concern.
- Delivery Group exception reporting (Maternity, Quality, Unscheduled Care, Planned Care and Cancer)
- Urgent and Emergency Care (UEC) boards at System and Acute Provider level
- Monitoring of key performance metrics via Quality and Performance Report (QPR) GHFT
- 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

GAPS IN CONTROL

- Operational Plan 2024/25 not fully compliant in every domain (Activity agreed to delivery 107%; Financial gap identified and not fully mitigated).
- Delays in financial plan and therefore planning cycle significantly delayed.
- No current approach to business planning cycle from Service to Board.
- Performance Assurance Framework not embedded.
- Strategic plans on delivery of service.
- Operational Performance Delivery but with system ownership and buy in.
- Ambulance conveyance reductions identified as urgently necessary, however, insufficient buy in from SWAST.
- Community services delivered by GHC and GCC do not always align to prevention model.
- Integrated commissioning has not achieved integrated services.
- Finances aligned to responsive approach i.e., 3rd Party insourcing, workforce planning, Acute beds to house patients with NC2R.

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 April 2024

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
Continuation of Operational Plan (2024/25) delivery monitoring at system level	COO	May 2024	BAU
Recovery and Reset plan developed and being delivered in response to CAT2 performance and SWAST Offload times	COO	Oct 2024	BAU with assurance offered to Exec Tri, ICB and NHS SW
System oversight of new 111 and Community based services.	DUEC ICB & COO	November 2024	Tendering process is yet to complete.

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) reporting now integrated into Integrated Performance Report. • UEC Performance moved from Tier 1 to Tier 2 escalation (Positive) • Operational Plan 2024/25 monitored via Executive Reviews and Efficiency Board on a BAU basis	• Operational Plan 2024/25 not fully compliant in all domains against National KPIS • 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). • Lack of system integration reducing flow across whole system.	• 'Flow' focussed strategy and delivery group planned • Internal audit reviews 2024-25: ○ RTT Access Policies. ○ 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 17 April 24

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		Sept 2023	3x2=6
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	Feb 2023	3x3=9
					March 2022	3x3=9
					Aug 2022	3x2=6

CONTROLS/MITIGATIONS

- 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

GAPS IN CONTROL

- 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.

Membership Strategy 2023-2025	Corp Gov	Sept 2023	Development of refreshed Membership Strategy – engagement workshop with Governors to help influence plan and approach. Due to be published in October 2023

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• 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.	• 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.	Internal audit reviews 2022-25: • Patient Safety: Learning from Complaints/Incidents • Equalities, Diversity and Inclusion • ICS Citizens Panel

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR9: Financial sustainability

APRIL 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 NHS England 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
5 x 1 = 5	• 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**		
		April 2024	**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. • March 2024 - £1.5m deficit after application of system risk share protocol agreed at start of financial year. • £536k deficit was final M12 position.		• 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. March 2024 – Target risk score based on 23/24 but over medium term there is a higher risk profile to organisation given the level of sustainability scheme required and underlying position. From April 2024 this strategic risk will have greater focus on the longer-term position with the in-year risk being managed through risk register process.	

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 • 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.	• 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 • 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. • Reinforcing the emphasis on workforce controls has been communicated during April as pay is a major driver of expenditure. There is a gap in workforce reporting to help support the understanding of controls.

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

• 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.	

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).* Operational Planning lead / DCOO now working on this year's Operational Plan. Benefits realisation continue to be embedded as part of Financial Sustainability Programme and included within 24/25 planning in the development of savings trackers, PIDs and plans on a page.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Achieved key annual financial targets in 2020-21. • 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	• Temporary staff spend consistently above target. • Workforce spend is significantly above plan with productivity significantly below plan • Planned Trust and System underlying deficit moving into 23/24 a significant concern.	• Internal Audits planned 2022-25: • Cross health economy reviews • Shared Services reviews • Risk Maturity • Data Quality • Budgetary Control

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

• Improved and co-ordinated system working. • Development of productivity analysis at divisional level • Robust financial reporting highlighting key pressures in a timely manner	• 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	• Charitable Funds • Payroll Overpayments • NHSE/I scrutiny of Trust/system finances. • ICS accountability and assurance on system wide transformational changes.
UPDATE		
April 2024 – The Month 12 financial position achieved is reported as £536k deficit (subject to audit). The target risk shown above is for the 2023/24 year and shows an AMBER target was expected. The 2024/25 strategic risks for finances will be reframed in a new BAF risk and presented to Finance and Resources Committee in May 2024.		

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR10: Condition of the Estate

April 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 five 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
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

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

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

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.
April 2024 – Work underway to reflect actions agreed at Finance and Resources Committee in March 2024 which will come back to the Committee in May 2024.

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR11: Sustainable healthcare

APRIL 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** **3x3=9**	**Sept 2023** **3x3=9**	GHFT has been successful in securing external grants	Jan 2024 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	• 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

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

• 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 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

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

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

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 SR12: Cyber security — Apr 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 proposed to reduce the cyber BAF risk to 5x3. This is based on a reduction in the composite risk; detail provided below.	BAF risk was raised to 5x4 last year based on a set of composite indicators. The intention was to propose reducing the risk when a number of key areas were progressed.

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 • Regular phishing tests and firewall tests (planned system hacks) • Regular security updates and patches	The identified gaps in control have been progressed as follows • Insufficient in-house expertise in cyber security team – at time of increasing risk in summer 23 there were a number of vacancies in the cyber-security team, and the CITS team. Most of these vacancies have now been filled. There is further recruitment underway, and cyber skills will remain a challenge for recruitment into the NHS, but there is now more robust resource. • Inability to recruit specialist cyber staff because of cost (market forces) – this remains a challenge and will continue to remain so, however, as above there has been successful

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

• 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	recruitment with some of the newer members of staff now being in place for approximately six months. • Disaster recovery planning around support systems (out of IT control) not consistently in place • Operating model of cyber-technical & cyber-governance currently not optimal – the new operating model is now bedded in and working well. • Backlog of cyber-security issues requiring resolution – there is now greater clarity on the number of cyber-security issues raised and the process for resolving. • Device estate – assets not adequately recorded and maintained – there is now an IT Asset register with an acceptable level of completeness • ICS-wide incident response processes not operational – there is now an ICS-wide incident response process in place and two simulated events have taken place • Inadequate SIEM (Security Incident & Event Management) i.e monitoring and alerting – there is now a SIEM solution in place with high priority scenarios developed, and the internal team trained.

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) has continued with all first phase high priority processes developed. The internal team has been trained and is now able to continue the development and evolution of processes. The developed processes monitor and alert intelligently to incoming threats. 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, and an IT asset register has been developed. Medical Devices – aa bid to NHSE (NHS England Cyber security risk reduction fund was successful and the Trust has procured a tool to enable enhanced monitoring of medical devices on the network. This tool is currently in implementation. 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.

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

			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 September 24.

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

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

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	• Competing priorities for digital resource across clinical and corporate divisions • Balancing support priorities, programme delivery and foundational and stabilisation work • Lack of required investment in digital skills, resources and infrastructure to meet organisational demand • Maximising delivery versus ensuring stable environment versus pressure to release CIP and cut WTE. • Conflicting opinion and risk appetite across the ICS • Processes across corporate and clinical divisions to maximise benefits	• Reduced ability to innovate, use clinical intelligence and data effectively and plan. • Inability to deliver across the breadth of the demand. • 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 delivery plan for digital over the coming year is focussed on delivery of benefits rather than the technology itself. These benefits straddle financial, quality, safety and experiential. There is also an imperative to stabilise aspects of the digital environment, and certain systems, maximise the delivery of programmes across the organisation, particularly with the delivery of CIP, but the need to reduce WTEs.	**Feb 2024** **2x3=6**	There are a number of major programmes in the digital roadmap for 24/25 which will deliver not only technology to the organisation but will simplify processes, enhance the staff and patient experience, and also deliver financial savings. The target risk score is based on the stabilisation and/or improvement of certain systems leading to a more solid foundation on which to expand, and the completion of certain patient pathways which will reduce clinical risk, and deliver savings.	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Electronic Patient Record (Sunrise EPR) becomes single source of clinical information, wherever possible, removing the need for patient case notes in a number of settings. • Data Warehouse providing one version of the truth supporting clinical and operational dashboards used for planning across the ICS.	• 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. • Capacity versus demand in digital resource • Processes and engagement to ensure benefits are identified, delivered and recognised.

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

• New digital governance structure in place across clinical divisions, and Trust oversight and prioritisation provided by Digital Delivery Group. • Implementations must provide quantifiable benefits; financial, patient care and/or safety benefits – and reduce risk • Optimisation of EPR for users as part of a continuous improvement, responding to clinical demand	

ACTIONS PLANNED – Selection of major programmes for 24/25

Action	Lead	Due date	Update
Launch of new digital governance structure and Trust oversight and prioritisation	HA	April 24	All divisional Digital & Information Groups (DIGs) have now been established and divisional priorities defined
Electronic Prescribing and Medicines Administration Phase 2 & 3	JH	April 24 – March 25	EPMA Phase nearing completion with Nurse Supply Requests go-live in April 24, and Closed Loop Medicines Administration due to go live in June 24. EPMA Phase 3 agreed. Cross-professional working group established to optimise processes on wards and within pharmacy.
Paediatric EPR	JS	April 24 – March 25	Paediatric Admission Unit went live successfully in April 24. Roadmap for paediatric EPR being developed through the Women's & Childrens DIG.
Ophthalmology EPR go live	SA	May 24	Replacement of the Ophthalmology EPR - Medisights
Patient Engagement Portal – Outpatient Transformation	LW	May 24 – May 25	Patient Engagement Portal, Dr. Doctor, due to go live in May 24. First phase digital outpatient appointment letters, second phase text reminders for appointments and surgical TCIs, latter phases include patient amending of appointments, and other letter/information postal comms.
Trust-wide guest wifi go live	FF	May 25	Go-live of the new Trust guest wifi to replace current inadequate network
ICE – Order Communications system replacement	SA	Ju 24	Incumbent Order Communications System currently used by GPs, and in outpatient settings, to be launched.
PACS – new system go-live	SA	May 24	Go-live of the new PACS infrastructure and version following the implementation of Philips VUE PACS last year.
Sunrise EPR Order Communications	JA	Oct 24	First implementation of Sunrise in an Outpatient Setting, in a pilot speciality, including order communications.
Robotic Process Automation – incl. Outpatient Transformation	SA	Oct 24	First phase of administration Intelligent Automation (expected outpatient booking offices)
Sunrise EPR stabilisation conclude	JS	Oct 24	Two parallel programmes of work looking at the EPR infrastructure, and the back end data and configuration of Sunrise EPR, in partnership with Altera, to conclude
Doctor's bleep replacement	MH	Dec 24	Replacement of the Dr. Bleep which is end of life, procurement shortly underway.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

HIMSS Level Assessment Level 3 (old Level 5)	• Downtime for key systems not at acceptable levels	• Internal audit reviews 2022-25

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

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
3x4=12		**Feb 2024** **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.** **Execellent 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 **March 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	See Risk update March 2024

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
	• Lack of Head of EDI position

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	H of L&OD	September 2023 to September 2026	The workstream is progressing well with the first of the sessions with The Wellbeing Collective for wave 1 commenced in March. Planning for wave 2 is progressing well with some service lines identified and discussions taking place to identify service line with the remaining Divisions. The planning phase for wave 2 will run from 5th March to 19th April 2024, with delivery expected to begin May 2024 onwards
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	The EDI team have reviewed all the information available on the intranet in relation to discrimination, bullying and harassment and are in the process of designing a new EDI intranet presence. Meetings will take place with the inclusion network chairs and inclusion council to co-design this. Once agreed the prototype will be taken to the Staff Experience Improvement Programme Board and EDI Steering Group for approval. An options paper has been developed and presented to the Staff Experience Improvement Programme Board and EDI Steering group noting all the viable options to resolve the lack of reporting mechanism for discrimination, bullying and harassment. A GHT built platform is currently the only platform that meets the desired requirements. The next steps are to design, document and agree the process that will follow when reports are made. KPI's are currently being developed for this workstream.
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. Recruitment is currently out for the Associate Freedom to Speak up Guardian to support the building of a safe speak up culture workstream as part of the SEIP, and work through prioritising 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	April 2024	An executive closure report completed and submitted for review by the Staff Experience Improvement Programme Board. The recommendations for the 'Just sort it fund' and 'thank you/recognition' have been completed and handed over to BAU teams to implement. Further discussions are being held to explore vending machine options in more detail to deliver the 24 hours hot food provision. A Business case has been submitted for the new starter packs and funding options are being explored within exiting People and OD budgets and with Cheltenham and Gloucester Hospitals Charity.

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 ▪ A new Strategy and Transformation Project Manager has been secured to support the delivery of this workstream.
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 end of March 2024 H&W Steering Group commenced Jan 2024 – ongoing bi monthly	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 was 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. ▪ There are now 54 wellbeing champions across the trust and the number is rising. A monthly newsletter communicating all the support and events for the champions to share locally. Together with the mobile hubs, wellbeing information getting into wards and departments is quicker and more efficient. ▪ New 'suicide prevention' process has been drafted, with plan to roll out across the Trust taken through PODG in March. ▪ New approach to presenting and communicating the wellbeing offer is currently in development, to address lack of clarity. ▪ Currently working with comms to create the wellbeing space on the intranet.
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	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: 1. Board requirements -HIA 1 – work with the Chair throughout April 2024 2. Internationally Educated Colleagues

working document of activity and gaps identified.		Specific Action 8 dates for April – June for Divisional Action and Implementation plans	3. EDI Training – Plan and integration, including, Cultural Competence, Globis Sessions, Allyship, Review of current training offers and weaving and integration into training offerings 4. EDI Team Actions – Reports, Data, EDS data collection 5. Recruitment actions and alignment 6. SEIP 7. Patient and Colleague EDI Collaborative Plans 8. Divisional Action Plans Priority area throughout April – June is the specific Divisional reporting mechanisms and working through the accountability and responsibility with the Divisions.
Retention • National Programme for B2-B3 HCSW Job profiles and pay drift. To include addressing GHFT's legacy of varying pay and sick pay T&Cs for this staff group	DDfPOD	Roll out plans continue to be pushed out.	Whilst Staffside partners have agreed with the Trust's approach across this programme, GHFT negotiations continue with UNISON which is creating risks to delivery of the programme. GHC have already moved to launch in light of an earlier agreement and UNISON Ballot already undertaken.
• 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	H of L&OD	Timelines for delivery to be finalised	Three key projects continue under the newly formed Retention Group. Project leads have been identified and project plans/deliverables for Q4 23/24 include: • **Exit process -** To improve, broaden and deepen understanding of, and responses to, the reasons for staff leaving the Trust • **Flexible Retirement policy and promotion -** To standardise the Trust's approach to retire and return, and improve the visibility and promotion of flexible retirement options • **Substantive leavers moving to the Bank -** To improve the process and experience for staff to switch to the Bank once they have already handed in their notice.
Colleague Engagement and Communications • Brilliant Basic approach to improving Communications and Engagement • Implementation of strengthened internal communication and engagement channels • NHS Staff Survey was highest ever uptake • Recruitment to full establishment and fixed term service roles in place	DofComms	Jan-April 2024	Delivery of all actions are underway: • Staff Survey results shared Senior Leadership Forum and Divisions • Audio Guides launched with Sight Loss Council • Support for new Recruitment Website and campaign • New fortnightly Vlog programme • Elections of Governors • New monthly Staff Forums started • New monthly Senior Leadership Forums being established • Significant programme of engagement and communications in relation to Panorama • High profile VIP Visits, including Prime Minister and HRH • Completion of four Communications and Engagement Policies: VIP & Visitor Policy, Media Policy, Social Media Policy and, Branding Policy • Development of annual planner and monitoring for Engagement and Media

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

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
• Divisional colleague engagement plans
• Proactive Health and Wellbeing interventions covering physical, mental and financial wellbeing
	• Below average staff survey results
	• Diversity gaps in senior positions
	• Gender pay gap
	• WRES and WDES indicators
	• EDS22 ratings
	• Cost of living increases
	• Exit interview trends
	• Inconsistent Pay T&Cs for HCSWs
		• Staff Experience Improvement Programme
		• Internal audit reviews 2022-25:
		  ○ Cultural Maturity
		  ○ Cross health economy reviews
		  ○ Equality, Diversity and Inclusion
		  ○ 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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Workforce - Recruitment and Attraction

March 2024

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR17 Recruitment and Attraction	**Inability to attract a skilful, compassionate workforce that is representative of the communities we serve.**	**We have a compassionate, skilful and sustainable workforce, organised around the patient which describes us as an outstanding employer who attracts the very best people.**	Increased demand. Reduced pipeline locally and nationally to fill workforce gaps. Reduced training commissions. Hard to fill specialty posts across multiple professions on a national scale.	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	See Risk update March 2024

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY	
5x4=20	The pandemic has had a significant impact on the NHS to recruit to its expanding workforce. On a platform of increased operational pressures, rapid demand, a competitive market place, reduced pipelines, challenged training places and funding, the risk to the Trust is significant for filling its workforce gaps and developing its services. Staff shortages and deteriorating staff experience will impact further on the Trust's ability to attract and recruit to the organisation.	**March 2024** **3x4=12**	A number of workforce plans focused on recruitment, retention and improved culture would have positive impact on the Trust's ability to attract and retain a skilful, compassionate workforce	Risk score escalated to 20 New risk created for staff retention - see SR3	October 2022 January 2023

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• International recruitment pipeline • UK RN graduate cohorts • Increased apprenticeships, TNA Cohorts and student placement capacity • Induction pilot of cohorts for HCA/HCSW • Advanced Care and other alternative speciality roles • Accreditation of Preceptorship module • Formalised workforce Operational Plan submission 2023/2024 to NHSE, integrated with the ICS • National Education and Training Survey (NETS) Group created to promote survey, to review and action results • Wide-reaching Workforce Sustainability Programme	• Delays in time to hire • No formalised marketing and attraction strategy / plan • Inability to match recruitment needs (due to national and local shortages) • High dependency on temporary staffing • Poor establishment controls

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
To drive forward a transformation programme of the end-to-end transactional recruitment process, to create efficiencies in time to hire and improve both candidate and appointing manager experience. This workstream continues under the Workforce Sustainability Programme.	DDfPOD	January 2024 - August 2024	Progress continues which includes: ▪ Rollout of TRAC VCP functionality across Corporate Services is on target with training sessions completed. Implementation is planned for (April 2024) ▪ Ongoing discussions with BI to integrate online Time to Hire KPIs for Divisional reporting (April 24) ▪ Successful roll-out of Starter Forms module within TRAC is complete (To be evaluated March 2024) ▪ Integration between the new Occupational Health system and TRAC is underway, introducing efficiencies across new starter health checks. (Aug. 24) ▪ Final governance checks are being undertaken before live testing begins with candidates ID Verification Technology/TRAC integration. (From Feb 24) Manager's Recruitment Toolkit is under development providing essential information on how to manage end to end recruitment (May 24)
Development of a marketing strategy/plan This workstream continues under the Workforce Sustainability Programme.	DDfPOD	March 2024 - May 24	Progress continues as follows: ▪ The Employer Value Proposition (EVP) concept options and designs have been shared with the Trust for consultation and consideration. (March 24) ▪ Refresh of the current marketing assets to create an interim brand solution for campaigns and social media (Complete and in use) ▪ The Trust's main website continues to be updated to promote opportunities at GHFT, supported by a new 'current jobs' call to action to make it easier for candidates to search for jobs (May 24) ▪ First quarterly Recruitment 'Newsletter' has been designed and issued across the Trust. Positive feedback received (Ongoing evaluation and dissemination) ▪ Targeted advertising across a number of recruitment campaigns is building momentum through the Marketing and Attraction Lead. Evaluation follows after each campaign to assess return on investment. (Ongoing)
Temporary staffing controls and compliance This workstream continues under the Workforce Sustainability Programme	DDfPOD	January 2024 - April 2024	Milestones achieved/in progress: ▪ Recruitment to the non-clinical bank role is complete. (Service will launch from 1 April 2024 / DOAG April 2024) ▪ Following a Divisionally represented Task & Finish Group, an options appraisal has been drafted to remove the locally agreed medical locum bank enhancements. (DOAG April 2024) ▪ Monthly nurse roster reviews continue with a focus on high spend areas. Monitored through the monthly Nursing Agency Reduction meetings. ▪ On-going work with BI to produce automated temporary staffing reports, (Project expected to close 31 March 2024) ▪ A new recruitment/temporary staffing data dashboard is in development to support appropriate controls and recruitment demand/supply. (April 2024) ▪ A SW regional agency rate card for both Medics and RNs has been collaboratively developed for local consultation. (March 2024)

Interventions and activities to deliver the 2023/24 and 2024/25 workforce plan across the Trust	DDfPOD & AD of HR and R	Q4 23/24 Q1 24/25	▪ The Trust has completed its full target of recruiting 135 Internationally Educated Nurses (IEN). IEN OSCE first time pass rate is now best in South West. ▪ A business case is in development for IEN recruitment in 2024/25, using the existing overseas nurse recruitment budget. The ambition is to recruit up to 30 IENs in the next financial year. ▪ Generic events held monthly with sustained interest. The next Nursing, Midwives and AHP Trust Open Day is planned for April 2024. ▪ Q3 / Q4 - Hard to fill consultant posts in Medicine where cover has typically been high-cost agency locum use, has seen mapped recruitment activity and monitoring of a pipeline to fill vacancies, through the Agency Grip and Control Group. The Workforce Planning round for 24/25 commenced in the latter part of 2023, but with the formal national Operating Planning Guidance still to be published. With the demand for increased levels of financial scrutiny in 24/25, a Workforce Controls Framework is being developed, to come into effect from April 2024. The Framework lays out clear principles across a suite of workforce controls, creating rigour and challenge across WTE growth, vacancies, temporary staffing reliance, recruitment demand and supply. A workforce delivery plan will be developed which under-pins the 24/25 Operating Plan. The plan will reflect the impact on the workforce associated with the known operational activity in order for improved planning and forecasting to be undertaken.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
▪ Ability to offer flexible working arrangements ▪ Flexibility with the targeted use of Bank incentives and Trust-wide reward ▪ Extended funding into 23/24 on a number of initiatives ▪ Improving vacancy and turnover performance seen in June 2023 data ▪ Customer satisfaction survey positively improving	▪ Diversity gaps in senior positions ▪ Gender pay gap ▪ Significant workforce gaps ▪ Cost of living increases with AfC pay-scales not as competitive as some private sector roles ▪ WRES and WDES indicator 2 (likelihood of appointment from shortlisting)	▪ Financial Sustainability Programme Board ▪ Internal audit reviews 2022-25: ○ Workforce Planning ○ Cross health economy reviews ○ Equalities, Diversity and Inclusion ○ Recruitment and Selection

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	May 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 3 April 2024 the following changes were made to the Trust Risk Register:

Key issues to note

TRR updates:

- No new risks approved onto the TRR
- No risks were proposed for approval with a TRR score to be held at divisional level
- Two risks were downgraded from the TRR
- No risks were closed

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

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

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

No new risks were accepted on to the Trust risk register.

2.0 RISKS WITH AGREED TRR SCORE FOR HOLDING AT DIVISIONAL LEVEL

No new risks were accepted with a Trust risk register score, to be held at divisional level.

3.0 DOWNGRADE OF TRR RISK TO DIVISIONAL / SPECIALTY RISK REGISTER

The following risks were approved for downgrade from the Trust risk register.

Risk #123
Risk Lead: RG
Executive Lead: CR

Proposed for downgrade as international recruitment has been paused. Number later this year will be much lower. A network of accommodation providers has been established should this be needed in future for increased demand.

Inherent Risk				
The risk of delayed arrivals, poor candidate experience and withdrawals od overseas nurses due to lack of Trust accommodation				
Cause				
High levels of occupancy with the Sovereign Housing accommodation means there is limited capacity to provide accommodation for international staff recruited via the international recruitment programme				
Effect				
• Inability to confirm in advance available le Trust accommodation for arrivals • Resourcing team spending significant time looking for short term solutions – tenancy agreements, guest house etc. • Stress for staff arriving; in ability to confirm accommodation for incoming arrivals • Increased costs for short-term accommodation • Delayed arrivals and increased costs when using alterative accommodation • Multiple accommodation moves / relocation - giving poor staff experience • Continued agency spend as a result of delayed OSCE completion • Staff shortages • Unable to meet NHSIE funding MOU				
		New Scores		
Risk Category (domain)	**Previous Scores**	**Consequence**	**Likelihood**	**New Risk Rating**
Workforce	3 x 4 =12	Downgraded to **2**	Downgraded to **3**	**6**
Evidence of scoring				

International recruitment has been paused. Number later this year will be much lower. A network of accommodation providers has been established should this be needed in future for increased demand.
Controls
• Fill rate improved for IENS in Sovereign and no further cohorts being recruited • Now have empty rooms • Sovereign contract managed by GMS • Arrival numbers and timescales given to Sovereign • Have a good network of local providers of accommodation if there is ever a higher demand again.
Gaps in controls
• Contract oversight and owner for Sovereign not clearly defined • Process for managing expectations for occupants' length of stay
Actions
• All complete

Risk #407
Risk Lead: LR
Executive Lead: IQ

Inherent Risk				
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.				
Cause				
Temperature control across the Pathology laboratories is inadequate affecting all departments, but especially Clinical Chemistry. This used to be a problem only in summer but is now all year with temperatures uniformly over 25oC in Chemistry and over 30oC reached in parts of the Chemistry laboratory in winter. Ventilation does not meet HMT03-01 Specialist Ventilation in healthcare				
Effect				
• Breach of HMT03-01 • Over summer of 2019, 2020 and 2022, temperatures regularly reached 34 degrees C in Chemistry in Gloucester, noting that a temperature of 35oC results in complete shutdown of all analytical equipment in the laboratory (Datix W112541 and W112544 & attached emails to GMS). During 2019, the GHT Chemical Pathology laboratories were above ambient temperature for a combined total of 109 days (67 consecutive days at GRH and 42 consecutive days at CGH). • Potential for loss of ability to process in Clinical Chemistry samples on one side of the county, leading to delayed turnaround times, inability to support A&E waiting times, and various urgent clinical pathways thus affecting patient safety. • Temporary withdrawal of part of the repertoire of tests across all laboratories (as equipment failure noted across all disciplines at times of elevated ambient temperature). This would equate to a loss of approximately 25% of the available tests and a downgrading of the service to acute work only. • Prosecution for failings in healthcare, fine and associated costs.				
		New Scores		
Risk Category (domain)	**Previous Scores**	**Consequence**	**Likelihood**	**New Risk Rating**
Statutory	4 x 4 = 16	**4**	4 downgraded to **2**	**8**
Evidence of scoring				
Main works completed at the end of 2023. Fan Coil units and ceiling units installed - still awaiting connectivity of all units to the BMS which has prevented validation of the system and				

install. Survey carried out by Sauter's and plan to connect units within next month Therefore, the likelihood of the risk can be reduced to "unlikely" - reducing the overall risk score to 8. Once the installation and validation are complete, the score can be reduced to 4.
Controls
• Cooler Unit reinstated • Quality control procedures for lab analysis • Temperature monitoring • Replaced window film in chem path lab
Gaps in controls
• Awaiting connectivity of all units to the BMS which has prevented validation of the system and install
Actions
• Connectivity of all units to the BMS and validation of the system and install

4.0 PROPOSED CLOSURE OF RISKS ON TRR

No Trust level risks were closed.

5.0 OVERDUE REVIEWS OF TRR RISK

At the time of RMG in April, 12 risks on the TRR were overdue for review. An action was set for these to be reviewed by owners within two weeks. Those that were not reviewed by that date were contacted directly by the Medical Director on 17 April. The following four TRR risks remain overdue as of 23 April 2024.

Risk ID	Inherent Risk	Risk Owner	Division	Current Conse-quence	Current Likelihood	Current Rating	Date Next Review
348	3963 Risk of increased harm, breach in regulations, distress and poor quality experience to patients, staff and visitors when boarding patients in wards.	Risk transferred from CB to DT on 21.4.24	Corporate	3	5	15	29/02/2024
413	3767 The risk of harm to patients and staff due to being unable to discharge patients from the Trust	N H-L	Corporate	4	4	16	29/02/2024
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	SB	D&S	5	2	10	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.	KH	Medical	4	3	12	29/02/2024

6.0 OVERDUE ACTIONS ON TRR RISKS

At the time of RMG in April, there were 44 actions associated with TRR risks that were overdue. An action was set for these to be reviewed by owners within two weeks. Those that are not reviewed will be contacted directly by the Medical Director. The following 25 actions remain overdue as of 23 April 2024 and have been sent to the Medical Director.

Risk ID	Inherent Risk	Action ID	Action Title	Action Assigned To	Action Due Date
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.	188	Bespoke recruitment incentive	AJ	04/10/2023
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.	678	Front door streaming pilot	HL	29/02/2024
		675	Launch unscheduled care Improvement Group	AS	31/03/2024
		683	Implement Opel escalation action cards	CB	31/03/2024
281	3834 The risk of not being able to provide a pharmacy manufacturing service and losing MHRA Specials Licence due to staff shortage.	555	Active recruitment against the approved VCPs	MP	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	248	Formalised process to prioritise augmented care flushing	SG	31/10/2023
		245	Review of birthing pool testing	AO	30/09/2023
		244	Review water tanks	DP	30/09/2023
		249	To provide list of outlets	DP	07/12/2023
		247	Trust wide audit of outlets	DP	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	260	Conclude RAG audit of areas across the Trust	MK	11/11/2023
		259	Fire team trainer to add information to mandatory training package	DP	31/10/2023
		256	Rolling replacement programme for batteries	FF	31/03/2024
		258	To ascertain staff training requirements	FF	31/03/2024

		938	Close liaison between fire, capital and digital team	ED	01/04/2024
		940	Assurance required from digital team that Bytec/ digital team undertake monitoring & maintenance programme	FF	31/03/2024
443	2815 The risk to patient safety due to delays in the acute stroke pathway for patients attending Gloucestershire Royal Hospital (GRH) Emergency Department.	309	To work with ICB to improve patient awareness of stroke services not going to GRH	KH	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.	348	Bespoke Recruitment Incentive	AJ	09/11/2023
764	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 GRH	739	Increase Trauma operating theatres capacity	JM	01/02/2024
		741	Warming blankets funding proposal	AC	01/02/2024
		750	Work with NOK MDT – ward team starter training package	RM	01/04/2024
		751	Increase utilisation of theatre lists in GRH	JM	01/04/2024
		752	Kit list for a MOPS theatre	SW	01/03/2024
		753	Run training programme for 3 A nurses	AC	29/02/2024
		754	Run training for ED nurses, particularly in catheterisation	AC	29/02/2024

7.0 TRR RISKS WITH NO ACTIVE ACTIONS

At the time of RMG in April, there were seven TRR risks with no active actions. As of 23 April, this has reduced to three risks.

Risk ID	Inherent Risk	Risk Lead
160	1945 The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls.	CB
233	2669 The risk of harm to patients as a result of inpatient falls	CB
413	3767 The risk of harm to patients and staff due to being unable to discharge patients from the Trust	N H-L

Trust Risk Register

Risk ID	Risk	Type	Subtype	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	12/03/2012	8	5	4	20	12	↑	↗	30/06/2024
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	18/06/2021	10	4	3	12	4	↑	↗	30/06/2024
96	3826 Risk of delays in managing formal employee relations cases due to limited investigating officer capacity.	Workforce	Recruitment & retention	17/06/2022	12	4	3	12	2	↔	↗	14/06/2024
122	3755 The risk of significant disruption to service delivery, patient safety and financial position in the event of a successful cyber attack			11/09/2023	20	4	5	20	2	↔	↗	31/05/2024

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	20/02/2023	16	4	3	12	8			31/05/2024
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	16/01/2014	9	4	3	12	4			31/05/2024
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	20/02/2023	16	4	3	12	8			11/06/2024
160	1945 The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls.	Safety	Infection Control	19/08/2014	9	4	3	12	6			30/06/2024
161	2667 The risk to patient safety and quality of care and/or outcomes as a result of	Safety	Infection Control	05/02/2018	16	3	4	12	6			15/07/2024

	hospital acquired C .difficile infection.											
233	2669 The risk of harm to patients as a result of inpatient falls	Safety	Clinical Assessment	06/02/2018	15	3	4	12	6	↓		30/06/2024
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	16/10/2018	4	4	4	16	6	↑		31/05/2024
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	02/12/2016	9	4	4	16	6	↑		19/07/2024
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	22/11/2021	15	4	4	16	6	↑		08/05/2024

281	3834 The risk of not being able to provide a pharmacy manufacturing service and losing MHRA Specials Licence due to staff shortage.			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	14/12/2022	9	3	4	12	6	↑		31/05/2024
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	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	01/11/2022	15	2	5	10	2	↓		23/04/2024
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	17/10/2022	10	3	5	15	5	↑		07/05/2024

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	05/08/2022	16	4	4	16	2	⟷	📈	29/04/2024
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	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	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	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	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	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	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	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	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	Workforce	Recruitment & retention	20/05/2021	15	5	4	20	6	↑		30/04/2024

	harm, including treatment delays.											
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	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	21/11/2019	20	5	3	15	4	↓		02/04/2024
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	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	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	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	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	18/06/2020	6	4	4	16	8			06/06/2024

Gloucestershire Hospitals NHS Foundation Trust

RISK MANAGEMENT GROUP
RISK SYSTEMS ASSURANCE REPORT – APRIL 2024

1. KPI DASHBOARD

KPI	Medicine	Surgery	D&S	W&C	Corporate /IT/Finance	Trust
Risks without identified controls	0/75 0%	0/89 0%	0/134 0%	0/41 0%	0/140 0%	0/479 0%
Risks without identified actions	29/75 38%	10/89 11%	44/134 32%	12/41 29%	43/140 31%	138/479 29%
Risks not reviewed by due date	47/75 60%	39/89 44%	31/134 23%	5/41 12%	85/140 61%	207/479 43%
Moderate/ major harm incidents not reviewed within 7 days as % of those reported in the 7-day reference period	0/9 0%	2/8 25%	0/2 0%	1/6 17%	0/0 0%	3/25 12%
No/ low harm with high or extreme risk not reviewed within 7 days as % of those reported in the 7-day reference period	0/58 0%	52/37 140%	34/31 109%	0/10 0%	2/5 40%	88/146 60%
No and minor harm incidents with high or extreme risk rating not investigated as % of those reported in the last 12 months	211/1898 11%	159/1756 19%	79/504 15%	23/463 5%	25/164 15%	497/4785 10%
Overdue priority moderate+ harms within the division / Trust as percentage of those reported in the last 12 months	6/34 18%	5/30 17%	0/10 0%	13/95 14%	0/2 0%	24/171 14%
DOCs overdue as percentage of the total declared in the last 12 months	1/61 2%	2/12 16%	0/7 0%	0/6 0%	0/0 0%	3/86 3%
SIs overdue as percentage of the total declared in the last 12 months	1/22 4%	0/6 0%	0/3 0%	3/19 16%	0/0 0%	4/50 8%
Health and safety harm incidents affecting staff with no contributory factors identified on DATIX (before closure) for relevant month	0/27 0%	0/5 0%	0/5 0%	0/4 0%	0/1 0%	0/40 0%
Overdue actions as a percentage of all open actions in division/ Trust	94/154 61%	126/203 62%	44/151 29%	40/119 33%	90/226 40%	393/853 46%

RAG key is provided at the end of the report.

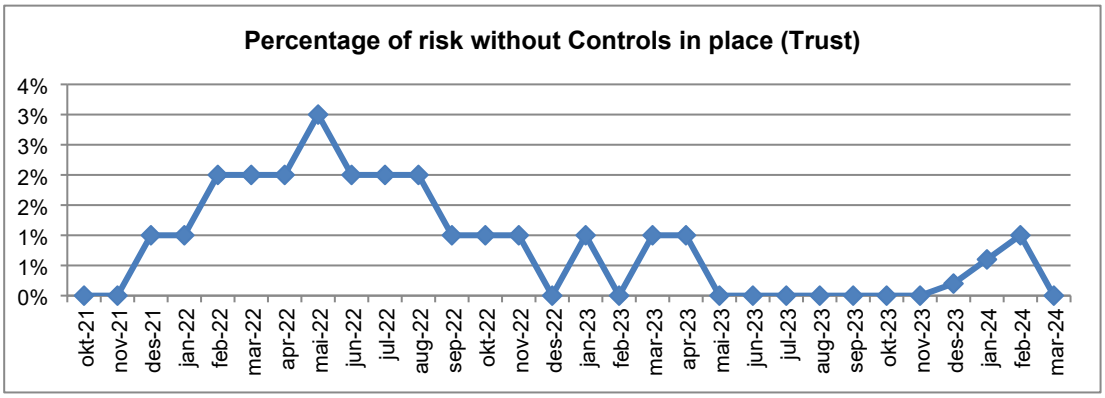
2. INTERIM PERFORMANCE DATA FOR RISK

2.1 All risks must have controls

Performance is excellent for this KPI. 100% of risks have controls.

	Medicine	Surgery	D&S	W&C	Corporate	Trust
Risks without controls	0/75	0/89	0/134	0/41	0/140	0/472
	0%	0%	0%	0%	0%	0%

	GMS
Risks without controls	0/33
	0%



2.2 All risks must have actions

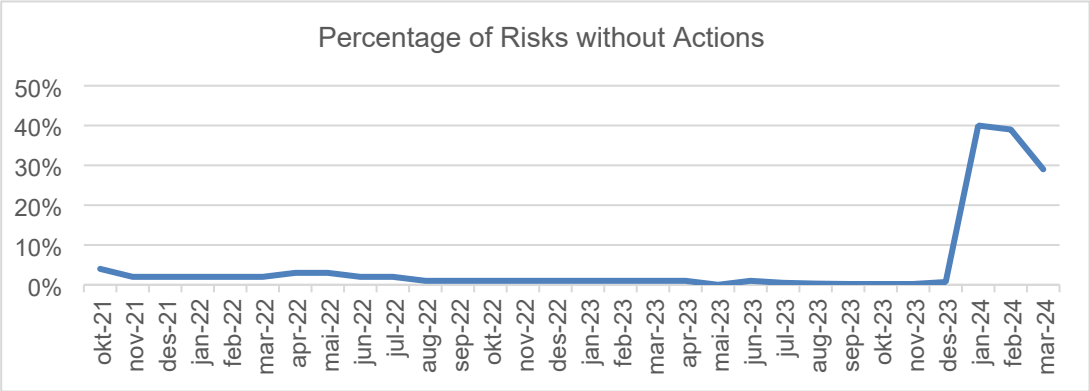
On transfer to Cloud closed actions were added as an attachment to the risk, therefore on Cloud only open / on-going actions are recorded within the actions field on the system. This has resulted in greater number of risks showing as having no actions.

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	29/75	10/89	44/134	12/41	43/140	138/479
	38%	11%	32%	29%	31%	29%

	GMS
Risks without actions	16/33
	50%



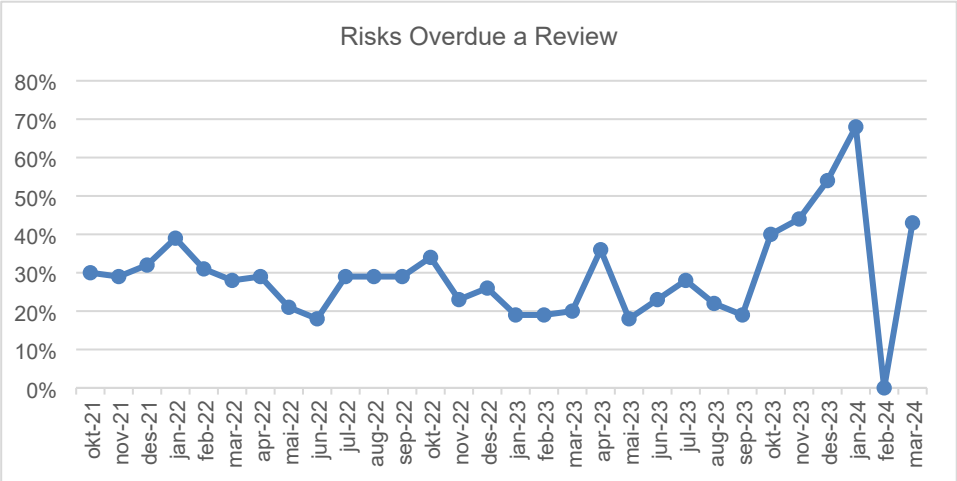
Risks with no actions are shown in Appendix 1

2.3 Risks to be reviewed by specified review date

There are 207 risks overdue for review, these are shown below for each division. The sharp rise in risks due for review occurred at the end of February as the 6 week grace period agreed for owners to review risks on the new system came to an end.

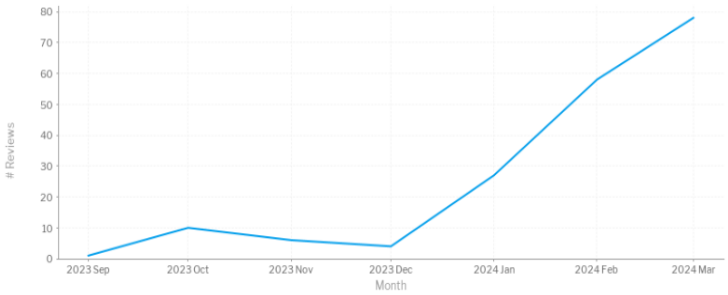
	Medicine	Surgery	D&S	W&C	Corporate	Trust
Overdue risk reviews in comparison to total number of risks	47/75	39/89	31/134	5/41	85/140	207/479
	60%	44%	23%	12%	61%	43%

	GMS
Overdue risk reviews in comparison to total number of risks	12/33
	36%



Whilst there are still a number of risks to be reviewed, the chart below shows that during February and March, 58 and 78 risks were reviewed respectively.

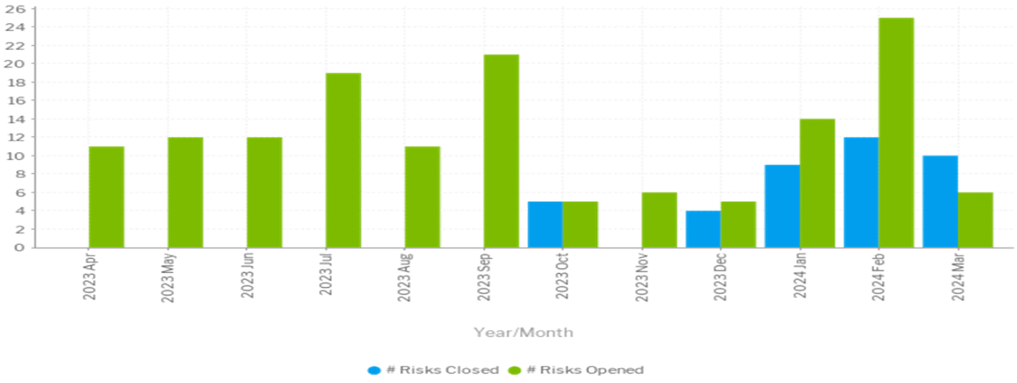
Risks reviews per month
This charts shows the number of risks reviewed per month.



Month	# Risks reviewed	# Reviews
2023 Sep	1	1
2023 Oct	10	10
2023 Nov	6	6
2023 Dec	4	4
2024 Jan	27	27
2024 Feb	58	58
2024 Mar	72	78

2.4 New Risks & Risk Closures

In March there 6 new risks opened across all registers, one of which was closed on the same day. 10 risks were closed across all registers. These are enclosed in Appendix 1.



3.0 INTERIM PERFORAMNCE DATA FOR INCIDENTS

3.1 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	0/58	52/37	34/31	0/10	2/5	88/146
	0%	140%	109%	0%	40%	60%

	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	3/5
	60%

3.2 Initial Review of Moderate harm incidents

Three 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	0/9	2/8	0/2	1/6	0/0	3/25
	0%	25%	0%	17%	0%	12%

	GMS
Incidents reported as moderate harm+ not reviewed within 7 days as % of all those reported in 7-day period	0/1
	0%

3.3 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	211/1898	159/1756	79/504	23/463	25/164	497/4785
	11%	19%	15%	5%	15%	10%

	GMS
No or Minor Harm Incidents with high or extreme rating not investigated as % of all those reported in last 12 months	30/332
	9%

3.4 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	6/34	5/30	0/10	13/95	0/2	24/174
	18%	17%	0%	14%	0%	14%

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

3.5 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
DOCs open beyond the deadline date as % of DOCS declared in last 12 months	1/61	2/12	0/7	0/6	0/0	3/86
	2%	16%	0%	2%	0%	3%

Those overdue are:

Ref	Division	Description	Date Due	Investigator
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	JW
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	CS
W217378	Surgical	On 11th August, patient was prescribed treatment dose (12,500 iu bd) of Fragmin for AF, as advised by cardiology. He was 11 days post op 1st stage revision for infected total hip replacement. No monitoring of this was performed and this continued until 13th August, when he had a large bleed into his thigh. This was diagnosed on a CT scan performed on 13th August. He had a peroneal nerve injury as a result of this.	27/02/2024	NH

3.5 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	1/22	0/6	0/3	3/19	0/0	4/50
	4%	0%	0%	16%	0%	8%

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 CT scan to investigate, but this was not arranged. PT confirmed that they did not have a private CT scan	DW	28/12/2023
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	WH	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	LB	16/02/2024
W2226995	W&C	*Incident reported in retrospect* Attended triage with abdominal pain and no fetal movements at 33+1. History of PET- not medicated. Fetal bradycardia on admission- transferred to theatre for CAT 1 LSCS. Placental abruption confirmed, baby born in poor condition and required resuscitation. Transferred to tertiary unit and sadly NND on 26/11/23	HP	07/03/2024

3.6 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	0/27	0/5	0/5	0/4	0/1	0/40
	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	0/5 0%

4. Overdue Actions

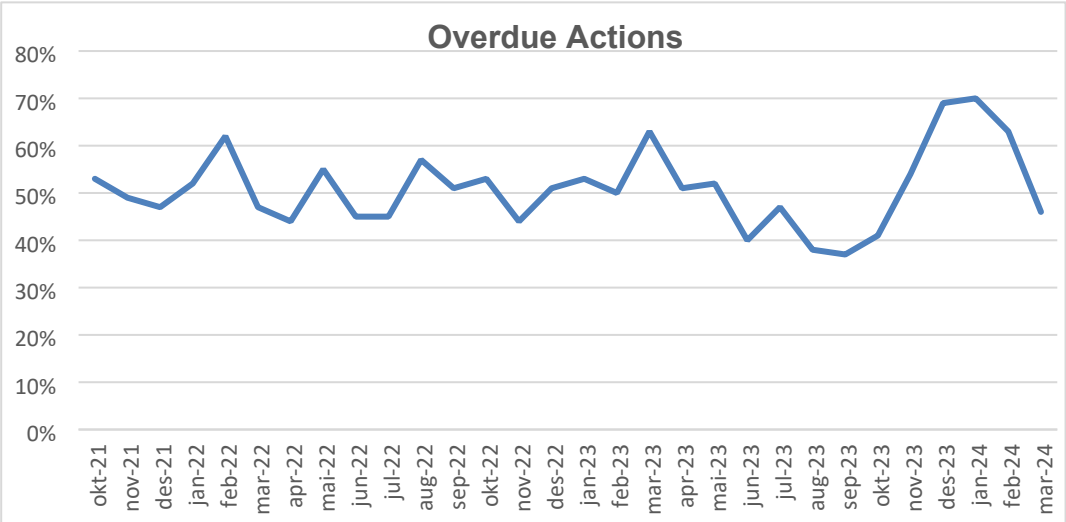
In the incident module, currently 132/237 (56%) are overdue for completion
In the risk module currently 302/ /616 (49%) of actions are overdue.

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	94/154 61% ⬇	126/203 62% ⬇	44/151 29% ⬇	40/119 37% ⬇	90/226 40% ⬇	393/853 46% ⬇

	GMS
Actions overdue in comparison to all open actions in the division / trust	45/67 67% ⬇

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

Gloucestershire Hospitals
NHS Foundation Trust

TRUST BOARD – May 2024

REPORT TITLE	
Freedom to Speak Up Report	
AUTHOR(S)	**SPONSOR**
Louisa Hopkins - Lead Freedom to Speak Up Guardian	Dr Claire Radley- Executive Lead for Freedom to Speak Up

EXECUTIVE SUMMARY

This report provides an update on the progress the Trust continues to make. Including-

- Review and update on matters raised in 2022/ 23 Annual Report
- Freedom to Speak up Guardian assessment of the current position
- Annual review of concerns raised to Freedom to Speak Up
- National, Regional and Local work

RECOMMENDATIONS

- Discuss and note the Freedom to Speak Up update and
- Support on going work to ensure an open and transparent culture of speaking up is achieved in the organisation

ACTION/DECISION REQUIRED

INFORMATION

IMPACT UPON STRATEGIC OBJECTIVES (PLEASE TICK RELEVANT ONES)

Outstanding care	☒	Centres of excellence	☐
Compassionate workforce	☒	Financial balance	☐
Quality improvement	☒	Effective estate	☐
Care without boundaries	☐	Digital future	☐
Involved people	☒	Driving research	☐

Supporting the organisational work on compassionate culture and just culture

IMPACT UPON CORPORATE RISKS

Board Assurance Frameworks:
3
16

REGULATORY AND/OR LEGAL IMPLICATIONS

Freedom to Speak Up arrangements and learning are reviewed as part of the Well Led domain in CQC inspections.

The Trust is required to meet the following legal/regulatory requirements in relation to raising concerns:

- NHS contract (2016/17) requirement to nominate a Freedom to Speak Up Guardian.
- National NHS Freedom to Speak Up raising concerns policy (2022)

- NHS Constitution: The Francis Report emphasises the role of the NHS Constitution in helping to create a more open and transparent reporting culture in the NHS which focuses on driving up the quality and safety of patient care.

SUSTAINABILITY IMPACT

No impact on sustainability

EQUALITY IMPACT

Staff have spoken up about concerns regarding discrimination.

Staff disclose to the Freedom to Speak up service protected characteristics of disability, pregnancy, maternity, religion, LGBTQ+ race and age.

PATIENT IMPACT

Staff share patient safety concerns and they are responded to on a case to case basis.
Concerns with elements of patient safety or quality are reported nationally to the National Guardians Office on a quarterly basis.

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

ACTION/DECISION REQUIRED

Report provided for information – no action required

COMMITTEE AND/OR TRUST LEADERSHIP TEAM (TLT) REVIEW DATES								
Audit & Assurance Committee	☐	MM/YY	People & OD Committee	x ☐	04/24	Trust Leadership Team	☐	MM/YY
Estates & Facilities Committee	☐	MM/YY	Quality & Performance Committee	☐	MM/YY	Other (specify below)	☐	MM/YY
Finance & Digital Committee	☐	MM/YY	Remuneration Committee	☐	MM/YY	Other?		

OUTCOME OF DISCUSSION FROM PREVIOUS COMMITTEES/TLT /MEETINGS

Purpose

This is an update report of the Lead Freedom to Speak up Guardian capturing a year of activity, bench marking where possible against National data.

Background

The National Guardian's Office and the role of the Freedom to Speak Up Guardian were created in response to recommendations made in Sir Robert Francis' report 'The Freedom To Speak Up' (2015 www.freedomtospeakup.org.uk/the-report/). In this report, Sir Robert found that the culture in the NHS did not always encourage or support workers to raise concerns that they might have about quality and safety of care provided, potentially resulting in poor experiences and outcomes for patients and colleagues.

Concerns can be raised about anything that gets in the way of providing good care. When things go wrong, it is important to ensure that lessons are learnt and improvements made. Where there is the potential for something to go wrong, it is important that staff feel able to speak up so that potential harm is avoided.

Even when things are going well, but could be even better, staff should feel confident to make suggestions and that these would be taken on board. Speaking up is about all of these things.

Freedom to Speak up Guardians are employed to promote an open and transparent culture of speaking up and raising concerns. FTSUG provide impartial support to speaking up matters, monitoring and supporting any concerns of detriment or disadvantages behaviour toward staff as a result of speaking up. The FTSU Guardian values are Impartiality, Empathy, Courage and Learning.

The National Guardian's Office is an independent, non-statutory body with the remit to lead culture change in the NHS so that speaking up becomes business as usual. The office is not a regulator, but is sponsored by the CQC and NHSE.

The Trust has responded to data from the staff survey (please see data below) and CQC report April 2022 (https://api.cqc.org.uk/public/v1/reports/2a68a3e9-5335-4c90-8c07-ea5c55ec2370?20221129062700) citing a lack of trust in the freedom to speak up system and a lack of action when concerns were raised.

Review and update on matters raised in 2022/23 FTSU annual report:

The FTSU 2022 report committed to continue to review the FTSU function and service.

Further review initiated the following improvements:

Improving the whole FTSUG function to protected time to carry out FTSUG duties, thus improving response rates and ensuring all cases are supported with escalation appropriately. This has led to an additional 0.4 WTE Band 7 FTSU Guardian being recruited to the team.

Refreshing the focus on consistently improving staff experience when speaking up.

Improvements to data recording to expand staffs voice throughout the organisation.

Implement NGO guidance for staff raising concerns of detriment.

Finally, the feedback function has changed to an anonymised function, in line with NGO guidance. Data is captured as set out by the NGO.

Further updates on matters raised in 2022/23 report:

Progress on developing a FTSU Strategy has paused due to the increase in cases and need to improve staff experience as a priority.

Developing a champion network remains a priority but capacity has not allowed. With the support of the additional recruited FTSU guardian, the FTSU service will commence recruitment for Champions in July 2024. This investment into the service will also enable the FTSU service to respond strategically to the speak up needs of the organisation while still supporting the reactive needs of staff concerns.

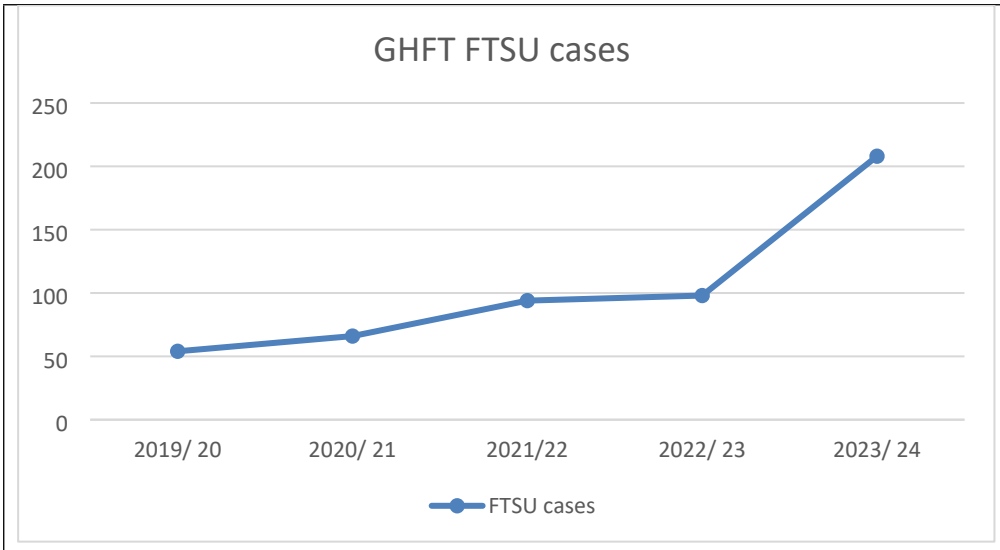
There remains a need to address training needs in the organisation. FTSU listen up, speak up, follow up training is available for all staff to access, however this approach needs to be reviewed in order to ensure all staff access the training.

FTSU has a live communications plan and support to promote the service.

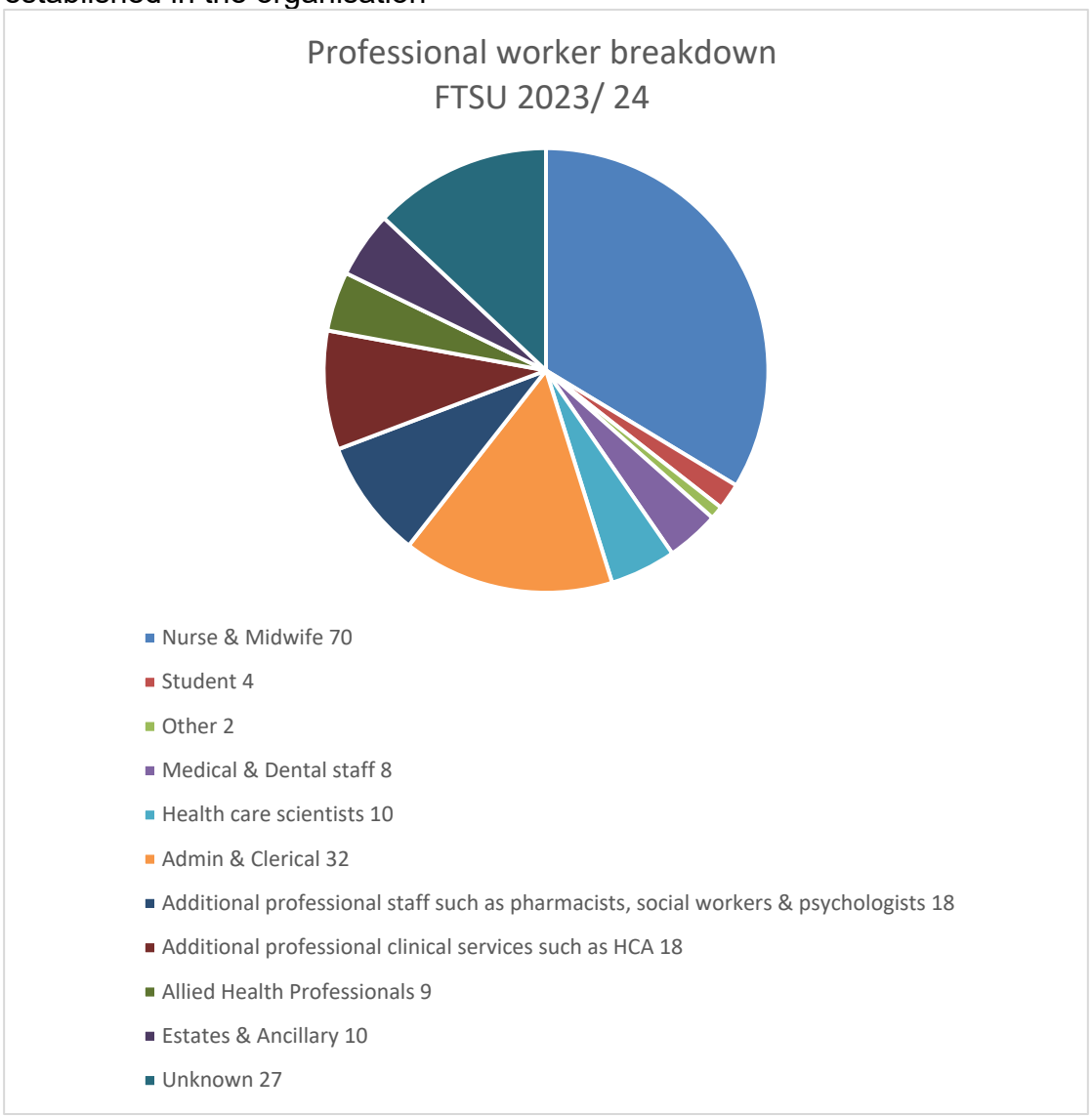
Finally, in our last annual report The National Guardians Office Ambulance Trust review – *Listening to workers* was referred to, setting out guidance for organisations to follow. An update on the progress can be found in Appendix 1.

2023- 24 FTSU data and activity:

208 staff have accessed FTSU to raise concerns this year, more than doubling the activity of the previous year. A dedicated Lead full-time Guardian has, as expected increased provision in the service and processes of FTSU.

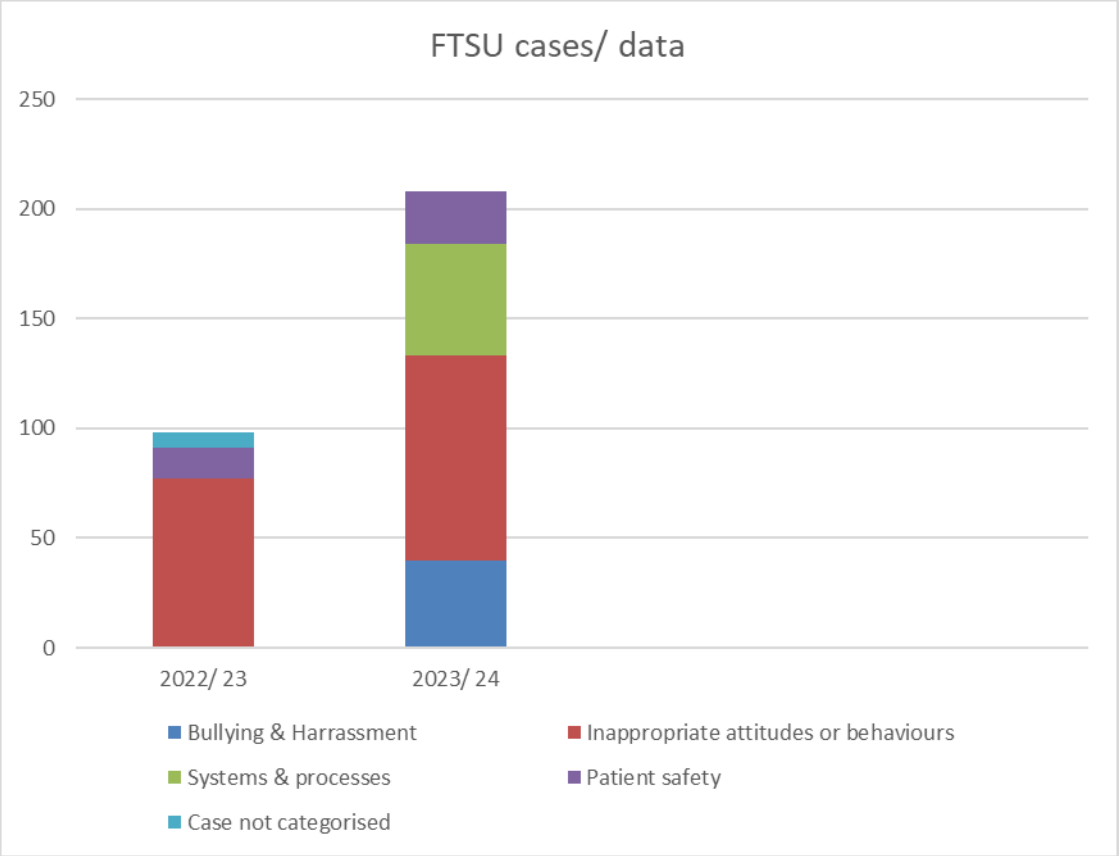


The types of cases that staff raise are broad and staff access the service from all staff groups which is reassuring that the reach of the service is becoming established in the organisation



As can be identified below, inappropriate attitudes or behaviours (previously captured as behaviours), remain the organisations highest reason for contacting FTSU with nearly half of all total cases. Staff are fearful of repercussions and also fearful of trusting the organisation in speaking up matters.

Themes have been captured in the FTSU service as fear of speaking up; discrimination; poor experience as new starters; poor experience as a disabled person requiring reasonable adjustments; nepotism in recruitment and general poor behaviours witnessed or experienced in the organisation.



Some examples of anonymised staff concerns are captured here show the complexities of some of the issues staff are raising:

Cases with an element of worker safety	• Staff reporting concerns about fear in relation to speaking up • Staff safety concerns connected to others behaviours
Examples of patient safety concerns	• Staff concerned about a training issue • Concerns connected to safe staffing levels • Staff raising a patient safety issue connected to care • Staff experiencing a poor response when they try to speak up to their line manager
Examples of bullying and harassment concerns	• Staff experiencing discrimination • Staff reporting harassment
Examples of a system and process concerns	• Staff expressing concerns about a lack of process connected to a safe working environment • Staff speaking up about the length of time a grievance process takes to resolve

Examples of cases with inappropriate attitudes or behaviour	• Staff worried about the behaviour of their line manager if they speak up • Staff reporting recruitment behaviours, believed to be nepotism

Staff experience of speaking up in Gloucestershire Hospitals:

A common theme staff express is a poor collective experience of the organisation.

Staff report a poor collective experiences as; reaching out to the organisation and being given incorrect advice about their issue; a concern not considered significant by their line manager in the climate of speaking up; a worker over hearing a manger speak about a colleague in a poor manner that impacts the workers trust; a worker sending e mails seeking help and not receiving a response; a worker accessing a reporting system and not knowing the outcome. Staff approaching FTSU have often experienced all, or some of the above before approaching FTSU.

This poor collective organisational experience means staff need more time to gain psychological safety which has impacted on the capacity of the FTSU service.

Futility has been reported in the National Guardian's Office Annual report 2022- 23 as an element for organisations to overcome as people stay silent in organisations for fear of speaking up. It is essential that our managers and leaders respond to concerns with a growth mindset, where concerns are welcomed and seen as an opportunity for learning and improvement.

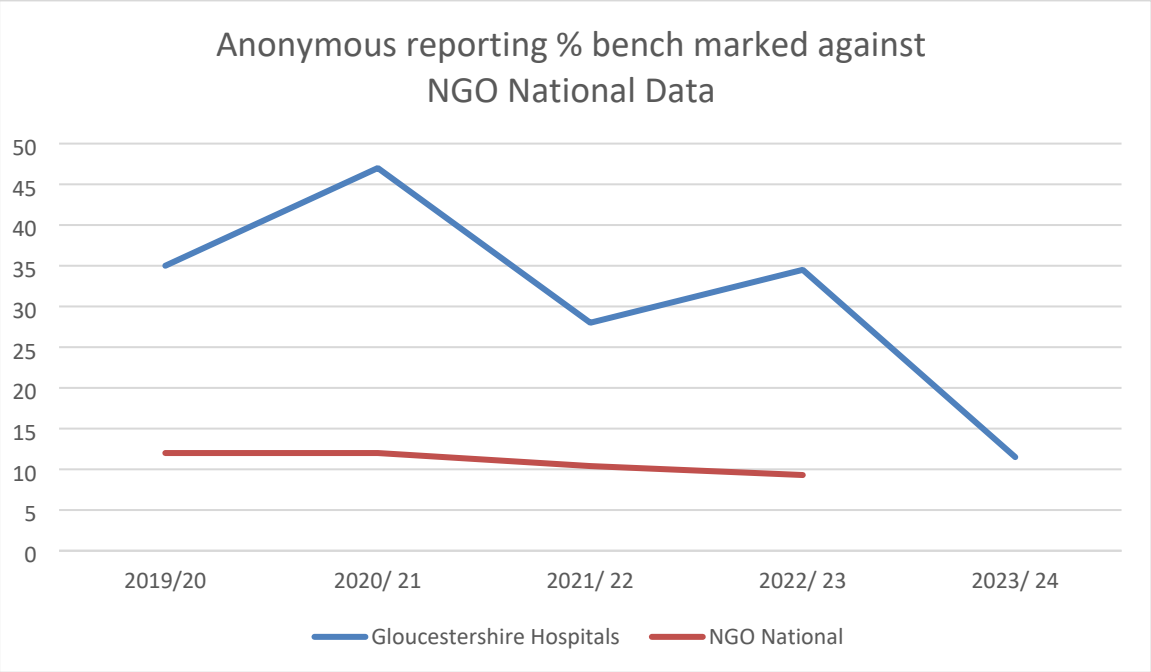
In addition, there are times when staff report; their only options is to follow a chaotic approach to trying to resolve issues, such as accessing Consultant line management in their team rather than Nursing line management or going outside of the organisation to express concerns rather than accessing available internal routes.

There is confusion in the organisation at times as to the FTSU function. FTSU has captured this learning to prioritise communication of the service with NGO guidance as the next priority. This will include producing extra support information for managers and staff as well as prioritising the Champion network and training in the next two quarters.

Improvements

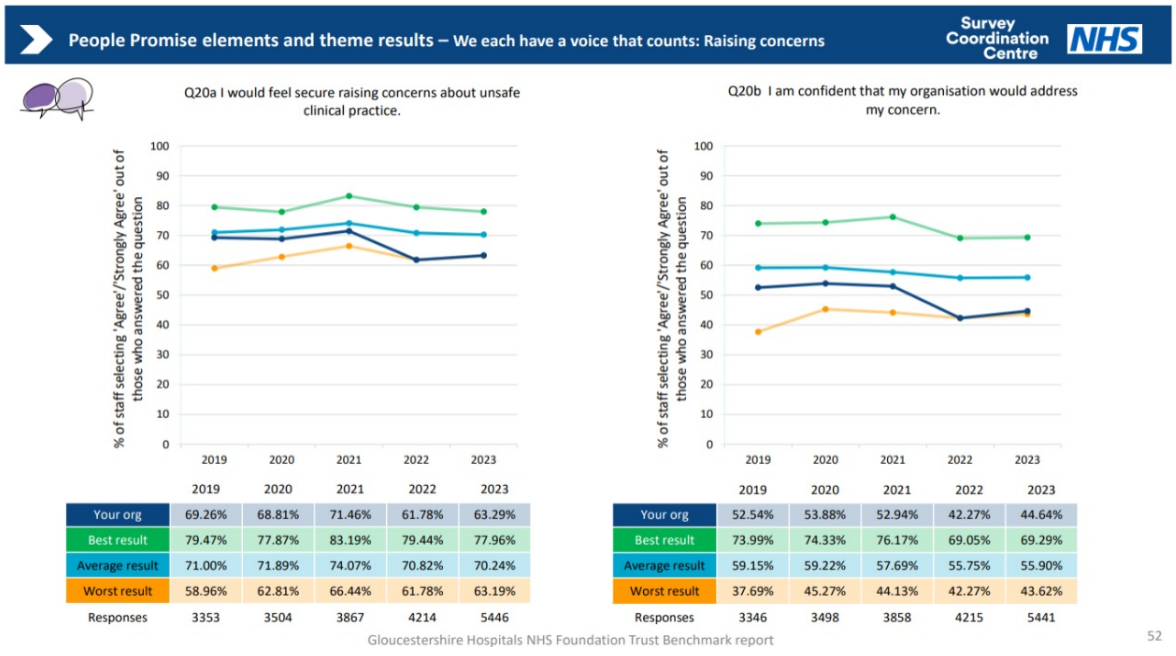
As reported last year, it was noted that anonymous reporting at Gloucestershire Hospitals has been higher than the national average sitting at 34.5% last year.

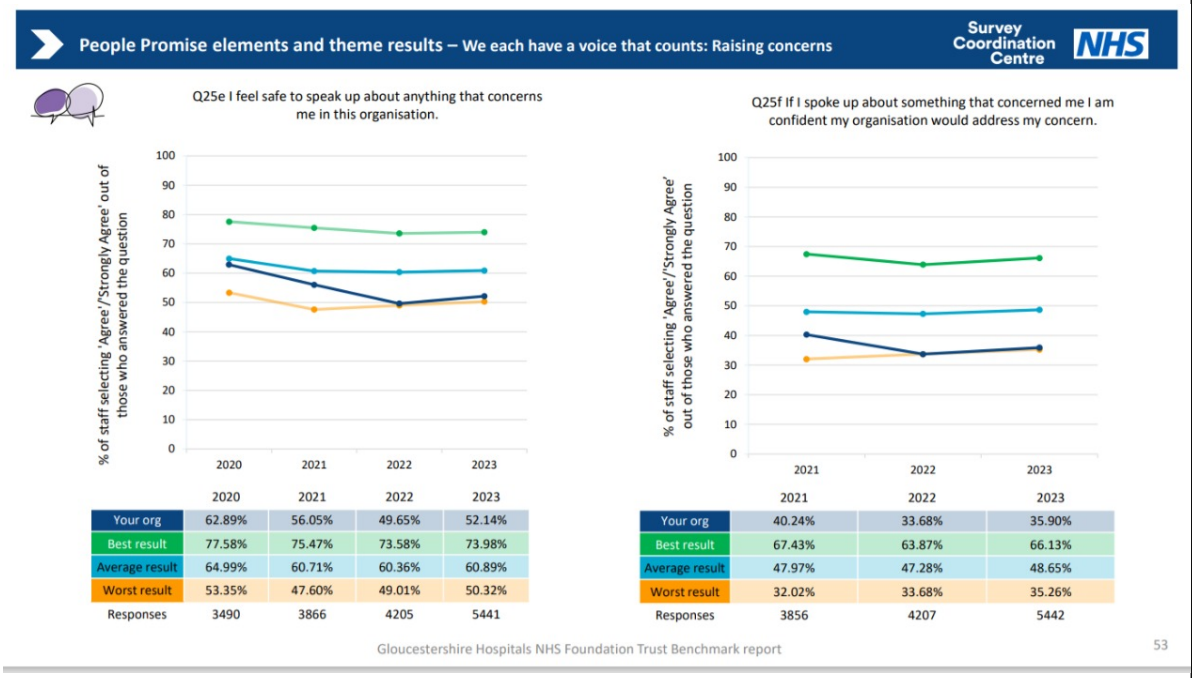
The graph below shows the anonymous reporting trends bench marked with National Data over the last 5 years.



Anonymous reporting is highlighted by the NGO as an indicator of staff potentially feeling a lack of trust in the organisation and fear of detriment. As expected, the stability of a Lead Guardian has decreased anonymous reporting to more open concerns and less anonymised concerns raised.

As previously reported, the Trust has responded to data from the staff survey (please see data below) and CQC report April 2022. (https://api.cqc.org.uk/public/v1/reports/2a68a3e9-5335-4c90-8c07-ea5c55ec2370?20221129062700) citing a lack of trust in the freedom to speak up system and a lack of action when concerns were raised. This year with a high response rate of 68%, staff report improvements in speaking up matters.





A Panorama programmed aired on BBC in January focusing on maternity services, led to additional activity in the FTSU service with additional staff speaking up in the following week. Although maternity staff access FTSU, the programme did not increase activity in the form of concerns from maternity during that time. It was noted that the organisation were actively supporting staff and continue to support staff with speaking up, by advertising the FTSU service and offering support to staff.

Other improvements include previously mentioned investment into the FTSU service in the form of an additional FTSU Guardian on a 23 month fixed term contract. This will move the service from simply reactive to include a strategic function as well.

Staff experience and feedback

As reported, an anonymised feedback reporting system has been introduced. Over the last 5 years, feedback has been captured by the Trust as 'the majority of staff would speak up again' so there is not an opportunity to benchmark.

To date, 15 staff have accessed this avenue to provide feedback, other avenues have been written or verbal communication. Some staff voice they would speak up again. Others are disillusioned as they believed the FTSU service would do something outside of the FTSU function.

Would you speak up again?	Total responses	What was helpful about the FTSU service?	Other comments
Yes	11		"I felt heard and listened to thank you"

		"being listened to and I felt safe" "Positive input received within a short time" "I was listened to" "Someone sat down with me and finally listened"	"FTSUG spent time with me and helped me have a voice" "The issue I raised was complex but FTSU took time to chat things through and understand" "It was prompt and quickly resolved"
No	2	"Sorry but I didn't find anything helpful."	"It was pointless."
Maybe	1		
Don't know	1		

To date, 62 cases remain open and 146 cases have been closed. Of the 146 closed cases, 100 staff have shared feedback, with 15 of those staff accessing anonymous feedback service. 72 staff said they would speak up again, 8 staff said no and 20 were unsure. The current national data is not yet available, but last year's national data shared that 82.8% of staff would speak up again in comparison with GHFT 72%.

Local, Regional and National Work:

The National Guardian Office 2022/ 23 reports a 25% increase in concerns raised leading to a national total of 25,382.

Future priorities of the National Guardians Office have been highlighted as

- Improving systems to better support the NGO offer to Freedom to Speak up Guardians
- Ensuring all workers have a voice wherever they work
- Exploration into how the NGO can better support knowledge and skills of Non- executive Directors and those with organisational oversight
- Build on insights from the first NGO speak up review, initiating the next review and establishing a framework for future assessments (NGO Annual report 2022/23)

Gloucestershire Hospitals Lead FTSU Guardian continues to actively engage with the National Guardian's Office, seeking support for the organisation on speaking up matters and providing support to peers and mentorship for newly registered guardians nationally.

Please see below the responses to the 'verdict in the trial of Lucy Letby' letter sent by NHS England to Integrated Care Boards (ICBs) and NHS Trusts the organisation:

Recommendations	FTSU update

All staff have easy access to information on how to speak up	FTSU comms plan in place where regular references are made to FTSU service and support available in the organisation
Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme	National Speaking up support scheme and active referrals have been made by the Lead FTSUG in 2024
Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place	The new Champion network will actively support staff who may have cultural barriers Weekend and unsocial hours are provided to staff raising concerns *Building a safe speak up culture* is a workstream within the Staff Experience Improvement Programme and has project support. Building healthy and supportive cultures is part of the workstream, alongside improving communication
Last year we rolled out a strengthened Freedom to Speak Up (FTSU) policy. All organisations providing NHS services are expected to adopt the updated national policy by January 2024 at the latest	The FTSU policy FTSU updated in August 2022 in accordance with new FTSU national guidance Work is underway to make the policy more user friendly and accessible

In addition, the Director for People and the Chief Nurse and Director of Quality have commissioned a review to identify any associated risks with past FTSU cases in response to the 'verdict in the trial of Lucy Letby' letter . This review continues to be underway and will be reported on in due course during Q1 24/25.

Learning

Learning is promoted by the NGO as one of the key FTSU values. Learning as a function in response to FTSU concerns in Gloucestershire Hospitals is in its infancy and needs to grow and develop in a meaningful way. The majority of concerns provide local opportunities for learning and reflection but often the FTSU service meets a more punitive response to concerns in the organisation rather than a restorative, learning response.

One concern that has successfully captured learning stemmed from a staff member speaking up about the impact of the launch of TCLE. In response to the staff members concerns, the organisation commissioned a review of the lessons learnt.

Taken from the review, lessons learnt are reported as:

- Improved planning and assurance processes have been established to ensure the right decisions are made at the right time in a project life cycle.
- A rigorous change management process is in place and provides accurate assurance that changes have been logged and applied.
- Stakeholders are identified at the start of each new project, and involved in a project board from the start. A dedicated Testing lead directs teams

through a process to ensure all areas of a new product/system have been properly tested, including end users.
- Go-lives themselves are now led by a dedicated lead, with standardised processes to ensure that the process is uneventful. Projects would not now go-live if the testing, training and communications, and sign-off was complete.

The review has been shared with the staff member with openness and transparency from the Trust.

Conclusion:

The Freedom to Speak Up function is designed to support staff to have a voice in the organisation where there are barriers to speaking up. The FTSU service has focused on case management and support to provide staff with an excellent speaking up experience, where speak up, listen up and follow up is supported by the organisation. With anonymous reporting reducing, there is evidence to suggest that trust is gaining in the service and the organisation is more trusted by staff to respond to their concerns.

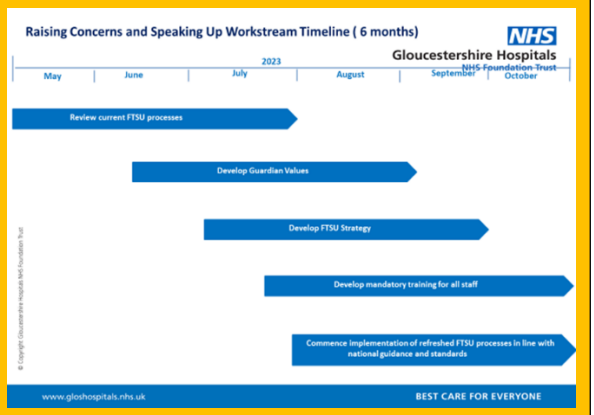
Cases have increased and the organisation has responded by supporting the recruitment of a new 0.4 WTE FTSUG to support the need of growing a dedicated FTSU team with protected time.

There is genuine support from senior leaders to respond to cases and support staff speaking up.

With the continued alignment with the NGO and communicating those processes to staff through training and education, it is hoped FTSU will continue to develop into a valued and trusted service by staff to further impact speaking up being ‘business as usual’ in the organisation.

Appendix 1

Recommendation taken from Ambulance Review Feb 2023 ***'Listening to workers'***	Review and update on action from Gloucestershire Hospitals FTSU Service April 2024
Recommendation 1: Review broader cultural matters	Cultural Review work is underway in Gloucestershire Hospital's NHS Foundation Trust Improvement programme is in place with a workstream focused on raising concerns and safe speaking up titled '*building a safe speak up culture'*
Recommendation 2: Make speaking up business as usual This recommendation requires; • Mandate training on speaking up - in line with guidance from the National Guardian's Office - for all their workers, including volunteers, bank and agency staff, as well as senior leaders and board members.	Training for all staff is available for all staff on ESR, however a review is planned in July 2024 to assess the needs for each module and to review how staff will be informed etc Essential or mandatory training requirements will be finalised by October 2024 in time for FTSU awareness month
• Trust leadership (including managers, senior leaders and board members) to fully engage with Freedom to Speak Up, evidenced by board members undertaking development sessions	New FTE Lead FTSU Guardian recruited and in post with 2nd 0.4 WTE FTSU Guardian recruited to start in May 2024
	Engagement for FTSU Strategy commencing June 2023 has been paused to support staff speaking up. Board development- this is in discussion with NGO

	Work plan review: 
	• FTSU review is complete and findings and update can be found at the beginning of this report • Implementation of refreshed process in line with NGO guidance was moved *forward* to May 2023 in response to FTSU review findings exposing poor staff experience.
Embed speaking up into all aspects of the trusts' work by proactive engagement by leadership, managers and Freedom to Speak Up guardians across the trusts through regular communications.	• Open communication established with senior leaders and board • Regular communication with Lead Exec and CEO and Lead FTSU NED in place.
	• A 0.4 Band & FTSUG 23 months has been recruited to support strategic FTSU work
Trust leadership teams should identify the professional groups/areas within the trust that need support in implementing Freedom to Speak up by diagnosing root causes and putting in place a support mechanisms for managers and workers to feel psychologically safe when speaking up and reduce detriment.	• Comms plan in place • Engagement for strategy will include liaising with networks to provide gap analysis
	• Diagnosing root causes and using data in a meaningful way is in progress but not achieved to date
	• Correct process for cases of detriment is now in place

Trust Boards to annually evaluate the effectiveness of speaking up arrangements; including effectiveness of facilitating all workers, including those from groups facing barriers to speaking up, being able to speak up about all types of issues and action being taken in response to speaking	• NGO Board assessment tool review needs to be completed, in discussion with NGO
Recommendation 4: Implement the Freedom to Speak Up Guardian role in accordance with national guidance to meet the needs of workers This recommendation requires all trusts to:	
• Meaningfully invest in the Freedom to Speak Up Guardian role. In discussion with their Freedom to Speak Up Guardian(s), leaders should identify the time and resources needed to meet the needs of workers in their organisation.	FTSU FTE Lead Guardian in post with time and resources provided to support staff
• Create (if not already in place), maintain and regularly evaluate a network of Freedom to Speak Up Champions/Ambassadors to support raising awareness and promoting the value of speaking up, listening up and following up.	FTSU Champion network with be launched in July 2024
• Provide emotional and psychological well-being support to Freedom to Speak Up Guardian(s). This support should reflect the challenges of the role and ensure the need for confidentiality. There should also be periodic check-ins with Freedom to Speak Up Guardian(s) about the effectiveness of this support.	Supervision support is available for the FTSU Team

NHS
Gloucestershire Hospitals
NHS Foundation Trust

People and Organisational Development Performance Dashboard

March 2024

Deborah Tunnell
Deputy Director for People & Organisational Development

the Best Care for Everyone
care / listen / excel

Executive Summary

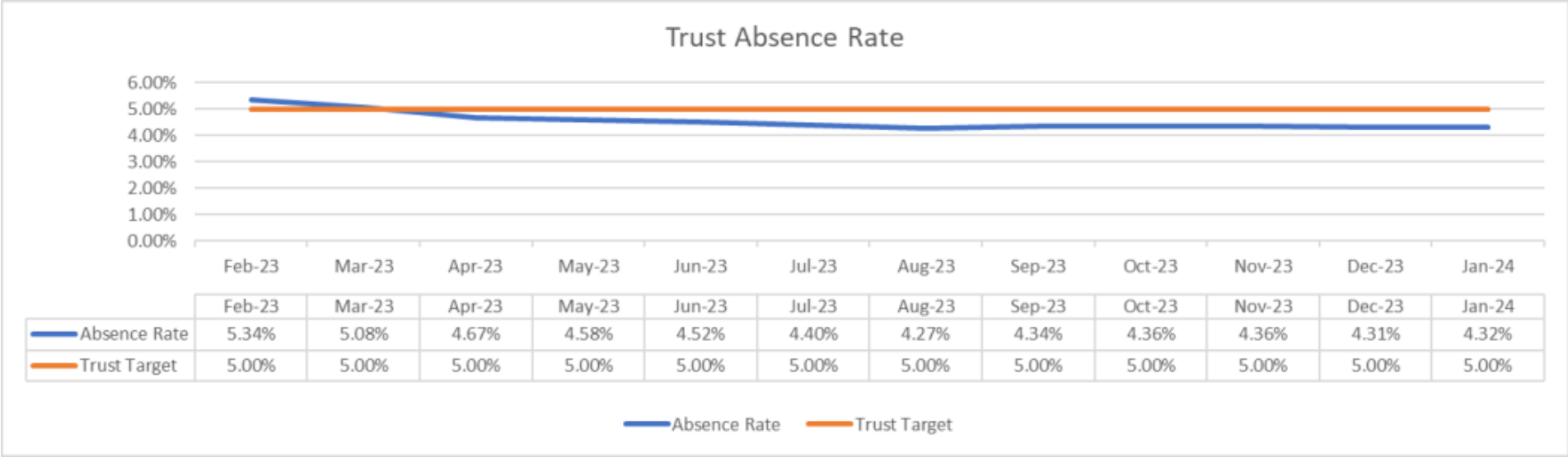
Performance Indicator	Target	Feb-23	Mar-23	April-23	May-23	June-23	July-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan 24
Turnover	**13%**	13.70%	12.92%	13.05%	12.62%	12.23%	12.12%	11.65%	11.56%	11.38%	11.37%	11.27%	11.02%
Vacancy	**8%**	7.58%	7.16%	7.61%	7.67%	7.40%	7.05%	7.05%	6.31%	6.43%	5.86%	6.54%	6.90%
Sickness	**5%**	5.34%	5.08%	4.67%	4.58%	4.52%	4.40%	4.27%	4.34%	4.36%	4.36%	4.31%	4.32
Appraisal	**90%**	79%	81%	81%	80%	80%	79%	79%	79%	79%	79%	80%	79%
Essential Training	**90%**	85%	86%	87%	88%	88%	87%	87%	87%	86%	86%	85%	85%
Agency (FTE & % of workforce)	**2%**	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%)	119.06 (1.61%)
Bank (FTE & % of workforce)	**6.5%**	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 (8.0%)	535 (7.24%)

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

Absence: Sickness (BAF SR16 Workforce - Culture, Experience and Retention)

Key Points to note
Sickness absence has seen a 0.01% increase from Dec 23 to Jan 24 at 4.32%
January 2024 is the tenth consecutive month that sickness absence has been recorded below the Trust target of 5%.
January 2024 sickness absence is currently 0.68% under the Trust target.

Improvement actions	Due Date	RAG
Focus has stalled in the sickness absence project under the Workforce Sustainability Programme, due to the Project Lead leaving post. Discussions are being held with the Health & Wellbeing Lead to explore an effective way of utilising the national funding and retain traction on existing activities, with synergies across the two portfolios.	May 2024	
The People Advisory Team has obtained HR Management access to ESR, significantly improving real-time access to sickness absence data. Training to improve the use of ESR for the whole team has been scheduled for May	May 2024	
Review of staff survey data is underway to identify any trends/issues related to sickness absence	April 2024	

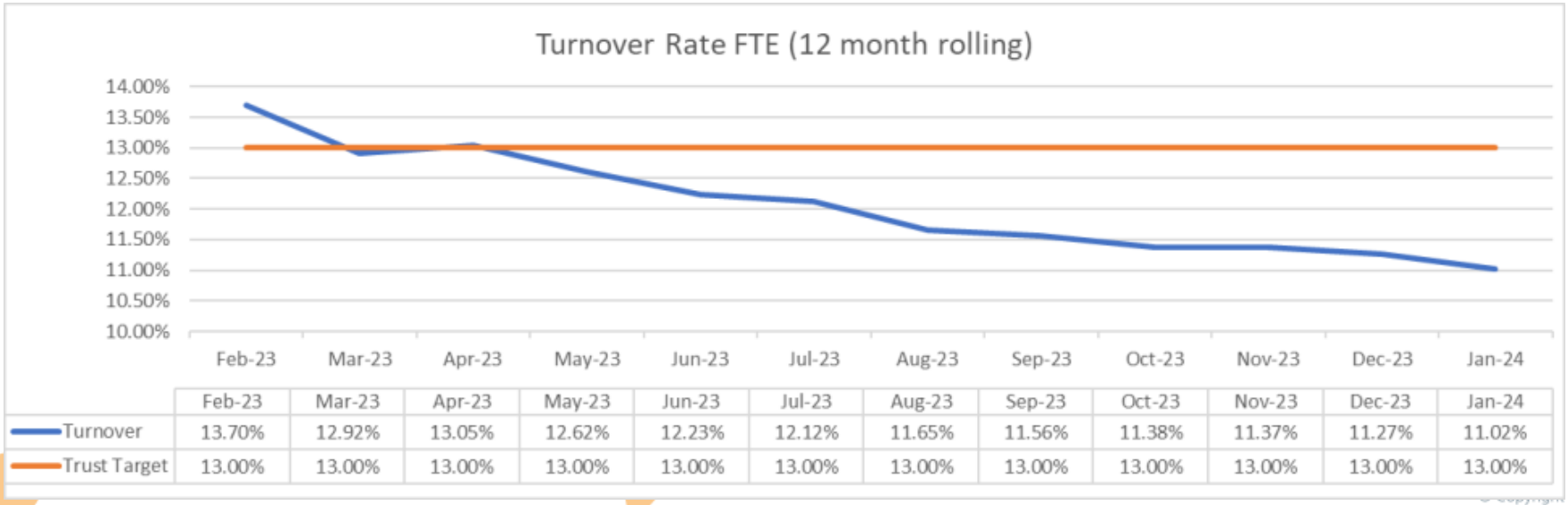


	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Absence Rate	5.34%	5.08%	4.67%	4.58%	4.52%	4.40%	4.27%	4.34%	4.36%	4.36%	4.31%	4.32%
Trust Target	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%

Turnover (BAF SR16 Workforce - Culture, Experience and Retention)

Key Points to note
Turnover has seen a 0.25% decrease from Dec 23 to Jan 24, with 11.02% recorded in Jan 24.
January 2024 is the ninth consecutive month that has seen a month on month decrease in turnover and also the ninth consecutive month which has seen turnover under the Trust target of 13%.
January 2024 Turnover is currently 1.98% under the Trust target.

Improvement Actions	Due Date	RAG
The Staff Experience Improvement Programme continues with its focus across the three core workstreams, each with defined action target dates.	Ongoing	
The Retention Group is making progress with three projects: Improving the exit process, Flexible retirement policy and transition from substantive to bank.	Q4 23/24	
The new nationally funded People Promise Partner post is out to advert, with interviews scheduled for mid-March. The role will partner across existing programmes, focussing on staff retention.	March 2024	



	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Turnover	13.70%	12.92%	13.05%	12.62%	12.23%	12.12%	11.65%	11.56%	11.38%	11.37%	11.27%	11.02%
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%

Statutory & Mandatory Training (BAF SR16 Workforce - Culture, Experience and Retention)

KPI - 90% compliance target

Division	31-Jan-24	31-Dec-23
Corporate Division	90%	91%
Diagnostic & Specialty Division	88%	88%
Medicine Division	85%	85%
Non-Division	83%	81%
Surgery Division	84%	84%
Women & Children Division	80%	78%
GHT Total	**85%**	**85%**

Training Compliance % by Date : Breakdown by Subject

Subject	31-Jan-24	31-Dec-23
318|LOCAL|Moving and Handling Level 2 (2yr)|	85%	84%
318|LOCAL|Safeguarding Adults Level 2|	42%	41%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	91%	93%
NHS|CSTF|Fire Safety - 1 Year|	88%	87%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	92%	94%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	96%	96%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	84%	83%
NHS|CSTF|Information Governance and Data Security - 1 Year|	87%	86%
NHS|CSTF|Moving and Handling - Level 1 - 1 Year|	88%	89%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	92%	92%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year|	89%	88%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	90%	90%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	88%	88%
NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - 3 Years|	86%	85%
318|LOCAL|Resuscitation Level 2 Adult Basic Life Support (2yr)|	n/a	n/a
GHT Total	**85%**	**85%**

Key Points to note

The Trust's overall compliance has remained consistent at 85% from Dec 23 to Jan 24.

Non Division are the only division to see an improvement (2%) from Dec 23 to Jan 23. Corporate and W&C divisions have seen a decrease from Dec 23 to Jan 24.

While Safeguarding Adults L2 and Information Governance remain non compliant, both programmes have seen a 1% increase from Dec 23 to Jan 24.

Improvement Actions	Due Date	RAG
Head of Corporate Learning & Development has commenced a full Stat/Man review, working with stakeholders to review the numbers of programmes, relevancy and ability to undertake the requirements	August 2024	
Task and Finish Groups established to review training Passporting, (Organisation and ICS System wide)	August 2024	
All pre-tests are now completed and live. Information Governance will not contain a pre-test however, in partnership with the Trust's IG Lead, focus is on developing job role specific training pathways to ensure relevance of training.	April 2024	
A review of the current content of Safeguarding is being undertaken, including the way it is reported across the higher levels (L2 & L3). The Safeguarding SME is also identifying whether there is an appetite to develop an ICB/ICS wide safeguarding training offering.	April 2024	

Appraisal (BAF SR16 Workforce - Culture, Experience and Retention)

KPI - 90% compliance target

Division	31-Jan-24	31-Dec-23
Corporate Division	73%	75%
Diagnostic & Specialty Division	76%	78%
Medicine Division	82%	84%
Non-Division	75%	81%
Surgery Division	86%	88%
Women & Children Division	73%	70%
GHT Total	**79%**	**80%**

Appraisal Compliance % by Date : Breakdown by Staff Group

Staff Group	31-Jan-24	31-Dec-23
Add Prof Scientific and Technic	59%	62%
Additional Clinical Services	83%	84%
Administrative and Clerical	74%	76%
Allied Health Professionals	77%	76%
Estates and Ancillary	73%	77%
Healthcare Scientists	75%	81%
Medical Staff - Consultants	89%	93%
Medical Staff - SAS	78%	81%
All Medical Staff	91%	91%
Nursing and Midwifery Registered	83%	83%
GHT Total	**79%**	**80%**

Key Points to note

The Trust has seen a 1% decrease in overall compliance at 79% in Jan 24

All divisions have seen a decrease in compliance from Dec 23 to Jan 24, with the exception of W&C who has seen a 3% increase in compliance.

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

Healthcare Scientists have seen the greatest decrease in compliance of 6% from Dec 23 to Jan 24. Allied Health Professionals are the only staff group to have seen an increase (1%) from Dec 23 to Jan 24.

Improvement Actions	Due Date	RAG
Review and rewrite of non-medical appraisal policy, procedures and paperwork is underway. Revising planned launch to Q1 2024, as stated in Organisational Readiness Audit management response	June 2024	
Review of training support for appraisers and appraisees to be developed, alongside refreshed policy and paperwork	May 2024	
New draft paperwork being tested with sample of stakeholders in Trust. Feedback planned for March 2024 which will inform the new approach	March 2024	

Freedom to Speak Up (BAF SR16 Workforce - Culture, Experience and Retention)

Key Points to note
FTSU cases peaked in January with 20 new cases raised in the week of the Panorama programme, taking the current total to 185 cases. FTSU currently has 50 open cases and has closed 135 this year.
During Q3, anonymous reporting has reduced to an all time low of 10% in the organisation, with staff choosing to have open conversations with the FTSU team.
The team has achieved protected time for all Guardians, resulting in meeting the NGO guidance. New support is being built into the team to ensure timely escalation of cases, support and learning is achieved.
Staff now have access to an anonymous feedback system to share their experience of FTSU enabling to capture data on staff experience.
Staff are talking about poor behaviours, discrimination, impact work has on staff wellbeing and work safety due to poor staffing. An additional emerging theme is staff voicing that Working Well adjustments are dismissed by managers giving staff poor experiences in the work place.

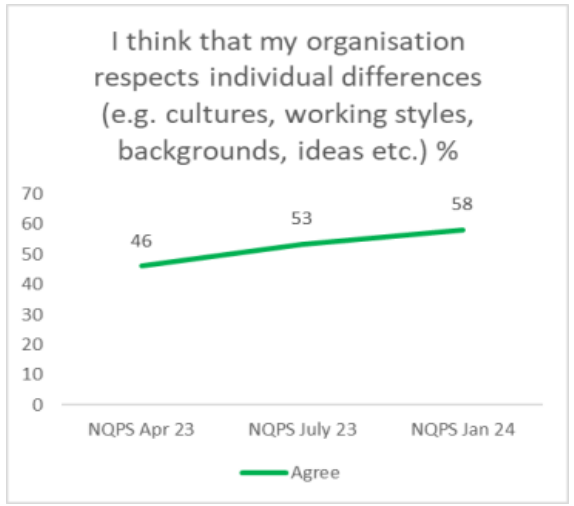
Improvement Actions	Date Due	RAG
Review of patient safety concerns raised to FTSU. Terms of Reference set Jan 2024	March 2024	
Q4 Audit in progress	April 2024	
Recruitment of additional FTSU Guardian has been pushed out due to a couple of internal process challenges	April 2024	

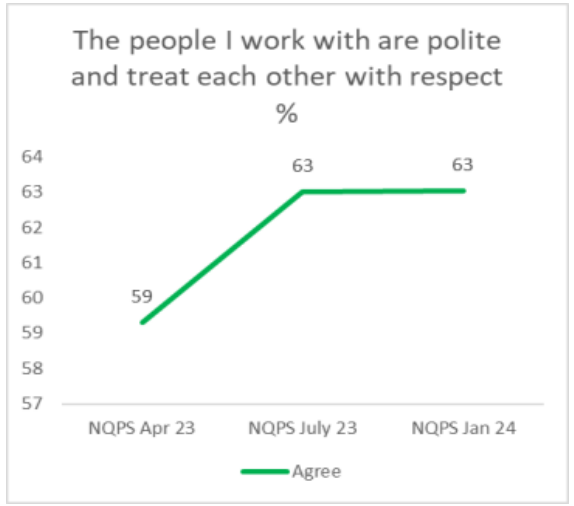
Freedom to Speak Up Guardian
www.nationalguardian.org.uk

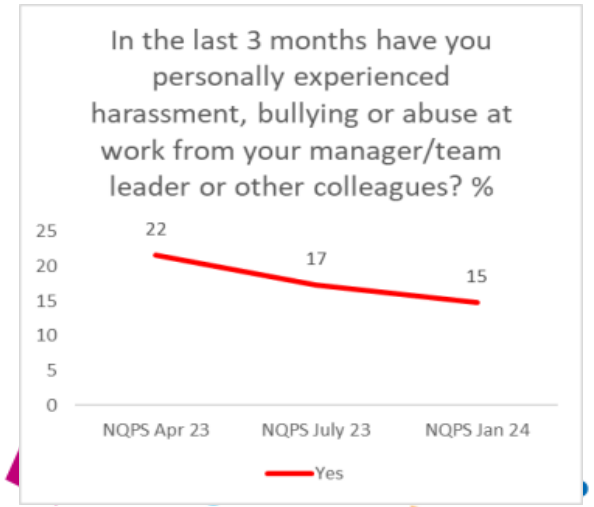
Your voice matters

Staff Engagement and Experience (BAF SR16 Workforce - Culture, Experience and Retention)

People Promise element 1: We are compassionate and inclusive



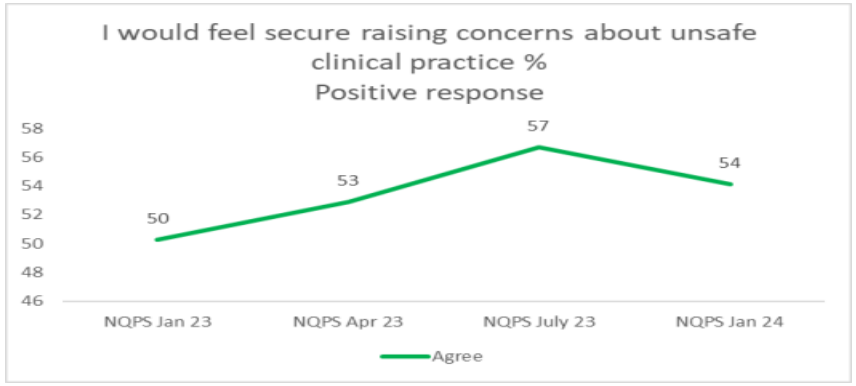


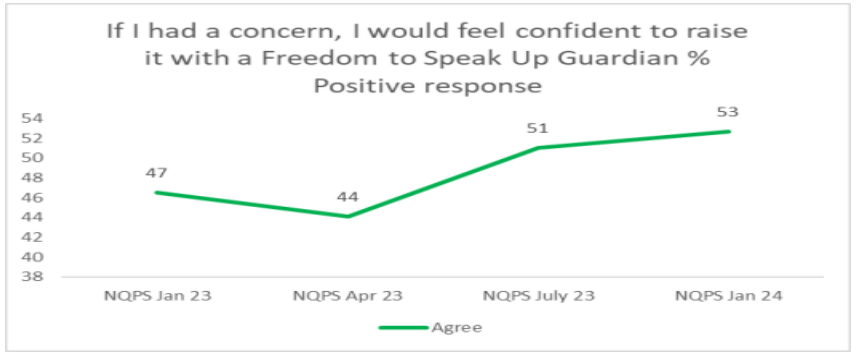


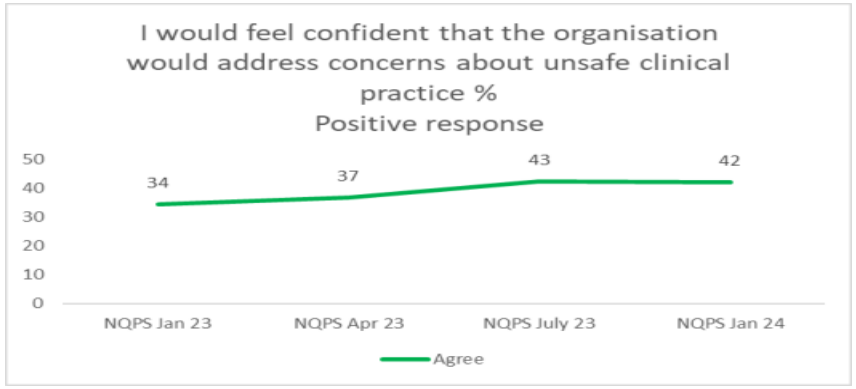
Key Points to note
The number of staff who believe the organisation respects differences has increased, with more people moving from “neither agree nor disagree” to agree
Whilst the positive response to “the people I work with are polite and treat each other with respect” has remained the same, the number of people answering “neither agree nor disagree” has moved to disagree
The number of people who have experienced discrimination from a manager or colleagues has increased by 0.3%
The number of people who have personally experienced harassment, bullying or abuse from a manager or colleague has decreased, which is positive.

Staff Engagement and Experience (BAF SR16 Workforce - Culture, Experience and Retention)

People Promise element 3: We each have a voice that counts



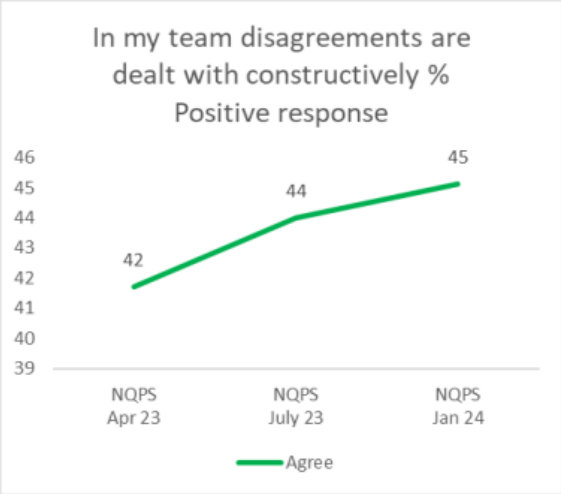


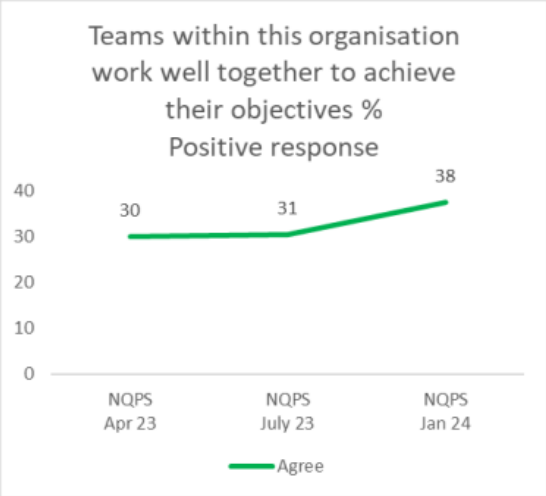


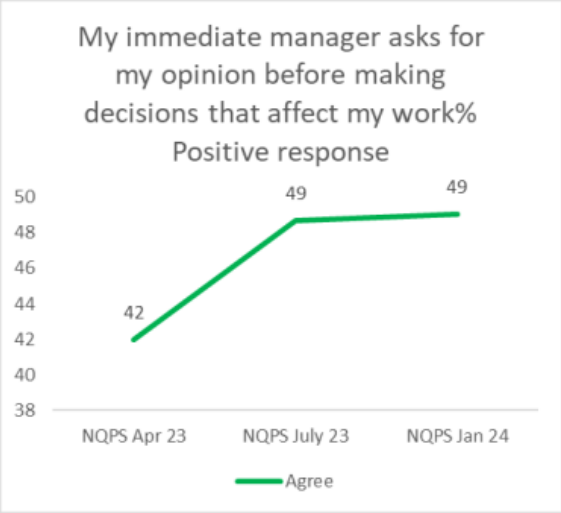
Key Points to note
Whilst there is still an improvement from when first being asked, the number of people positively responding to the question “I would feel secure raising a concern about unsafe clinical practice” has decreased by 3%
The number of people feeling confident to raise a concern with a Freedom to Speak up Guardian has increased.
The number of people who “prefer not to say” which Division they are in has increased potentially indicating a lack of trust in the confidentiality of the NQPS and a lack of psychological safety

Staff Engagement and Experience (BAF SR16 Workforce - Culture, Experience and Retention)

People Promise element 7: We are a team







Key Points to note

Three out of the four questions for this element have positively improved

The number of people positively answering the question “my line manager asks my opinion before making decisions” has remained the same. However, the number of people who have moved from answering “neither agree nor disagree” has decreased, but the number of people answering negatively has increased

Improvement Actions

The January 2024 NQPS together with the annual staff survey results 2023 are being analysed in detail to inform the relaunch of the Staff Experience Improvement Programme which is being presented to the Trust Leadership Team in April 2024.

The Leadership and Teamwork workstream is progressing well with the first of the sessions with The Wellbeing Collective for Wave One are planned to take place early March 24.

The Anti-Discrimination workstream has been focussing on agreeing the most appropriate reporting platform.

The Taskforce has formally completed, but there are next steps which are being taken forward to finalise the projects undertaken.

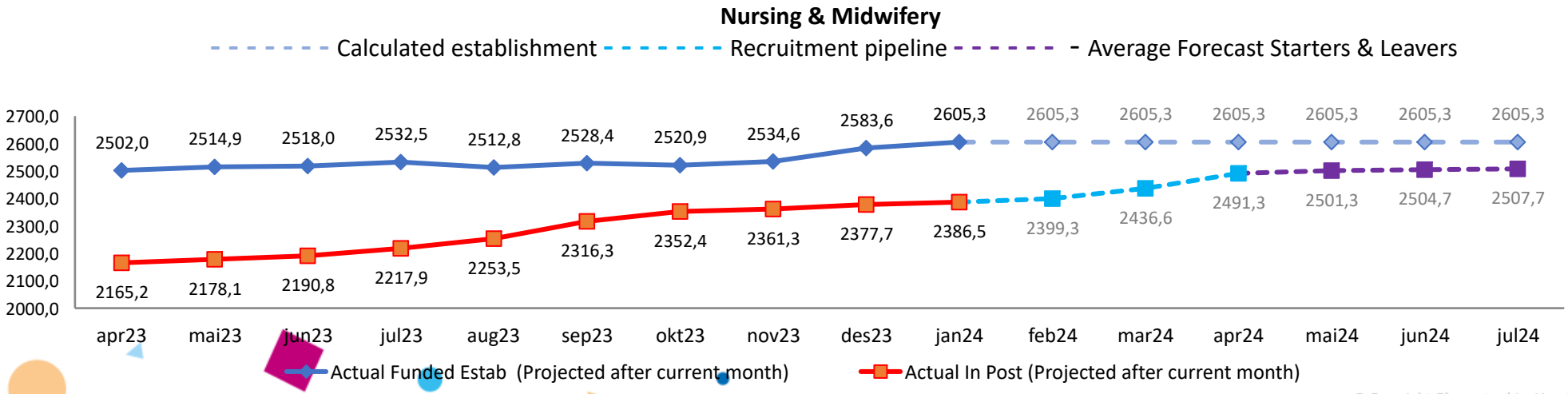
The Speaking Up workstream continues to be a success relating to the improvements to the FTSU service.

The Restorative Just and Learning Culture workstream continues to develop a background briefing paper in readiness to implement the RJC approach

Recruitment Pipeline (BAF SR2 Workforce - Recruitment & Attraction)

Key Points to Note
There has been a further increase of staff in post of 8.8 FTE from December 23 to January 24.
The gap between in post and funded establishment for nursing and midwifery for Jan 24 currently sits at 218.8 FTE. Funded establishment has increased by 21.7FTE.
Current projections from the staff in the recruitment pipeline indicate that by July 2024, the vacancies for Nursing and Midwifery will have reduced to 97.6 FTE.
The 'Average forecast of starters & leavers' line includes domestic recruitment and newly qualified nurses.

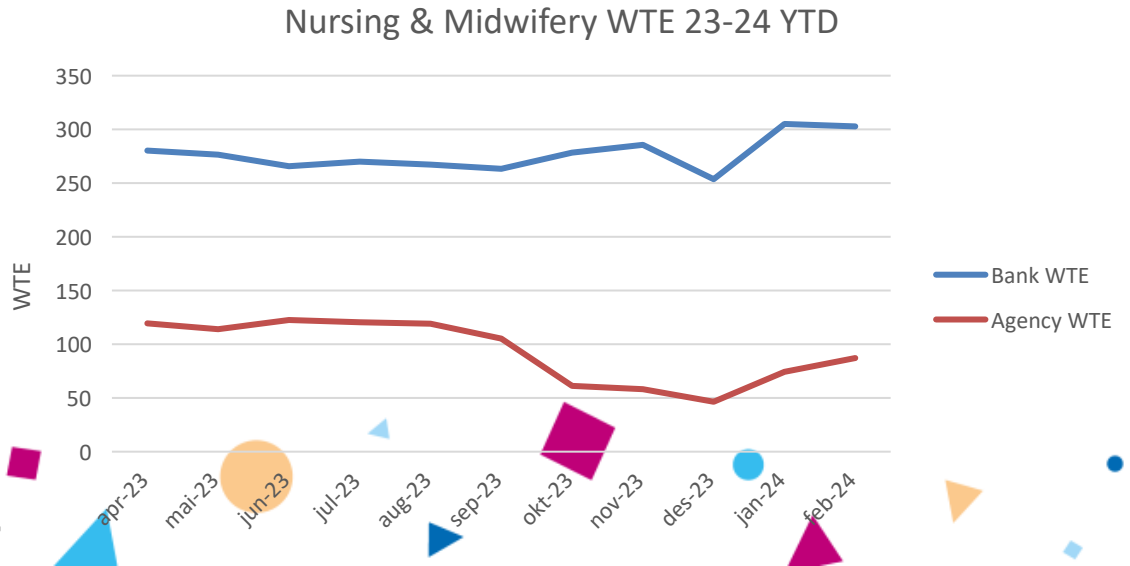
Improvement Actions	Date Due	RAG
Planning for 2024/25 remains ongoing particularly in light of the removal of NHSE funding going forward to support further overseas nurse recruitment. Options are being explored together with a focus on the domestic pipeline.	March 2024	
Final cohort of Internationally Educated Nurses (30) were brought in during January 2024 and are currently undertaking their OSCE exams. On completion, they will receive their NMC Registration and contribute to our nursing 'actual' totals below	April 2024	
The Nursing, AHP and Midwifery Spring Jobs Fair takes place on Saturday 20th April 2024 at Sandford Education Centre and is supported by all specialties across the Trust.	April 2024	

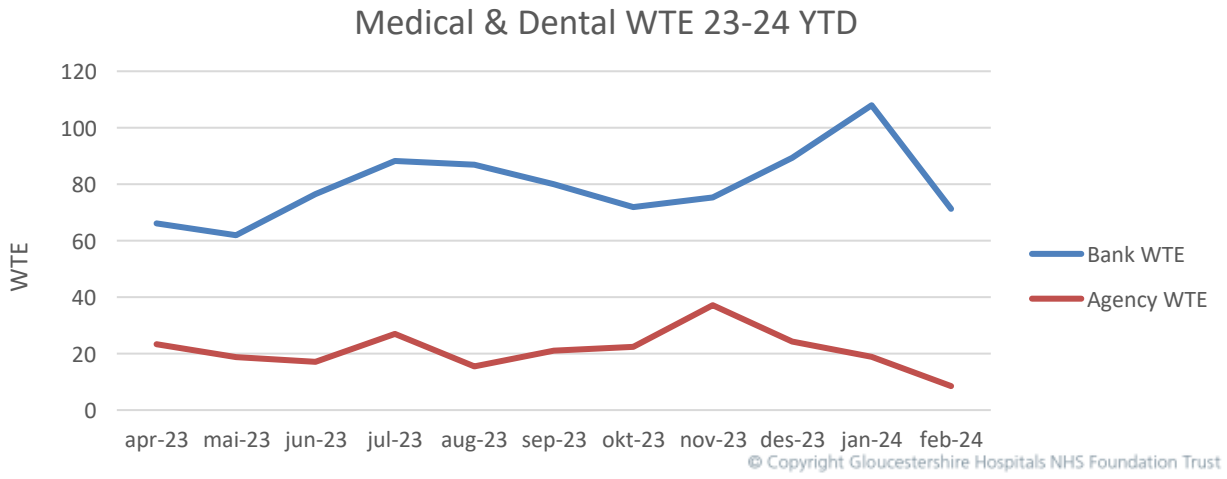


Bank and Agency WTE (BAF SR2 Workforce - Recruitment & Attraction)

Key Points to Note
Bank spend for Medics in M10 - £2,342,980 (increase from M09) Agency spend for Medics in M10 - £461,215 (increase from M09)
Bank spend for Nursing & Midwifery in M10 - £2,223,440 (decrease from M09) Agency spend for Nursing & Midwifery in M10 - £604,516 (increase from M09)
Bank spend for Medics increased in M10 due to Industrial Action in month. Rates for shifts prior to, in between and during the strikes were enhanced to secure cover, ensure patient safety and support recovery.
Bank spend for Nursing & Midwifery is at the lowest it has been this financial year. However, agency spend is the highest it has been since M06. There has been a marked increase in Midwifery shifts being escalated to off-framework agencies such as Thornbury.

Improvement Actions	Date Due	RAG
All bank and agency bookings for non-clinical staff will be centralised through the Bank Service and recorded on HealthRoster from April 2024. Progress has been made to train 20 new departments on the system.	April 2024	
A task & finish group has been reviewing the Trust's local medical locum rate enhancements. The group has seen cross divisional representation. An options paper is now being drafted for initial consideration by the Corporate Agency Grip & Control Group. Target launch date set as April 2024.	April 2024	
BI and Temporary Staffing continue to work together on automated reporting. Decision to be made on affordability of system that will allow this.	March 2024	

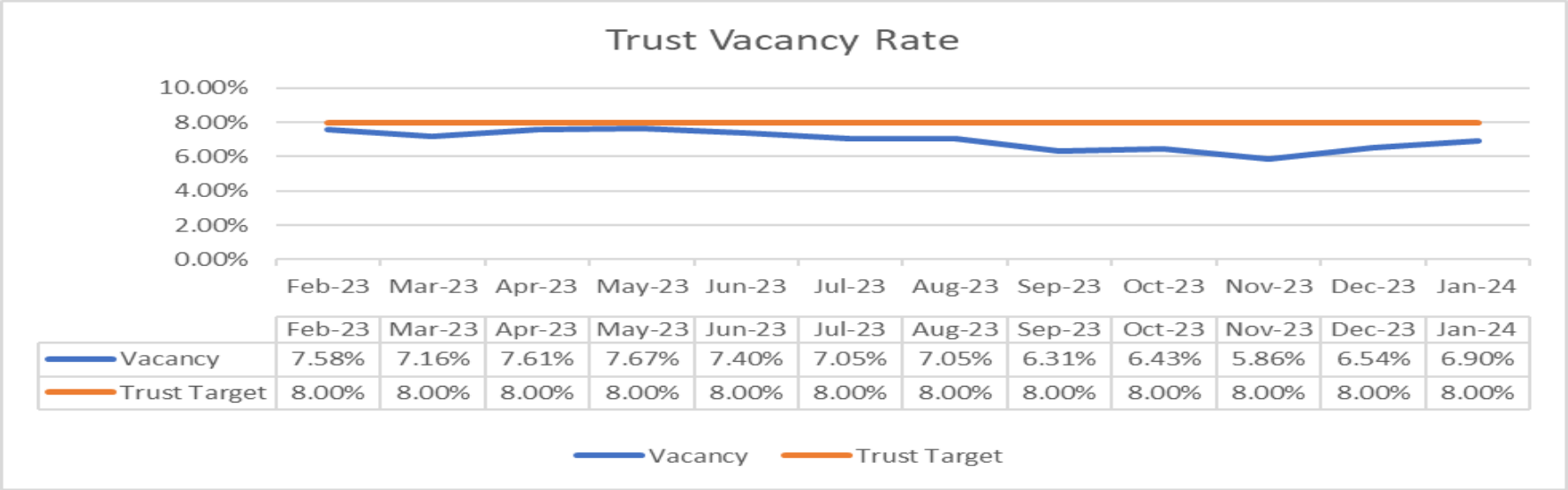




Vacancies (BAF SR2 Workforce - Recruitment & Attraction)

Key Points to note
Trust wide vacancies have seen a slight increase of 0.36% from Dec 23 to Jan 24, being recorded at 6.9%.. Funded establishment has increased by 83, actuals have increased by 56.5 FTE.
January 2024 is the 12th month that total vacancies have been under the Trust target of 8%.
In January 2024, the Vacancy is 1.1% under the Trust target.

Improvement Actions	Date Due	RAG
Improvements in Time To Hire, together with the reduction in staff turnover are realising a positive impact on vacancy reduction.	Ongoing focus	
Recruitment drives across some hard to fill roles has delivered positive results: the Trust's Nurseries, Dietitians, Stroke and Vascular Consultants, and Maternity.	March 2024	
Ongoing targeted focus across 2024/25 utilising the Trust's new marketing brand and a range of innovative attraction solutions	EVP to be launched April 2024	
A review of existing Welcome Incentives (Golden Hellos) remains a focus to evaluate the effectiveness of these incentives and benchmark against local NHS Trusts	April 2024	

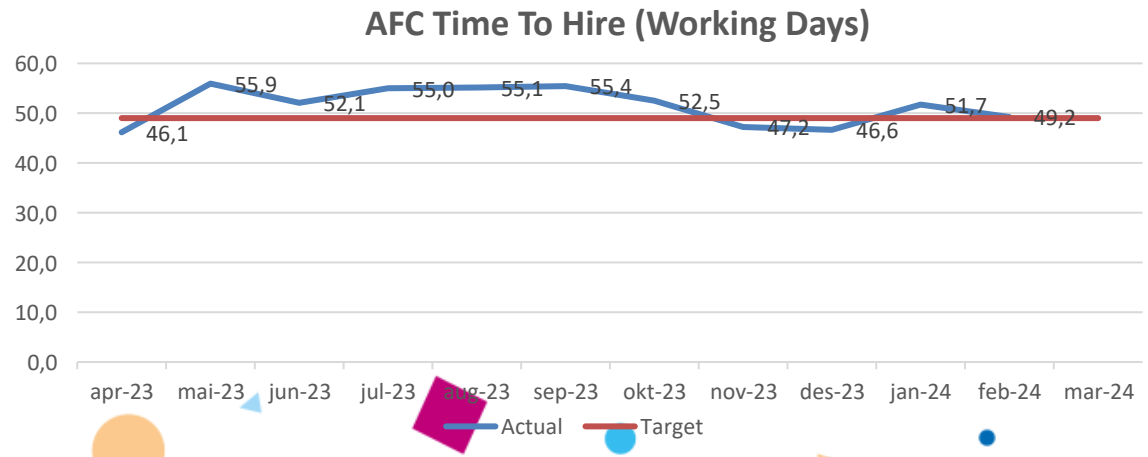


	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24
Vacancy	7.58%	7.16%	7.61%	7.67%	7.40%	7.05%	7.05%	6.31%	6.43%	5.86%	6.54%	6.90%
Trust Target	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%

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

Key Points to note
January 2024 saw an increase in Time to Hire due to seasonal challenges over Christmas, due to both candidate and recruiting managers delays in processing recruitment actions. This trend is on par with last year, where an increase of 5.6 days was recorded between December 2022 and January 2023. Knowing this trend, focus will be on mitigations for the same period this year.
Work continues to ensure the 'Time to Hire' target reflects an industry standard. NHSE has benchmarked 52 trusts at 52 days.
As rollout of TRAC into the divisions continues, 'Time to approve on TRAC' is now being counted as part of overall 'Time to Hire' KPI performance. This has added circa 6 days to the KPI, but it should be noted that the overall KPI target has continued to be met from Nov. 23 (with the exception of January 2021).

Improvement Actions	Date Due	RAG
Roll-out of TRAC VCP has been fully implemented within D&S, Medicine and W&C. Discussions with the Surgical Division are to continue.	April 2024	
Corporate TRAC VCP training was completed in December 2023. Final review of approval process for separate directorates within the Corporate division being completed. Phased roll-out will be delivered to support the use of TRAC for approvers.	February 2024	
User surveys for both Recruiting Managers and Candidates closed in January with feedback is showing positive progress in the experience of new candidates joining the Trust and support provided to recruiting managers during the process.	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
Jan-24	51.7	49.0
Feb-24	49.2	49.0

Attrition (BAF SR2 Workforce - Recruitment & Attraction)

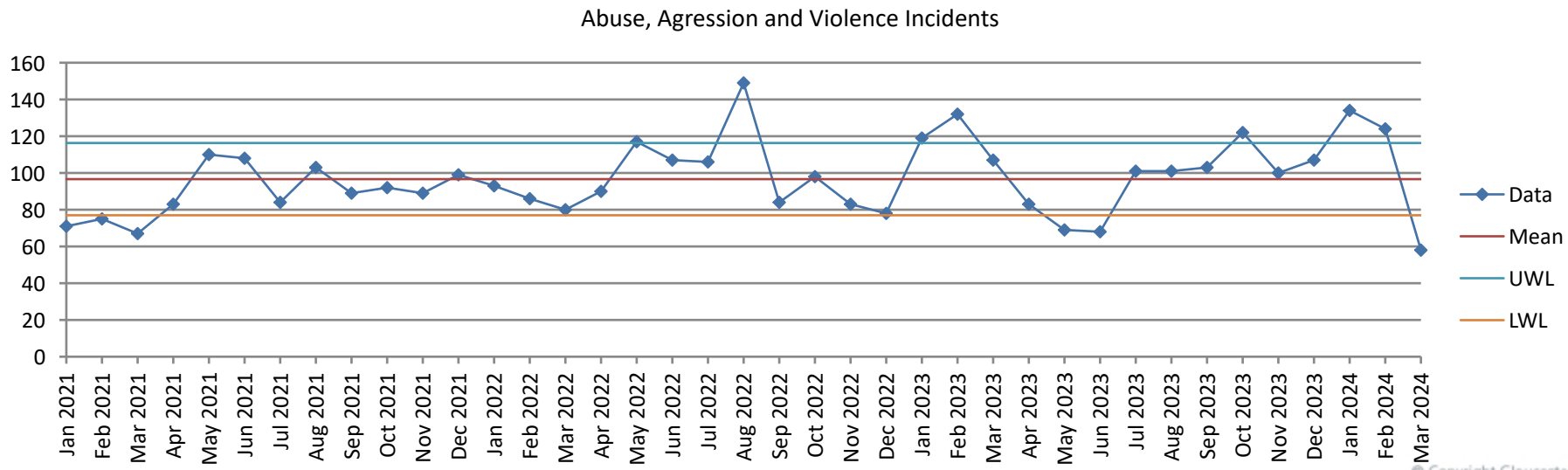
Key Points to note	Improvement Actions	Date Due	RAG
The highest attrition rate during recruitment is sill being seen at the Interview Process stage, with the main reason given by candidates as having received another job offer and decided to withdraw from GHFT.	Attrition data continues to be reviewed to understand candidates reasons for withdrawal. This ongoing deep dive is needed to help inform appropriate action. The data still suggests applicants are applying for multiple posts and accepting one job, resulting in candidates retracting their application.	Ongoing monitoring	
The Admin and Clerical staff group still remain with the highest attrition through the recruitment process			
Overall, 283 candidates withdrew their applications during the recruitment stages shown below in January 2024			

	Additional Clinical Services	Additional Professional Scientific and Technical	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Grand Total
Interview	34	1	88	4	12	10	3	31	183
Longlisting	2		10	1	2	3	34	4	56
Offer	5		7		4	2	2	9	29
Shortlisting	1		7	1			1	3	13
Starting	1		1						2
Grand Total	**43**	**1**	**113**	**6**	**18**	**15**	**40**	**47**	**283**

Health and Safety (BAF SR16 Workforce - Culture, Experience and Retention)

Key Points to Note
HSE Inspection took place in February. No formal feedback yet but Inspectors indicated the Trust is likely to receive a letter of material breach in relation to our security response.
Significant incident occurred in March in which staff were exposed to formalin.
Issues relating to exposure to Entonox are ongoing. Mechanical ventilation.
Fire safety remains a key risk, with a number of long term risks around fire and no fire safety action plan.

Improvement Actions	Due Date	RAG
An external consultant has been commissioned to review security and training and make recommendations	May 2024	
An investigation has been completed into the formalin incident and immediate safety actions implement. Further actions are in progress to improve safety	May 2024	
Ventilation issues will be raised at the Ventilation Group.	April 2024	
An extraordinary meeting and an action plan has been requested	March 2024	



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

KEY ISSUES AND ASSURANCE REPORT
FINANCE AND RESOURCES COMMITTEE – MARCH 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 – No items were rated red this month

Item	Rationale for rating	Actions/Outcome
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Model Hospital ERIC return	This report compares Trust performance against peers and identifies opportunities for improvement/savings. The level of potential savings falls short of existing FSP targets – thereby increasing pressure on GMS budgets.	The Committee noted the contents of the return. Further work to be undertaken in liaison with Director of Finance to assess impact.
Contract Management Group exception report	The Committee received an update on the strategic review of GMS arrangements including Terms of Reference of the Contract Management Group. A number of areas of concern and remedial actions were discussed. Of particular concern was the commitment of Trust HQ representatives to Contract Management Group business and meetings.	The Committee noted the risks outlined in the report. Chief Executive to review current arrangements and engagement from Trust HQ with Contract Management Group and related business.
Estates Risk Register	Concern remains around the levels of risk and the ability to clear/mitigate them to an acceptable level. The risk of business interruption to theatres due to potential failures in ventilation was noted.	The Committee noted the position, remaining risks and mitigating actions. A Trust wide workshop to review estates risks is to be convened with the aim of identifying any further risks and updating in the light of the 2024/25 capital programme. The Committee noted the position including risks surrounding delivery and mitigating actions.
Financial Sustainability Report	Performance at M11 was behind plan by £4.6m and the likely year end under achievement against target was subject to system wide risk management. £26.3m of efficiencies had been delivered in year of which £8.9m was non-recurrent. 2024/25 plans continued to be developed with £20m identified to date – final plans were to be agreed by early May. Particular focus was	Consideration to be given to a focus on controls over establishment at the next meeting and whether "deep dives" into projects at committee could be helpful (as per the productivity initiative).

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.

	needed on controls of establishment if savings targets were not to increase in year.	
Productivity Deep Dive	The Committee received an update on the Creating Capacity to Care programme with particular reference to the Outpatient Transformation and Theatre Utilisation Programmes. There had been significant improvements in information availability, working practices and achievement of targets – the task now is to convert the new methods of working into measurable additional capacity etc.	The Committee noted the report and the improvements taking place. Costs and outputs would be included in future reports.
Operational Plan 2024/25	This was the latest version of the plan – national guidance had just been received. It excluded high risk schemes which were the subject of further work. The current position was a circa £28m deficit. Elective activity targets at 5% was considered to be ambitious as was the target for No Criteria to Reside numbers – substantial concern remained around the system wide risks in these areas.	The Committee APPROVED the changes to the Full submission made since the March Board meeting and noted the work remaining prior to final sign off.
2024/25 Budget Setting Sign Off	The proposed 2024/25 budget remained unchanged from the position reported in February – a £45.5m deficit budget. Cost pressures and high risk investments continued to be considered within the system. Financial Sustainability schemes to the value of £20.3m had been identified against a target of £26.2m.	The Committee received the report as a source of assurance that the financial position was understood.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
GMS Strategic Review	The Committee received an update which was focussed on the contractual relationship between the Trust and GMS.	Consideration be given to a workshop/similar prior to presentation of recommendations to the Committee.
Financial Performance Report 2023/24	At month 11 there was a surplus of £1,890k which was £3,819k favourable to plan. The forecast year end position for the Integrated System was for a £50k surplus. Gloucestershire Hospitals forecast was a £1,490k deficit.	
Capital Plan 2024/25	two changes had been made to the Plan since the March Board meeting – the Hardware Refresh project had been dropped and the “right of use” calculation updated.	The Committee APPROVED the draft plan and agreed that funding could begin to be committed in order that schemes could commence.
M11 Capital Programme report	M11 Capital Programme report – At the end of M11 capital expenditure was £47.1m against a	the Committee noted the month 11 position and the

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

	planned spend of £55.8m. Overall, the forecast outturn for the system was a potential overspend of £200k.	risks around the forecast outturn.
Commercial and Innovations Group KIAR	The Committee received the KIAR and noted the work in progress around gaps in assurance, risks and the establishment of a new Medical Advisory Committee. Commercial activities, including new rates of payments for insurers of private patients were making a positive contribution to the Trust finances.	

Items not Rated

GMS Dividend Approval 2023/24	GMS Workforce Action Plan	GMS Legal Fees
New Finance System	GMS Business Plan 2024/25	

Investments

Case	Comments	Approval	Actions
None			.

Impact on Board Assurance Framework (BAF)

SR9: Failure to deliver recurrent financial sustainability - agreed to incorporate a longer term perspective to the next iteration.
SR10: Condition of the estate – to be redrafted in the new financial year
SR11: Sustainable healthcare – to be revisited with particular reference to the realism of achieving 2040 targets

Glossary:
H1/H2= first/second half of the financial year
CIP: Cost Improvement Programme
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KEY ISSUES AND ASSURANCE REPORT
FINANCE AND RESOURCES COMMITTEE – APRIL 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 – No items were rated red this month

Item	Rationale for rating	Actions/Outcome
	There were no items rated red.	

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Trust Operational Plan 2024/5 sign off	NHS performance targets are challenging and the current rating for delivery of planned Urgency and Emergency Care Services activity targets was Amber. The Financial Plan was for a £41.6m deficit for the Trust after including for delivery of a Financial Sustainability Plan of £30.3m – this would be exceedingly difficult to achieve. Workforce – delivery of the target of 8083 whole time equivalents would require a step change in controls over establishment levels.	Full submission due w/c 2/5/24, delegated to Trust Chair, Chief Executive, Chief Operating Officer and Director of Finance. The Committee supported the system's proposed submission of a c£19.6m deficit plan and noted the significant risk to delivery and to the Trust's own financial position.
Financial Sustainability Report 2023/24	Performance at M12 was behind plan by £6m - £28.7m of efficiencies had been delivered in year of which £8.9m was non-recurrent. 2024/25 plans continued to be developed with £22m identified to date – final plans were to be agreed by early May. Particular focus was needed on controls of establishment if targets were not to increase in year.	Consideration to be given to a focus on controls over establishment at the next meeting and whether "deep dives" into projects at committee could be helpful (as per the productivity initiative).
Productivity Deep Dive	The Committee received an update based on Month 11 reports. Work continues to improve reporting and identifying and sharing successes. There was optimism around reaching 85% theatre utilisation in line with NHSE targets – the true measure of success will be to maintain or exceed this rate continually. A presentation from the Ophthalmology team about their positive experiences of the Engagement Value Outcome work demonstrated the potential contribution of this approach to service rationalisation initiatives	The Committee noted the progress underway in improving productivity and the vital importance of performing at these new levels as "business as usual" once the focus moved to other areas.

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.

Cyber Security Report	The Committee received assurance on cyber security actions and an update on the current picture, performance and risk indicators and the ICS wide cyber related projects programme.	The Committee received assurance on a number of cyber security actions and the wider support to the ICS system provided by the Trust.
Learning from Pathology System Implementation	The Trak Care Lab Enterprise system in Pathology went live in 2021. The implementation had been problematic and the "go live" and following period had proved difficult. This review of this "lessons learned" project identified a number of problems around planning, delivery and ownership of decisions.	The Committee welcomed the report, the honesty of all involved and acceptance of recommendations for improvement.

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Financial Performance Report 2023/24.	An outturn deficit of £536K and 100% delivery of 19/20 activity levels	
Capital Plan 2023/24	An outturn position of £35K underspend on a budget of £56m.	
Digital Transformation Report 2023/4	Successful delivery of a large digital programme.	
Information Governance Bi-Annual Report	A positive report was received.	
HIMSS/EMRAM Digital Maturity Level	The Trust has a positive digital maturity level of almost 6, the highest level. The Committee congratulated the various teams on their achievement of these outcomes.	

Items not Rated			
Planning and Budget Setting	Costing Update	Provider Selection Regime	Digital Risk Register
Committee End of Year Annual Report			

Investments			
Case	**Comments**	**Approval**	**Actions**
New Finance System	The tender process had been considered at an earlier meeting and a preferred supplier appointed in January. Due to the nature of the scheme, it was not yet clear whether it was to be a charge to revenue or capital – this remained to be resolved but was an issue requiring national guidance.	The Committee Agreed to proceed to contract signing stage	A number of preferred options for implementation were agreed including a "go live" date of 1/4/25. A full summary of costs to be provided.

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

Gloucestershire Cancer Institute	The Committee received a confidential briefing on progress to date in securing funds for this scheme.	The Committee supported the move to Full Business Case stage	Clarity over source of funding to be confirmed. Recurrent revenue implications needed to be worked up.

Impact on Board Assurance Framework (BAF)
SR 9: Failure to deliver recurrent financial sustainability - agreed to incorporate a longer term perspective to the next iteration. SR 10: Condition of the estate – to be redrafted in the new financial year – next meeting SR 11:Sustainable healthcare – to be revisited with particular reference to the realism of achieving 2040 targets – June/July meeting

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

Report to Board				
Date	9 May 2024			
Title	**Financial Performance Report (Month 12 – Ended 31 March 2024)**			
Author /Sponsoring Director/Presenter	Hollie Day, Caroline Parker, Craig Marshall Karen Johnson			
Purpose of Report		Tick all that apply ✓		
To provide assurance		✓	To obtain approval	
Regulatory requirement			To highlight an emerging risk or issue	
To canvas opinion			For information	
To provide advice			To highlight patient or staff experience	

Summary of Report

Purpose

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

Revenue

The Trust is reporting a full year deficit of £536k which is £536k adverse to plan. This is the position after adjusting for donated assets impact and Salix grant and is subject to audit.

The Integrated Care System full year position is £541k surplus which is £541k favourable to plan. This is the result of a £536k adverse to plan position from GHFT, a £984k favourable position at Gloucestershire Health and Care NHS Foundation Trust and a £93k surplus position at Gloucestershire Integrated Care Board.

Capital

The Trust is reporting a full year position of £55.2m against a planned spend of £56.5m which is a variance of £1.3m. The position includes £1.27m in relation to the nationally funded Community Diagnostic Centre lease charge that had been previously reported and noted by NHS England, leaving a net underspend of £35k versus expectations.

Recommendation

The Board is asked to **RECEIVE** the contents of the report as a source of assurance that the financial position is understood.

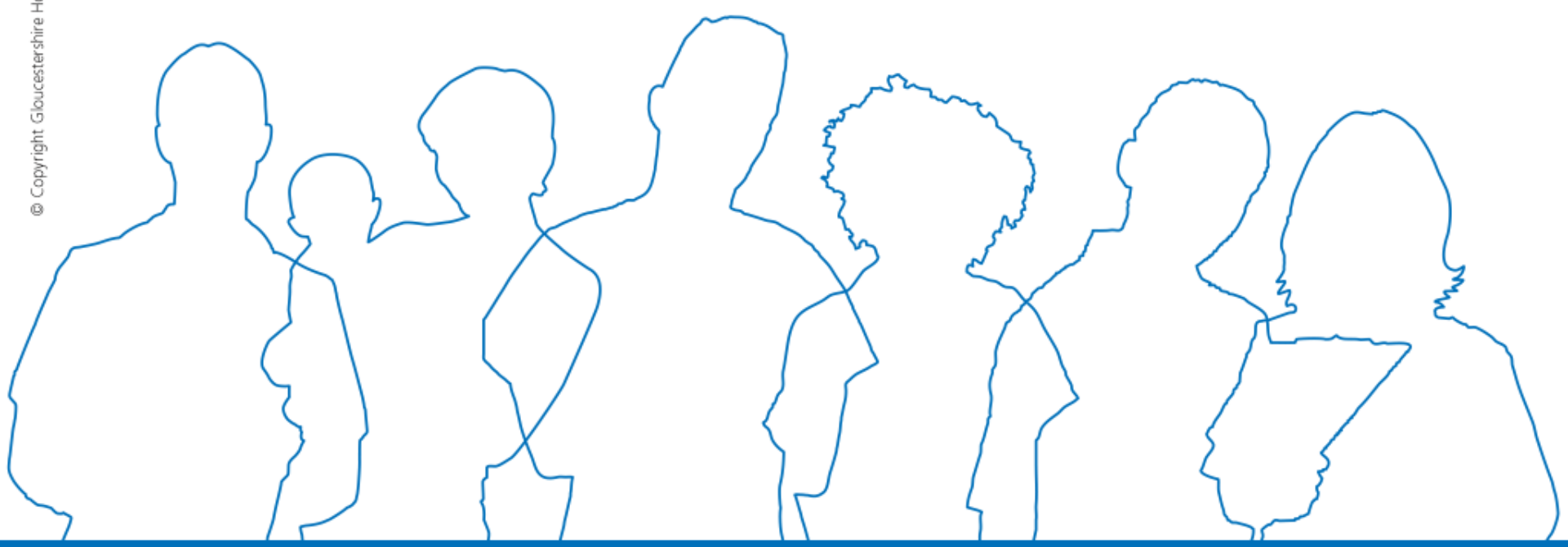
Enclosures

Finance report

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Financial Performance Report
Month Ended 31 March 2024



Gloucestershire Hospitals
NHS Foundation Trust

Revenue & Balance Sheet

M12 Group Position versus Plan

Gloucestershire Hospitals NHS Foundation Trust

The financial position as at the end of March 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 March the Group's consolidated position shows a deficit of £536k which £536k adverse to plan. The position is subject to audit. The position is driven by divisional pressures including urgent & emergency care and financial sustainability shortfalls which are offset by non recurrent income and balance sheet releases. These are explained further on the following slide.

Statement of Comprehensive Income (Trust and Gloucestershire Managed Services (GMS))

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 12 Financial Position	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	682,581	708,583	26,002			0	682,581	708,583	26,002
PP, Overseas and RTA Income	4,457	4,642	185			0	4,457	4,642	185
Other Income from Patient Activities	13,220	27,379	14,159			0	13,220	27,379	14,159
Operating Income	29,002	55,771	26,770	71,351	95,226	23,875	30,185	62,395	32,210
Total Income	**729,260**	**796,375**	**67,116**	**71,351**	**95,226**	**23,875**	**730,443**	**802,999**	**72,556**
Pay	(430,769)	(465,798)	(35,029)	(24,210)	(27,488)	(3,278)	(442,928)	(492,894)	(49,966)
Non-Pay	(301,262)	(335,225)	(33,963)	(44,559)	(66,521)	(21,961)	(289,614)	(313,535)	(23,921)
Total Expenditure	**(732,031)**	**(801,023)**	**(68,992)**	**(68,770)**	**(94,009)**	**(25,239)**	**(732,542)**	**(806,429)**	**(73,887)**
EBITDA	**(2,772)**	**(4,648)**	**(1,876)**	**2,582**	**1,218**	**(1,364)**	**(2,099)**	**(3,431)**	**(1,332)**
EBITDA %age	**(0.4%)**	**(0.6%)**	**(0.2%)**	**3.6%**	**1.3%**	**(2.3%)**	**(0.3%)**	**(0.4%)**	**(0.1%)**
Non-Operating Costs	(10,011)	(8,671)	1,340	(2,582)	(1,218)	1,364	(10,684)	(9,888)	796
Surplus / (Deficit)	**(12,783)**	**(13,319)**	**(536)**	**(0)**	**(0)**	**(0)**	**(12,783)**	**(13,319)**	**(536)**
Dontated Asset, Impairment & Salix Grant Adjustment	12,783	12,783	0	0	0	0	12,783	12,783	0
Adjusted Surplus / (Deficit)	**(0)**	**(536)**	**(536)**	**(0)**	**(0)**	**(0)**	**(0)**	**(536)**	**(536)**

* Trust position excludes £45m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £88.6m of inter-company transactions, including dividends

Month 12 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
Revenue position is £536k deficit which is £536k adverse to plan		Revenue Position year to date is £536k deficit which is £536k adverse against the plan of breakeven.
Full year Income is £803m which is £72.6m favourable to plan		M12 income position is £803m which is £72.6m favorable to plan. This includes £20m year end notional pension adjustment which is matched by notional pay costs. It also includes the reporting of Gloucestershire Managed Service reporting additional income due to pay award funding and capital margin. The income position is also above plan due to 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.
Full year Pay costs are £493m which is £50m adverse to plan		Pay costs are £493m which is £50m adverse to plan. This includes £20m year end notional pension adjustment which is matched by notional income. The Trust position includes £18m divisional pressures due to the use of escalation areas and medical staffing pressures. It also includes £3.6m costs of industrial action which have been funded by additional income.
Full year Non Pay costs are £323m which is £23m adverse to plan.		Non Pay costs (included non-operating costs) are £323m which is £23m adverse to plan. This position includes year end adjustments. It also includes overspends on clinical supplies within the Surgery Division, theatre consumables, increased Private Finance Initiative costs due to indexation and undelivered Financial Sustainability Schemes of £6m.
Delivery against Financial Sustainability Schemes		The Financial Sustainability Plan (FSP) target for the Trust is £34.7M. The Trust has achieved £28.7M.
The cash balance is £65.9m		Cash has increased by £8.1m in month.

Oversight Framework – Financial Matrix

Gloucestershire Hospitals
NHS Foundation Trust

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 12 full year position is below. The System is also required to monitor against these metrics plus achievement of Mental Health Standard.

Group Position	FY Plan £000s	FY Actual £000s	FY Variance £000s
Financial efficiency – variance from efficiency plan	34,721	28,690	(6,031)
Financial stability – variance from breakeven*	(0)	(536)	(536)
Agency spending against ledger budget	(7,636)	(18,476)	(10,840)
**adjusted position*			

The Trust is adverse to plan for all metrics.

Financial Sustainability Programme Full Year 23/24

Gloucestershire Hospitals
NHS Foundation Trust

£34.7M Programme	Full Year		
	Plan	Actual / Forecast	B/(W) vs Plan
£14.2M Programme	14,200	14,126	(74)
£12.4M Programme	12,422	7,900	(4,522)
System Stretch	1,435	-	(1,435)
Covid Spend Reduction	6,664	6,664	-
Financial Sustainability Programme	**34,721**	**28,690**	**(6,031)**

Trust Overview

- The Financial Sustainability Programme has delivered £28.7M of efficiencies 2023/24, £9.4M of which is Non-Recurrent. The programme finished behind plan by £6M as high risk transformation schemes either failed to deliver or have had delivery pushed back. The learning from the 23/24 plan has helped to shape the robust and rigorous sign-off process for the coming year's FSP schemes.

£12.4M Programme

- Finished £4.5M behind target, achieving £7.9M (64%) of its FSP target. This under-delivery has informed the target split for 24/25 with a smaller share of the target allocated to transformational schemes, to allow them time to unfold
- Part of the shortfall within this programme element has been added to the 24/25 target, to become part of an internal stretch target

£14.2M Programme

- Achieved £14.1M efficiencies against a target of £14.2M.
- Medicine, Diagnostics and Specialist, and Surgery all delivered 100% of their targets, albeit with some delivery on a non-recurrent basis
- Procurement and Medicines Optimisation cross-cutting schemes have exceeded 23/24 Targets
- Non-recurrent shortfall has been carried forward into 24/25 and will become part of an internal stretch target.

Stretch Target £1.4M

- This represents GHFT's portion of the system stretch to reach a balanced plan at the start of the year
- This forms part of the £6M gap to target

Covid £6.7M Fully Delivered

Balance Sheet

	Group Closing Balance 31st March 2023 £000	GROUP Balance as at M12 £000	B/S movements from 31st March 2023 £000
Non-Current Assests			
Intangible Assets	16,483	15,221	(1,262)
Property, Plant and Equipment	357,717	367,771	10,054
Trade and Other Receivables	3,901	3,424	(477)
Total Non-Current Assets	**378,101**	**386,416**	**8,315**
Current Assets			
Inventories	12,312	12,505	193
Trade and Other Receivables	46,622	26,563	(20,059)
Cash and Cash Equivalents	49,193	57,741	8,548
Total Current Assets	**108,127**	**96,809**	**(11,318)**
Current Liabilities			
Trade and Other Payables	(104,686)	(94,844)	9,842
Other Liabilities	(11,160)	(17,508)	(6,348)
Borrowings	(5,904)	(4,305)	1,599
Provisions	(7,929)	(4,002)	3,927
Total Current Liabilities	**(129,679)**	**(120,659)**	**9,020**
Net Current Assets	**(21,552)**	**(23,850)**	**(2,298)**
Non-Current Liabilities			
Other Liabilities	(7,603)	(4,881)	2,722
Borrowings	(53,914)	(61,073)	(7,159)
Provisions	(2,824)	(3,299)	(475)
Total Non-Current Liabilities	**(64,341)**	**(69,253)**	**(4,912)**
Total Assets Employed	292,208	293,313	1,105
Financed by Taxpayers Equity			
Public Dividend Capital	397,288	407,649	10,361
Reserves	28,113	32,180	4,067
Retained Earnings	(133,194)	(146,516)	(13,322)
Total Taxpayers' Equity	292,208	293,313	1,105

Gloucestershire Hospitals NHS Foundation Trust

The table shows the M12 balance sheet and movements from the 2022/23 closing balance sheet.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

Funding

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m. Agreed funding adjustments during the year for additional System and IFRS 16 allocations, National Programme funding, Donations and Grants brought the agreed programme funding to £56.5m.

YTD Position

The Trust reported goods delivered, works done or services received in the year to the value of £55.2m against a funded position of £56.5m, a variance of £1.3m under the funding allocation. The position includes £1.27m in relation to the nationally funded CDC lease charge that had been previously reported and noted by the Region, leaving a net underspend of £35k versus expectations.

In month, the Trust delivered a £7.3m gross capital spend.

The Total Charge against Capital Allocation (including IFRS 16) reported to NHSI in the M12 Provider Financial Return (PFR) was £33.0m versus a plan allocation of £27.4m, an overspend of £5.6m. Additional funded allocations of £5.7m were agreed during the year resulting in a net underspend position of £35k.

The Capital Departmental Expenditure Limit (CDEL) outturn was £46.4m versus a plan allocation of £48.7m, an underspend of £2.3m. Agreed funded adjustments of (£1.0m) to the plan allocation, bring the adjusted CDEL variance position back to a £1.3m underspend of which, as noted above, £1.27m had been previously reported and noted by the Region.

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. Agreed funding adjustments during the year for additional System and IFRS 16 allocations, National Programme funding, Donations and Grants brought the agreed programme funding to £56.5m.The revised allocation of funding can be broken down as follows: Operational System Capital (£27.6m), National Programme (£13.7m), STP Capital – GSSD (£0.6m), IFRIC 12 (£1.1m), Government Grant (£7.1m), Donations (£1.0m) and IFRS16 capital (£5.4m).

in £000's

	Plan	Revised Allocation	Variance
DIGITAL	5,700	5,700	0
MEDICAL EQUIPMENT	5,996	4,851	1,145
ESTATES	14,192	14,207	(15)
CENTRAL CONTINGENCY	0	2,886	(2,886)
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**25,888**	**27,644**	**(1,756)**
RIGHT OF USE ASSET	1,478	5,404	(3,926)
Total Charge against Capital Allocation (including impact of IFRS 16)	**27,366**	**33,048**	**(5,682)**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	441	326	115
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	7,176	5,641	1,535
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	8,703	1,176	7,527
NAT PROG: RIGHT OF USE ASSET: NEW	4,098	4,098	0
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	0	2,205	(2,205)
NAT PROG: CYBER IMPROVEMENT PROGRAMME	0	100	(100)
NAT PROG: CONNECTING CARE RECORDS	0	175	(175)
STP PROGRAMME: GSSD	561	561	0
IFRIC 12	1,126	1,126	0
DONATIONS VIA CHARITABLE FUNDS	1,075	971	104
GRANT	6,724	7,088	(364)
Total Additional Capital	**29,904**	**23,467**	**6,437**
Gross Capital Funding Total (including IFRS 16)	**57,270**	**56,515**	**755**

23/24 Programme Spend Overview

Gloucestershire Hospitals NHS Foundation Trust

The Trust reported goods delivered, works done or services received in the year to the value of £55.2m against a funded position of £56.5m, a variance of £1.3m under the funding allocation. The position includes £1.27m in relation to the nationally funded CDC lease charge that had been previously reported and noted by the Region, leaving a net underspend of £35k versus expectations. In month, the Trust delivered a £7.3m gross capital spend.

The Total Charge against Capital Allocation (including IFRS 16) reported to NHSI in the M12 Provider Financial Return (PFR) was £33.0m versus a plan allocation of £27.4m, an overspend of £5.6m. Additional funded allocations of £5.7m were agreed during the year resulting in a net underspend position of £35k.

The Capital Departmental Expenditure Limit (CDEL) outturn was £46.4m versus a plan allocation of £48.7m, an underspend of £2.3m. Agreed funded adjustments of (£1.0m) to the plan allocation, bring the adjusted CDEL variance position back to a £1.3m underspend of which, as noted above, £1.27m had been previously reported and noted by the Region.

in £000's	Plan £000's	Funding £000's	Actual £000's	Variance to Funding £000's
DIGITAL	5,700	5,700	4,257	1,443
MEDICAL EQUIPMENT	5,996	4,851	2,027	2,824
ESTATES	14,192	14,207	21,424	(7,217)
CENTRAL CONTINGENCY	0	2,886	0	2,886
VAT RECLAIMS	0	0	(900)	900
RIGHT OF USE ASSET : (FINANCE LEASE)	0	0	1,818	(1,818)
NBV DISPOSAL OF ASSETS	0	0	(85)	85
NAT PROG: ADJUSTMENTS/BROKERAGE	0	0	(1,407)	1,407
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**25,888**	**27,644**	**27,133**	**511**
RIGHT OF USE ASSET	1,478	5,404	5,880	(476)
Total Charge against Capital Allocation (including impact of IFRS 16)	**27,366**	**33,048**	**33,013**	**35**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	441	326	(0)	326
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	7,176	5,641	5,066	575
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	8,703	1,176	1,177	(0)
NAT PROG: RIGHT OF USE ASSET: NEW	4,098	4,098	2,828	1,270
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	0	2,205	1,755	450
NAT PROG: CYBER IMPROVEMENT PROGRAMME	0	100	86	14
NAT PROG: CONNECTING CARE RECORDS	0	175	133	42
NAT PROG: ADJUSTMENTS/BROKERAGE	0	0	1,407	(1,407)
STP PROGRAMME: GSSD	561	561	561	0
IFRIC 12	1,126	1,126	1,126	0
DONATIONS VIA CHARITABLE FUNDS	1,075	971	971	0
GRANT	6,724	7,088	7,088	(0)
Gross Capital Spend Total	**57,270**	**56,515**	**55,211**	**1,305**

Gross Capital Spend Total	**57,270**	**56,515**	**55,211**	**1,305**
Less Donations and Grants Received	(7,799)	(8,059)	(8,059)	0
Less PFI Capital (IFRIC12)	(1,126)	(1,126)	(1,126)	(0)
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	335	335	335	0
Total Capital Departmental Expenditure Limit (CDEL)	**48,680**	**47,665**	**46,360**	**1,305**

Permissable Underspend Agreed by Region	1,270
Net Underspend Position	**35**

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a deficit of £536k deficit which is £536k adverse to plan. This position is subject to audit
- Note the Trust capital position as of the end of March 2024

Authors:	**Hollie Day – Associate Director of Financial Management** **Caroline Parker - Head of Financial Services** **Craig Marshall - Project Accountant**
Presenting Director:	**Karen Johnson – Director of Finance**
Date:	**May 2024**

Report to Board of Directors

Agenda item:		Enclosure Number:	
Date	9th May 2024		
Title	Perinatal Quality and Safety Report Q3 2023-24		
Author /Sponsoring Director/Presenter	Lisa Stephens- Director of Midwifery		

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

Summary of Report

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the GHNHSFT Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward-to-board' insight across the multi-disciplinary, multi-professional maternity services team. This is also presented to the LMNS.

During the quarter:

- No maternal deaths were reported
- 4 still births
- 1 neonatal death; within both the LMNS target of 0.89/1000 and 2021 national average of 2.7/1000
- 8 Serious incidents were reported, of these 3 incidents met criteria for MNSI referral.
- There was a total of 23 moderate harm incidents during the quarter, 19 of which were related to massive obstetric haemorrhage (MOH). Due to the large volume of MOH's reported (moderate harm & SI), a collaborative review to assess trends was planned to be undertaken by a Maternity Improvement Advisor and the LMNS.
- To note: Moderate harm incidents are at their highest level for 18 months. Following the CQC section 29a warning notice, we have increased incidents that are classified as moderate harm events.
- 73 incidents overdue as at the 31 December 2023, this remains a challenge. The Patient Safety Team and Deputy HOM are reviewing current approaches in an effort to find a sustainable solution.
- Average rate of term admissions is stable at 3.4% and within the national target of 5%.
- Average positive FFTs are 82.6%, an ANC refresh group has been set up with input from the Obstetric Improvement Advisor to improve the most common theme from outpatients regarding wait times/late clinics.

- POPAM storage 99.5% in September.
- Training compliance for mandatory study days is between 89-95%, with aim of 90%.
- Childrens L3 SG Interagency day- the data for compliance has been and around 40% of 'non-compliance' is due to how or if the data is being captured. In some cases, such as long term sick or maternity leave, it is not possible to improve compliance, however further analysis is required, particularly for the 110 midwives where there is 'no record'.
- Staffing covered in quarterly report.

Risks or Concerns

- The volume of massive obstetric haemorrhages (MOH) reported. Concerns escalated and a collaborative review including MIA and LMNS planned.
- Red rated CQC actions- Overdue incidents and safeguarding training. Review approach to overdue incidents and further analysis of safeguarding training with subsequent plan.

Recommendation

- Note the risks highlighted including our MOH rate and red rated CQC actions with subsequent plans.
- Note the ongoing improvement work.

Enclosures

Q3 PQS report V0.01

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Perinatal Quality and Safety Report
Q3 2023-24

Glossary

Term	Description/Definition
AFE	Amniotic Fluid Embolism
ATAIN	Avoiding Term Admissions to Neonatal Units
CGH	Cheltenham General Hospital
CQC	Care quality Commission; The independent regulator of health and social care in England
ELCS	Elective Caesarean Section
GHFT	Gloucestershire Hospitals NHS Foundation Trust
GRH	Gloucestershire Royal Hospital
HSIB	Health Safety Investigation Branch
MIS	Maternity Incentive Scheme
MNSI	Maternity Neonatal Safety Investigations (Formerly HSIB)
NHS	National Health Service
PET	Pre-eclampsia Toxaemia
PQS	Perinatal Quality and Safety
SBL/SBLCB	Saving Babies Lives Care Bundle
TC	Transitional Care
Trust	Means Gloucestershire Hospitals NHS Foundation Trust

Introduction

Progress update: This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020). The purpose of the report is to inform the LMNS Board and GHNHSFT Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward-to-board' insight across the multi-disciplinary, multi-professional maternity services team. The information within the report reflections actions in line with Ockenden and progress made in response to any identified concerns at provider level. The report will also provide monthly updates to the Local Maternity and Neonatal System (LMNS) via the clinical quality assurance group.

Work has been undertaken during the month to remodel the monthly Perinatal Quality and Safety Report to provide enhanced signposting, benchmarking and compliance status, thus enabling greater visibility of concerns affecting the Division.

The report has been divided into:

12. Mortality and Morbidity
13. Safety
14. Workforce
15. Quality
16. National Assurance Programmes

Monthly Dashboard

CQC Maternity Ratings 2022*	Overall	Safe	Effective	Caring	Responsive	Well-Led
	Inadequate	Inadequate	Good	Good	Good	Inadequate
Maternity Safety Support Program: Yes						
*Previous ratings were not all updating during this inspection. The maternity rating for safe and well-led went down to inadequate. The previous rating for effective, caring and response remained as good. Overall the Trust was rated as inadequate						

	2023/24												
	Benchmark		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Morbidity and Mortality														
1. Direct Maternal Deaths		0	0	0	0	0	0	0	0	0	0			
2. Serious Incidents														
2.1 New SIs (excluding MNSI referrals)		0	0	0	0	0	0	3	3	2	3			
2.2 Open SIs		0						4	8	6	8			
2.3 New MNSI Referrals (also SI's)		0	0	4	1	2	1	1	1	1	1			
2.4 Open MNSI Investigations								6	7	6	5			
3. Moderate Harm Incidents		0	0	0	1	0	2	11	6	6	11			
4. Stillbirths rate per 1000 live & stillbirths	LMNS Target Nat Av. 2021	2.52 4.1	4.7	5.9	2.1	0.0	4.6*	2.2	2.2	2.1	6.5			
5. Neonatal mortality rate per 1000 live births (>24/40)	LMNS Target Nat Av. 2021	0.89 2.7	0.0	0.0	0.0	0.0	0.0*	2.2	0.0	2.1	0.0			
6. Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0	0	0	0			

	2023/24												
	Benchmark		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Safety														
7. Incidents														
7.1 Reported			123	124	137	147	185	171	136	116	138			
7.2 Overdue (incidents open> 30 days, i.e. at 1st day of the preceding month being reported)	=/<20	0	217	271	198	166	71	15	16	54	73			
8. Risks														
8.1 Risks on register		NA	18	18	19	19	18	18	18	18	16			
8.2 Overdue actions on risk register		0			5	3	2	6	6	7	7			
9. Training Compliance YTD														
Mandatory Training %	National													
Midwives	(by 1/12/23)	90	85	75	8%	70	78	74	83	)				
MSW's/MCA's		90	72	65	71	72	72	57	65	) 85	89			
Prompt Part 1 %														
Midwives			80	85	84	84	84	83	90	)				
MSW's/MCA's			75	75	68	67	67	69	76	)				
Obstetricians			61	90	100	100	100	62	79	) 86	95			
Anaesthetics			58	61	69	66	66	60	93	)				
Theatre Staff			57					82	82	)				
Prompt Part 2 &														
Midwives			84	85	94	88	88	84	89	)				
MSW's/MCA's			74	68	75	69	69	69	78	)				
Obstetricians			67	98	100	100	100	62	79	) 87	93			
Anaesthetics			58	61	69	68	68	60	96	)				
Theatre Staff			66					84	82	)				
Fetal Monitoring %														
Midwives			83	86	96	89	59	73	88	)				
Obstetricians			46	82	74	75	75	72	89	) 89	91			
10. Appraisal Compliance %			78	76	73	67	67	66	63	63	65			

	2023/24												
	Benchmark		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
11. Periprem Births <27 wks		0	1	1	0	2	1	1	2	0	0			
12. Term Admissions to Neonatal Unit (ATAIN) %		5%	2.6	3.9	3.9	4.6	2.2	3.3	2.8	3.5	3.9			
13. NICE Guidance														
Number action plans overdue		0	22	2		3	3	3	5	5	3			
14. Audit/Guidelines Programme														
15. POPAM Storage		95%	99%	99%	100%	98%	100 %	100 %	100 %	100%	TBA			
16. Maternity Production Board														
Workforce														
17. Annual Survey														
17.1 Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment – reported annually			36.9	36.9	36.9	36.9	36.9	36.9	36.9	36.9	36.9			
17.2 Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours – reported annually			90.7	90.7	90.7	90.7	90.7	90.7	90.7	90.7	90.7			
18. Medical Staffing														
18.1 Gaps in Medical Rota- Mid Staff Grade	0 (uncovered)		44	49	39	31	16	16	7	6	9			
18.2 Obstetric Consultants	0 (uncovered)		6	4	0	0	0	2	3	2	6			
19. Midwifery Staffing														
19.1 Midwifery vacancy rate %	TBA		12.8	13.9	14.9	14.4	13.3	9.6	8.51	8.45	7.85			

	2023/24												
	Benchmark		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Quality														
20. Service User Voice Feedback														
20.1 FFT- % of responses that are positive			86.7	83.1	72.7	87.1	80.4	79.6	79.7	88.1	80.2			
National Assurance Programmes														
21. Ockenden 2														
Actions Completed	National	92												
22. CQC Section 29a	Local	41	*October – combined reporting based on 2022 & 23 29a's ^November onwards April 2023											
Actions graded as blue								27	27*	1^	1^			
Actions graded as green								6	6*	2^	2^			
Actions graded as amber								6	6*	3^	3^			
Actions graded as red								2	2*	1^	1^			
23. Maternity Incentive Scheme Y5	National													
Safety Action		Current Compliance RAG Status												
1: National Perinatal Mortality Review Tool														
2: Maternity Service Data Set (MSDS)														
3: Transitional Care and ATAIN														
4: Medical Workforce Planning														
5: Midwifery Workforce Planning														
6: SBLCB														
7: Patient Feedback														
8: In-House Training														
9: Board Assurance on Maternity and Neonatal Safety and Quality Issues														
10: HSIB/NHST Reporting														
Denotes no available or comparable data														

Morbidity and Mortality

1. Direct Maternal Deaths

As a consequence of a disorder specific to pregnancy, e.g. haemorrhage, pre-eclampsia, genital tract sepsis and maternal suicide.
No maternal deaths were reported during the month

2. Serious Incidents

2.1 New Serious incidents

8 Serious incidents were reported during the quarter:

Incident No.	Incident Date	Incident detail
October 2023		
W222036	12/10/2023	23+0, spontaneous birth of twins (PERIPrem place of birth exception reporting). Twin 1 rapid spontaneous birth following admission to triage- transferred to tertiary unit ex-utero for ongoing care, Sadly RIP following transfer Twin 2 breech birth with slow birth from body to head- sadly RIP at 6.5 hours of age
W222024	13/10/23	Postnatal readmission on day 6- sepsis requiring DCC admission. (Pneumonia)
W222983	24/10/23	MOH following 19+2 wk IUD Blood loss 4L - Hysterectomy, ITU
November 2023		
W226042	23/11/23	33+1 placental abruption – RIP baby – unmedicated PET
W226045	25/11/23	MOH 5891 – return to theatre x 3
December 2023		
W227314	12/12/2023	Homebirth – retained placenta, transferred for MROP, return to theatre, 3L MOH and DCC admission
W227347	12/12/203	Placental abruption at 36/40, Cat 1 EMCS, 2.8L MOH, DIC, DCC admission
W227802	18/12/2023	35/40 Placental abruption, IUD, Cat 1 EMCS, MOH 4.5L, DIC, DCC admission

2.2 Open Si's :

Open SI's: 8 (as at 31/12/23)		
Incident number	**Category**	**Latest Update**
W213115/W206667	Neonatal bowel perforation	Trust Pt Safety Team ongoing (also serious complaint)
W220170	ELCS. AFE & cardiac arrest	Trust Pt Safety Team - ongoing
W220683	Liver Capsule Haematoma	Trust Pt Safety Team - ongoing
W221531	PERIPrem - mother not referred to pre-term birth clinic	For summary DOC letter
W222036	PeriPrem twins – RIP	Trust Pt Safety Team - ongoing
W222983	IUD 19 wks. MOH, Hysterectomy. DDC admission	? SI TBC following further senior discussion
W226042	33+1 unmedicated PET, placental abruption, RIP baby	Maternity Unit Investigation
W226045	MOH 5891 return to theatre x 3 - hysterectomy	Maternity Unit Investigation

2.3 New MNSI Referrals

From 1st October 2023 the HSIB split into two branches, with **MNSI (Maternity and Neonatal Safety Investigations)** ensuring the continuation of the maternity programme and maintain the independence of maternity investigations within the NHS.

All MNSI referrals are also deemed as serious incidents, but for the purpose of this report are counted separately

The National Maternity Safety Ambition launched in November 2015 aims to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. This strategy was updated in November 2017 with a new national action plan called Safer Maternity Care, which set out additional measures to improve the rigour and quality of investigations into term stillbirths, serious brain injuries to babies and deaths of mothers and babies. The Secretary of State for Health asked HSIB to carry out the work around maternity safety investigations outlined in the Safer Maternity Care action plan.

HSIB undertake maternity investigations in accordance with the Department of Health and Social Care criteria (Maternity Case Directions 2018), taken from Each Baby Counts and MBRRACE-UK. In accordance with these defined criteria, eligible babies include all term babies (at least 37 completed weeks of gestation) born following labour who have one of the following outcomes:

1. Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy

2. Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.
3. Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.
4. Severe brain injury diagnosed in the first seven days of life, when the baby:
5. Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
6. Was therapeutically cooled (active cooling only) or
7. Had decreased central tone and was comatose and had seizures of any kind

All qualifying cases have been referred to HSIB/ MNSI and/or to NHS Resolution's Early Notification (EN) Scheme and the family have received information on the role of HSIB//MNSI and NHS Resolution's EN scheme. There has been compliance, where required, with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour with a letter to the patient with this information. A full unredacted record of this including referrals is held within maternity but not shared here.

3 incidents met criteria for referral during the quarter:

Datix Ref	Ref Category	Incident/Detail	Accepted for Investigation		Reason Rejected
			Yes	No	
October 2023 - 1					
W191854	IP SB	Incident from Oct 2022. 40+11, stillbirth following admission with RFM *Retrospective ref: Did not initially meet criteria for MNSI investigation as not in labour, however new information from mother advising she was experiencing contractions, therefore this has been reclassified as* ***an IPSB***	✓		
November 2023 - 1					
W224308	Therapeutic Cooling	8 minute shoulder dystocia	✓		
December 2023 - 1					
W227185	Therapeutic Cooling	38+0, Spontaneous labour-admitted in advanced labour, birth 33 minutes following admission. Bradycardia and SVB-baby born in poor condition requiring transfer for cooling due to abnormal CFM.		✓	Normal head MRI, not family concerns

2.4 Open MNSI Investigations

There are 5 ongoing MNSI Investigations (at 31/12/23):

Incident No.	Category	Latest Update
W215202 MI-029985	Therapeutic cooling	Arranging interviews and information gathering
W216108 MI-030777	Therapeutic cooling	Arranging interviews and information gathering
W217227 MI-031635	Early NND	Arranging interviews and information gathering - awaiting PM
W219309 MI-033153	Early NND	Arranging interviews and information gathering PM received – meconium aspiration syndrome
W219309 MI-036387	Therapeutic Cooling	Information gathering

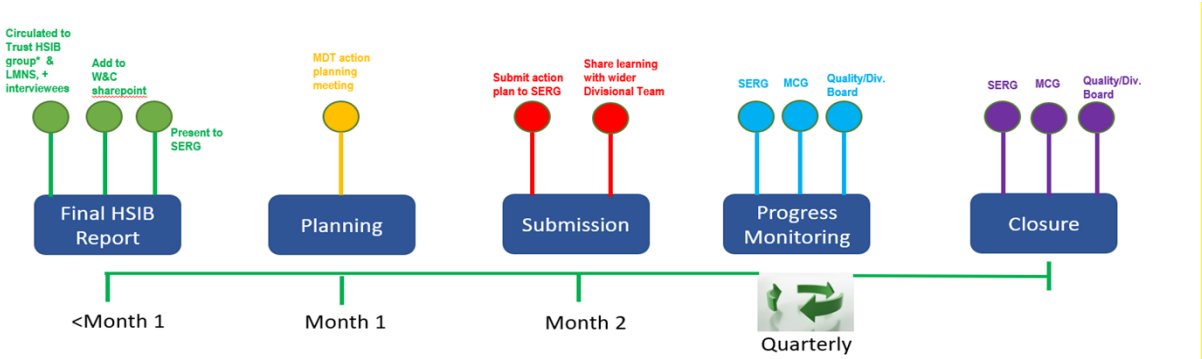
2.4 Rejected HSIB Referrals during the month

1 (see 2.3 above)

2.5 HSIB Reports received during the quarter:

3 MNSI reports received during the quarter:

Incident No.	Category	Latest Update
W210683 MI-027279	IP SB	Final report received - no safety recommendations
W211523 MI-027642	Therapeutic Cooling	Final report received – 2 safety recommendations
W212905 MI-028533	Therapeutic Cooling	Final report received - no safety recommendations



3. Moderate Harm Incidents

Moderate harm incidents are at their highest level for 18 months. Following the CQC section 29a warning notice, a Maternity Improvement Advisor was assigned to the Trust in a bid to regain our previous 'good' rating. One of the observations made concerned the categorisation of incidents such as massive obstetric haemorrhage, perineal trauma and shoulder dystocia. It was subsequently recommended that these be classified as moderate harm events. Following this, it has been agreed within the Division that until the Patient Safety Team are at optimal capacity, a gradual implementation of this recommendation will be undertaken. In the first instance all massive obstetric haemorrhage (weighed blood loss of 2000mls or above) will be classified as moderate harm. Other categories, such as shoulder dystocia, 3a and above perineal trauma, will be graded on a case-by-case basis. For instance, if a woman suffers a shoulder dystocia, but the baby births following the adoption of one manoeuvre only, and the baby is born in good condition, this will, for the time being, be graded as a no harm event. However, if this scenario resulted in all manoeuvres being applied, a baby born in poor condition and requiring admission to the neonatal unit – this would likely be classified as moderate harm.

There was a total of 23 **moderate harm incidents** during the quarter, 19 of which were related to massive obstetric haemorrhage.
Due to the large volume of MOH's reported (moderate harm & SI), a collaborative review to assess for trends is to be undertaken by a Maternity Improvement Advisor and the LMNS.

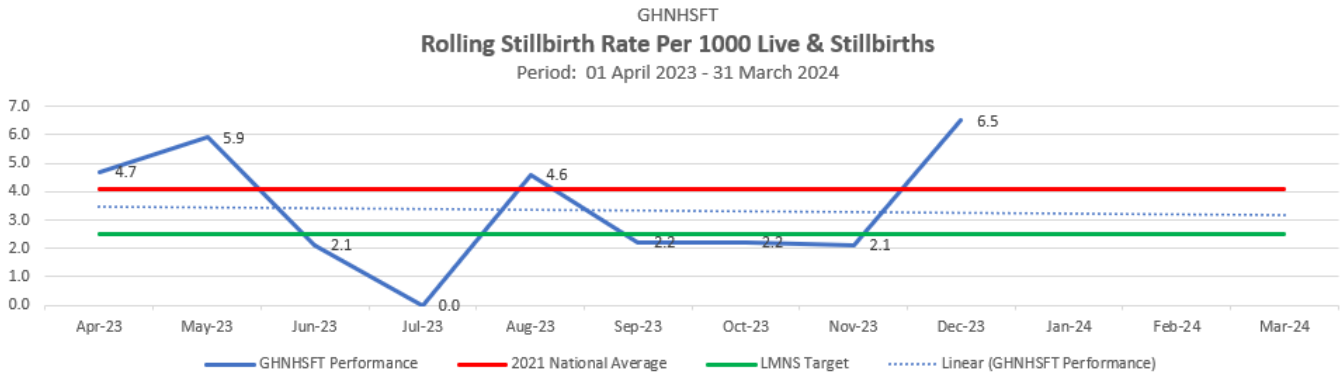
Other moderate harm categories:
2 x babies born in poor condition
1 maternal DCC admission desaturating
1 X RIDDOR reportable incident where a staff member slipped and broke her arm (outside of the Maternity Unit)

4. Stillbirths rate per 1000 live & stillbirths

There were 4 stillbirths during the quarter at GRH:

October 0:
November 1: • 31+5 CMW unable to auscultate FHR, attended Triage where intrauterine death was confirmed
December 3: • 35/40 Abruption/DCC admission (as per SI reported in section 2.1) • 37+2 Triage admission, no fetal movements for 24 hours • 25+4 CMW unable to auscultate FHR, IUD confirmed by USS in Stroud

Plus one 32-33/40 concealed pregnancy, breech BBA at home, severely macerated fetus, ambulance services in attendance

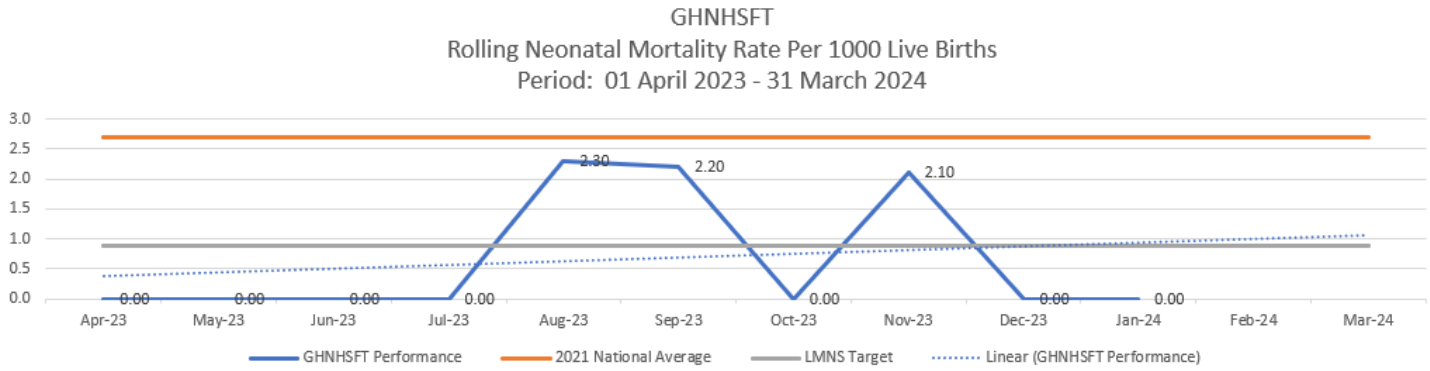


5. Neonatal mortality rate per 1000 live births

There was 1 NND's during the quarter:

October : 0	
November: 1	33+1 EMCS for placental abruption – untreated PET (also SI)
December: 0	

Neonatal death (>24/40) during the quarter were within both the LMNS target of 0.89/1000 and 2021 national average of 2.7/1000:



The PMRT October & November report is attached in appendix 2

The PMRT December & January report is attached in appendix 3

6. Coroner Reg 28 made directly to Trust

None

Safety

7. Incidents

7.1 Reported

390 incidents reported during the quarter

7.2 Overdue (incidents open> 30 days, i.e. at last day of the preceding month being reported)

73 incidents overdue as at the 31 December 2023

Early incident investigation is an essential element in ensuring safety within the Department.

Overdue incidents were one of the main concerns reported by CQC and formed part of the section 29a served to the Trust. The prompt review, investigation and closure of incidents remain one of the highest priorities within the Patient Safety Department and efforts to maintain overdue incidents <20 continue. However, this is proving challenging as clinical requirements can result in conflicting priorities. A collaboration

between the Patient Safety Team and Deputy HOM are reviewing current approaches in an effort to find a sustainable solution.

8. Risks

8.1 Risks on register

Key Risk Domains	Totals
Total Number of Current Risk's Open [January 2024]	16
Top Risk Themes	**Risk Registers**
Staffing	Divisional Risk Register = 5
	Speciality Risk Register = 9
	Trust Risk Register = 2
Risks Score's Overviewed	**Current Risk Score's, Highest to Lowest Totals/Percentages**
15-25 Extreme	2
8-12 High Risk	5
4-6 Moderate Risk	9
1-3 Low Risk	0
Highest Scoring Domain	**Risk Domains, Highest to Lowest Totals/Percentages**
Safety	9
Workforce	4
Quality	3
Year Risk Added to Risk Register, Oldest to Newest	**Total Number of Open Risks by Year**
2018	1
2020	2
2021	5
2022	4
2023	4
5 New Risks have been accepted at MCG but are yet to be uploaded/updated on datix cloud therefore aren't included in the above figures.	

8.2 Overdue actions on risk register

7 overdue actions remain on the risk register, relating to 4 risks, this position remains unchanged from the November report

Action ID:	Risk	Action Assigned to	Due for completion
10511	**3264: The risk of non-compliance with NICE guideline NG137 Twin and Triplet Pregnancy, due to no dedicated multiple pregnancy clinic** Action: Development of business case	CE	31/10/23
11386	**4069: The Risk of patient developing a surgical site infection following caesarean section** Action: Prepare business case for use of warming gowns for patients having caesarean sections	RR	31/10/23
11387	Action: liaise with digital team regarding post-natal information following Caesarean Section to ensure on badgernet	RH	31/08/23
11389	Action: Training with regard to vaginal prep pre-op	RH	31/10/23
11676	**4059: The risk of harm coming to families we care for due to staff not receiving mandated safeguarding supervision** Action: Some staff have been trained to provide supervision and this is being currently done on an ad hoc basis until business case reviewed	SM	30/11/23
11725	**Risk 3255: The risk is reduced safety in the maternity unit due to the reduced function of our baby tagging system** Action: Complete table top exercise for testing of baby abduction procedures planned	KL	01/11/23
11833	Action: Complete security review	SK	31/10/23

9. Training Compliance

9.1 Safeguarding Children L3

Compliance Rate Highlight key:		
Less than 70%	70% - 89%	90% and above

Childrens L3 SG Interagency day, percentages up to 31/10/23 (data supplied by B8 Maternity Matron for Safeguarding). This has been broken down and categorised and includes where data has not been captured, accounting for around 40% of 'non-compliance'. In some cases, such as long term sick or maternity leave, it is not possible to improve compliance, however further analysis is required, particularly for the 110 midwives where there is 'no record'.

Midwives

Total Number of Midwives	totals	Percentages
Completed	206	53.5
Booked	20	5.1
No record	110	28.5
Bank only (no record)	16	4.1
Long term sick (no record)	8	2.07
Mat leave (no record)	20	5.19
Secondment	1	0.25
total	381	99.01

Doctors

Total numbers of doctors	totals	Percentages
Complete	21	45.6
booked	17	36.9
No record	8	17.3
total	46	99.8

Local Yearly (as supplied by training team)

	Compliance
GHT Total	54%
Corporate Division	33%
Diagnostic & Specialty Division	55%
Medicine Division	47%
Surgery Division	53%
Women & Children Division	57%

Local Yearly Safeguarding training remains in the red with <70% compliance throughout the Division, and whilst in comparison to other Divisions within the Trust our non-compliance is not the worst, it is a CQC concern and therefore requires attention. Work is ongoing to make the training less confusing and more user friendly.

9.2 Maternity and Neonatal Training

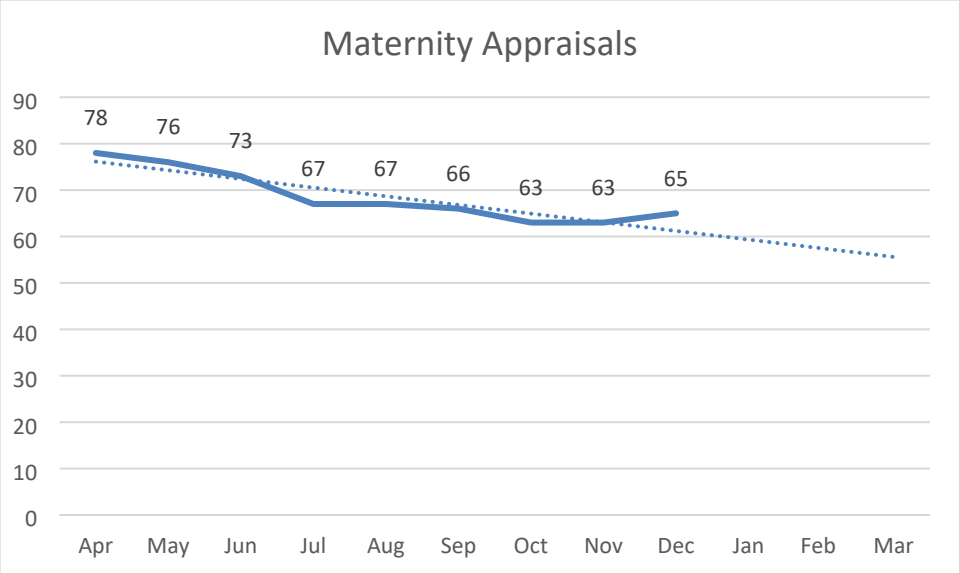
Mandatory Day	Overall Compliance		
	Oct	Nov	Dec
Maternity Mandatory Day (Midwives & MCA's Only)	85%	85%	89%
PROMPT Part 1 (Combined) (MDT: Midwives, MCA's, Obstetricians & Anaesthetic Team – Theatre team not included in calculation)	81%	86%	95%
PROMPT Part 2 (Combined) (MDT: Midwives, MCA's, Obstetricians & Anaesthetic Team – Theatre team not included in calculation)	82%	87%	93%
Fetal Monitoring (Midwives & Obstetricians)	85%	89%	91%

A report providing an update on the local training and development that is ongoing within the maternity and neonatal service, including a response to year 5 of the maternity incentive scheme action 8 is expected next month. The Maternity and Neonatal service must demonstrate that a local training plan is in place for implementation of Version 2 of the Core Competency Framework and that the plan has been agreed with the quadrumvirate and signed-off by the Trust Board and the LMNS/ICB. The CCFv2 sets out clear expectations for all Trusts, aiming to address known variation in training and competency assessment across England. It ensures that training to address significant areas of harm are included as minimum core requirements and standardised for every maternity and neonatal service.

Following on from the update to the Core Competency Framework, version 2. The education team have updated our training plans for 2023 and for 2024. This has been signed off by the divisional quadrumvirate on 20th November 2023.

10. Appraisal Compliance

Although marginally improved from November, appraisal compliance continues to be a concern, with a downward trajectory within Maternity Services.



Compliance Rate Highlight key:
Less than 70% | 70% - 89% | 90% and above

Division Total		522	227	70%
Service Line	Organisation	In Date	Out of Date	Compliance (%)
318 Obstetrics	318 Community Midwives - West Hub 31722	22	10	69%
318 Obstetrics	318 Consultants-Obs & Gynae & Gynae Onc 69593	10	1	91%
318 Obstetrics	318 Consultants-Obs & Gynae-GRH 68793	10	1	91%
318 Obstetrics	318 Continuity Teams Chelt West 47941	6	1	86%
318 Obstetrics	318 Continuity Teams Glos West 31322	6	3	67%
318 Obstetrics	318 Maternity Antenatal Clinics 31822	24	4	86%
318 Obstetrics	318 Maternity Specialist Posts - NR 47793	1		100%
318 Obstetrics	318 Maternity Specialist Posts GRH 47822	30	22	58%
318 Obstetrics	318 Maternity Triage 26222	12	8	60%
318 Obstetrics	318 Maternity Ward 32022	40	30	57%
318 Obstetrics	318 Midwife in the Ambulance Hub 12741	2		100%
318 Obstetrics	318 Obstetrics Admin - GRH 71822	19	3	86%
318 Obstetrics	318 Other Medical-Obs&Gynae-GRH 61022	2	1	67%
318 Obstetrics	318 Stroud Birthing Unit 32023	25	11	69%
318 Obstetrics	318 Womens Health Admin 79222	12	8	60%
318 Obstetrics Total		**287**	**153**	**65%**

11. Periprem Births

A key and potentially the most challenging element to the PERIPrem care bundle is birth in the right place – this applies to extreme preterm infants under 27 weeks, under 800g or under 28 weeks if a multiple birth. This is because extremely preterm babies (<28wks) born in a non NICU centre have a 2-3x higher risk of severe brain injury than babies born in the right place. This means we must strive, where safe to do so, to transfer those women at risk, to a tertiary NICU unit.

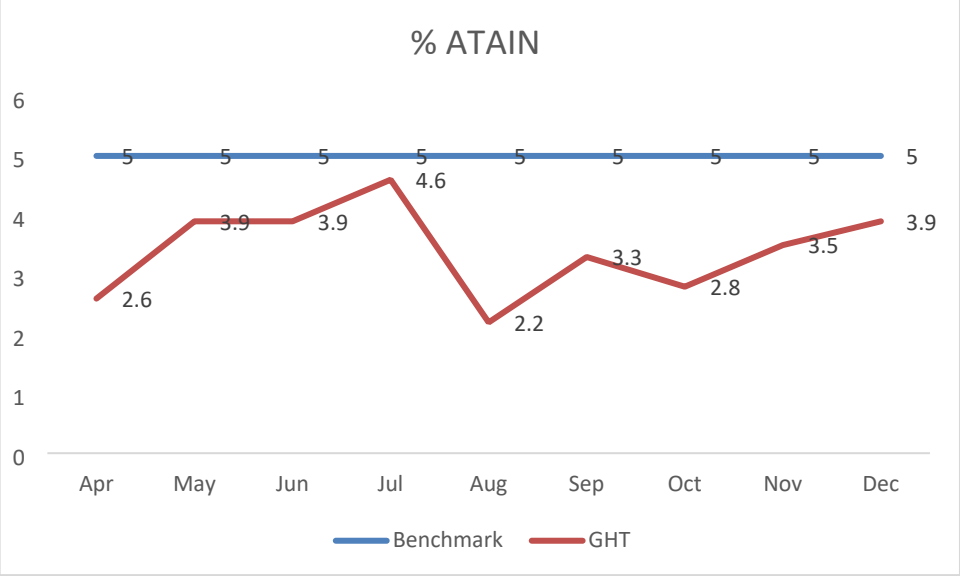
There were 2 Periprem births (twins) during the quarter.

- P0 twin pregnancy 23/40 attended with Triage with abdominal pain. Rapid birth on arrival: Twin 1 delivered into toilet - no BP at birth but resus - RIP 20/10, Twin 2 ? breech entrapment RIP 12/10/23

12. ATAIN (Term Admissions to NNU)

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals

The Trust is working towards providing a transitional care (TC) pathway for babies from 34 weeks and above in alignment with the BAPM framework.



The number of term admissions to the NNU for the quarter averages at 3.4%, and reasons for admission are broken down into the following categories:

Respiratory distress	46%
Hypoglycaemia	14%
Jaundice	0%
Hypothermia	0%
Other (eg poor condition, investigation, metabolic disorder, feeding etc)	40%

The Q3 ATAIN report can be found in Appendix 1

13. NICE Guidance

There has improvement on the speciality position regarding NICE guidance. Leads have been contacted and an update requested for the following:

Title	Ref	Lead	3 months deadline date to provide baseline assessment and action plan	9 month deadline date to confirm action plan completed and/or closed via Risk Register
PN care	NG194	K Lilly	01/08/2021	01/02/2022
IP Care for health women and babies	CG190	T Jorgensen	Received 29/03/23	01/09/2023
Fetal Monitoring in Labour	NG229	L Elbashir/S Wainfur	01/04/2023	01/09/2023

14. Audit & Guidelines

33.85% of policies are out of date – plan TBA

15. POPAM Storage

Overall Compliance for October & November is 100% December data awaited

Standard	Area				Overall Compliance
	AN	BU	CDS	MAT	
3. Drugs cupboard locked	100%	100%	100%	100%	100%
4. Drugs left out	100%	100%	100%	100%	100%

6. Fridge temp. monitored	100%	100%	100%	98%	99.5%

16. Production Board

The Maternity Production Board sets out to review the elements of Quality and which are of most concern within the Division. Data extraction has been challenging since June for a number of reasons, such staff redeployment during escalation, the formation of an enhanced midwifery senior leadership team and the transition from paper to EPR/paperlight records. Work will continue in the forthcoming months to improve data quality, enabling deeper analysis and improvements to the areas we are concerned about.

MEASURE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
MOEWS Chart Present	96%	95%	No data	No data	100%	100%	100%	93%	98%
MOEWS Escalated Appropriately A/N	100%	N/A	No data	No data	No data	No data	No data	No data	No data
MOEWS Escalated Appropriately P/N	50%	100%	No data	No data	No data	No data	No data	No data	No data
1:1 Care in Labour	98%	96%	98%	100%	99%	97%	99%	98%	98%
Emergency Equipment Checks	99%	94%	81%	88%	89%	85%	92%	99%	
L3 Safeguarding Training Compliance	No data	No data	No data	No data	No data	63%*		70%*	
Elearning Compliance	79%	80%	79%	78%	78%	77%	76%	77%	77%
Appraisal Compliance	78%	76%	73%	67%	67%	66%	63%	63%	65%
PROMPT Training - part 1		74%	81%	No data	80%	71% #	81%	86%	95%
PROMPT Training - part 2		81%	89%		83%	72% #	82%	87%	93%
Overdue incidents	217 (16	271 (13	198	166	71	15	19	54	73
Overdue Actions (Risk Register, Incidents, Complaints)	2	5	19	16	12		28	20	26
Overdue Actions (Risk Register)									7
Overdue Actions (Complaints)									1
Overdue Actions (Incidents)									18
CO Monitoring at 36/40	No data	No data	No data	No data	No data	No data	No data	No data	No data
PMA RCS Sessions	5	9	11	5	No data	7	12	9	
External Opinion - Requested	1	0	1	1	1	5	3	3	
External Opinion - Attended	1	0	1		1		0	1	
Intrapartum Risk Assessment Completed									

Workforce

17. Annual Survey

17.1 Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment – reported annually

Not applicable – yearly report – remains at 36.9%

17.2 Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours – reported annually

Not applicable – yearly report – remains at 90.7%

18. Medical Staffing

18.1 Medical Gaps in Rota- Mid Staff Grade

22 gaps – **all covered** with locum posts

18.2 Obstetric Consultants

11 rota gaps - all covered with locum posts

19. Midwifery Staffing

19.1 Midwifery vacancy rate %

OCT	NOV	DEC
8.51	8.45	7.85

Midwifery vacancies remain of concern, but have improved this month to 7.85%, compared to 8.45% in November. The Recruitment and Retention team continue in their efforts to improve the staffing picture.

Quality

20. Service User Voice Feedback

20.1 FFT % of responses which are positive

Average for Oct/Nov/Dec 82.6%)

(December feedback)
Maternity services received 247 responses to the FFT in December 2023, of which 80.2% were rated positively. A decrease in positive ratings was seen for all services, most notable decreases were for Midwife episodes and the Maternity Ward.

There were some comments about postnatal care in the community regarding problems with midwives not showing up or cancelling appointments via the app. Missed tongue ties were also mentioned.

On the Maternity ward there were comments about general lack of information and confusing advice re breastfeeding.

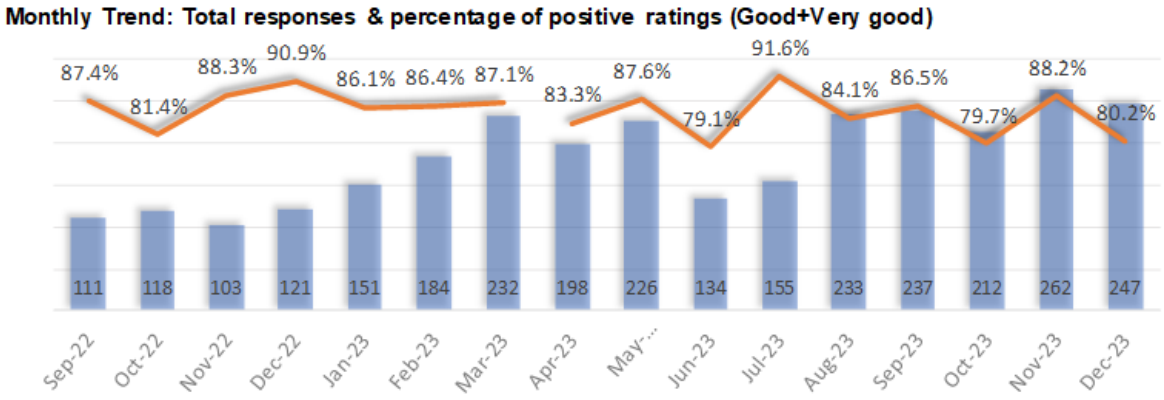
Note: fewer comments mentioning lack of pain relief or missed observations this month

Table showing breakdown of response ratings and positive scores: December 2023

	Very good	Good	Neither	Poor	Very poor	Dont know	Total Count	Total Positive
Maternity	144	54	21	11	12	5	247	80.2%
Outpatients	51	12	5	4	5	0	77	81.8%
Midwife episode	33	7	4	3	2	0	49	81.6%
Obstetrics	18	5	1	1	3	0	28	82.1%
Birth Unit, GRH	11	4	0	1	0	0	16	93.8%
Delivery Suite, GRH	49	13	6	3	3	1	75	82.7%
Maternity Ward, GRH	33	25	10	3	4	4	79	73.4%

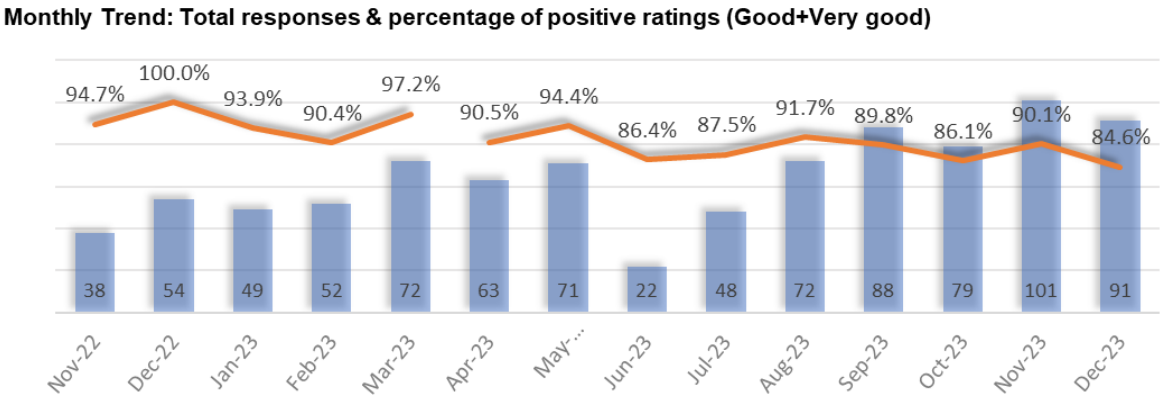
Outpatients:

Obstetrics feedback was mostly positive, most common theme is wait times/late clinics. A couple of comments mention not being given enough checks to fully reassure of any issues or didn't have a chance to ask all questions.
Midwifery feedback was quite mixed, there were several comments noting long wait times, and 2 mentioning not being allowed to have partners or children with them for scan appointments.



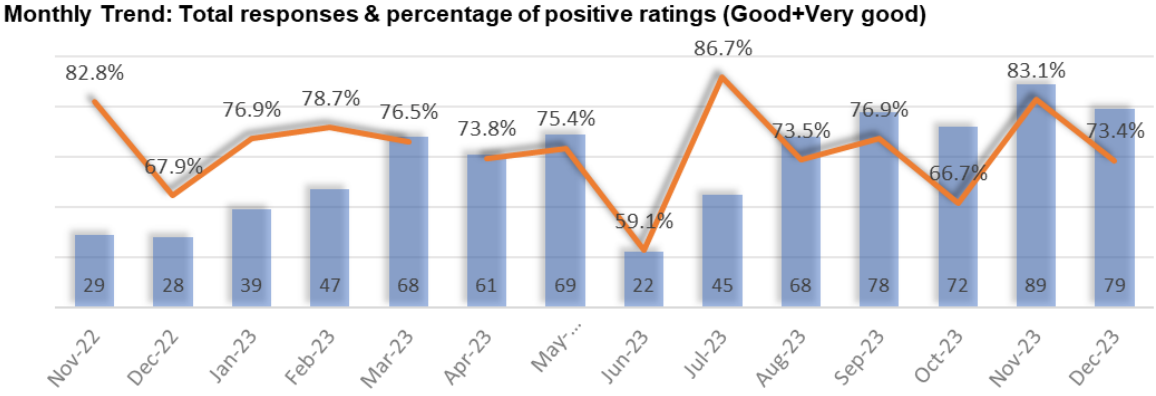
Delivery Suite/Birth Unit

Quite different experiences described on the birth Unit compared to delivery suite. Comments mention long waits to get to a bed on the delivery suite and then feelings that they were not always listened to and not much effort to follow birth plans. In contract to the birth unit where comments mention staff going out of their way to follow birth plans and respect wishes



Maternity Ward

Noise on the ward was mentioned several times. Also, not enough general information about the ward being given out.
There were a few comments made about being given conflicting advice in regards to breastfeeding causing confusion. And a couple of mentions about privacy.



20.2 Maternity & Neonatal Voices Partnership

An event was held in December where 12 service users attended along with babies and toddlers, along with 6 representatives from community groups and 15 healthcare professionals, including midwives and health visitors.

During the event, two presentations were made by members of the Neonatal and Maternity Teams.

Neonatal:

A survey co-produced with parents who had experienced neonatal care and data has now been gathered and an action plan is to be created. The presentation was well received with questions about ensuring voices of all communities were heard. There is ongoing work to ensure that seldom heard voices are captured and supported to be part of projects.

Maternity:

An updated was given by the Consultant Midwife on maternity services in the Forest of Dean and upon build completion, the new hospital will offer dating, nuchal and anomaly scans once a week. This news was well received

The event also involved focus group discussions around Antenatal education, unit tours and experience in Triage

20.3 PALs Summary

18 issues raised in Maternity which include:

Appointment – availability	1
Communication with patient	3
Cannula management	1
Accuracy of health records (e.g. errors, omissions, other patient's records in file)	1
Discrimination/equality/disability	1
Patient incorrectly identified	1
Waiting times	1
Delay or failure in treatment or procedure	2
Communication with relatives/carers	1
Staff attitude	3
Trust admin/policies/procedures including patient record management	2
Loss of/damage to personal property including compensation issues	1

20.4 Complaints

16 new complaints were received during the quarter month as follows:

ID	Date	Brief Description of Patient Experience
OCTOBER		
68038	24/10	Lack of communication prior to birth and after regarding baby having macrocephaly. Measurements were not taken by sonographer prior to birth
67930	16/10	Delayed IOL due to long waitlist on CDS
67863	16/10	Placenta retained after c section. No security tag on infant. No stockings given to patient. Understaffed
67469	09/10	Patient had a bad experience on the maternity ward and delivery suite. She has had a debrief session but still wants a written response top her unanswered questions
67854	02/10	Awareness under surgery. Inappropriate comments from midwife. Poor nursing care. Overfeeding of infant by midwife. Poor communication and overall poor nursing care re catheter and mobility. No follow up advice re c stion after care. Stitches left behind causing infection. Retained placenta
67730	02/10	Patient was traumatised on her birthing experience (3rd stage), She raised some questions about the procedure
NOVEMBER		
68648	24/11	Poor attitude of sonographer
56889	15/11	Poor communication and attitude of midwives. Alleged racial prejudice. No translator. Resulted in emergency c-section. Told by health visitor charge for notes. GHT to answer if there is as complainant thinks this is not acceptable. If not HV will need to answer why pt told this
68354	10/11	Poor communication with patient, delay in treatment or procedure, inadequate pain management, insufficient information provided, medication errors and cleanliness clinical.
68397	08/11	Penalty charges received due to midwife forgetting to register patient
68196	08/11	Blood pressure medication oversight. Observation procedures in question. Medication timings
68338	06/11	Attitude of Triage member of staff
68296	06/11	Patient had a traumatic experience in the ward, poor attitude of staff and was given incorrect course of antibiotics.
DECEMBER		
69006	27/12	Admission arrangements, delay in procedure, lack of communication with patients
68841	13/12	Wrongly served 2 penalty charges for prescriptions while pregnant due to midwife not completing maternity exemption certificate
68833	11/12	Inappropriate comments made re patients' previous mental illness

20.5 Patient Safety Champion Walkabout

Patient Safety Champion walkabouts have been scheduled to continue in the New Year, and updates will be reported when received.

National Assurance Programmes

21. Ockenden 2

No update

22. CQC Section 29a

As reported on dashboard within this report

23. Maternity Incentive Scheme Y5

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care. The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund. The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds. Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

We are compliant for all 10 safety actions of the maternity incentive scheme and this has been presented and approved by the Board for submission to NHSR on 1st February 2023.

Appendix 1

Maternity Incentive Scheme – Year 5, Safety action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?

Avoidable Term Admissions to the Neonatal Unit (ATAIN) Report & Transitional Care Audit Report– Q3 October, November & December 2023-2024

Authors and contributors: Perinatal Patient Safety Midwife: Jane Bolton

Report Overview

ATAIN is an acronym for Avoiding Term Admissions into Neonatal units. It is a national programme of work initiated under patient safety to identify harm leading to term neonatal admissions. The current focus is on reducing harm and avoiding unnecessary separation of mothers and babies.

This report outlines the term admission rates at the NNU at Gloucestershire NHS Foundation Trust, findings from audits of the pathway / policy, findings from the ATAIN reviews both term and late pre-term babies and provides assurance of actions being taken and progress being made.

The national ambition

In August 2017 NHSI mandated a Patient safety alert to all NHS Trusts providing maternity care. The safety alert was issued to reduce harm from avoidable admissions to neonatal units for babies born at or after 37 weeks. This fell in line with the Secretary of State for Health's ambition to reduce stillbirth, neonatal brain injury and neonatal death by 50% by 2030. This ambition is also aligned with the vision created within Better Births (2016), which aims to drive forward the NHS England-led Maternity Transformation Programme, with a key focus on;

- Reducing harm through learning from serious incidents and litigation claims.
- Improving culture, teamwork and improvement capability within maternity units.

Why is it important?

There is overwhelming evidence that separation of mother and baby so soon after birth interrupts the normal bonding process, which can have a profound and lasting effect on maternal mental health, breastfeeding, long-term morbidity for mother and child. This makes preventing separation, except for compelling medical reason, an essential practice in maternity services and an ethical responsibility for healthcare professionals.

Collaboration between neonatal and maternity staff within Gloucestershire Hospitals has seen several positive changes, with a real focus around improving maternity and neonatal care. Several projects have been identified to support the reduction in the unnecessary separation of the mothers and babies that use our service. This includes the introduction of an ATAIN protocol for the Neonatal team to work through when attending deliveries of 37/40 plus infants to try and avoid term admissions for the most common referral reason – the need for respiratory support.

A Band 7 neonatal nurse has also been appointed (from January 2023) as TC lead and there has been a consequent improvement in the ability of the NNU to provide TC nursing cover to babies who require it, whether they be on delivery suite or the maternity ward. It is hoped that this will help reduce separation due to feeding problems, hypothermia or hypoglycaemia.

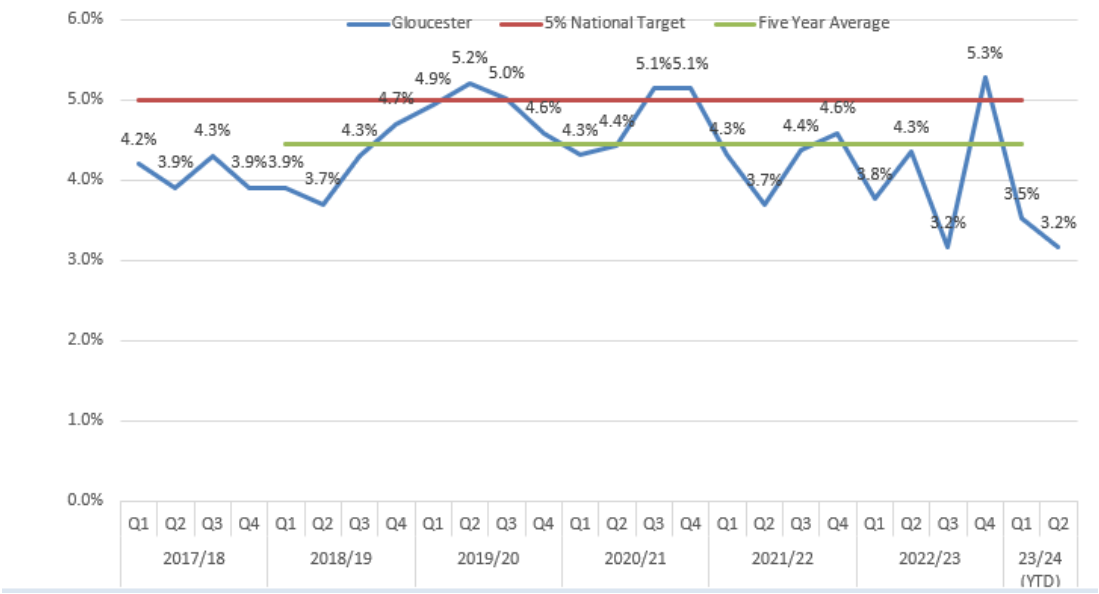
The national aim for term admissions to the neonatal unit is less than 5% of all term babies, however Trusts should strive for this rate to be as low as possible.

Trust ATAIN rates

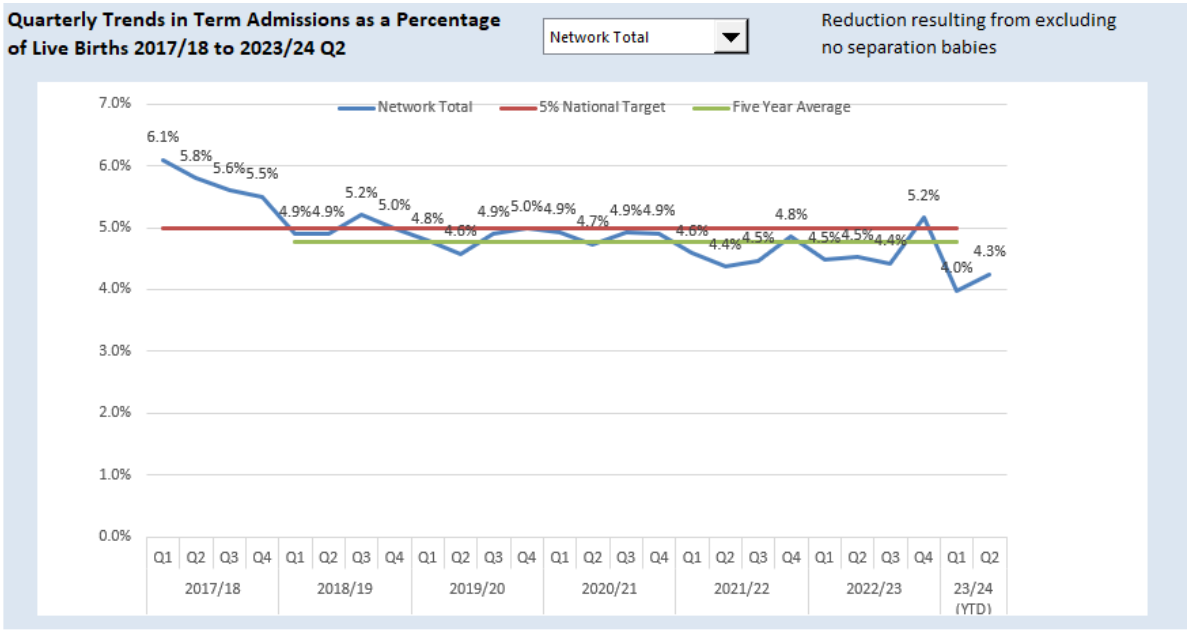
The following graph outlines the ATAIN rates for Gloucestershire Hospitals NHS Trust.

Q3 data not available on South West Neonatal Network at the time of writing this report, will be included within the Q4 report.

Q3 23/24 = 3.8%



Southwest Network total rates



ATAIN

TC / ATAIN report Q3 2023-2024

ATAIN Reviews within the Trust – for Year 5 MIS it was identified that the process of reviews within the Trust needed to change to be compliant.

The process changed August 2023. Prior to this, each term admission to NNU was reviewed separately by a midwife (maternal records) and a Paediatric or Neonatal Nurse (baby's records). Any cases with issues identified were discussed by an MDT at a Quarterly ATAIN meeting. Any actions were added to the ongoing Action Plan.

In August 2023 it was identified that this was not compliant with Safety Action 3 guidelines:

'b) A robust process is in place which demonstrates a joint maternity and neonatal approach to auditing all admissions to the NNU of babies equal to or greater than 37 weeks. The focus of the review is to identify whether separation could have been avoided. An action plan to address findings is shared with the quadrumvirate (clinical directors for neonatology and obstetrics, Director, or Head of Midwifery (DoM/HoM) and operational lead) as well as the Trust Board, LMNS and ICB.'

Therefore, necessary changes were made to ensure each ATAIN case from January 2023 onwards, was reviewed jointly by an MDT to include – a midwife, an Obstetrician, a Neonatologist and a Neonatal Nurse. The cases from June and July 2023 were the focus of the first MDT reviews during September 2023.

During September, October and November 2023 there were frequent/regular MDT meetings to continue with the reviews from January, February, March, April, May, August, September, October and November 2023. In January 2024 the remaining cases for November and December were reviewed at an MDT.

ATAIN reviews (babies equal or >37 weeks gestation)

	October 2023	November 2023	December 2023
Total number of admissions in month	14	22	18
Number of babies where the MDT review identified **that separation of mother and baby may have been avoided.**	**1**	**1**	**3**
Number of babies admitted to **NNU where mother and baby separation was avoided,** as the mother remained on NNU with the baby during the admission.	0	**1**	0
Number of babies admitted to the NNU that **would have met current TC admission criteria** but were admitted to the NNU due to capacity or staffing issues.	**1**	0	0
Number of babies that were admitted to or **remained on NNU because of their need for nasogastric tube feeding** but could have been cared for on TC if nasogastric feeding was supported there.	1	0	0

	October 2023	November 2023	December 2023
Total number of case reviews undertaken in month	14	21	16
Total number of case reviews with both maternity and neonatal staff present	14	21	16
Total number of live births for the month.	493	481	461
% of term births admitted to NNU for the month.	**2.8%**	**4.6%**	**3.9%**

There were five babies identified by the MDT review in Q3 where separation could have been avoided.

Month	Reason for admission	Modifiable factors that may have prevented the separation of mother and baby (NNU admission).
October 2023	Parenting and feeding support, baby scoring on Neonatal Abstinence Syndrome Chart.	
November 2023	Baby risk factors for hypoglycaemia- • Mother Type 1 diabetes • Baby LGA Baby - Hypoglycaemia at 10 hours of age.	Trust Guideline 'Neonatal hypoglycaemia' not followed: the recommended volumes of formula (10-15mls per KG), not given. First feed given– 10mls (38-52mls required). Second feed given – 5mls.
December 2023	Baby risk factors for hypoglycaemia • Mother Type 1 diabetes • Fetal compromise in labour • Mother administer terbutaline in labour. Baby – Hypoglycaemia at 5 hours of age	Trust Guideline 'Neonatal hypoglycaemia' not followed: the recommended volumes of formula (10-15mls per KG), not given. First feed given– 15mls (34-52mls needed). Second feed given – 25mls.
December 2023	Baby risk factors for hypoglycaemia • Mother Type 1 diabetes • Baby LGA • Fetal compromise in labour	Trust Guideline 'Neonatal hypoglycaemia' not followed: BM/second BF not within 3

	Baby – Hypoglycaemia at 12 hours of age	hours of the first feed – was 5 hours after the first feed.
December 2023	Baby born with significant acidosis admitted for CPAP and cerebral Function Monitoring.	Opportunity to have expedited birth. Sub optimal fetal monitoring, there was a prolonged period of no fetal monitoring as likely recording maternal pulse.

ATAIN Results Data by Quarter 2023-2024

The Charts below provides a summary of the rates in % of term infant admissions to the neonatal unit each quarter/year.

	No. of Live Births	No. of Unexpected Term admissions to NNU	% of live term births admitted to NNU.
Q1 April – June 2023	1394	50	3.6%
Q2 July-Sept 2023	1356	44	3.2%
Q3 Oct-Dec 2023	1435	54	3.8%
Q4 Jan-March 2024			

Issues and actions identified by Review of cases in Q3 2023-2024

ATAIN meeting members:

October 2023 – J Bolton (midwife), K. Horton (Sister NNU), L. McDermott (Obstetric Consultant), M Grant (ANNP), J. Lee (Obstetric Registrar), R. Swingler (Obstetric Consultant), S. Bhakthavalsala (Neonatal Consultant), L. Elbeshir (Obstetric Consultant), I. Das (Obstetric Consultant), R. Evans-Jones (Obstetric Consultant), J. Doraiswamy (Obstetric Consultant).

November 2023 – J Bolton (midwife), K. Horton (Sister NNU), L. McDermott (Obstetric Consultant), M Grant (ANNP), J. Lee (Obstetric Registrar), Das (Obstetric Consultant), L. Elbeshir (Obstetric Consultant), R. Evans-Jones (Obstetric Consultant), R. Swingler (Obstetric Consultant), M. Richardson (Interim Matron NNU).

December 2023 – J Bolton (midwife), L. McDermott (Obstetric Consultant), M Grant (ANNP), R. Swingler (Obstetric Consultant), M. Richardson (Interim Matron NNU).

Oct 2023	Area focus/modifiable factors	Actions	Time scale and identified lead	Update/progress	Completion date
5.Other	Cord gas results difficult to find on Badgernet, however documented as taken.	D/W digital midwives to check on where they should be entered on badgernet, then for NEWSLETTER	KH 31/12/23		
5.Other	Badgernet documentation – no time entry for the actual time of instrumental attempt in the room.	NEWSLETTER Reminder to document actual time of events on Badgernet.	JB/KH 31/12/23	Added to December 2023 newsletter JB	27/12/23

Nov 2023 MDT date:	Area focus/modifiable factors	Actions	Time scale and identified lead	Update /progress	Completion date
2. Hypogly-caemia	1.No feeding plan in place for baby on Mat. Ward, and increasing the feed interval to 4 hours exacerbated the hypoglycaemia. 2.For consideration of whether women on Fragmin for previous provoked VTE warrant growth scans.	1.Importance of feeding plans for IUGR to be highlighted on Newsletter. 2.Obstetric Consultant present at the MDT to discuss with the other Obstetric consultants.	JB/KH 31/3/23 31/1/23 RS/JB	2. D/W Obs Consultants – if only a provoking factor – thromboprophylaxis from 28 weeks, nil else. 14/12/23	

2. Hypogly-caemia	Baby risk factors for hypoglycaemia- • Mother Type 1 diabetes • Baby LGA Trust Guideline 'Neonatal hypoglycaemia' not followed: the recommended volumes of formula (10-15mls per KG), not given. First feed given– 10mls (38- 52mls needed). Second feed given – 5mls. First feed given within an hour of birth as per policy, however 2nd feed given 5 hours after the first feed. Baby admitted at 10 hours of age with hypoglycaemia.	1. Neonatal Consultant to do an awareness drive of the guidelines. 2. NEWSLETTER – Patient Safety Midwife to do a 'feature' newsletter on the issue. 3. Request for the issues to be included within the words of the week for Delivery Suite and Mat ward.	1.R.P 29/2/24 2.JB 29/2/24 3.JB 29/2/24	2. 19/1/24 email sent to D/S & mat ward leads.	
5. Other	Baby had a late onset of sepsis. Admitted day 3 with respiratory distress, CRP 92. Mother commenced Post-natal antibiotics Day 0, ?Chorio, however it appears that the Neonatal team were not informed of this. This information would have changed the management of the baby – septic screen and IV antibiotics.	Discuss with Ward Lead Midwife – ask if this can be included in the Team talk as a reminder to discuss with neonatal team when changes in mother's care may require a review of the baby by the neonatal team.	J.B & E. R 31/1/24	27/12/23 Email sent to Ward lead Midwife asking for this to be included in ward team talk.	27/12/23

Dec 2023 MDT date:	Area focus/modifiable factors	Actions	Time scale and identified lead	Update /progress	Completion date
2. Hypoglycaemia	Baby risk factors for hypoglycaemia • Mother Type 1 diabetes • Fetal compromise in labour • Mother administered terbutaline in labour. Trust Guideline 'Neonatal hypoglycaemia' not followed: the recommended volumes of formula (10-15mls per KG), not given. First feed given– 15mls (34-52mls needed).	1. Neonatal Consultant to do an awareness drive of the guidelines. 2. NEWSLETTER – Patient Safety Midwife to do a 'feature' newsletter on the issue. 3. Request for the issues to be included within the words of the week for Delivery Suite and Mat ward.	1.R.P 29/2/24 2.JB 29/2/24 3.JB 29/2/24	2. 19/1/24 email sent to D/S & mat ward leads.	

	Second feed given – 25mls. Baby admitted at 4 hours of age with hypoglycaemia.				
2. Hypoglycaemia	Baby risk factors for hypoglycaemia • Mother Type 1 diabetes • Baby LGA • Fetal compromise in labour Trust Guideline 'Neonatal hypoglycaemia' not followed: BM/second BF not within 3 hours of the first feed – was 5 hours after the first feed. Baby admitted at 12 hours of age with hypoglycaemia.	1. Neonatal Consultant to do an awareness drive of the guidelines. 2. NEWSLETTER – Patient Safety Midwife to do a 'feature' newsletter on the issue. 3. Request for the issues to be included within the words of the week for Delivery Suite and Mat ward.	1.R.P 29/2/24 2.JB 29/2/24 3.JB 29/2/24	2. 19/1/24 email sent to D/S & mat ward leads.	
5. Other	Mother with Anti C red cell antibodies, delay obtaining Hb, DAT and bilirubin cord blood results after birth.	NEWSLETTER To highlight the importance of labelling cord blood correctly, sending to lab marked as urgent, and following up on results ASAP	JB/MG 29/2/24		

		to avoid delays in treatment. Blood tests needed for HB, Direct Antiglobulin Test (DAT) and bilirubin.			
5. Other	For 40 mins prior to delivery, sub optimal fetal monitoring - prolonged period of no fetal monitoring as likely recording maternal pulse.	Action required to be discussed with Fetal Monitoring Midwife for appropriate learning for this case.	JB/SW 29/2/24	19/1/24 email to Lead for FM to follow up the learning for this case.	
5. Other	Several cases only 1 cord gas result present on badgernet.	To discuss with digital midwives on communicating this to all staff, to ensure Arterial and Venous cord gases are recorded on badgernet in the correct way.	JB/JC 29/2/24	16/1/24 email to digital midwife to ask for some comms. on this to staff.	

ATAIN learning was captured and shared with team members to improve care

The learning captured from the ATAIN cases in Q3 2023, and shared with appropriate team members in the following ways:

- ATAIN Newsletter – distributed widely within the Maternity and Neonatal teams.
- Information communicated to staff through Unit 'Words of the Week'
- Neonatal Consultant – awareness drive of the Trust Guidelines for Neonatal Hypoglycaemia - Prevention and Management.
- Fetal Monitoring Lead Midwife to share learning.

The ongoing action plan with updates and progress from the last report is embedded.

ATAIN ONGOING A
Plan for Q3 Report

Transitional Care Audit Report

Data Collection Period:	01st October 2023- 31st December 2023
Presentation details:	Location: Transitional Care (Maternity Ward / Neonatal Unit / Delivery Suite) Date: 13/02/2024
Author:	Catherine Carmichael
Standards:	
Summary of Results:	• TC occupancy (at a ratio of 1:4 nurse: patient allocation) is an average of 68.2% up from 67.66% and therefore there is still a possibility for criteria expansion. • The overwhelming reason for meeting current TC criteria is for being on IVAB's.
Version of Guideline Audited:	
A copy of the Action Plan and Data Collection Proforma can be found at the end of the report	

Introduction

Transitional Care is currently situated where ever transitional care babies are situated. This may be on the Maternity Ward, Delivery Suite or Neonatal Unit. Criteria for admission for TC is to be a late preterm infant (35 – 36 weeks gestation), following step-down care of NNU, receiving IV antibiotics or on the recommendation of neonatal medical team for other monitoring and support.

The current situation is for a neonatal nurse to be allocated to TC to help care for these infants, with midwives continuing to be responsible for maternal care. Currently, the ratio for a nurse to TC infant is 1:4.

Audit is to comply with Maternity Incentive scheme (MIS) guideline requirements and provide data which can be used to develop the service.

Aim

The aim of this audit is to comply with MIS guidelines and provide data which can be used to develop the TC service.

The particular questions to be answered are:

1) How many infants are identified daily to meet the TC criteria within the Maternity Unit and Neonatal Unit?
2) Is there capacity for the TC criteria to be extended to include more infants?
3) What is the trend for the reasons for meeting the TC criteria?
4) What percentage of these infants are being primarily cared for by a neonatal nurse?

Methodology

The data for the audit has been prospectively compiled from the neonatal BadgerNet and from the neonatal medical handover database.

Daily data from Badgernet was examined which identified infants on Maternity Ward or delivery Suite being cared for by a neonatal nurse and meeting the TC criteria. The meeting of TC criteria was ascertained from Badgernet.

Not all infants meeting the TC criteria will currently be identified through Badgernet. TC eligible infants being cared for by midwives alone will not be on Badgernet and therefore attempts have been made to identify these infants through the daily neonatal medical handover database and maternity badgernet.

This data is collated monthly on an Excel spreadsheet. It highlights:

- The number of infants identified as meeting the TC criteria on Maternity Ward.
- The reason they met the TC criteria.
- Whether they were primarily cared for by a neonatal nurse.
- Readmission rates of TC babies
- 34–36-week gestation babies cared for on NNU who meet the TC criteria and of birth weight 1.6Kg-1.8Kg

This audit incorporates the 3rd quarter of 2023 (October-December 2023).

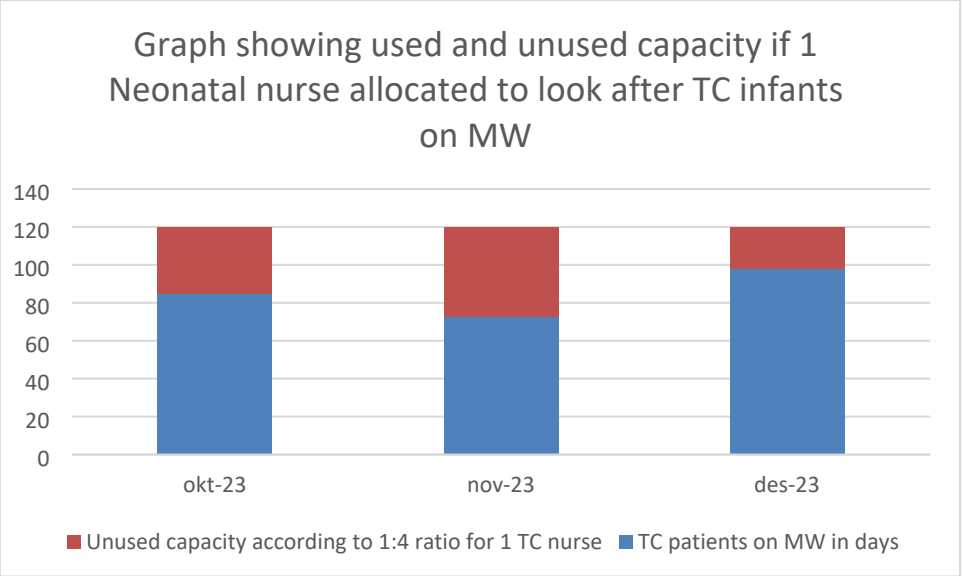
There are recognised exceptions to the audit which is currently to do with data collection problems. Only infants that meet the TC criteria who are included on Badgernet or on the daily neonatal medical handover database are included in the audit. There are likely to the TC eligible infants who are being missed from this audit on the basis of this methodology.

Analysis of Results

1) How many infants are identified daily to meet the TC criteria on Maternity Ward?

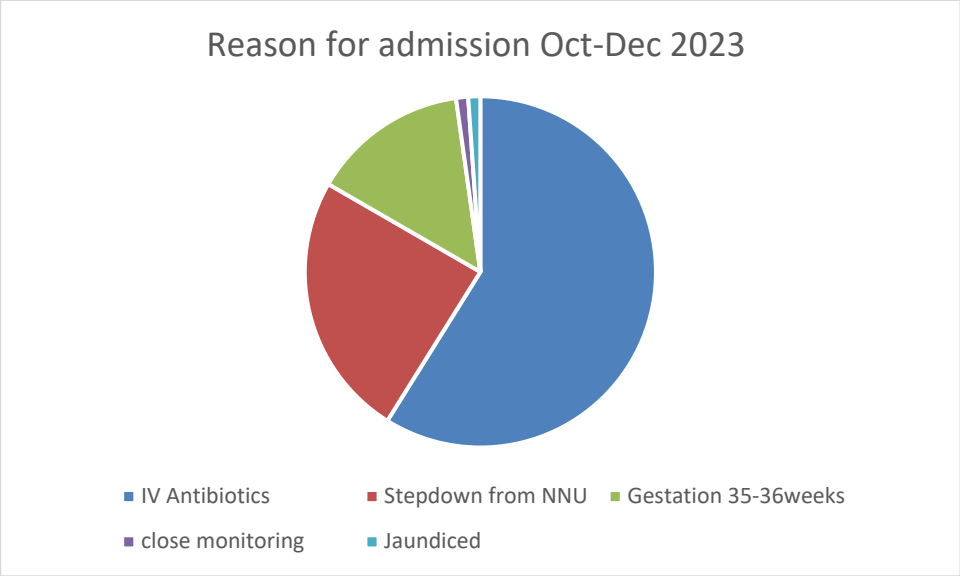
Month	No of TC cot days	Infants identified eligible but no TC nurse allocated cared for by midwives in TC cot days
Oct 2023	80	0
Nov 2023	73	5 (for 5 ½ hrs on 3 days)
Dec 2023	98	3 (for 5 ½ hrs on 1 day)
TOTAL days Oct- Dec 2023	251	8

2) Is there capacity for the TC criteria to be extended to include more infants?
Average number of TC cot days on Maternity Ward is 120 TC cot days per month.



For the months in question, a TC Nurse was allocated except for 6 shifts. In this instance the babies were cared for by the midwifery team. However, if the assumption could be made that one nurse would be allocated to TC daily to look after four infants (ratio 1:4) then occupation for this time period was only 68.2%. This suggests that there continues to be capacity to increase the TC criteria to include more infants.

3. What are the identified reasons for meeting the TC criteria?



The overwhelming reason for meeting the TC criteria is because the baby was on IVAB's. A percentage of patients were identified as being, preterm or growth restricted or Neonatal step down or requiring feeding support or required closer monitoring. Some babies were both step down and IV antibiotics so these have just been categorised into IV antibiotics

3) What percentage of these infants are being primarily cared for by a neonatal nurse?

It has not always been possible to allocate a neonatal nurse to TC due to NNU staffing issues, or NNU capacity issues. Overall, 99.3% of shifts were covered by NNU staff in the 3 months from Oct 23 – Dec 23

	Total shifts not covered by NNU staff (based on 3 shifts per day)	Shift when no eligible TC babies on Maternity ward
Oct 23	0	0
Nov 23	5	3
Dec 23	1	1

	Number of TC babies eligible but cared for by midwife.
Oct 23	0
Nov 23	5 (from 15:00-20:00 on 3 days)
Dec 23	3 (from 15:00hrs - 20:00hrs on 1 day)

Readmission rates of TC babies

Of the babies readmitted within 1 month of discharge, reasons included. 7 were admitted to maternity ward with jaundiced and

weight loss.3 babies were to the paediatric ward within 1 month of discharge were due to increased work of breathing.

3 babies were readmitted to NNU 2 who were hypothermic/ poor feeding, 1 requiring a blood transfusion.

It is not possible to compare readmission rates with those having 'normal care' as this is not audited by the midwifery team.

34 - 34+6-week babies not admitted to TC on mat ward

A total of 10 babies would have been eligible to be admitted to TC if the criteria was increased to include gestation 34-34+6 and babies' weight of 1.6Kg-1.8kg.

October 5 babies, November 2 babies and December 3 babies.

Impact of Audit

The audit shows that there is a capacity for the TC criteria to be extended to include a greater number of patients which should reduce the need for certain infants to be admitted to the NNU. This could include, for example, infants born at lower gestations 34 - 34+6 and those with lower birth weights. A change in education has led to more step-down babies from NNU being identified and these numbers have significantly increased.

There has been a significant improvement in the allocation of a TC nurse allocated to work. An escalation guide has been devised to ensure if that if more than 4 TC babies are identified and no 2nd TC nurse can be allocated that late preterm infants will be prioritise to TC care. This is beneficial in terms of producing the best service and preventing NNU admissions in late preterm infants.

There have been occasions where more than 4 TC babies have been identified and 2 TC nurses have been allocated. However, there is currently no robust way to record this data.

SOP for TC guidelines have been approved and uploaded onto the trust intranet policy and guidelines area.

Objectives from last report

A TC leaflet for families has been approved and is available for both high risk antenatal families and those who enter the service postnatally.

A change in practice is to be implemented on the Neonatal Unit and is used to identify more accurately eligible TC babies within the NNU department. These babies are now cared for within the TC environment but on NNU

A video has been recorded and uploaded on to the MVP site for families to access regarding the TC service. It has also been sent to SWNN to be uploaded onto the network web site.

Going forward

There is currently a plan to develop the TC service further to incorporate 34-34+6 preterm infants and those of birth weight 1.6 -1.8KG.

Part of this role will be to review the TC admission criteria and develop an environment where these infants can be cared for as part of a more integrated and specialised service. TC is a concept not a specific location.

A dedicated area is yet to be identified on the maternity ward to allow the TC service to be further enhanced, and improve education of families who meet the criteria.

Meetings are to be held to discuss the impact of badgernet on TC and the potential of how the service can move to being paperless.

Specific midwifery and neonatal policies are being aligned to aid continuity of care between midwives and TC staff.

Recommendations

Safety Action 3/ATAIN/TC report Q3 2023-2024, sent on: 16/02/24

Report sent to: Maternity Assurance Programme Manager.

This will then be shared with: Quality Divisional Board, Maternity Delivery Group, LMNS Trust Board, ICB System Quality Group, Quality & Performance Committee and Trust Board.

The Trust Board are asked to note the contents of the report and agree to sign off the action plan.

Appendix 2

Gloucestershire Hospitals NHS Foundation Trust

PERINATAL MORTALITY & MORBIDITY REVIEW GROUP

PERINATAL MORTALITY REVIEW TOOL (PMRT) BI-MONTHLY REPORT

(October and November 2023)

1. INTRODUCTION

The aim of this quarterly report is to provide assurance to Gloucestershire NHS Foundation Trust, Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

The PMRT (Perinatal Mortality Review Tool) is a standardized approach utilized by maternity units in England, Wales and Scotland. The Tool aims to support a systematic, multidisciplinary, high-quality review of the circumstances and care leading up to and surrounding each stillbirth and neonatal death.

For those deaths of babies in the Trust eligible for review the PMRT is utilized so that the review undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify losses that are eligible for notification and surveillance data collection, these deaths must be notified to meet MIS year 5 requirements and meet safety action 1 standards.

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.

- **Late neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Terminations of pregnancy:** terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

The PMRT has been designed to support the review of the following perinatal deaths and these deaths should be reviewed to meet MIS Year 5 Safety action one standards.

- Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g;
- All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g;
- Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

2. STANDARDS

A report has been received by the Trust Executive Board from April 2023 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report will evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this will be documented within the PMRT review.

The MIS Year 5 scheme was released in May 2023 and will apply to babies who die between 30 May 2023 until 7 December 2023.

MBRRACE-UK/PMRT - standards for eligible babies.	**Standard**
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within 7 working days	**100%**
Surveillance information of all perinatal death's must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	**100%**
A PMRT review must be commenced within two months following the death of a baby	**95%**
A draft PMRT report must be completed within four months of a baby's death	**60%**
A PMRT must be completed within six months of the death of a baby's death	**60%**
For all the deaths of babies eligible for PMRT review, parents should have their perspectives of care and any questions they have sought.	**95%**

Quarterly reports will have been submitted to the Trust Executive Board from 30th May 2023 onwards, that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**100%**

3. RECOMMENDATIONS

3.1 Eligible deaths of babies in 2023-2024 (appendix A)

There has been a total of 10 deaths reported to MBRRACE-UK in October/November 2023, by Gloucestershire NHS Foundation Trust, and no deaths reported by other Trusts.

No cases have met the threshold for referral to the Healthcare Safety Investigation Branch (HSIB).

No concerns have been raised with the notification and surveillance submission and the current reporting process is to continue after the MIS Year 5 time period.

Parent engagement – parents are informed that a local review will take place and are asked if they have any reflections or questions about their care. Parents are sent the MBRRACE feedback form, a letter explaining about the review and a bereavement card. For parents with literacy or language barriers their reflections/questions are discussed with the Trust Bereavement midwife with an interpreter if required. Parents are given a second opportunity to provide their perspectives/questions if no response from the parents.

3.2,Summary of all PMRT reviews completed from 1st May to 31st July 2023 (appendix B)

Please note: this section of the report relates to this earlier period (as per Safety Action 1 Guidance), this lag behind is due to the PMRT process taking 3-5 months.

There have been three PMRT reviews completed to final report between 1st May – 31st July 2023. Also, one PMRT case during this period is awaiting Perinatal Mortality Review, this is a HSIB case and the published HSIB report is awaited. HSIB representative to be invited to the Perinatal Mortality Review, as an external Reviewer.

PMRT Grading of Care

Late Fetal Loss/ Stillbirth - Grading of Care of the mother and baby up to the point that the baby was confirmed as having died.

- 2 cases had no issues identified with care.
- 1 case had care issues identified which would have made no difference to the outcome for the baby.
- 0 cases had care issues identified that may have made a difference to the outcome for the baby.
- 0 cases had care issues identified which were likely to have made a difference to the outcome for the baby.

Grading of care provided to the mother after the death of the baby

- 2 cases had no issues identified with care for the mother.

- 1 case had care issues identified that would have made no difference to the outcome for the mother.
- 0 cases had care issues identified that may have made a difference to the outcome for the mother.
- 0 cases had care issues identified that were likely to have made a difference to the outcome for the mother.

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix B.

3.3 CNST Compliance as per MIS Year 5 Standards (appendix C)

Gloucestershire NHS Foundation Trust is currently compliant with all eligible standards for MIS CNST Year 5.

3.4 Learning and Action Logs for Outstanding Cases (appendix D)

Learning and progress against previous actions are included in appendix D.

Author

Name: Jane Bolton

Title: Perinatal Patient Safety Midwife.

Date: 7/12/23

Appendix A – Summary of all Eligible deaths reported in October & November 2023

Please note: Trust where baby died is responsible for notification and lead of PMRT Review.

PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Location of Delivery	Location of Death (reporting hospital)	Parents perspectives sought?	HSIB Case/ SI	Notification < 7 days	Surveill-ance < 1mth	Review started < 2mth	Draft Review Ready < 4mth	Review Publish < 6mth
89670	Feticide T18	23+3	1/10/23	28/9/23 confirmed	Glos	Glos	N/A		Yes Notification only	N/A	N/A	N/A	n/A
89696	Stillbirth	33	2/10/23	2/10/23	Glos	Glos	Yes		yes	yes	yes	Post-qualifying date	Post-qualifying date
89814	TOP/NND T21	21+1	10/10/23	10/10/23	Glos	Glos	N/A		Yes Notification only	N/A	N/A	N/A	N/A
89856	NND Twin 1 & 2	23+0	12/10/23	T1 21/10/23 T2 13/11/23	Glos	T1 UHBWT T2 Glos	yes	SI	yes	yes	yes	Post-qualifying date	Post-qualifying date
89984	TOP	22+6	19/11/23	19/11/23	Glos	Glos	N/A		Yes, Notification only	N/A	N/A	N/A	N/A
90176	Late fetal loss	22+0	2/11/23	30/10/23 confirmed	Glos	Glos	yes		Yes	Yes	Yes	Post-qualifying date	Post-qualifying date
90415	TOP/T18	22+0	17/11/23	17/11/23	Glos	Glos	N/A		Yes, Notification only	N/A	N/A	N/A	N/A
90626	Stillbirth	31+5	25/11/23	23/11/23	Glos	Glos	yes		yes	yes -Post-qualifying date	Post-qualifying date	Post-qualifying date	Post-qualifying date
90627	NND	33+1	23/11/23	26/11/23	Glos	Glos	yes		yes	yes -Post-qualifying	Post-qualifying	Post-qualifying	Post-qualifying

											date	date	date	date
	90690	Stillbirth	25+4	1/12/23	29/11/23 confirmed	Glos	Glos	yes		Yes	yes -Post-qualifying date	Post-qualifying date	Post-qualifying date	Post-qualifying date

Appendix B – Summary of all incidents closed in from 1st May to 31st July 2023.

Case	Cause of Death	**Grading of Care** of the mother and baby up to the point that the baby was confirmed as having died	**Grading of care** of the mother following confirmation of the death of her baby.	Issues Identified	Actions	Responsible/ Date	Update
87442 **Antepartum Stillbirth** **40+2** *Was there an external opinion at this review?* **Yes**	Undetermined	The review group concluded that there were **no** issues with care up to the point that the baby was confirmed as having died = **A.**	The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her Baby = **A**	*Issue not relevant to the outcome but action is needed.* At T+3 the CMW identified Static SFH and referred for USS growth. At the review this was discussed - the limitations of growth scans in terms of accuracy at advanced gestations (late third trimester and especially post-term) and therefore suggested when genuine concern about SFH plots (static growth or falling trajectory) at 40+ a referral to an obstetrician rather than request for a growth scan would be most appropriate.	Action: Communication to Trust CMW's that if any concerns about fundal height from 40 weeks - an Obstetric opinion should be sought rather than referral for USS growth. Email sent 15/9/23 to Community matron to communicate with all Community Midwives.	Community Matron and Patient Safety Midwife.	Action Completed.

Case	Cause of Death	Grading of Care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following confirmation of the death of her baby.	Issues Identified	Actions	Responsible/ Date	Update
87673 **30+0** **Stillbirth** *Was there an external opinion at this review?* **Yes**	Placental abruption	The review group identified care issues which they considered would have made no difference to the outcome for the baby. = **B**	The review group concluded that there were **no** issues with care identified for the mother following confirmation of the death of her Baby = **A**	*Issue not relevant to the outcome and no action is needed.* Graded B for 2 reasons- 1.no urine toxicology was sent throughout the pregnancy at all (during CMW or ANC appointments). 2. no formal OGTT was undertaken. Given the patient had a DNA history it is unknown if the appointment was made and the patient didn't attend or if the OGTT appointment was never made by CMW at 24/40. The HBA1C nonetheless was normal at booking (CMW had identified the patient did require screening for GDM given her family history) and post-delivery. Aspirin was discussed and the referral paperwork from the CMW to consultant ANC did specify that aspirin had been recommended from 12/40. The care by the CMW with regards to CO monitoring and re-discussing smoking cessation at subsequent visits was commended.	No actions identified.		

Case	Cause of Death	Grading of Care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following confirmation of the death of her baby.	Issues Identified	Actions	Responsible/ Date	Update
88177 **Stillbirth** **38+0** *Was there an external opinion at this review?* ***No**	No definitive cause for stillbirth identified by PM, but a number of changes in the placenta which may have contributed. -thin layer basal haematoma. -infarct beneath the cord insertion. -organising thrombi in some vessels, suggesting a degree of fetal vascular Malperfusion.	The review group concluded that there were **no** issues with care identified up the point that the baby was confirmed as having died = **A**.	The review group identified care issues which they considered would have made no difference to the outcome for the mother = **B**	*Issue not relevant to the outcome but action is needed.* From Parent's perspectives – the parents experienced a 2 hour wait for the Obstetrician to explain what would happen next after the scan that confirmed their baby had died. The reviewers felt this was too long, and later contacted the parents to find out more information about the wait they experienced. The unit activity was checked and was in red escalation at the time of their wait. Feedback on this issue will be provided to the parents at the debrief with the Obstetric consultant.	Communication to Midwives to explain to future bereaved parents to press the call bell when they are ready to talk. This would ensure attention if staff are busy. The Trust Bereavement Lead Midwife will add this to the training sessions.	Lead Midwife for Bereavement.	Completed Nov 2023

*there was an external opinion sought but no-one was available to attend.

Appendix C – Summary of CNST Compliance as per MIS Year 5 Standards.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	% for compliance	April, May, June & July 2023	August & Sept 2023	Oct, Nov & up to 7th Dec 23 2023	Total for MIS year 5.
Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days	100%	2 out of 2	7 out of 7	10 out of 10	19
		100%	100%	100%	100%
Surveillance of all perinatal death's information must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	100%	1 out of 1	4 out of 4	6 out of 6	11
		100%	100%	100%	100%
A PMRT review must be commenced within two months following the death of a baby. *3 additional cases not eligible as post-qualifying date.	95%	1 out of 1	3 out of 3	*3 out of 3	7
		100%	100%	100%	100%

A draft PMRT report must be completed within four months of a baby's death Of note – only one case eligible for this standard from 30th May – 7th December 2023, as all other cases post -qualifying period.	60%	No eligible cases	1 out of 1	No eligible cases	1
		0	100%	0	100%
A PMRT must be completed within six months of the death of a baby's death. Of note – no eligible cases for this standard from 30th May – 7th December 2023, as all cases post -qualifying period.	60%	No eligible cases for year 5 MIS.	No eligible cases for year 5 MIS.	No eligible cases for year 5 MIS.	N/A
		0	0	0	N/A
All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	95%	1 out of 1	3 out of 3	7 out of 7	11
		100%	100%	100%	100%
Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	100%	1	1	1	3
		100%	100%	100%	100%

Appendix D – Summary of all Learning and Action Logs for Outstanding Cases

Case IDs	Issue	Action	Responsible / Date	Update / progress
	No outstanding Actions/learning.			

Appendix 3

Gloucestershire Hospitals NHS Foundation Trust

PERINATAL MORTALITY & MORBIDITY REVIEW GROUP

PERINATAL MORTALITY REVIEW TOOL (PMRT) BI-MONTHLY REPORT

(October and November 2023)

2. INTRODUCTION

The aim of this quarterly report is to provide assurance to Gloucestershire NHS Foundation Trust, Maternity Safety and Board level Safety Champions (MatNeo Group) that every eligible perinatal death is reported to MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

The PMRT (Perinatal Mortality Review Tool) is a standardized approach utilized by maternity units in England, Wales and Scotland. The Tool aims to support a systematic, multidisciplinary, high-quality review of the circumstances and care leading up to and surrounding each stillbirth and neonatal death.

For those deaths of babies in the Trust eligible for review the PMRT is utilized so that the review undertaken is robust along with the quality of care provided. The actions and learning will be identified.

1.1 DEFINITIONS

The following definitions from MMBRACE-UK are used to identify losses that are eligible for notification and surveillance data collection, these deaths must be notified to meet MIS year 5 requirements and meet safety action 1 standards.

- **Late fetal losses** – the baby is delivered between 22^{+0} and 23^{+6} weeks of pregnancy (or from 400g where an accurate estimate of gestation is not available) showing no signs of life, irrespective of when the death occurred.
- **Stillbirths** – the baby is delivered from 24^{+0} weeks gestation (or from 400g where an accurate estimate of gestation is not available) showing no signs of life.
- **Early neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring before 7 completed days after birth.

- **Late neonatal deaths** – death of a live born baby (born at 20 weeks gestation of pregnancy or later or 400g where an accurate estimate of gestation is not available) occurring between 7 and 28 completed days after birth.
- **Terminations of pregnancy:** terminations from 22^{+0} weeks are cases which should be notified plus any terminations of pregnancy from 20^{+0} weeks which resulted in a live birth ending in neonatal death. Notification only.

The PMRT has been designed to support the review of the following perinatal deaths and these deaths should be reviewed to meet MIS Year 5 Safety action one standards.

- Late fetal losses where the baby is born between 22^{+0} and 23^{+6} weeks of pregnancy showing no signs of life, irrespective of when the death occurred, or if the gestation is not known, where the baby is over 500g;
- All stillbirths where the baby is born from 24+0 weeks gestation showing no signs of life, or if the gestation is not known, where the baby is over 500g;
- All neonatal deaths where the baby is born alive from 22^{+0} but dies up to 28 days after birth, or if the gestation is not known, where the baby is over 500g;
- Post-neonatal deaths where the baby is born alive from 22^{+0} but dies after 28 days following neonatal care; the baby may be receiving planned palliative care elsewhere (including at home) when they die.

2. STANDARDS

A report has been received by the Trust Executive Board from April 2023 that includes details of the deaths reviewed. Any themes identified and the consequent action plans. The report will evidence that the PMRT has been used to review eligible perinatal deaths and that the required standards a), b) and c) have been met. For standard b) for any parents who have not been informed about the review taking place, reasons for this will be documented within the PMRT review.

The MIS Year 5 scheme was released in May 2023 and will apply to babies who die between 30 May 2023 until 7 December 2023.

MBRRACE-UK/PMRT - standards for eligible babies.	**Standard**
Notification of all perinatal deaths eligible to notified to MBRRACE-UK to take place within 7 working days	**100%**
Surveillance information of all perinatal death's must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	**100%**
A PMRT review must be commenced within two months following the death of a baby	**95%**
A draft PMRT report must be completed within four months of a baby's death	**60%**
A PMRT must be completed within six months of the death of a baby's death	**60%**
For all the deaths of babies eligible for PMRT review, parents should have their perspectives of care and any questions they have sought.	**95%**

Quarterly reports will have been submitted to the Trust Executive Board from 30th May 2023 onwards, that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	**100%**

3. RECOMMENDATIONS

3.1 Eligible deaths of babies in 2023-2024 (appendix A)

There has been a total of 10 deaths reported to MBRRACE-UK in October/November 2023, by Gloucestershire NHS Foundation Trust, and no deaths reported by other Trusts.

No cases have met the threshold for referral to the Healthcare Safety Investigation Branch (HSIB).

No concerns have been raised with the notification and surveillance submission and the current reporting process is to continue after the MIS Year 5 time period.

Parent engagement – parents are informed that a local review will take place and are asked if they have any reflections or questions about their care. Parents are sent the MBRRACE feedback form, a letter explaining about the review and a bereavement card. For parents with literacy or language barriers their reflections/questions are discussed with the Trust Bereavement midwife with an interpreter if required. Parents are given a second opportunity to provide their perspectives/questions if no response from the parents.

3.2,Summary of all PMRT reviews completed from 1st May to 31st July 2023 (appendix B)

Please note: this section of the report relates to this earlier period (as per Safety Action 1 Guidance), this lag behind is due to the PMRT process taking 3-5 months.

There have been three PMRT reviews completed to final report between 1st May – 31st July 2023. Also, one PMRT case during this period is awaiting Perinatal Mortality Review, this is a HSIB case and the published HSIB report is awaited. HSIB representative to be invited to the Perinatal Mortality Review, as an external Reviewer.

PMRT Grading of Care

Late Fetal Loss/ Stillbirth - Grading of Care of the mother and baby up to the point that the baby was confirmed as having died.

- 2 cases had no issues identified with care.
- 1 case had care issues identified which would have made no difference to the outcome for the baby.
- 0 cases had care issues identified that may have made a difference to the outcome for the baby.
- 0 cases had care issues identified which were likely to have made a difference to the outcome for the baby.

Grading of care provided to the mother after the death of the baby

- 2 cases had no issues identified with care for the mother.

- 1 case had care issues identified that would have made no difference to the outcome for the mother.
- 0 cases had care issues identified that may have made a difference to the outcome for the mother.
- 0 cases had care issues identified that were likely to have made a difference to the outcome for the mother.

Where actions have been identified, appropriate deadlines have been put in place and can be found in appendix B.

3.3 CNST Compliance as per MIS Year 5 Standards (appendix C)

Gloucestershire NHS Foundation Trust is currently compliant with all eligible standards for MIS CNST Year 5.

3.4 Learning and Action Logs for Outstanding Cases (appendix D)

Learning and progress against previous actions are included in appendix D.

Author

Name: Jane Bolton

Title: Perinatal Patient Safety Midwife.

Date: 7/12/23

Appendix A – Summary of all Eligible deaths reported in October & November 2023

Please note: Trust where baby died is responsible for notification and lead of PMRT Review.

PMRT ID	Reason for entry to PMRT	Gestation (weeks)	Date of Birth	Date of Death	Location of Delivery	Location of Death (reporting hospital)	Parents perspectives sought?	HSIB Case/ SI	Notification < 7 days	Surveill-ance < 1mth	Review started < 2mth	Draft Review Ready < 4mth	Review Publish < 6mth
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89696	Stillbirth	33	2/10/23	2/10/23	Glos	Glos	Yes		yes	yes	yes	Post-qualifying date	Post-qualifying date
89814	TOP/NND T21	21+1	10/10/23	10/10/23	Glos	Glos	N/A		Yes Notification only	N/A	N/A	N/A	N/A
89856	NND Twin 1 & 2	23+0	12/10/23	T1 21/10/23 T2 13/11/23	Glos	T1 UHBWT T2 Glos	yes	SI	yes	yes	yes	Post-qualifying date	Post-qualifying date
89984	TOP	22+6	19/11/23	19/11/23	Glos	Glos	N/A		Yes, Notification only	N/A	N/A	N/A	N/A
90176	Late fetal loss	22+0	2/11/23	30/10/23 confirmed	Glos	Glos	yes		Yes	Yes	Yes	Post-qualifying date	Post-qualifying date
90415	TOP/T18	22+0	17/11/23	17/11/23	Glos	Glos	N/A		Yes, Notification only	N/A	N/A	N/A	N/A
90626	Stillbirth	31+5	25/11/23	23/11/23	Glos	Glos	yes		yes	yes -Post-qualifying date	Post-qualifying date	Post-qualifying date	Post-qualifying date
90627	NND	33+1	23/11/23	26/11/23	Glos	Glos	yes		yes	yes -Post-qualifying	Post-qualifying	Post-qualifying	Post-qualifying

											date	date	date	date
	90690	Stillbirth	25+4	1/12/23	29/11/23 confirmed	Glos	Glos	yes		Yes	yes -Post-qualifying date	Post-qualifying date	Post-qualifying date	Post-qualifying date

Appendix B – Summary of all incidents closed in from 1st May to 31st July 2023.

Case	Cause of Death	**Grading of Care** of the mother and baby up to the point that the baby was confirmed as having died	**Grading of care** of the mother following confirmation of the death of her baby.	Issues Identified	Actions	Responsible/ Date	Update
87442 **Antepartum Stillbirth** **40+2** *Was there an external opinion at this review?* **Yes**	Undetermined	The review group concluded that there were **no** issues with care up to the point that the baby was confirmed as having died = **A.**	The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her Baby = **A**	*Issue not relevant to the outcome but action is needed.* At T+3 the CMW identified Static SFH and referred for USS growth. At the review this was discussed - the limitations of growth scans in terms of accuracy at advanced gestations (late third trimester and especially post-term) and therefore suggested when genuine concern about SFH plots (static growth or falling trajectory) at 40+ a referral to an obstetrician rather than request for a growth scan would be most appropriate.	Action: Communication to Trust CMW's that if any concerns about fundal height from 40 weeks - an Obstetric opinion should be sought rather than referral for USS growth. Email sent 15/9/23 to Community matron to communicate with all Community Midwives.	Community Matron and Patient Safety Midwife.	Action Completed.

Case	Cause of Death	Grading of Care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following confirmation of the death of her baby.	Issues Identified	Actions	Responsible/ Date	Update
87673 **30+0** **Stillbirth** *Was there an external opinion at this review?* **Yes**	Placental abruption	The review group identified care issues which they considered would have made no difference to the outcome for the baby. = **B**	The review group concluded that there were **no** issues with care identified for the mother following confirmation of the death of her Baby = **A**	*Issue not relevant to the outcome and no action is needed.* Graded B for 2 reasons- 1.no urine toxicology was sent throughout the pregnancy at all (during CMW or ANC appointments). 2. no formal OGTT was undertaken. Given the patient had a DNA history it is unknown if the appointment was made and the patient didn't attend or if the OGTT appointment was never made by CMW at 24/40. The HBA1C nonetheless was normal at booking (CMW had identified the patient did require screening for GDM given her family history) and post-delivery. Aspirin was discussed and the referral paperwork from the CMW to consultant ANC did specify that aspirin had been recommended from 12/40. The care by the CMW with regards to CO monitoring and re-discussing smoking cessation at subsequent visits was commended.	No actions identified.		

Case	Cause of Death	Grading of Care of the mother and baby up to the point that the baby was confirmed as having died	Grading of care of the mother following confirmation of the death of her baby.	Issues Identified	Actions	Responsible/ Date	Update
88177 **Stillbirth** **38+0** *Was there an external opinion at this review?* ***No**	No definitive cause for stillbirth identified by PM, but a number of changes in the placenta which may have contributed. -thin layer basal haematoma. -infarct beneath the cord insertion. -organising thrombi in some vessels, suggesting a degree of fetal vascular Malperfusion.	The review group concluded that there were **no** issues with care identified up the point that the baby was confirmed as having died = **A**.	The review group identified care issues which they considered would have made no difference to the outcome for the mother = **B**	*Issue not relevant to the outcome but action is needed.* From Parent's perspectives – the parents experienced a 2 hour wait for the Obstetrician to explain what would happen next after the scan that confirmed their baby had died. The reviewers felt this was too long, and later contacted the parents to find out more information about the wait they experienced. The unit activity was checked and was in red escalation at the time of their wait. Feedback on this issue will be provided to the parents at the debrief with the Obstetric consultant.	Communication to Midwives to explain to future bereaved parents to press the call bell when they are ready to talk. This would ensure attention if staff are busy. The Trust Bereavement Lead Midwife will add this to the training sessions.	Lead Midwife for Bereavement.	Completed Nov 2023

*there was an external opinion sought but no-one was available to attend.

Appendix C – Summary of CNST Compliance as per MIS Year 5 Standards.

MBRRACE-UK/PMRT standards for eligible babies following the PMRT process	% for compliance	April, May, June & July 2023	August & Sept 2023	Oct, Nov & up to 7th Dec 23 2023	Total for MIS year 5.
Notification of all perinatal deaths eligible to be notified to MBRRACE-UK to take place within 7 working days	100%	2 out of 2	7 out of 7	10 out of 10	19
		100%	100%	100%	100%
Surveillance of all perinatal death's information must be completed within one month of the death. Deaths where the surveillance form needs to be assigned to another Trust for additional information are excluded from the latter.	100%	1 out of 1	4 out of 4	6 out of 6	11
		100%	100%	100%	100%
A PMRT review must be commenced within two months following the death of a baby. *3 additional cases not eligible as post-qualifying date.	95%	1 out of 1	3 out of 3	*3 out of 3	7
		100%	100%	100%	100%
A draft PMRT report must be completed within four months of a baby's death Of note – only one case eligible for this standard from 30th May – 7th December 2023, as all other cases post -qualifying period.	60%	No eligible cases	1 out of 1	No eligible cases	1
		0	100%	0	100%

A PMRT must be completed within six months of the death of a baby's death. Of note – no eligible cases for this standard from 30th May – 7th December 2023, as all cases post -qualifying period.	60%	**No eligible cases for year 5 MIS.**	**No eligible cases for year 5 MIS.**	**No eligible cases for year 5 MIS.**	**N/A**
		0	**0**	**0**	**N/A**
All parents will have been told that a review of their baby's death is taking place and asked for their contribution of questions and/or concerns.	95%	**1 out of 1**	**3 out of 3**	**7 out of 7**	**11**
		100%	**100%**	**100%**	**100%**
Quarterly reports will have been submitted to the Trust Board from 6 May 2022 onwards that include details of all deaths reviewed and consequent action plans. The quarterly reports should be discussed with the Trust maternity safety and Board level safety champions.	100%	**1**	**1**	**1**	**3**
		100%	**100%**	**100%**	**100%**

Appendix D – Summary of all Learning and Action Logs for Outstanding Cases

Case IDs	Issue	Action	Responsible / Date	Update / progress
	No outstanding Actions/learning.			

Report to Board of Directors

Agenda item:		Enclosure Number:	
Date	9th May 2024		
Title	Midwifery, Maternity and Neonatal Staffing Report Q3 2023-24		
Author /Sponsoring Director/Presenter	Lisa Stephens- Director of Midwifery		

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 purpose of this report is to provide assurance to the Trust Board that there is an effective system of maternity workforce planning and an effective system for the monitoring of safe staffing levels. The report covers the period October to December 2023.

During the quarter:

- Appraisal rates are at 65% at the end of the quarter and below the target. Working with the organisational development lead to improve appraisal process from staff feedback.

Midwifery

- Incident reporting on staffing, Red Flags and birth to midwife ratio illustrate a concerning picture within midwifery staffing. Initiatives to enhance recruitment and retention are being actioned and it is anticipated that the next 6 months will see an improved recruitment picture. Attrition continues to be of significant concern and actions to address this are ongoing.
- The vacancy rate has fallen significantly by the end of Q3.
- During December 2023 there was combined **49.22 WTE** shortage of midwifery staff due to vacancies, maternity leave, and sickness absence, a reduction from the summer months which peaked at 63.57 for July.
- Safe staffing is informed by the acuity tool and reviewed every 4 hours. Mitigations are taken in line with the escalation policy.
- There were no occasions when supernumery status of the co-ordinator was reported to be compromised.
- One- to-one care in labour remains at 98.6% with an ongoing action plan.
- An extensive midwifery staffing plan for 2023/24 has continued and is progressing with notable achievements.

Obstetrics

- 3 new obstetric consultants have been appointed and will join the team in April, June and September.
- This will enable a complete split of the gynae and obstetric on-call rota so that there will always be an obstetric and a gynaecology consultant available.
- The increase in obstetric workforce will also enable more of the SPA roles to be undertaken so job planning is currently underway and will inform remaining shortfalls in the obstetric team.
- Junior doctor industrial action has had a significant impact. However, all obstetric sessions, including planned caesarean section lists, antenatal clinics, fetal medicine and preterm birth clinics, have been staffed.
- There remains one unfilled gap on the on-call rota, which will be covered internally.

Neonatal and anaesthetic

- The Neonatal unit continues to be challenged around neonatal nurse staffing and therefore not compliant with BAPM standards. A plan is being actioned with decreasing red rated items.
- Neonatal medical staffing and anaesthetic availability remain stable.

Risks or Concerns

- Reduced support from the Organisational Development Lead due to reduced hours in maternity services.
- Midwifery staffing remains on the risk register due to:
  - Workforce vacancies and turnover rate
  - Low morale associated with poor staffing levels
  - Level and pace of change
  - Not achieving 100% compliance with 1:1 care in labour – there is an ongoing action plan in place that has trust sign off.
  - Community on-call utilisation for escalation.
- The increased workload in both obstetrics and gynaecology has made it untenable for one consultant to be responsible for both services.
- Junior doctor industrial action has had a significant impact.
- Neonatal nursing staffing not achieving BAPM standards.

Recommendation

- Note the ongoing workforce risks particularly in midwifery, obstetrics and neonatal nursing.
- Note the ongoing improvements and progress against action plans.

Enclosures

Midwifery and maternity staffing report Q3 V2

Gloucestershire Hospitals
NHS Foundation Trust

QUARTERLY MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT

QUALITY AND PERFORMANCE COMMITTEE – 27th March 2024

BOARD – 09th May 2024

MATERNITY STAFFING REPORT

1. Purpose of Report

1.1 The purpose of this report is to provide assurance to the Trust Board that there is an effective system of maternity workforce planning and an effective system for the monitoring of safe staffing levels.

1.2 This report covers the period October to December 2023. Our focus is to ensure women, babies and their families receive the maternity care they need, including care in all:

- maternity services (for example, pre-conception, antenatal, intrapartum and postnatal services, clinics, home visits and maternity units)
- settings where maternity care is provided (for example, home, community, free-standing and alongside midwifery-led units, hospitals including obstetric units, day assessment units, and fetal and maternal medicine services).

1.3 This should be regardless of the time of the day or the day of the week. The service should be able to deal with fluctuations in demand (such as planned and unplanned admissions and transfers, and daily variations in requirements for intrapartum care).

2 Background

2.1 It is a requirement that as NHS providers we continue to have the right people with the right skills in the right place at the right time to achieve safer nursing and midwifery staffing in line with the National Quality Board (NQB) requirements.

2.2 Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings.

2.3 Previously midwifery staffing data has been included in the nurse staffing paper, however since 2022, to provide evidence for NHS Resolutions Maternity CNST Incentive Scheme, a separate paper is now provided which also includes staffing data on other key groups, obstetricians, and anaesthetics.

2.4 Midwifery Staffing expectations include the following:

- Deliver all pre-conception, antenatal, intrapartum and postnatal care needed by women and babies
- Provide midwifery staff to cover all the midwifery roles needed for each maternity service, including co-ordination and oversight of each service
- Allow for locally agreed midwifery skill mixes (for example, specialist and consultant midwives)
- Provide a woman in established labour with supportive one-to-one care
- Provide midwife to birth ratios as per Birthrate plus
- Allow for planned and unplanned leave
- Time for professional midwifery advocate role
- Ability to deal with fluctuations in demand
- Ensure professional support and leadership for clinical teams (Midwifery, Obstetric Neonatal, anaesthetic) in and out of hours

3 Executive Summary

3.1 This report gives a summary of all measures in place to ensure safe midwifery staffing; including workforce planning, planned versus actual midwifery staffing levels, the midwife to birth ratio, specialist hours, compliance with supernumerary labour ward coordinator, one to one care in labour and red flag incidents. It also gives a summary of key workforce measures for obstetricians and anaesthetics to provide evidence for the maternity incentive scheme year 5.

3.2 An **unannounced focused inspection by the CQC** to Maternity Services in April 2022 has led to an overall **inadequate rating** of the service in July 2022. The rating was influenced by their findings that the service did not always have enough staff to care for women and keep them safe. Actions against the CQC action plan are reported monthly by the service at Maternity Delivery Group and the Quality and Performance Committee (Q&P).

3.3 Midwifery Staffing has remained critical with vacancies during this period in the region of 23.5-36.85 whole time equivalents (WTE). The vacancy rate in September 2023 was 9.63%. Absence related to sickness and maternity leave rates remains high, with variation in temporary fill. Midwifery staffing remains on the **Trust Risk Register** with a score of 20 for safety. Controls are in place to mitigate the risk and a staffing improvement plan is being enacted with oversight of the plan at the Executive led Maternity Delivery Group (MDG) supported by the Deputy Director of Quality.

3.4 A **BirthRate plus** (BR+) full review of midwifery staffing has been completed. The final paper has been received. The recommended total workforce requirement (Band 3 – Band 9) to provide total clinical specialist and management is 274.15 WTE to compare with 278.62 resulting in an overall positive variance of 4.47 WTE. The service and the LMNS are supportive of no change to funded establishment during this period of national and local drivers and the minimal uplift of 21% which is low in comparison with other trusts.

3.5 An extensive midwifery staffing plan for 2023/24 has continued and is progressing with **notable achievements** of:

- Establishment and commencement of full senior midwifery leadership team Band 8's- July 2023.
- Incentivised shifts continued
- Staff listening and update events established 2 weekly (July-Sept) now monthly.
- Maternity Transformation Programme manager commenced.
- Organisational Development Lead has launched to second round and positively received.
- Four International recruitment midwives recruited and aimed to be in post by December 2023.
- Five GHNHSFT Registered Nurses have been commenced on the maternity ward, having significant positive impact.
- Midwifery Recruitment & Retention team recruited to and in post by end of October 2023.
- 15 new midwifery starters in September.
- Commencement of long-line agency midwife, currently finding work positive and enjoying her shifts.

3.6 Midwifery staffing remains on the risk register with RISKS:

- Workforce vacancies and turnover rate
- Low morale associated with poor staffing levels
- Level and pace of change
- Not achieving 100% compliance with 1:1 care in labour – there is an ongoing action plan in place that has trust sign off.
- Community on-call utilisation for escalation.

4 Birthrate Plus Workforce Planning

4.1 A formal Birth Rate Plus assessment was completed in January 2023, which reviewed the acuity of women who used maternity services, at GHNHSFT

4.2 This review recommended a birth to midwife ratio of 24.4:1 births across the Trust.

4.3 NICE (2017) recommend that an assessment is carried out every three years. The recommended total workforce requirement (Band 3 – Band 9) to provide total clinical specialist and management is 274.15 WTE to compare with 278.62 resulting in an overall positive variance of 4.47 WTE. The service and the LMNS are supportive of no change to funded establishment during this period of national and local drivers and the minimal uplift of 21% which is low in comparison with other trusts.

4.4 The service does employ a significant number of Band 2 maternity care assistants. This will be changing with the upcoming Trust change for all band 2 Heath Care and Maternity Care Support Workers to be upskilled from a

band 2 to band 3. Only Band 3 Maternity Support Workers can offset the midwifery establishment with a 90/10 for postnatal skill mix.

5 Midwifery Staffing

5.1 Midwifery staffing remains as a risk on the Trust Risk Register scoring 20 for safety (WC35360bs). Due to midwifery staffing issues, the decision was made with Board agreement to consolidate care provision. This has meant the Cheltenham Aveta Birth Unit has remained temporarily closed to intrapartum care. This has been reviewed, and a provisional plan made for opening with the newbuild in the Autumn 2024. Postnatal Beds at Stroud have also been temporarily closed and will be reviewed in October 2023.

5.2 There is a robust action plan in place to monitor staffing and this is reviewed monthly by the Executive Led Maternity Delivery Group.

5.3 During December 2023 there was combined **49.22 WTE** shortage of midwifery staff due to vacancies, maternity leave, and sickness absence, a reduction from the summer months which peaked at 63.57 for July.

Table: Combined Midwifery Shortfall (WTE) Source: Maternity Workforce PMO

Month (2023)	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**
Combined shortfall (WTE)	44.26	35.74	53.69	51.76	56.44	57.81	63.57	62.38	52.24
	Oct	**Nov**	**Dec**						
	51.34	52.2	49.22						

5.4 The **vacancy of 19.36 WTE is multifactorial** due to resignations associated with retirement, dissatisfaction with midwifery, internal and external promotion or movement into non-clinical post and health related reasons as well as an increase in establishment associated with Ockendon clinical funding. In addition, some long-term sick is converting to leavers as illustrated in the reducing sickness rate. It is noted that many staff are opting to reduce hours or resign, whilst converting to Bank contract.

5.5 There are currently 13.19% of Midwifery Managers and specialist midwives and midwives employed and this exceeds the BR+ recommendation of 8-10%. However, the emphasis on midwifery leadership and specialism posts has arisen post national reports.

5.6 The table below is a breakdown of the various managerial and specialist midwives' total. The In-post total exceeds funded establishment as there has been significant external funding sought with fixed term posts for specialist posts arising from drivers such as Ockendon, Maternity Incentive Scheme and local and national Maternity Improvement programmes.

	Band	Funded establishment				WTE in Post			
		Dec 22	June 23	Sep 23	Dec 23	Dec 22	Jun 23	Sep 23	Dec 23
Managerial Position	8/9	6	9.2	9.2	9.2	5.8*	10.2*	10.2*	10.2
Specialist Midwives	6/7	15.71	17.07	17.67	21.86	21.65	20.35	25.32	27.2

5.7 Below is the breakdown of the midwifery clinical establishment

Table 4: Funded midwifery clinical establishment Sept 23 *(Source: ESR)*

		Funded Establishment			WTE in post		
	Band	**June 23**	**Sep 23**	**Dec 23**	**June 23**	**Sep 23**	**Dec 23**
Team Leaders	7	27.52	20.34	22.98	25.80	24.8	28.84
Clinical Midwives	5/6	218.25	223.79	223.79	184.55	195.83	198.57
Total		**245.77**	**244.13**	**246.77**	**210.35**	**220.63**	**227.41**

5.8 Specialist midwives within the Trust have a key role in the wider public and social health. Additional funds NHSE/I funds were made available to the Trust to support meeting CNST MIS and Ockendon requirements.

		Funded			WTE in post			
Role	**Band**	**Jun 23**	**Sep 23**	**Dec 23**	**Jun 23**	**Sep 23**	**Dec 23**	
Director of Midwifery	9	1.0	1.0	1.0	1.0	1.0	1.0	
Head of Midwifery	8C	1.0	1.0	1.0	1.0	1.0	1.0	
Consultant Midwife	8B	0.6	0.6	0.6	0.6	0.6	0.6	
Lead Midwife (Healthy Lifestyles & TDD)	8A	0.6	0.6	0.6	0.6	0.6	0.6	

		Funded			WTE in post			
Role	**Band**	**Jun 23**	**Sep 23**	**Dec 23**	**Jun 23**	**Sep 23**	**Dec 23**	
Midwifery Matrons	8A	5.2	5.2	5.2	5.2	5.2	5.2	
Safeguarding Midwife	8A	0.8	0.8	0.8	0.8	0.8	0.8	
Governance Lead	8A	1.0	1.0	1.0	1.0	1.0	1.0	
Specialist Midwives	6/7	17.07*	17.67	21.86	20.35	25.32	27.2	
	Total	27.27	27.87	32.06	30.55	35.52	37.4	

6 Midwifery Recruitment and Retention

6.1 The maternity service has a range of strategies to attract, recruit, retain and develop our staff, as well as managing and planning for predicted loss of staff to avoid over reliance on temporary staff. This is essential as there is limited access to agency midwives in Gloucestershire

6.2 In anticipation of annual leave disproportionate to the agreed 17% due to excessive sickness, maternity leave and vacancies an incentive proposal was presented to Pay Assurance Group (PAG). These incentives were extended again in December 2023. The extended incentives within service budget included – Enhanced Bank pay rate Temporary Standby rotas for unsocial hours, and a Golden Welcome for new starters. Additional incentives include enhanced bank rates for community and unit on call staff called in during escalation

6.3 There are currently 20.78 WTE (Sept 2023) vacancies in the clinical workforce funded establishment.

6.4 A regular Band 5/6 advert has seen significant interest with the appointment of a number of both experienced and newly registered midwifery staff. The R&R team are linking with all midwives who have accepted posts to maintain communication, outlining their role and significant support and offer the ‘Golden Welcome’.

6.5 In the period, Oct-Dec 2023 10 new Midwives have joined the trust having accepted the ‘Golden Welcome’.

Table: New Starters – headcount (Source: R&R New Starter Tracker)

Month	Jan	Feb	Mar	April	May	June	July	Aug	Sept
Starter number	0	5	2	3	0	1	2	0	15
	Oct	Nov	Dec						
	6	3	1						

6.6 Higher than average levels of turnover and slow recruitment over Q1 and into Q2 led to the high vacancy rate, however this has fallen significantly by the end of Q3.

7 Turnover, absence and sickness

7.1 Currently there are 52.25 WTE shortage of midwifery staff due to turnover, maternity leave, and sickness absence.

Table 8: Staffing leave/ absence and secondment Oct-Dec 23* *(Source: Health-Roster)* *
March 23 included as comparator

Month/Yr	WTE			
	Sickness	Maternity Leave	Vacancy	Total
Mar 23*	**15.42**	**8.6**	**29.67**	**53.69**
Oct 23	17.7	12.86	20.78	51.34
Nov 23	17.7	13.7	20.8	50.76
Dec 23	18.45	11.41	19.36	49.22

7.2 It is notable that the peak associated with absence in March 2022 led to a combined rate of 77.82 WTE, one year later, the same combination fell to 53.69 in March 2023. Now, vacancy rates, sickness and maternity leave are starting to settle with some small fluctuation.

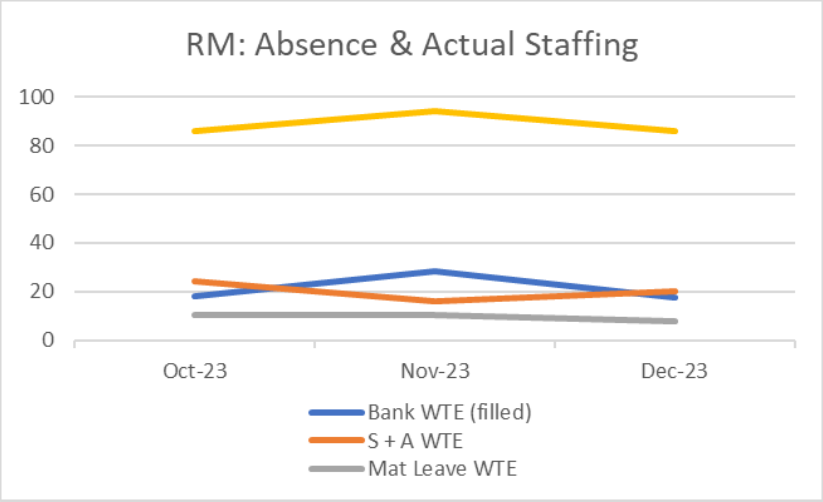
7.3 Temporary staffing fill has included both agency and bank. Whilst fill rate has varied between 23.4 and 18.8 WTE, it has not met the demands associated with midwifery absence and the vacancy rate however it has enhanced safer staffing.

7.4 The use of Bank nurses has been well received supporting midwives on the maternity ward and on delivery suite to care for high risk surgical and medical patients and fixed term roles for Band 5 nurses now in place with more posts being advertised.

7.5 The opportunity to work within maternity strengthens their application for the MSc programme.

7.6 Eight HEE funded places have been acquired for March 2024 and communication about recruitment to these places are in progress. Currently five RN's are in post on fixed Term Contracts on maternity ward with another 1.0 going out for a recovery nurse on Central Delivery Suite.

Graph – Midwifery Absence and Fill rates Oct – Dec 23:



7.7 In response to the poor staffing rates, actions within the service have previously included closure or reconfiguration of elements of the maternity service. This has improved throughout Q3 with no full-service closures required, but occasional relocation of the GBU has continued albeit much less frequently.

8.0 Midwifery leadership

8.1 Each clinical area has a defined midwifery lead providing professional leadership, clinical expertise and managerial responsibility ensuring effective use of staffing resource and safe delivery of care to women accessing the service.

8.2 In addition, the central delivery suite is funded to have a supernumerary Band 7 shift coordinator allocated to each shift to provide professional leadership, clinical expertise and will have responsibility for the shift; this individual should have detailed knowledge of activity on the delivery suite supplemented by an awareness of activity within the inpatient areas and pending admissions from outpatient and triage areas. The Band 7 Flow and Quality Midwife role is now embedded. This 'helicopter view' is essential for overall assessment of the acuity and to support staff redeployment when required 24/7.

8.3 The 'Flow and Quality' Midwife role has embedded. This is a Band 7 midwife who supports the 'Band 8 of the day' and Delivery Suite co-ordinator to manage flow associated with staffing and activity throughout the service in and out of hours.

8.4 The Band 7 Flow & Quality midwife are supported 24 hours a day, 7 days a week either by the "Band 8 of the day" or the Senior Midwife on call. They are responsible for liaising with all areas to ensure safe and effective use of resources to ensure safe delivery of care at all times.

8.5 The responsibility for addressing known midwifery staffing shortfalls rests with the Senior Band 7 who has responsibility for managing the area. When staffing shortages remain an issue on a day-to-day basis this is escalated to the "Band 7 Flow & Quality Midwife" or "Band 8 of the day".

8.6 Further actions in response to staffing shortfall over the past 6 months have been a feature of managing the service based on midwifery availability.

8.7 The Band 7 team are recruited too, however current scoping is underway to establish where funding lies for each post, with the intention to develop a band 7 CDS ward manager post from existing vacancy.

9.0 Escalation and Trust risk register entry

9.1 Escalation policies and contingency plans are in place for when staffing capacity and capability fall short of what is needed for safe, effective and compassionate care, and staff are aware of the steps to take where capacity problems cannot be resolved.

9.2 Throughout the day, clinical and managerial leaders compare the actual staff available with planned and required staffing levels, and take appropriate action to ensure staff are available to meet women's and babies' needs.

9.3 The risk associated with midwifery staffing (**W&C3536OBS)** remains on the Trust Risk Register (score:20). An improvement action plan was developed.

9.4 The Midwifery Workforce Improvement plan was reviewed and expanded in July 2023 resulting in a total of 48 actions with progress against them as below:

Workforce Action plan	October 22	March 2023	July 2023	Dec 2023
Closed	0	3	23	32
Overdue	16	1	6	1
In Progress	10	15	7	1
Complete	1	7	12	16
Total number of elements	**26**	**26**	**48**	**48**

9.5 Significant progress has been notable around preceptorship programme, midwifery landing internet page, regular Infographic updates to staff, leaver and stay data.

9.6 Day to day management of the suboptimal staffing is being managed by increased, visible midwifery leadership in key areas. A daily and weekly service wide overview of staffing continues to enable oversight and planning ahead for staffing issues in the form of a daily (Mon-Fri) touchpoint call. In addition, responsive Multidisciplinary Huddles which includes the Service Tri are conducted on CDS during periods of significant activity. Similarly, the introduction of twice daily MDT induction huddle supports clinical decision making for the team when faced with high levels of acuity.

10.0 Right skills – mandatory training, development and education

10.1 Our staffing establishments take account of the need to enable clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students. The CQC 29a warning notice was received in June 2022 in response to not complying with legal requirements on minimum staffing.

10.2 The service has identified the need to expand administrative and clerical roles to release midwifery time. A paper has been submitted to the clinical safety group. This remains an ongoing issue, and has been escalated through to the Quadrumvirate.

Table 12 – Mandatory Training Compliance – All Staff groups – Oct-Dec 2023
(Source: Local Training Data)

Mandatory Day	Overall Compliance		
	Oct	Nov	Dec
Maternity Mandatory Day (Midwives & MCA's Only)	85%	85%	89%
PROMPT Part 1 (Combined) (MDT: Midwives, MCA's, Obstetricians & Anaesthetic Team – Theatre team not included in calculation)	81%	86%	95%
PROMPT Part 2 (Combined) (MDT: Midwives, MCA's, Obstetricians & Anaesthetic Team – Theatre team not included in calculation)	82%	87%	93%
Fetal Monitoring (Midwives & Obstetricians)	85%	89%	91%

10.3 Those with line management responsibilities ensure that staff are managed effectively, with clear objectives, constructive appraisals, and support to revalidate and maintain professional registration.

10.4 During the pandemic and surges of Covid-19 **appraisal rates had decreased from 68% in December 2021 to 60% in July 2022** (Trust target 90% compliance). A recovery plan was put in place with additional training dates so that compliance can be met by end of December 2023. This forms part of the CQC 'Must Do's'

Table: Appraisal Compliance rates Oct- Dec 2023

Month	Appraisal compliance %
Oct 23	66%
Nov 23	63%
Dec 23	65%

10.5 The progress in completion rates for maternity has declined reflecting on the pressure over previous months on our staff and managers. Completion rates averaged at 64% There is still some way to go to reach or exceed 90% completion which the summer months where staffing was very challenging has caused risk associated with compliance. Compliance for the CQC 'Must Do's' has not been met, despite the efforts taken. This has been reported, and senior leaders and managers are aware of this failing and requirement to be prioritised.

10.6 The Organisational Development Lead post which commenced in August 2022 is supporting the overall compliance with appraisals, however they have commenced a secondment 3 days a week removing them from maternity services.

10.7 The maternity service analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework. The maternity service Practice Development team have completed a Training Needs Analysis exercise to ensure that all six core modules of the Core Competency Framework are included in our unit training programme over the next 3 years (NHSR, MIS safety action 8). The training plan includes:

- Saving Babies Lives Care Bundle
- Fetal surveillance in labour
- Maternity emergencies and multi-professional training.
- Personalised care
- Care during labour and the immediate postnatal period
- Neonatal life support
- Local learning from incidences

11.0 Planned Versus Actual Midwifery Staffing Levels

11.1 Fill rate is calculated monthly. The following table outlines percentage fill rates for the clinical areas (in-patient and community) month by month. The midwifery fill rate is RAG rated and illustrates actual staffing with consideration of absence and agency and bank shifts. Enhancement and incentives for Bank and standby continue with acknowledgement of the longer-term impact upon the health and wellbeing of the midwifery workforce. In addition, a growing picture where staff are converting from contract to Bank only posts. Fill rates have been stable since October 2022 however summer staffing saw a decline as low as 84%. This is monitored on a daily basis and staff are redeployed across the service based on activity and the acuity.

Table: Registered Midwives – Clinical Establishment fill rate (source: ESR/Health Roster)

Month	Fill rate - percentage
Oct 23	90%
Nov 23	93%
Dec 23	90%

The following table outlines percentage fill rates for the inpatient areas by month.

Maternity Service Fill rate Oct- Dec 2023 Source: Health Roster

	Day qualified %	Night qualified %
Oct 23	87%	85%
Nov 23	90%	93%
Sept 23	88%	89%

11.2 Fill rates have started to stabilise at more sustainable levels. The fluctuations in this quarter have been for several reasons, including school and public holidays, short-term sickness, maternity leave, and long-term sickness. This is monitored daily, and staff redeployed based on the acuity. There have been several new starters recently which has improved these.

11.3 In addition, a significant number of bank hours have been used across the service to cover maternity leave and long and short-term sickness. Over the past 2 years an extensive ongoing Midwifery Workforce Action plan has been implemented.

12.0 Birth to Midwife Ratio

12.1 The birth to midwife ratio is calculated monthly using Birth Rate Plus methodology and the actual monthly delivery rate. This has now been added to the maternity dashboard so that it can be monitored alongside clinical data. The table outlines the real time monthly birth to midwife ratio.

12.2 The Birthrate plus report published in Feb 2023 highlighted the local overall birth to midwife ratio based on casemix, taking into account the variation in complexity within obstetric led and midwifery led settings. This was calculated at: 24.4 births to 1 wte

Table: Midwife to Birth ratio (BR+ overall local ratio 24.4:1)

Month	Midwife to Birth Ratio
Oct 23	1:27
Nov 23	1:26
Dec 23	1:24

13.0 Specialist Midwives

13.1 Birth Rate Plus recommends that 8-11% of the total establishment are not included in the clinical numbers, with a further recommendation of this being 11% for multi-sited Trusts. This includes management positions and specialist midwives. The current percentage for GHNHSFT is calculated to be 9.35.

13.2 Some new posts have been recruited to following the BR+ review and there are additional posts that are being recruited to following MiS and additional fundings allocated such as LMNS.

13.3 Specialist midwife posts in Band 6 and Band 7 in GHNHSFT include:

- Perinatal Mental Health Team

- Vulnerable Women's Team
- Safeguarding Team
- 2 Patient Safety Midwives
- Recruitment and Retention Midwife
- Digital Midwife – this team expanded for support with new EPR
- Screening Midwife
- 2 Bereavement midwives
- Contraception Midwife
- Audit & Guidelines Midwife
- Practice Development Midwives
- MSW Project Midwife
- Fetal Monitoring Midwife
- Infant Feeding Support
- Frenulotomy Midwife
- Practice Facilitators (Delivery Suite/Community)
- Specialist Midwife: Preterm Birth/Complex Pregnancies
- Quality Midwife: PMRT/HSIB/Audit and Guidelines
- Specialist Midwife: Treating Tobacco Dependency
- Saving Babies Lives lead midwife

New posts being advertised:

- *Band 6 Digital midwife*
- *Patient safety midwife*

14.0 Birth Rate Plus Live Acuity Tool

14.1 The Birth Rate Plus (BR+) Live Acuity Tool was introduced a number of years ago in the Central Delivery Suite and more latterly in the alongside Birth centre (Gloucester birth unit). The tool is not utilised in the standalone birth centres. The tool has been purchased for use in the Maternity Ward (Antenatal and postnatal inpatient area), however the BR+ team are updating the tool so it has not yet been implemented.

14.2 The BR+ tool enables midwives to assess their 'real time' workload arising from the number of women needing care, and their condition on admission and during the processes of labour, delivery and postnatally. It is a measure of 'acuity', and the system is based upon an adaption of the same clinical indicators used in the well-established workforce planning system Birth Rate Plus.

14.3 The Birth Rate Plus classification system is a predictive/prospective tool rather than the retrospective assessment of process and outcome of labour used previously. The tool is completed four hourly by the labour ward coordinator. An assessment is produced on the number of midwives needed in each area to meet the needs of the women based on the minimum standard of one-to-one care in labour for all women and increased ratios of midwife time for women in the higher need categories. This provides an assessment on admission of where a woman fits within the identified Birth Rate Plus categories and alerts midwives when events during labour move her into a higher category and increased need of midwife support.

14.4 This safe staffing tool kit supports most of the components in the NICE Guidance (and is endorsed by NICE) on safe midwifery staffing for maternity settings necessary for the determination of maternity staffing requirements for establishment settings. It provides evidence of what actions are taken at times of higher acuity and use of the escalation policy when required.

14.5 The following provides evidence of actions taken (both clinical and management) to mitigate any shortfalls in staffing or for periods of high acuity. The following mitigations are taken in line with the escalation policy:

- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically
- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Activate the on-call midwives from the community to support labour ward.
- Request additional support from the on-call midwifery manager.
- Review birth unit activity

14.6 All the above actions are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

15. Clinical Activity and Staffing

15.1 Acuity is assessed by four hourly recording of staffing and clinical activity is undertaken via the Birthrate Plus Acuity tool on both Gloucester Birth Unit and Central Delivery Suite. The confidence factor related to the Gloucester birth unit data remains consistently low and this will be prioritised by the Matron responsible for this area once in post. All Birthrate plus data within this report therefore only relates to Central Delivery Suite data. Birthrate Plus acuity tool for the maternity ward will go live in January 2024 with support of their matron.

15.2 Despite a very favourable birth to midwife ratio associated with lower than monthly average birth-rates, the incidences of acuity exceeding staffing levels illustrate a variable trend when there are 3 or more midwives short on Central Delivery Suite during the period of January 23 – Dec 23. This illustrates complexity in caseloads

Table: Staffing levels meeting acuity Jan – Dec 23 Source: Birthrate plus

Month	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23
Staffing levels met acuity	57%	49%	67%	53%	34%	38%
	Jul 23	**Aug 23**	**Sept 23**	**Oct 23**	**Nov 23**	**Dec 23**
	41%	49%	42%	48%	47%	51%

Charts: Monthly Acuity by RAG status (Source: BirthRate Plus Acuity Tool – CDS)

16.0 Supernumerary Labour Co-ordinator

16.1 Availability of a supernumerary labour ward co-ordinator is recommended as best practice to oversee safety on the labour ward. This is an experienced midwife available to provide advice, support, and guidance to clinical staff and able to manage activity and workload through the labour ward.

16.2 There were no occasions when supernumery status of the co-ordinator was reported to be compromised during the 3-month period:

The following table outlines the compliance by month: *Supernumery Status of Delivery Suite Co-ordinator Source: BR+ Acuity tool*

	Number of days per month	Number of shifts per month	Compliance
Oct 23	31	62	100%
Nov 23	30	60	100%
Dec 23	31	62	100%

16.3 Confidence factor in the inputting of the data into the BR+ tool is continuously reviewed by the senior midwifery team and reported to the Maternity Delivery Group.

16.4 Work is in progress by the Band 8 of the day and flow midwife continue to support data quality during periods of high acuity.

17.0 One to One in Established Labour

17.1 Women in established labour are required to have one to one care and support from an assigned midwife. One to one care will increase the likelihood of the woman having a 'normal' vaginal birth without interventions and will contribute to reducing both the length of labour and the number of operative deliveries. Care will not necessarily be given by the same midwife for the whole labour.

17.2 If there is an occasion where one to one care cannot be achieved, then this will prompt the labour ward co-ordinator to follow the course of actions within the acuity tool. These may be clinical, or management actions taken.

17.3 The following table outlines compliance by Month for the whole service.

Table: 1:1 Care in labour compliance – all areas (Source: Badgernet from 7th June 2023)

Month	1:1 care in labour compliance
Oct 23	99%
Nov 23	98%
Dec 23	99%
YTD	**97%**

Table 1:1 Care in labour compliance – each area (Source: Badgernet from 7th June 2023)

	Oct 23	Nov 23	Dec 23
Central Delivery Suite	99%	99%	99%
Gloucester Birth Centre	100%	100%	98%
Aveta Birth Centre	Closed	Closed	Closed
Stroud Maternity Unit	100%	100%	100%

17.4 This continues to be monitored via the CQC action plan and remains below 100%. The 1:1 care in labour action plan has now been enhanced to increase focused work and communication by the clinical Maternity Patient Safety Champions.

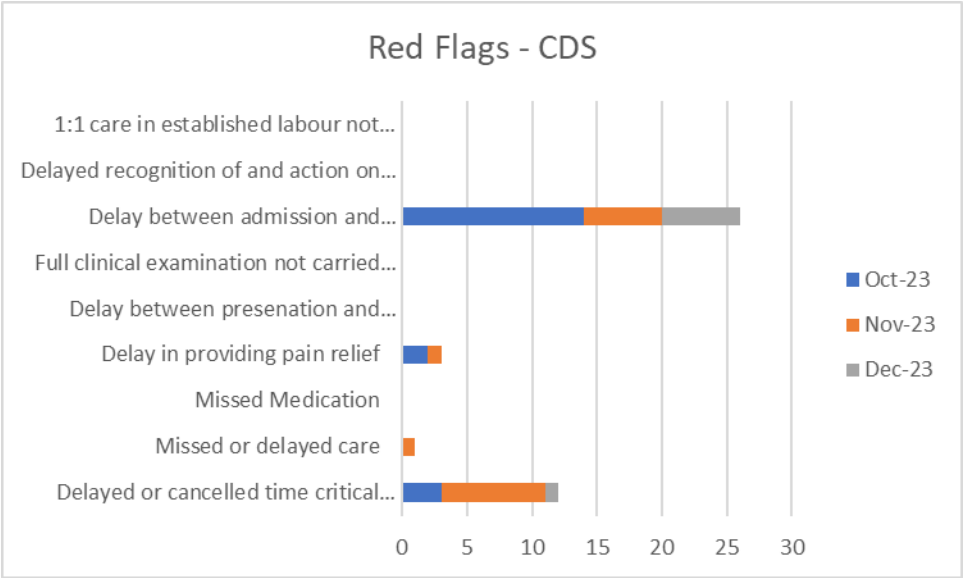
18.0 Red Flag Incidents

Safer Midwifery Staffing

18.1 Ongoing monitoring of safety metrics and data

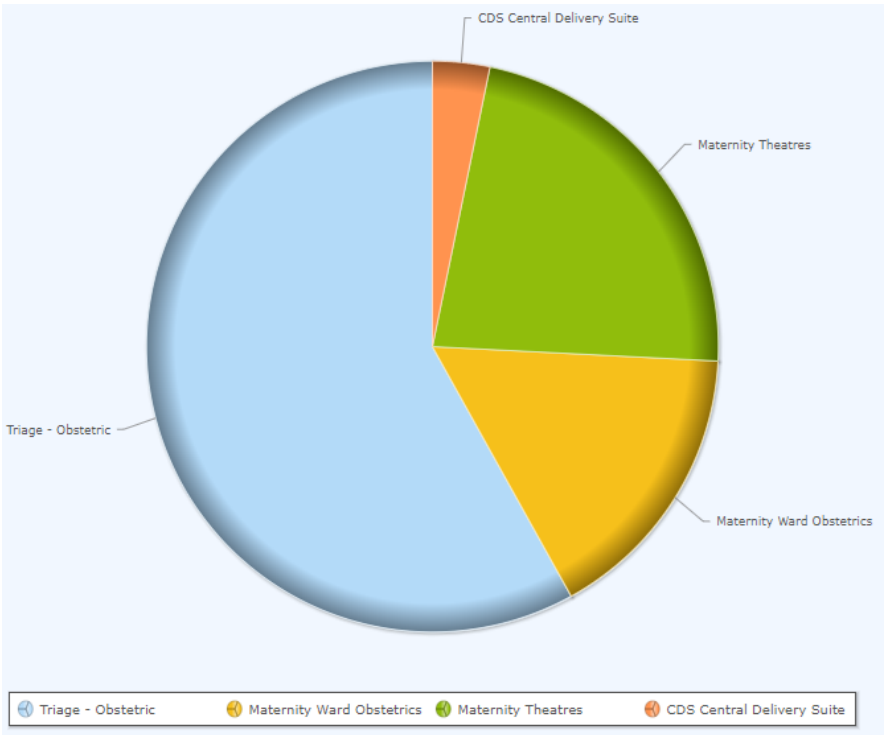
- Safe midwifery staffing is monitored by the completion of the Birthrate Plus acuity tool (4 hourly), daily staffing safety huddles, monitoring of the midwife to birth ratio and monitoring of red flags as per NICE Guidance (NICE NG4, 2021).
- The Birthrate+ Acuity tool monitors compliance with supernumerary labour ward co-ordinator status and provision of 1:1 care in labour.
- Red flags are highlighted with a monthly breakdown below
- A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.
- The following tables demonstrate red flag events on CDS during the reporting period:

Chart: Red Flags recorded on Central Delivery Suite Oct - Dec 23 Source: BR+ Acuity Tool



18.2 During the months of October-December there were 31 Datix incidences reported related to midwifery staffing. The majority of these related to insufficient staffing in Maternity Triage. The largest reporting area was Triage particularly in relation to breeches of primary assessment time.

Graph: Incidences associated with staffing Source: Datix



Area	Number of Datix
Triage	**18**
Mat Ward	**5**
Maternity Theatres	**7**
CDS	**1**

18.3 HSIB referrals are monitored via the maternity dashboard. During the period of July-September 2023 the HSIB referrals fluctuated, with a total of 4 cases. This is monitored via the Quality and Safety Divisional Group and Maternity Clinical Governance.

Month	Oct 23	Nov 23	Dec 23
HSIB referral number	1	1	1

Midwifery Continuity of Care (MCoC) and impact on funded establishment

18.4 NHS England (NHSE) (Oct 2021) has provided guidance to Trusts for the delivery of the MCoC programme. The roll out of MCoC will impact on the establishments as there will need to be redesigned pathways and models of care. This will impact positively upon perinatal outcomes and empowers midwives to achieve excellence in care. The approach, which is underpinned by a changing service delivery, is supported by the NHSE Midwifery Work Force Tools.

18.5 The existing MCoC service delivery model and business plan is being reviewed to revaluate how we can achieve the national ambition of the MCoC model locally in light of the most recent additional guidance. Three teams were rolled out. One has since paused and the remaining two continue to provide care in the MCoC model.

19.0 Obstetric staffing

19.1 The obstetric consultant team and maternity senior management team acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. This includes obstetric staffing on the labour ward and any rota gaps.

19.2 Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-

attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.

19.3 Trust compliance has been audited for the period covering the 7th June to the 6th July 2023. The aim of the audit was to assess local compliance against RCOG standards for situations where the consultant must attend. The audit identifies compliance against the following situations:

1. Situations where consultant presence is mandated
2. Situations where the consultant should attend, if the registrar is not signed off as competent.

19.4 The audit concludes that a consultant was present in 100% of situations where they MUST attend, and documented compliance in 91% of 'should attend' situations.

19.5 Data collection was challenging as the audit timescale co-incided with the launch of the BadgerNet Maternity EPR. An action plan is included as an appendix to the audit. The findings have been circulated to Maternity Delivery Group and Safety Champions Meeting. Any recommendations following the audit will be monitored.

19.6 The Trust has implemented the RCOG guidance on the engagement of short-term locums in maternity care. An audit of short-term locum doctors working within the Obstetrics & Gynaecology service on tier 2 or 3 (middle grade) rotas for the period February – August 2023 demonstrates 100% compliance with the criteria contained within the guidance.

19.7 The Trust has implemented the RCOG guidance on engagement of long-term locums in maternity care.

19.8 Following an audit of long-term locums working within the Obstetrics & Gynaecology service for the period February – August 2023, the Trust has been unable to demonstrate full compliance with guidance.

19.9 During this time period, the Trust employed one long-term locum, a locum Consultant. An audit of the recruitment process for this individual has shown that the RCOG monitoring and effectiveness tool was not completed as part of the recruitment process.

19.10 3 new obstetric consultants have been appointed and will join the team in April, June and September. This will enable a complete split of the on-call rota so that there will always be an obstetric and a gynaecology consultant available. The increased workload in both obstetrics and gynaecology has made it untenable for one consultant to be responsible for both services. There remains one unfilled gap on the on-call rota, which will be covered internally.

19.11 The increase in obstetric workforce will also enable more of the SPA roles to be undertaken. Job planning is currently underway. A team job planning process is underway and will inform remaining shortfalls in the obstetric team.

19.12 As a result, an action plan to review and update the recruitment and onboarding process for all long-term locums working within maternity care has been developed. The recruitment and onboarding process now includes completion of the RCOG monitoring and effectiveness tool. As of December 2023, all locum sessions have been filled by either current or previous registrars, and no external locums have been needed.

19.13 The Trust will undertake further audits covering the period September 2023 – March 2024 to provide assurance and evidence of improved compliance. Findings will be presented at Maternity Delivery Group and Safety Champions Meeting and any recommendations following the audit monitored.

19.14 The Trust has implemented the RCOG guidance on compensatory rest to ensure that all consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest.

19.15 The Trust has an agreed standard operating procedure in place to support the provision of compensatory rest as recommended by the RCOG.

19.16 The job plans of the Obstetric Consultant Team reflect the requirement for compensatory rest with job plans arranged to allow for a day off following a Monday-Friday on-call and provision for any direct clinical care (DCC) activity following a Sunday or Bank Holiday to be either cancelled / covered by another member of the Consultant Team.

19.17 Junior doctor industrial action has had a significant impact but all obstetric sessions, including planned caesarean section lists, antenatal clinics, fetal medicine and preterm birth clinics, have been staffed.

19.18 An audit of the Obstetric Consultant on-call rota for October 2023 demonstrated that all Consultants working non-resident on-call out of hours were able to take the required amount of compensatory rest in the period immediately following their on-call.

20 Anaesthetic staffing

20.1 There is no update to Anaesthetic staffing from the previous paper as fully compliant. For safety action 4 of the maternity incentive scheme evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times.

20.2 Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

20.3 The obstetric anaesthetist is a member of the delivery unit team. Approximately 60 per cent of women require anaesthetic intervention around the time of delivery of their baby. The staffing of anaesthetics for maternity services is allocated according to the RCoA GPAS 2023 and ACSA standard 1.7.2.1.

20.4 The duty anaesthetist's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention. The duty anaesthetist will be a Consultant, an anaesthetic trainee or a staff grade, associate specialist and specialty (SAS) doctor. Gloucester Hospitals Maternity service is fully compliant with this recommendation.

20.5 There is a duty anaesthetist immediately available for the obstetric unit 24/7. This person's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention. The role should not include undertaking elective work during the duty period. GHT Maternity Service is fully compliant with this recommendation (Appendix 2 Obstetric Anaesthetic Rota GHNHSFT).

20.6 The duty anaesthetist has a clear line of communication to the supervising consultant at all times

The following demonstrates compliance with this standard by month.

	Jan 23	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**	**Jun 23**
% compliance	100%	100%	100%	100%	100%	100%
	July 23	**Aug 23**	**Sep 23**	**Oct 23**	**Nov 23**	**Dec 23**
	100%	100%	100%	100%	100%	100%

20.7 In summary, to meet the NHSR MIS Standards (2021) GHT can confirm that there is a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant at all times. (RCoA GPAS 2023 and ACSA standard 1.7.2.1).

21.0 Neonatal medical staffing

21.1 To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

21.2 The Neonatal Unit are budget compliant with meeting the Local Neonatal Units Standards of Tier 1 and Tier 2 separate rotas for the junior medical workforce to meet BAPM requirements.

21.3 There are gaps within the rotas due to sickness absence and maternity leave, however these gaps are filled largely by internal locums. The LMNS have been informed of these standards being met through the SW NICU/LNU Medical Workforce Stocktake.

22 Neonatal nursing staffing

22.1 To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards.

22.2 The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

22.3 The Neonatal Unit is part of the Paediatric Service Line and is part of the Women and Children's Division.

22.4 The Clinical Lead and Matron; together with the Senior Sisters and other Neonatal Consultants comprise the Neonatal Unit Management Team and will devise the strategic plan for the unit. The Team will meet regularly to discuss on-going issues and will participate in Neonatal Risk and other meetings.

22.5 The unit is funded for 10 neonatal nurses and 1 nursery nurse on every shift and this is amended based on occupancy and dependency of the babies as per BAPM guidelines. Unit activity for Jan to June 23 has varied from 55% to 91% cot occupancy (monthly averages – staffing funded figures are based on an average of 80% occupancy). Fluctuating activity makes staffing consistently to BAPM standards for ratios of nurses to babies, alongside the necessity to adhere to differing ratios for acuity of NNU patients challenging (nurse:pt ratio of 1:1 for ITU, 1:2 for HDU, 1:4 for Special Care/Transitional Care). This is addressed by trying to flex nurses off days/nights with less activity/acuity (whilst maintaining a safe minimum staffing level to cope with anything that may present) and onto busier days, using annual leave flexibly, flexing admin, teaching and study time. This often relies on the goodwill of staff to change shifts/take leave at short notice however.

22.6 The unit funding for nursing staff also covers provision of outreach support to ex-NNU patients on home oxygen (19 babies as of June 2023), providing developmental assessment in follow up clinics, weekly ROP clinic support, providing senior Education nurse to maternity PROMPT training monthly and staffing a Palivizumab clinic through the winter months.

22.7 The Unit had a GIRFT deep dive visit on 24th May 2022. At that point in time Neonatal Qualification in Speciality (QIS) rates were at 63% which is below national recommendation of 70%. In January to June 2023 QIS rates averaged 65%. This remains below national recommendations but will improve to 68% in September presuming satisfactory completion of the course by this year's cohort of two attendees and no other changes to workforce. The QIS course runs annually, four places for September/December 2023 have been funded by the ODN and members of staff identified to fill these which will improve QIS rates but not until course

completion in the summer of 2024. The only other way to improve QIS compliance is to recruit in staff who already have the qualification however there is a small pool of such staff nationally and they are not traditionally a very mobile workforce.

22.8 The Unit remains challenged in relation to nurse staffing. August 2023 nurse staffing figures demonstrate a gap of 18 WTE (or 26%) comprised largely of maternity leave, long term sickness absence, a small number of vacancies and a small number of staff appointed but not yet in post. Maternity leave is predicted to rise from its current level of 6.2 WTE (August 2023) to a peak of 9.6 WTE (Oct/Nov/Dec 2023). The impact is roughly equally spread across both QIS and non-QIS nursing staff. Actions to mitigate have included attempts to boost the neonatal nurse bank through targeted recruitment adverts, liaison with DCC to identify any staff with transferable skills willing to take on bank, efforts to boost support services (admin and clerical roles, housekeeping, Band 4 nursery nurses) to reduce non-nursing tasks being carried out by nursing staff, and liaison with bank office to source and manage temporary staffing options to fill gaps.

22.9 An action plan has been developed to provide oversight of all activity relating to recruitment and retention on the Unit.

Neonatal Workforce Action plan	**Sept 23**	**Dec 23**
Closed	28	36
Overdue	16	7
In Progress	15	12
Complete	24	28
Total number of elements	**83**	**83**

22.10 Escalation plans have been instigated when activity increases/staffing is impaired to support nursing which has included utilising all nursing time into clinical shifts (cancelling/postponing study leave/admin time/teaching days), flexing staff on and off shifts to match demand and booking of bank/agency nurses.

22.11 Agency and bank are utilised if required however there is a very limited pool of bank/agency staff with neonatal skills, especially so if QIS cover is needed, and these staff tend to be employed with the higher agencies and are consequently more expensive.

22.12 Staffing is regularly reviewed with the South West Neonatal Network and Gloucester was awarded £52,600 from June 2023 for nurse quality roles

(Education and Governance) to bring the unit closer to recommended staffing numbers in these areas. Whilst these posts have been filled, they have been so from existing staffing pool.

22.13 The neonatal unit records all of its nursing numbers and acuity data on the electronic system Safe Care Live and this is reviewed daily by the senior nursing team to ensure the staffing is as per recommendation. Nursing skill mix is based on BAPM guidance and recorded on Badger which is also reviewed by the team locally as well as the Neonatal network.

22.14 A review is underway to review medical and nursing workforce. The outcome of this may lead to an action plan. Once completed this will be shared with the LMNS and Safety Champions and monitored via MDG.

23.0 Conclusions

23.1 The data within this report provides assurance that there are effective workforce planning tools being used currently to review current establishments. This report describes the urgent action being taken to tackle the staff shortages and the increased pressures this has on staff, which have been exacerbated by the Covid-19 pandemic and ongoing national maternity scrutiny.

23.2 Incident reporting on staffing, Red Flags and birth to midwife ratio illustrate a concerning picture within midwifery staffing. Initiatives to enhance recruitment and retention are being actioned and it is anticipated that the next 6 months will see an improved recruitment picture. Attrition continues to be of significant concern and actions to address this are ongoing.

23.3 Obstetric Consultant presence audit has concluded that in the period covering the 7th June to the 6th July 2023 that a consultant was present in 100% of situations where they MUST attend, and documented compliance in 91% of 'should attend' situations. There were data collection challenges which have been included in the action plan

23.4 Whilst the audit of short-term locum doctors demonstrates 100% compliance with the criteria contained within the guidance, the trust have been unable to demonstrate full compliance with guidance on long term locum. An action plan has been developed.

23.5 The Neonatal unit continues to be challenged around neonatal nurse staffing. An action plan has been developed which will be monitored in MDG

24.0 Recommendations

24.1 It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes non-compliance with BAPM standards for both neonatal nurse staffing and agree to the action plan

24.2 It is recommended that formally record to the Trust Board minutes non-compliance with RCOG audits and to note that an action plan has been developed and monitored through MDG.

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NHS Foundation Trust

Nursing Safer Staffing Report

March 2024

Report to Quality and Performance Committee			
Date	March 2024		
Title	**Nursing Safer Staffing Report**		
Author /Sponsoring Director/Presenter	Ana Gleghorn		
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 purpose of this paper is to provide the Quality & Performance Committee with an assessment of the nursing staffing levels at Gloucestershire Hospitals NHS Foundation Trust and assess compliancy with Developing Workforce Safeguards (NHSI, 2018) which builds on the National Quality Board (NQB 2016) standards and the National Institute of Health and Care Excellence Guidance (DH, 2014).

This paper provides an account of the process used to review staffing levels, the findings of the review and outlines the actions required by the Trust to ensure the right level of nursing care is provided to our inpatient's wards, assessment areas and the Emergency Department.

This paper supports the Ward Nursing Establishment review which was approved by the Executive Directors in November 2023, the purpose of that review was to provide a baseline of the nurse staffing following a series of ward moves between 2022-2024 with a request to increase in the total establishment by 44.18 whole time equivalents (wte).

Triangulation with nurse sensitive indicators and data from model health system is included.

Risks or Concerns

There are no risk or concerns detailed in this report

Financial Implications

There are no financial requirements, acknowledgement is given to the paper presented in November 2023 detailing the growth in the workforce required.

Recommendation

It is recommended that the Executive Team:

- Note the findings of the review
- Approve the next steps
  - Incorporate the Safer Nursing Care tool (SNCT) and Professional Judgement framework into establishment setting.
  - Incorporate Red Flags as part of the staff deployment conversation.

Enclosures

No enclosures

NURSING SAFER STAFFING REPORT

Purpose of the paper

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This paper does not report on the use of temporary staffing within nursing.

Methodology

Inpatient wards and assessment area's.

A table top review was undertaken to review each department, aligning the working practices with the recommendations from the review in 2023 and the Trust financial ledger. The process began in April 2023 and took a total of 8 months to complete, the final stage of aligning ward budgets was completed in December 2023.

The reviews were led by the Deputy Chief Nurse, Divisional Director of Quality and Nursing supported by the Divisional Finance Business Partners and the Associate Chief Nurse for Workforce and Education.

Each nursing establishment was reviewed against their bed base, taking into consideration any change in location or change in patient pathway. Incorporating professional judgement was key and the discussions centered around the following:

- Ward purpose.
- Ward layout.
- Patient acuity and dependency, including additional tasks.

Areas excluded from the review:

- Theatres
- Outpatient settings
- Day case settings.

Guiding principles of safer staffing included:

- The Senior Sister/Charge Nurse is 100% supervisory.
- The establishments in acute ward areas should be at a minimum of 65:35 - registered nurse to healthcare support worker ratio.
- The Registered Nursing Associates are included within the registrant staffing establishment where appropriate.
- Headroom of 22% is applied across all areas.

The report does not include a review of temporary staffing efficiency, spend or utilisation.

National Benchmarking.

Weighted activity Unit (WAU) and Care Hours per Patient Day (CHpPD) continue to be the main source of external benchmarking in the NHS Model Health System.

There is a lag in the Model Health system and the data not always directly comparable with other Trusts so whilst helpful, this data should be triangulated against other sources, intelligence and professional judgment.

Weighted Activity Unit (WAU).

The cost per WAU is the primary productivity measure used within Model Health system and compares organisational costs to the amount of output. A higher-than-average nursing staff cost per WAU suggest the organisation spends more on this staff group per unit of activity than a typical organisation. A lower-than-average nursing staff cost per WAU suggests the organisation spends less on this staff group per unit of activity than a typical organisation.

WAU is a measure of efficiency; more productive Trusts will have a lower cost per WAU and less productive Trusts will have a higher cost per WAU. The WAU metric does not directly correlate to the quality of care.

The cost per WAU detailed below (chart 1) shows the Trust in quartile 2 with a nursing staff cost per WAU of £865, which is significantly lower than regional peer median of £929 and higher than best Decile of £783.

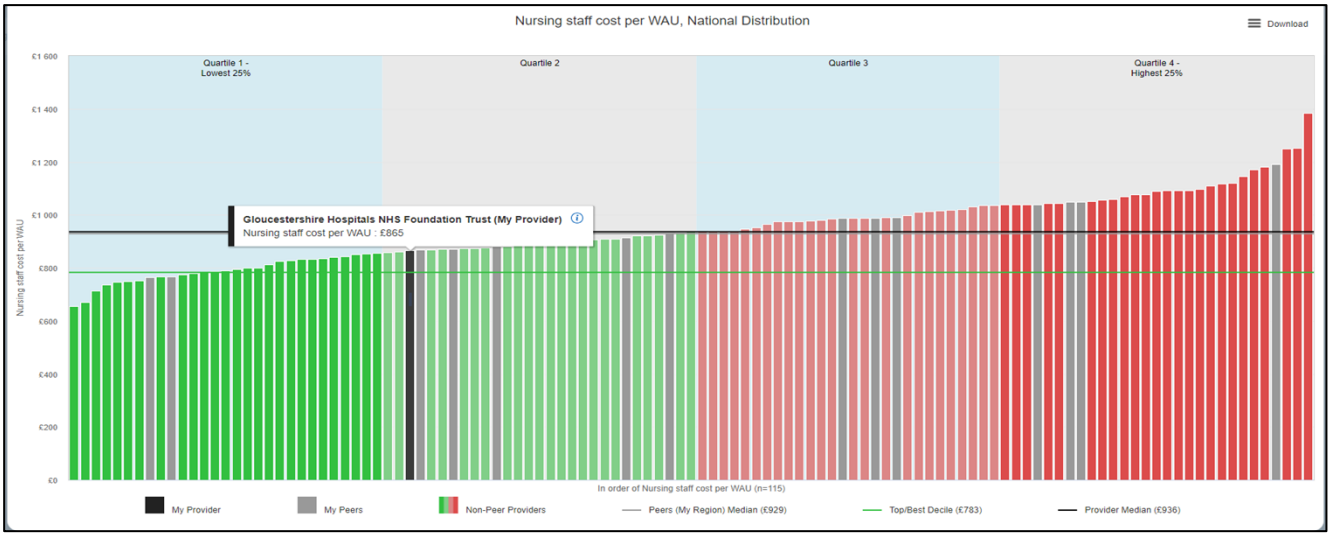


Chart 1: Nursing staff costs per WAU.

Care Hours per Patient Day (CHpPD)

The CHpPD is a measure of actual daily nursing and midwifery staffing levels in relation to daily patient numbers on inpatient wards.

CHpPD provided in the Model Health System as a standardised model for Trusts to benchmark and is calculated by taking the total care hours worked by Nursing and Midwifery staff divided by the total patient bed days. Very low rates indicate a potential risk to patient safety with very high rates being suggestive of inefficient rostering.

The information presented below relates to November 2023 (chart 2), detailing the Trust in the upper third quartile and above the provider median. The Trust CHpPD is at 8.7, peers at 8.2 and national median at 8.3.

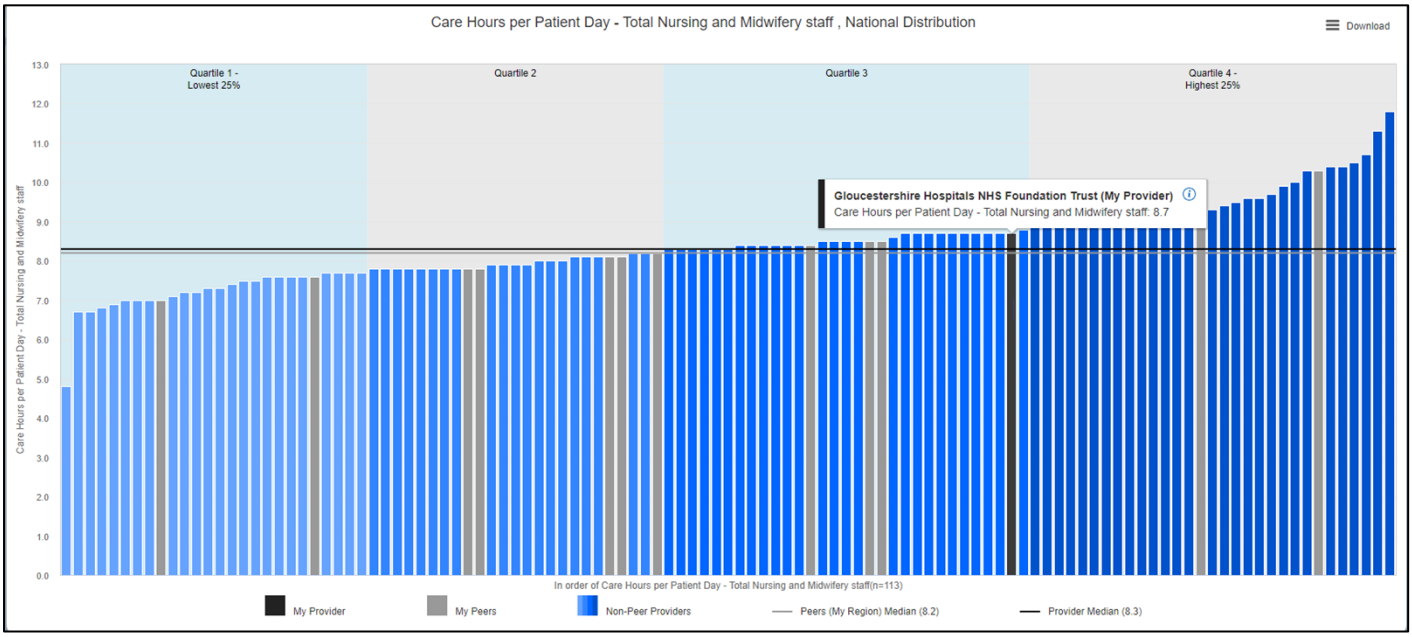


Chart 2: CHPPD benchmark at a national level.

Local CHpPD data

A review of the Trust level data illustrates how this translates to local level when comparing planned CHpPD to actual. With the exception of 8 departments, all other departments were within 0.5 of the planned hours for the month of November. Suggesting the planned care hours available sufficient to meet the care demand, an improvement on the position reported in March 2023.

ANNEX A NURSING STAFF FILL RATES ***Nov-23***		Planned CHPPD				Actual CHPPD			
		Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall	Midnight Occupancy	Registered nurses/ midwives	Care staff	Overall
CGH	ACUC	682	6.6	3.3	9.9	682	6.5	3.2	9.7
	DIXTON	419	5.0	3.6	8.6	419	5.0	3.6	8.6
	BIBURY/SNOWSHILL	518	6.3	2.9	9.2	518	6.5	2.8	9.2
	CARDIAC	592	6.6	1.3	7.9	592	6.2	1.3	7.6
	TIVOLI	488	5.5	4.0	9.5	488	5.5	3.5	9.0
	KNIGHTSBRIDGE	499	5.4	6.3	11.7	499	5.5	3.1	8.5
	LILLEYBROOK	389	8.1	4.2	12.3	389	8.1	4.1	12.1
	RYEWORTH	955	4.1	3.1	7.2	955	4.0	3.2	7.2
	WOODMANCOTE	975	4.3	3.2	7.5	975	3.9	3.3	7.2
GRH	AMU	1233	10.1	6.7	16.8	1233	10.0	6.4	16.4
	FRAILTY UNIT	467	3.2	2.6	5.8	467	4.8	3.2	8.1
	CARDIOLOGY	746	5.6	2.0	7.6	746	5.6	1.6	7.2
	SCBU	587	12.8	1.0	13.8	587	11.1	1.5	12.6
	2B	626	4.3	3.1	7.4	626	4.4	3.0	7.5
	3B	862	4.0	3.1	7.1	862	4.0	3.0	7.0
	4A	790	4.7	3.1	7.8	790	4.4	2.9	7.4
	4B	913	2.7	2.7	5.4	913	2.7	2.4	5.2
	5A / SAU	652	6.0	4.6	10.6	652	6.3	4.3	10.5
	6A	777	4.4	3.5	7.9	777	4.4	3.4	7.8
	6B	613	6.9	4.4	11.3	613	6.9	5.2	12.1
	7A	922	4.8	2.2	7.0	922	5.0	2.1	7.1
	7B	672	4.7	2.6	7.3	672	4.6	2.7	7.3
	9A / AMU3	333	5.9	3.6	9.5	333	5.9	3.4	9.3
	9B	823	4.7	2.4	7.1	823	4.9	2.7	7.6
	GALLERY WING 1	725	3.7	3.7	7.4	725	4.1	4.1	8.2
	GALLERY WING 2	749	3.6	3.6	7.2	749	3.6	3.5	7.1

Chart 3: Planned versus Actual CHpPD (Trust).

Patient harms sensitive to nurse staffing levels

There is a strong correlation between the number of care hours registered nurses can provide patients and patient safety incidents such as falls, pressure ulcers and infection. The following graphs show the run rates in a number of nurse sensitive indicators with a data stamp detailing the rate position at November 2023.

All run rates at the time of the review, November 2023 raised no concerns.

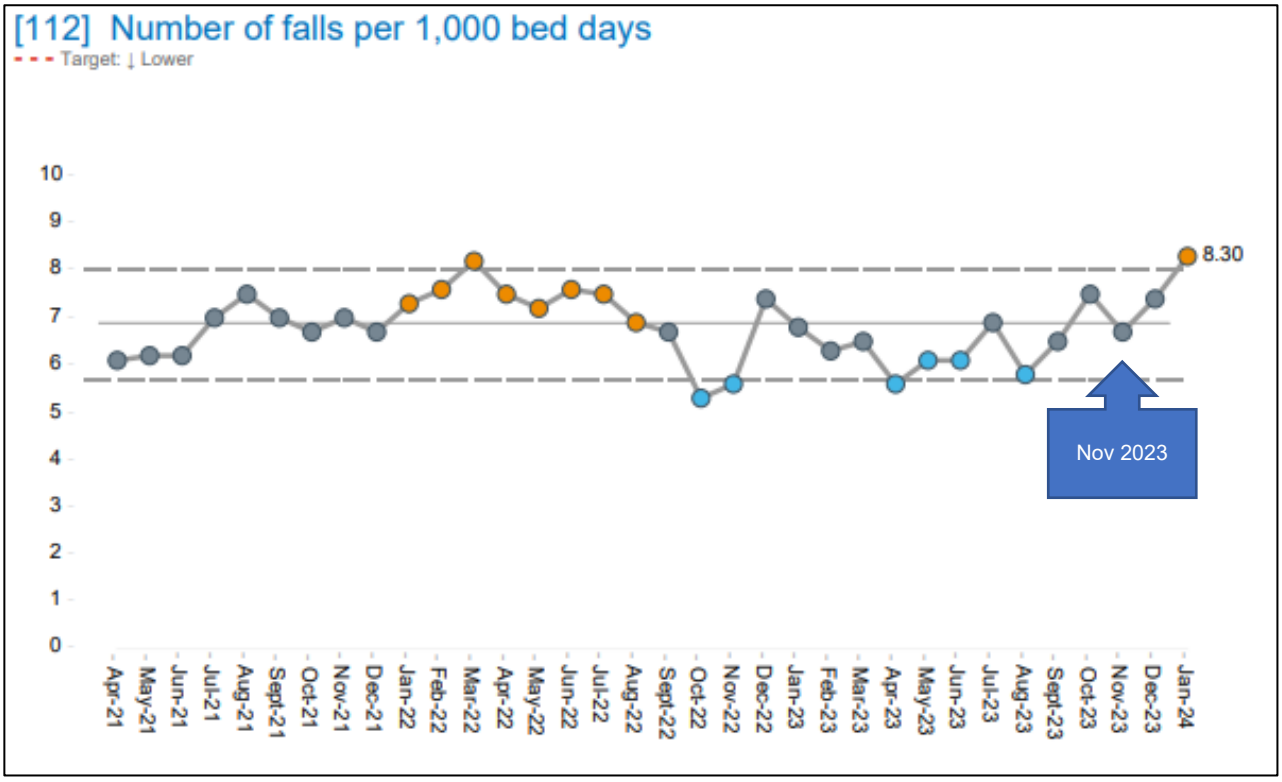
Patient Falls

In November the number of falls per 1000 bed days was below target as shown in graph 1 below, a reduction from 7.50 per 1000 bed days to 6.70.

The Trust Falls Prevention team monitor falls in Medicine, Surgery and Diagnostic Services. They assess and monitor repeat fallers and support wards with high incidents of falls to help them reduce the numbers of falls, though education and quality improvement projects.

Furthermore, they provide an advisory service for all staff, who need further advice and guidance on how to manage patients who are at risk of falling in our care. They provide monthly general falls training, which covers numerous elements of falls prevention, as well as training to many other groups of staff, including ward-based training if necessary.

The weekly Preventing Harm Hub are held locally, where falls resulting in harm are discussed to identify any immediate learning from the incident that can be taken at a ward level or need addressing at trust level. The main themes being lack of documentation, a person at risk not being identified and intervention not being in place. Learning is feedback at local level and included in the monthly training session if appropriate.



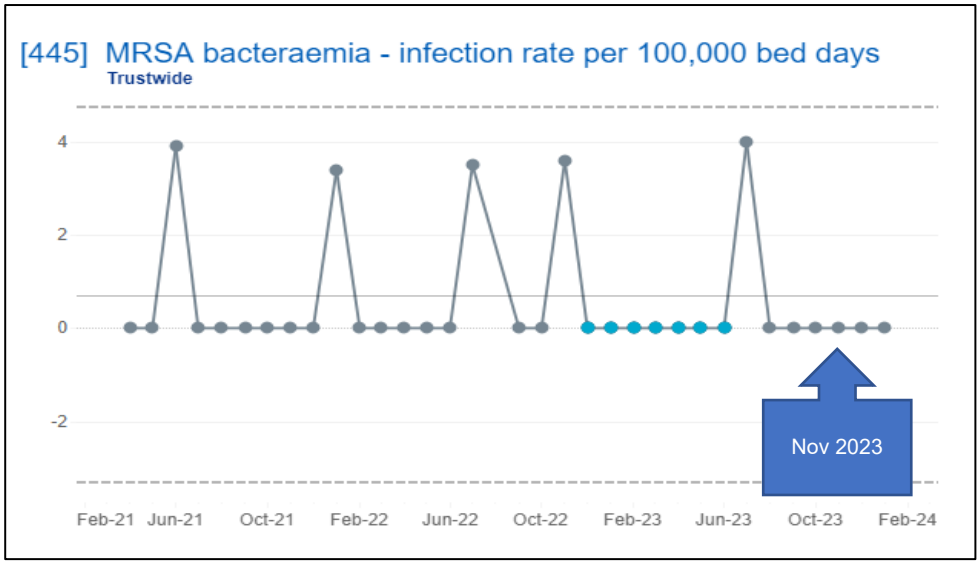
Graph 1:Falls per 1,000 days - Trust Level

Healthcare Acquired Infections

At the time of the review, the run rate suggests the Trust performance was at or below target for MRSA, MSSA and C.*difficile* as show in graphs 2, 3 and 4 below. However, the position had deteriorated from the October position for both MSSA and C. *difficile.*

MRSA Bacteraemia

In November there were no MRSA bacteraemia's reported, in keeping with previous months.

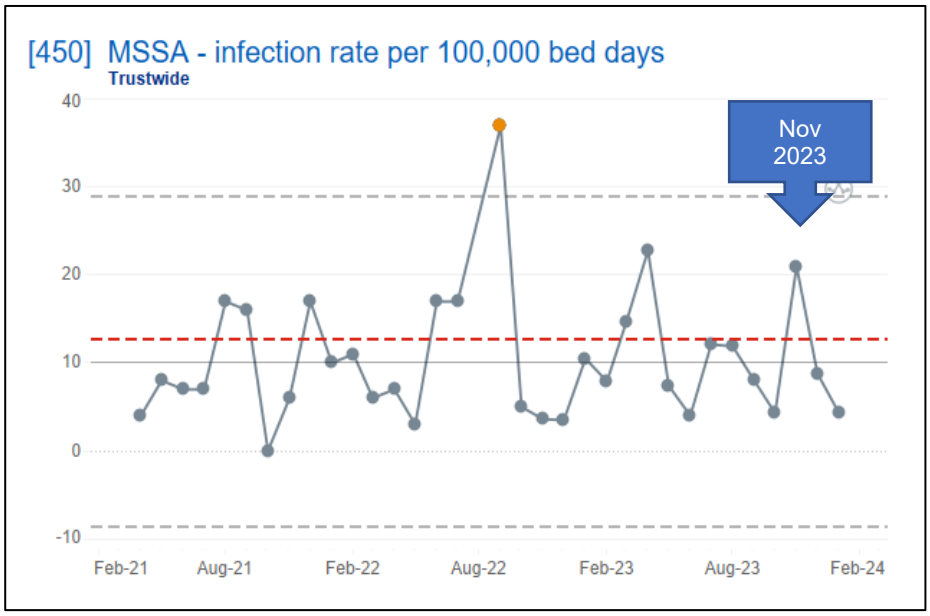


Graph 2: MRSA Bacteraemia per 100,000 bed days – Trust Level

MSSA Data

In November the Trust reported 21 infections per 100,000 beds days compared with 4.3 in October (graph 3).

Whilst there is no nationally set reduction target for MSSA bacteraemia's for the integrated care system (ICS) and/or acute NHS Trusts, the Infection Prevention and Control Team (IPCT) have included a programme of activities within the annual plan to support the reduction of blood stream infections, specifically for high-risk patient groups and those associated with invasive devices. The IPCTs across the system are currently reviewing all cases of MSSA bacteraemia's from this financial year, with a particular focus on exploring sources of these infection and risk factors, which will be used to develop a targeted quality improvement programme to reduce MSSA bacteraemia's across the system. This work is feeding into the regional SW IPC network improvement collaborative.



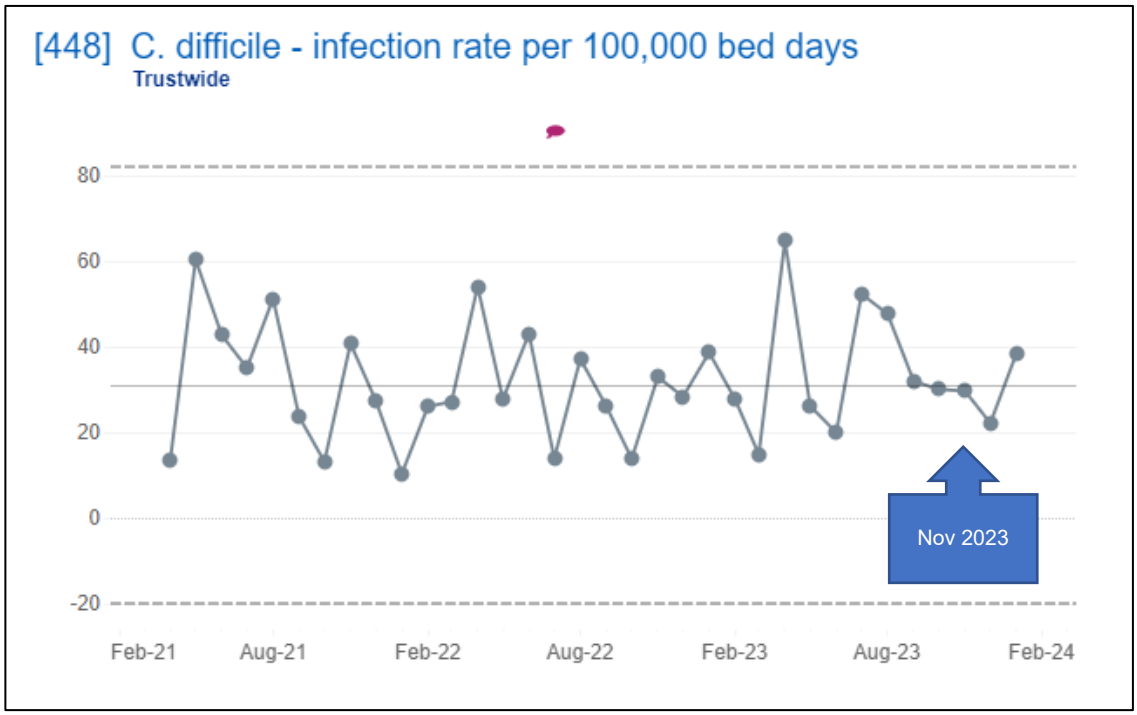
Graph 3: MSSA per 100,00 bed days – Trust level

C. *difficile* Data

In November the Trust reported 29.5 infections per 100,000 beds days compared with 29.0 in October.

The Trust wide reduction plan for *C. difficile* (CDI) for 2023/2024 focusses on actions to address cleaning, antimicrobial stewardship, PPE use and optimising management of patient with C. difficile. To enable all staff throughout the healthcare community to 'think CDI'; to support timely diagnosis and optimised management of those with CDI, a countywide study day was delivered earlier in the year. The ICS continue to engage in the NHS England South West CDI improvement collaborative and are working to address 3 key improvement areas which include antimicrobial stewardship, optimisation of CDI treatment and management and cleaning/ CDI IPC bundle.

Targeted work is also being implemented across the two wards that have had CDI outbreaks this year, both have multidisciplinary team action plans to improve IPC practices to optimise the detection, care and management of those with diarrhoea/ CDI, enhanced cleaning practices and improvements to the ward estate.



Graph 4: C. *difficile* per 100,000 bed days – Trust Level

Healthcare Acquired Harm

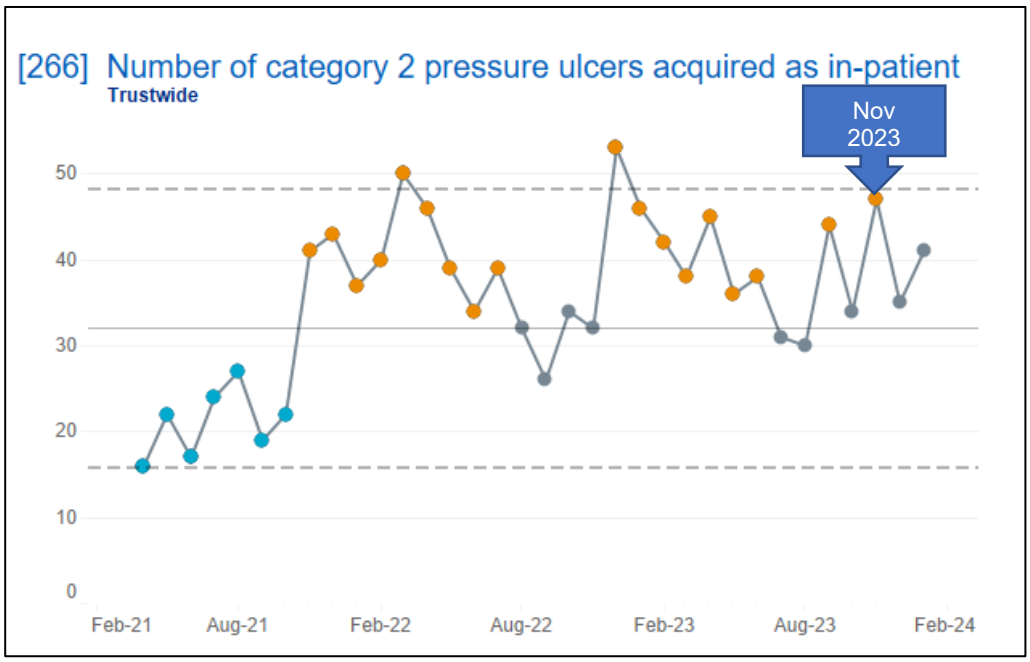
Whereas with healthcare acquired harm, Trust performance in category 2 and 3 pressure ulcers is above target and an area for attention.

In November there were 47 reported category 2 pressure ulcers, up from 34 reported in October and whilst the number reported was lower overall for category 3 pressure ulcers this too was on an upward trajectory from 1 in October to 4 in November.

Pressure ulcer prevention is a priority for the Trust and the team have been implementing a

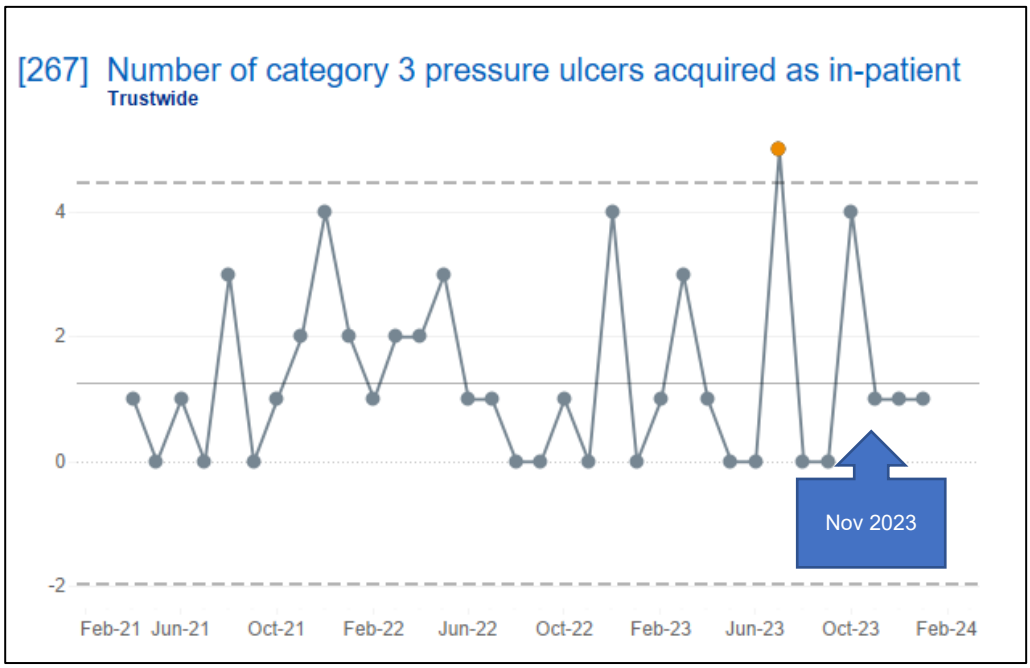
number of measures to improve pressure ulcer risk assessment (PURAT) compliance as detailed in CQUIN 12. The improvement strategy focuses on understanding the barriers to completion of PURAT, Pressure Ulcer Prevention (PUP) stimulation to support staff education and the re-introduction of the pressure ulcer steering group. Furthermore, in November, the Trust recognised International stop the pressure day and took the opportunity to raise awareness of PUP with staff.

Category 2 Pressure Ulcers



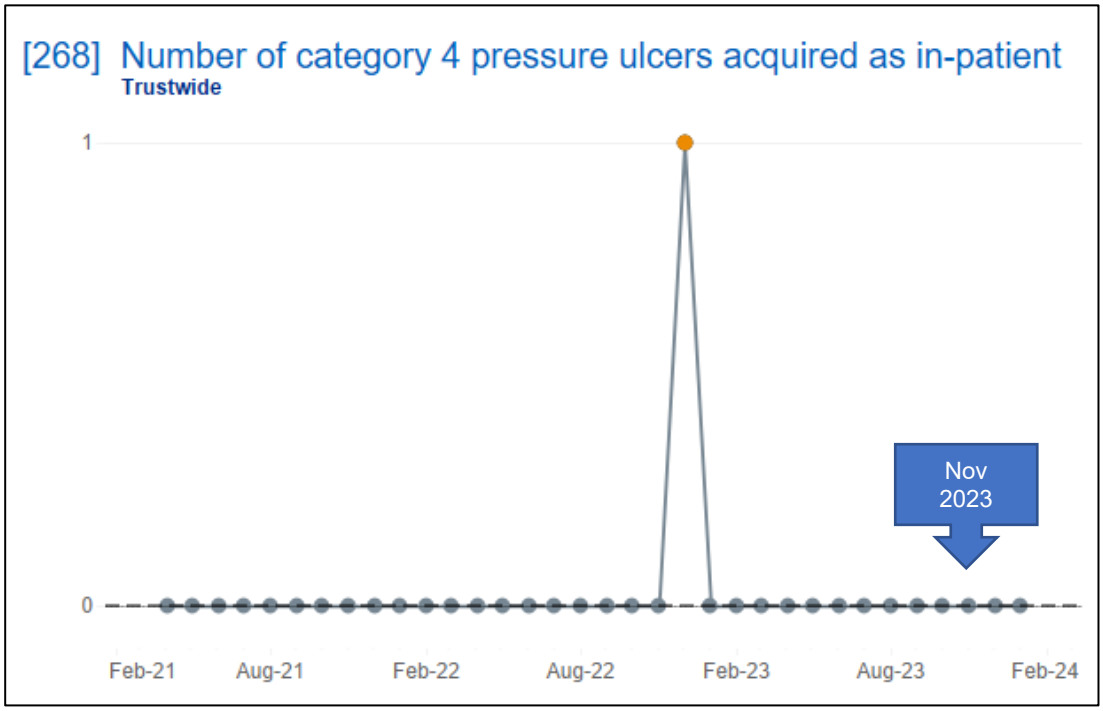
Graph 5 – Category 2 pressure Ulcers – Trust wide

Category 3 Pressure Ulcers



Graph 6 – Category 3 pressure Ulcers – Trust wide

Category 4 Pressure Ulcers



Graph 7 – Category 4 pressure Ulcers – Trust wide

Emergency department.
The emergency department was assessed using a different methodology.

Using the attendance only data for the previous 12 months and the ED Safer Nursing Care Tool provided the nurse staffing requirements. The attendance only function of the tool uses the national average percentage distribution of patients at each level of acuity and dependency.

For the purpose of accuracy, adjustment to the headroom, skill mix and Covid 19 data was made to reflect current practices.

Findings for Inpatients and the Emergency Department.
There is no further investment request required as a result of this review and has focused on:

- Aligning the roster templates to the budget.
- Addressing any change in workforce resultant from the reconfiguration of departments and ward moves.

Recommendations;
The recommendation to board is to note the findings and approve the next steps.

Next Steps
To further build the Trust compliance with both the national quality board expectations (2016) and the Developing Workforce Safeguards (NHSE, 2018) the following will be implemented;

- **Introduce a Safer Staffing policy**

The policy will support the Trust to deliver a sustainable staffing framework by ensuing the Trust has the right staff, with the right skills in the right place and at the right time.

- **Incorporate the Safer Nursing Care tool (SNCT) and Professional Judgement framework into establishment setting**

To implement a twice-yearly audit using SNCT which is then triangulated with professional judgement and nurse sensitive indicators. In preparation for the first audit in March 2024, key staff have been trained to use the tool in practice covering adult inpatient service, Children and Young People and the Emergency Department.

A total of 154 staff have been trained and are preparing to conduct the first audit, the results of which will be presented in the next safer staffing paper, alongside a more detailed review of the nursing workforce of the last 12 months.

Any recommendations to change the nursing workforce will be submitted for board consideration following a second annual cycle in September 2024 and in time for business planning. Going forward this will shape the annual nursing establishment review process.

The professional judgement framework will guide the Trust through the staffing reviews and the establishment recommendations. Like SNCT, this framework is an evidence-based tool for use on acute general wards and is there to help sense check and provide confidence in the results or else, flag circumstances where judgement should be used to recommend a variation from the suggested establishment.

- **The red flag system.**

The purpose of the red flag as set out within national safe staffing guidance is to have a consistent approach to reporting a shortage of registered nurse time. If an area is red RAG rated, this should prompt an immediate escalation response and mitigating actions.

Red flags are currently used ad hoc in the Trust, the plan is to roll out the use of red flags and for this to be incorporated into the daily staffing reviews and temporary staffing request conversation.

References

National Institute for Health and Care Excellence (2014) Safe staffing for nursing in adult inpatient wards in acute hospitals. London National Institute for Health and care Excellence.

National Quality Board (2016) Supporting NHS provider to deliver the right people, with the right skills, are in the right place at the right time – Safe sustainable and productive staffing. London National Quality Board

NHS England & Improvement (2018) Developing workforce Safeguards. London: NHS England & Improvement.

KEY ISSUES AND ASSURANCE REPORT

Quality and Performance Committee 27th March 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
Quality and Performance Report, including planned, cancer and urgent care reports	These reports were withdrawn from committee papers at short notice due to executive lack of confidence in providing the right data in the right way. Therefore due to a lack of data, committee could not take any assurance on those areas of performance in month.	Work being led by the Chief Operating Officer (COO) to ensure confidence in the data being reported to next committee and next Board. COO actions welcomed and supported by committee

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Patient safety and risk assurance report	Risk of care for fractured Neck of Femur patients added to trust risk register. Committee had previously heard that this was improving so questions raised about the timeliness of the risk addition. Updates provided on progress against safety alerts, implementation of PSIRF and national standards.	Committee to continue to review whilst on trust risk register. Confidence of timeliness around some of the actions noted, whether in identifying a lead to progress in a specific area or the additions to the trust risk register.
Regulatory report	Comprehensive report outlining extensive regulatory action and need for timely action plans. Noted that a full unannounced maternity inspection had taken place the previous day. Inconsistent timeliness of completing plans noted, including actions in ' well led' domain, reassurance by executive that improved governance will help mitigate this.	Reported monthly into committee.
Quality Delivery Group report	Poor performance nationally regarding food quality noted, committee concerned and surprised by this. Executives arranging a food summit to progress improvements. Patient property update, policy now in place – action plan complete.	Assurance needed back to committee on plans and timescales for improvement.
Maternity Delivery Group report	External maternity mortality review being planned. Reset meeting with NHSE and Improvement Advisors taken place. Improvements noted in midwifery services although still challenged, more work to do in obstetrics. Specific improvements noted, although wide range of issues still requiring progress and continued assurance of provision of a safe service.	Monthly reporting into committee.

Items Rated Green

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.

Item	Rationale for rating	Actions/Outcome
None.		
Items not Rated		
Potential emerging risk for patients and secondary care if GPs reject the new proposed contract.		
Links with System Mortality Group described and welcomed. Areas of concern needing system solutions raised at system level.		
Investments		
Case	**Comments**	**Approval** / **Actions**
N/A		
Impact on Board Assurance Framework (BAF)		
SR 1, 2, 5 and 6 reviewed in committee and updates noted.		

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

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee 24 April 2024		
The Committee fulfilled its role as defined within its terms of reference, noting that they remained under review following GGI review. 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	• NHSE National Review of Paediatric Hearing Services received a 'Red' rating – serious risk- The CQC have requested that Trust Boards are made aware of progress. • The service developed an action plan to respond to the inspection- This was reviewed by CMO who reported that he was not assured by delivery progress.	Outcome of review from CMO to be received at the next QPC
Patient Safety investigation and complaint report	103 complaints had been received in March; year-end figures indicate that highest for the last three years – assurance was sought regarding timeliness and handling of complaints – this had been noted as an area requiring grip and delivery by the CEO.	Request that a detailed report on complaints to come back to the May Committee for assurance.
Patient Safety and Risk Assurance report	A Never Event task and finish group had been established following two wrong side blocks in theatre – The committee were not assured that action had been taken to prevent recurrence given previous never events.	Assurance to be provided at next QPC
Water safety	• The Committee were informed that the water safety group are not assured that legionella assessment risks are being undertaken in a timely manner therefore missing the statutory requirement. • GMS colleagues had been able to demonstrate assurance with an audit of all the PPM (Planned Preventative Maintenance) expected in these areas which were now prioritised for completion by an external company. • The missing legionella assessments had been added to the Trust risk register. • Disruptions in GMS staffing had been noted with interims coming in to replace key roles and some longstanding members of staff leaving the organisation.	The Executive were progressing actions to ensure oversight of improvements required
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. • A recent update from the specialty director on the progress being made was positive.	Action plan delivery Update requested to come back to Committee.

	• The Committee noted that an external review into the endoscopy service was underway with an update planned to come to Committee in May.	Update due at committee in May
Quarterly Infection Prevention Committee (IPC) update	The Committee continue to seek assurance regarding a full picture of assurance regarding cleaning audits	Improvements to presenting this data are in progress
Board Assurance Framework (BAF)	Noted that the BAF requires a review as some areas out of date	Plans to work with new Director of Integrated Governance.
Board Assurance Framework - SR1	The Trust is being managed in Tier 2 for Urgent and Emergency Care.	The committee were updated in relation to the 'clinical vision of flow' work in which the organisation was in the middle of the '12 Days of Spring' Our discharge quality improvement programme and the virtual ward model.
Board Assurance Framework SR2	Meetings with the CQC to discuss progress against section 29a's continued, with dates for maternity and the emergency department planned for the following week.	The Committee will be updated on progress
Quality and Performance Report / Integrated Performance report	Revised Integrated performance report presented in full to provide greater clarity in reporting to committee.	Recommendation approved to cease the use of QPR – with agreement to develop a forward plan of deep dives into the five key domains of operational performance.
	There should be no 65wk waiters after September of this year and no 52wk waiters after March 2025.	
	Five cases over 78wks were reported at the end of March.	
	For 62-day patients, the standard from 1 April is for 85% of patients to be seen within 62-days. In March the performance was 64.8%. A non-compliance position was still being reported, but the backlog had gone down to 162 patients from 230, with the national tolerance at 150 of 8% of the total waiting list.	
	The faster diagnostic standard was currently unvalidated for March at 70.8% against a target of 75. The new target for 2024/25 was to achieve a 77% for patients told their diagnosis before day 28.	Committee noted that issues with diagnostic performance sat in the non-radiological services; mitigations were in place to resolve this along with elective recovery bids this year largely targeting areas such as gastroenterology and endoscopy to address investigations that contribute to the 28-day faster diagnosis.

Glossary:
H1/H2= first/second half of the financial year
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	The Trust was challenged with achieving histopathology sample reports within 10 days which would be monitored through the relevant performance Committee.	
	Committee were informed of a performance risk related to interventional cardiology patients waiting for cardiac catheters. There was significant challenge in this area, with an ambition to achieve a diagnostic test within six weeks at 95%. Currently achievement was at 35% with concerns with capacity in comparison to demand and an additional third catheter lab that was delayed until November. Performance within the three DMO1 domains highlighted challenge within endoscopy and gastroenterology.	Mitigations need to be put into place, as some patients were waiting up to 18 months which was resulting in inpatient admissions.
	Following a urology deep dive in response to the number of patients waiting over 62-days which had demonstrated effective governance to understand what was driving the issue.	Four key areas were highlighted; estate, staff and the availability of staff to treat patients, changes to the service and funding streams. The future plans for urology were sound and the forecast for this including getting the waiting list down, achieving 65wks by July and to manage the waiting list in a better way by reconfiguring their clinical staff and centralising services in Cheltenham.
Maternity Services	The year 5 Maternity Incentive Scheme (MIS) had received full compliance which was indicative that internal governance was starting to do what was needed for the organisation.	The Trust Chair commended the MIS achievement, gave suggestions for the presentation of information, and raised concern that antenatal screening remained a significant concern. – Maternity Delivery Group will continue to report monthly to QPC
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Patient Safety and Risk Assurance Report	Patient Safety Incident Response Framework (PSIRF)	Plan on track
Adult Inpatient Safer Staffing report	• The CNO presented an oversight of process used to review staffing levels and an outline of actions required by the Trust to ensure the right level of nursing care was provided to inpatient wards, assessment areas and the emergency department. • There were no risks or concerns detailed in reporting and there were no financial requirements	Next steps included the incorporation of the Safer Nursing Care tool (SNCT and Professional Judgement Framework into establishment settings and to incorporate 'Red Flags' as part of staff deployment.

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		The CNO agreed to revise wording in budget setting narrative to enable for clarity. The CNO agree to report the extent and impact of boarding in future papers as a narrative to give patient and workforce perspective. The CNO agree that future papers would triangulate data from the staff survey and patient feedback.
	Learning from Deaths Report – Q2	The Committee requested that more of the learning needed to be brought out in reporting for assurance for Q3.
OPERATIONAL PLAN 2024/25:	A detailed overview of the operational plan submission process was presented	Committee noted that the final submission would be presented at the Finance and Resources Committee
QUALITY ACCOUNT:	The CNO shared the quality account with the committee and requested feedback	

Items not Rated

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

GOVERNOR OBSERVATION – Maggie Powell and Helen Bowen- The Committee was commended for its interesting discussions and the highlighting of the 'so what' factor. The switch from the QPR to the IPR were significant and interesting, but background and explanation of the process would be welcomed by the Governors.

Investments

Case	Comments	Approval	Actions

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.

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NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period March 2024

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

URGENT & EMERGENCY CARE

The total level of attendances has increased by 7.8% in March (compared with February) and running at 12,986 (vs 12,041 in Feb-24). Despite the higher level of activity in the department, we saw a significant improvement in level of four-hour performance achieved in the month; this increased to 58.0% from 56.4% in the previous month. As a system we narrowly failed to achieve the national target of 76% for the month of March. A thorough breach validation process has been implemented and is capturing (and reversing) a proportion of inaccurately recorded breaches. To make this process more efficient, a process of real-time validation has been devised, the relevant changes to the EPR system have been completed, and further advice to the team will be circulated by the end of w/e 12 April. This will be followed up with additional training for team members through the remainder of the month such that real-time validation should be in place by the end of April 2024. In addition, and aligned to the forthcoming Perfect Week initiative, we intend to allocate additional operational staff to CGH with the specific view to expediting delivery of the four-hour target, recording actions and their impact, and providing feedback on significant obstacles. The aim, at the conclusion of this initial two-week period, will be to come up with a series of actions that can be maintained (for the ongoing support of services at CGH) but also can positively impact performance at GRH.

Despite this we've seen a small further deterioration in the average ambulance handover time in March. Whilst disappointing, this would seem to reflect the continued increase in the volume of attendances arriving at ED by ambulance. Immediate term actions to address this include the introduction of additional nursing staff into the Pit-Stop area, and looking at how we can maximise the space available to support triage and assessment within the department. There are also steps underway to develop delineated Red and Green pathways within Pit-Stop so that actions within this area can be flexed according to how busy the department is with a view to optimising throughput.

The number of SDEC attendances has increased by just under 4% in March (compared with February). The proportion of patients coming via ED has increased very slightly, to 31% in March. However, the proportion of patients admitted from SDEC has also increased, from 7% in February to 9% in March. The main concern regarding SDEC are the periodic pause of referrals from ED; this should be addressed once the AIM paper – which will enable the formalisation of medical staffing to support the SDEC service – is approved.

ELECTIVE CARE

The Trust did not achieve the target of zero patients waiting over 78 weeks at year-end. Although the final position is yet to be confirmed, the expected position is 5 breaches. This will include 2 Oral Surgery; 1 Cardiology; 1 Surgical Endoscopy & 1 Upper GI patient. Unfortunately the RTT performance dipped slightly in March (potentially due to reduced activity with early Easter holidays) with the anticipated month-end position being just over 65%. The number of patients waiting over 52 weeks for March is anticipated to remain similar to Februarys position with an approximate 2,850. Encouragingly the number of patients waiting 65 weeks or more reduced significantly in March moving from 689 in February to around 450, of which approximately 80% of those relate to Oral Surgery and ENT.

DIAGNOSTICS

The submitted DM01 breach performance for March has again improved in month, with the number of breaches having reduced by over 200. This has resulted in a month-end position of 16.79%. In March there were 2,165 breaches and 12,898 patients waiting, compared to 2,377 breaches and 12,943 patients waiting in February. The modalities demonstrating a deterioration in month are Flexi Sig, Echo's and Neurophysiology, with the latter having the highest number of breaches at 462.

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
All electives (including day cases)	6,561	5,087	6,174	6,185	5,901	6,302	5,843	6,258	6,477	5,600	6,713	6,591	6,871
Day cases	5,658	4,348	5,277	5,274	5,012	5,440	5,008	5,150	5,507	4,732	5,772	5,644	5,865
ED attendances	12,511	11,616	12,993	13,176	12,764	12,300	12,813	13,111	12,422	12,142	12,278	11,996	13,006
FUP outpatient attendances	38,513	30,822	34,946	36,691	34,746	35,288	34,718	37,346	38,422	31,671	39,630	37,342	35,365
GP referrals	11,941	9,362	10,650	11,184	10,478	10,746	10,486	11,237	10,648	8,837	11,115	10,684	10,153
New outpatient attendances	18,872	14,918	17,280	18,322	17,679	17,529	17,842	19,587	20,193	15,223	19,241	18,739	17,933
Non elective (Incl. Assessment)	5,728	5,318	5,610	5,708	5,467	5,299	5,656	6,100	6,035	5,659	5,923	5,664	5,641
Outpatient attendances	57,385	45,740	52,226	55,013	52,425	52,817	52,560	56,933	58,615	46,894	58,871	56,081	53,298

Guidance

Gloucestershire Hospitals NHS Foundation Trust

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**

Source: NHSI Making Data Count

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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%	Mar-24	21.9%	
	Cancer - 28 day FDS (all routes)	≥ 75.0%	Mar-24	74.4%	
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%	Mar-24	92.8%	
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%	Mar-24	100.0%	
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%	Mar-24	85.6%	
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%	Mar-24	71.3%	
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%	Mar-24	75.3%	
	Number of patients waiting over 104 days with a TCI date	No Target	Mar-24	23	
	Number of patients waiting over 104 days without a TCI date	No Target	Mar-24	67	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%	Mar-24	16.79%	
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600	Mar-24	347	
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%	Mar-24	94.5%	
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%	Mar-24	19.37%	
	% of ambulance handovers < 15 minutes	No Target	Mar-24	15.37%	
	% of ambulance handovers < 30 minutes	No Target	Mar-24	39.89%	
	% of ambulance handovers over 60 minutes	≤ 1.00%	Mar-24	42.75%	
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%	Mar-24	50.6%	
	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%	Mar-24	37.7%	
	ED: % total time in department - under 4 hours (type 1)	≥ 78.00%	Mar-24	57.83%	
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0	Mar-24	826	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Emergency Department	Number of ambulance handovers 30-60 minutes	↓ Lower	Mar-24	576	
	Number of ambulance handovers over 60 minutes	= 0	Mar-24	1,271	
Maternity	% of women booked by 12 weeks gestation	> 90.0%	Mar-24	94.9%	
Operational Efficiency	% day cases of all electives	> 80.00%	Mar-24	85.36%	
	Average length of stay (spell)	≤ 5.06	Mar-24	5.67	
	Average patients with discharge ready date	≤ 100	Mar-24	117	
	Cancelled operations re-admitted within 28 days	No Target	Mar-24	88.31%	
	Intra-session theatre utilisation rate	> 85.00%	Mar-24	92.99%	
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40	Mar-24	2.28	
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65	Mar-24	6.51	
	Number of patients stable for discharge	≤ 70	Mar-24	147	
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380	Mar-24	468	
	Urgent cancelled operations	↓ Lower	Mar-24	0	
Outpatient	Did not attend (DNA) rates	≤ 7.60%	Mar-24	6.08%	
	Outpatient new to follow up ratio's	≤ 1.90	Mar-24	1.91	
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%	Feb-24	8.41%	
Research	Research accruals	No Target	Feb-23	141	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower	Mar-24	204	
	Referral to treatment ongoing pathways 35+ Weeks (number)	No Target	Mar-24	10,332	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target	Mar-24	5,144	

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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 pathways over 52 weeks (number)	= 0		Mar-24	2,889	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%		Mar-24	66.06%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	≥ 90.00%		Mar-24	68.20%	
	% patients receiving a swallow screen within 4 hours of arrival	No Target		Mar-24	80.00%	
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target		Mar-24	71.1%	
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%		Feb-24	92.0%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	≥ 65.00%		Feb-24	0.00%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%		Feb-24	100.0%	

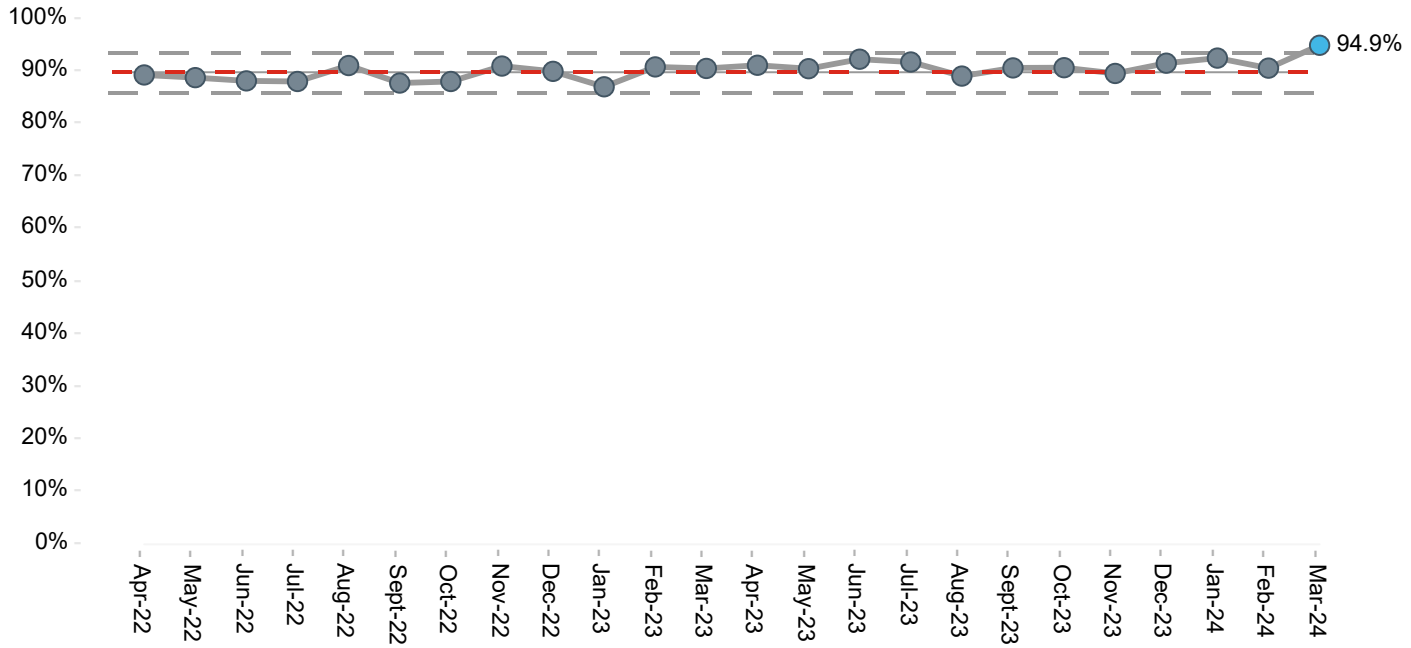
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[138] % of women booked by 12 weeks gestation

Target: > 90.0%



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.

Commentary

This is a positive variance based on a target of (what appears to be) 90%

Divisional Director of Quality and Nursing and Chief Midwife

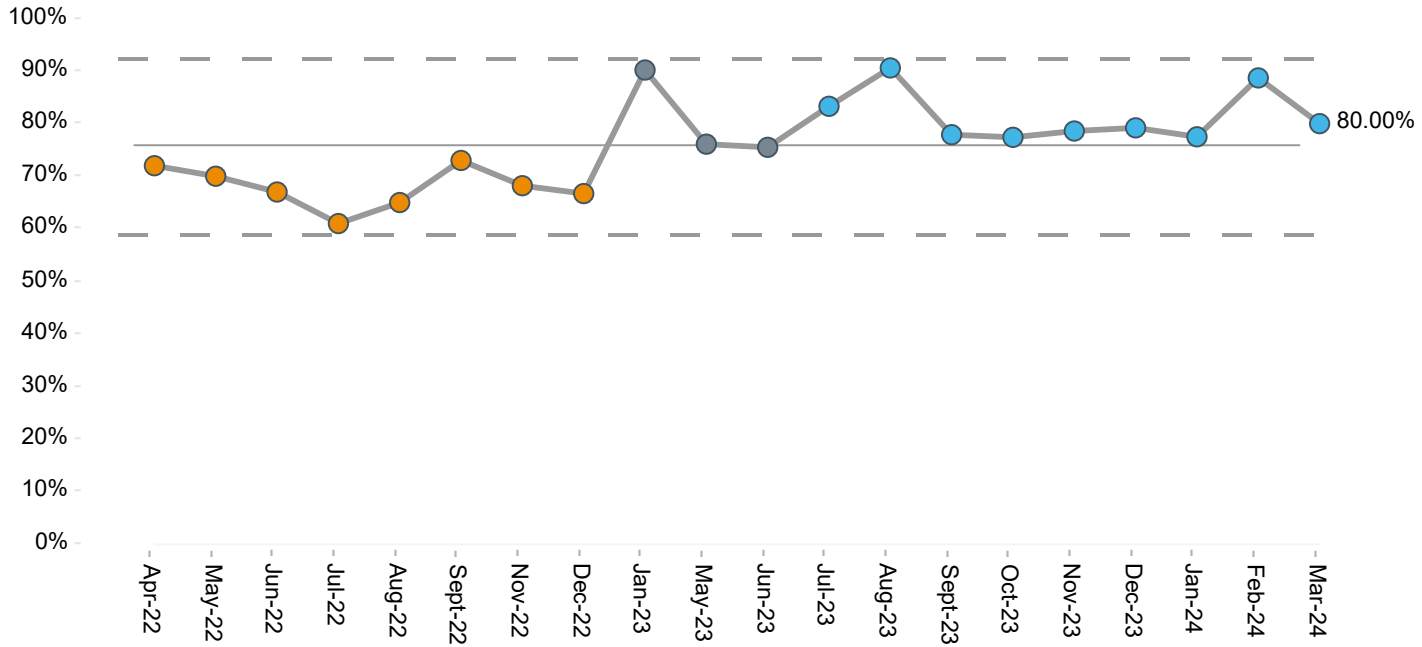
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - 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

General Manager - COTE, Neuro and Stroke

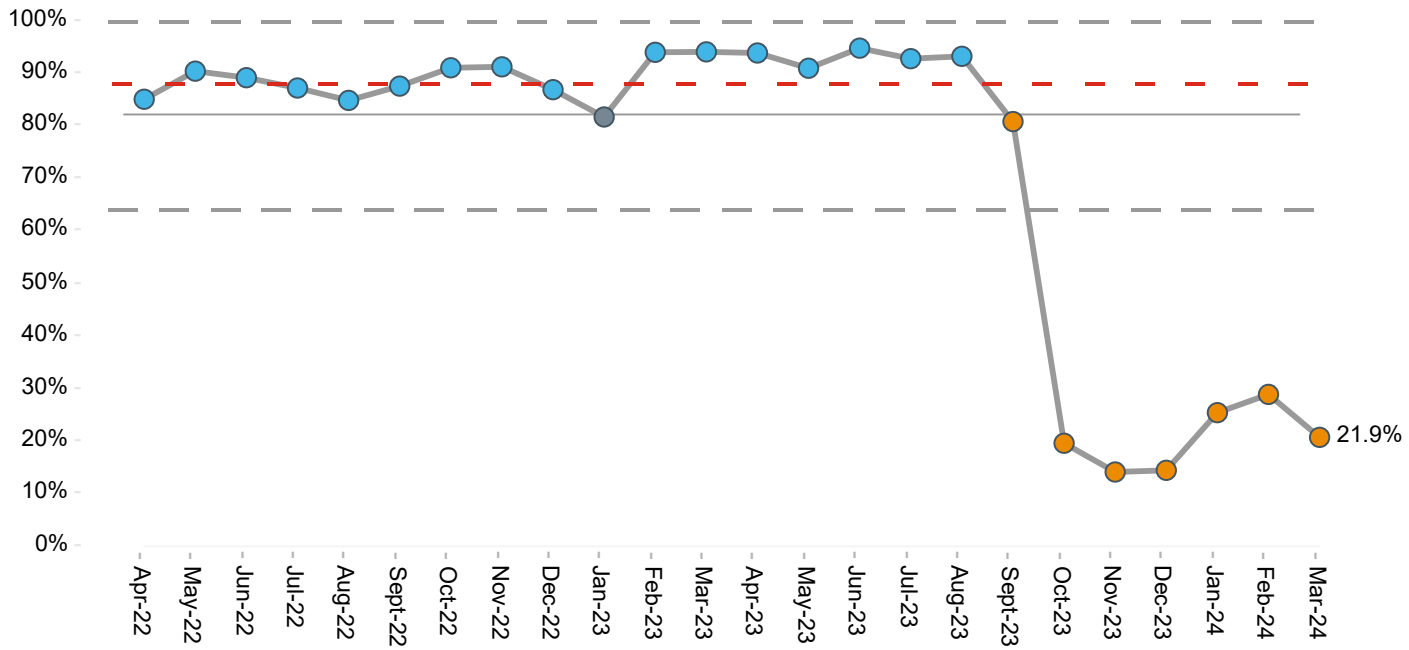
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[170] Cancer - 2 week wait breast symptomatic referrals

- - - Target: ≥ 93.0%



Data Observations

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[2] SHIFT

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Commentary

Please find Cancer 2-week wait exception report attached
Divisional Director of Operations

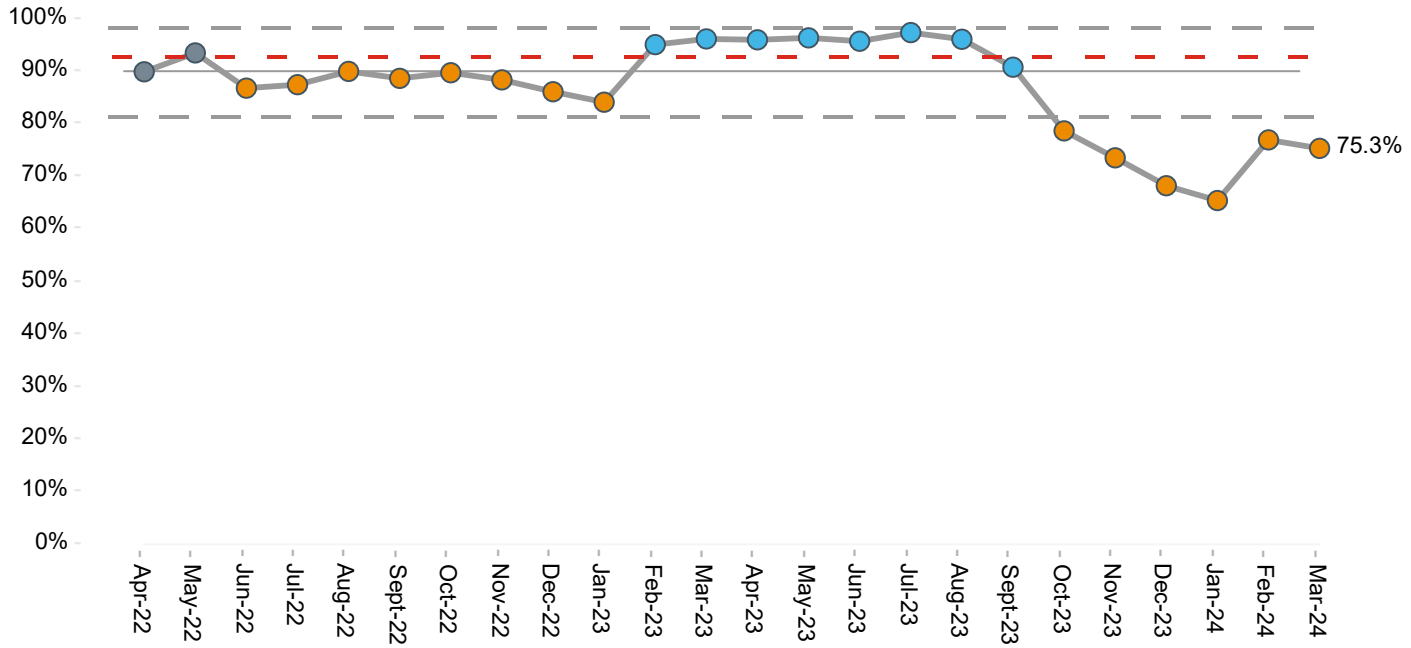
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 93.0%



Data Observations

[1] SINGLE POINT

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[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.

[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

March continues to see a decline in 2WW Performance, achieving 75.3%. This has been due to staffing issues and capacity within the Breast service who are currently at 10%. LGI and Endoscopy STT capacity is also impacting ability to see Colorectal patients within 2 weeks and are currently at 59.6%

Divisional Director of Operations

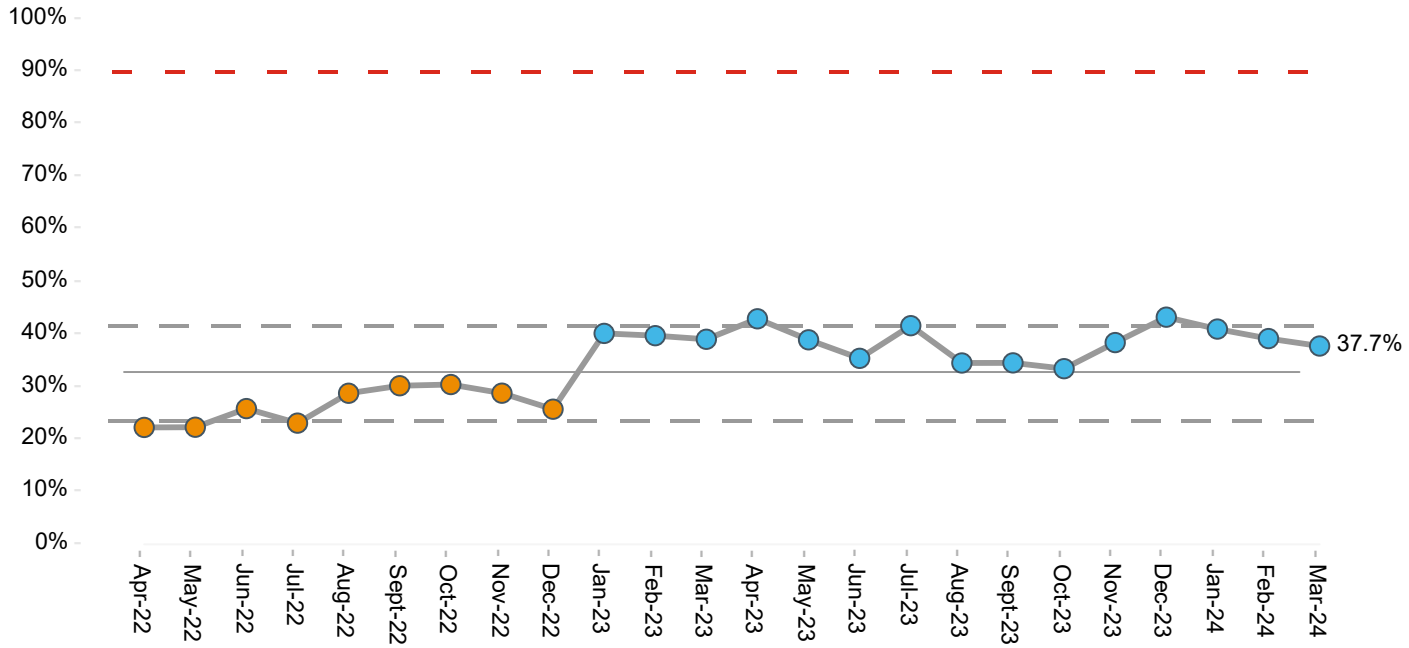
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 90.0%



Commentary

The periods of the day when time to start of treatment increases most significantly, are during the evenings and night-times. Whilst staffing rotas have historically been aligned to the volume of patient arrivals in the department, this hasn't taken full account of the congestion in the department. As part of the recent paper submitted to address staffing levels in ED, it's proposed to change the staffing profile somewhat, and to put more doctors (and particularly more senior decision-makers on shift during these times, in an effort to reduce the time patients wait to be seen by a clinician.

Data Observations

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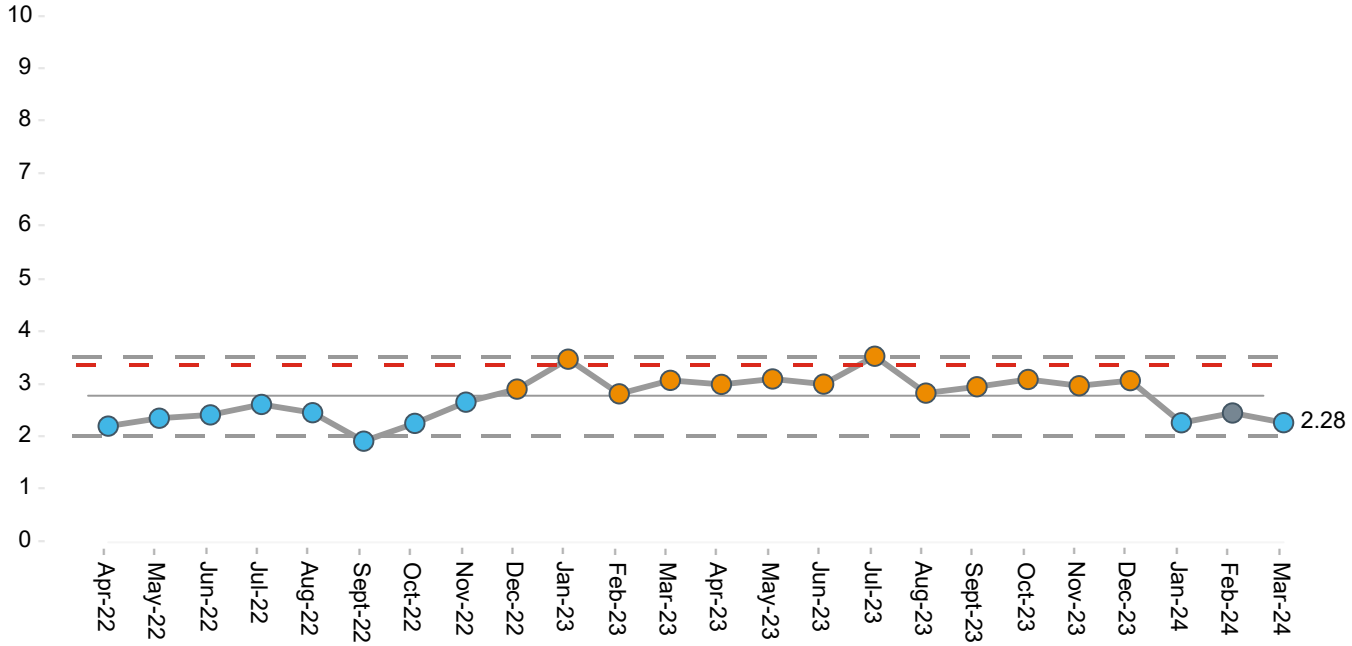
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≤ 3.40



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

March saw a recovery and return to Jan 24 figures for elective LOS, linked with ongoing work to drive 0 day procedures and post operative improvements. Performance overall remains well below the set target, being currently 1.12days better.

Deputy Chief Operating Officer

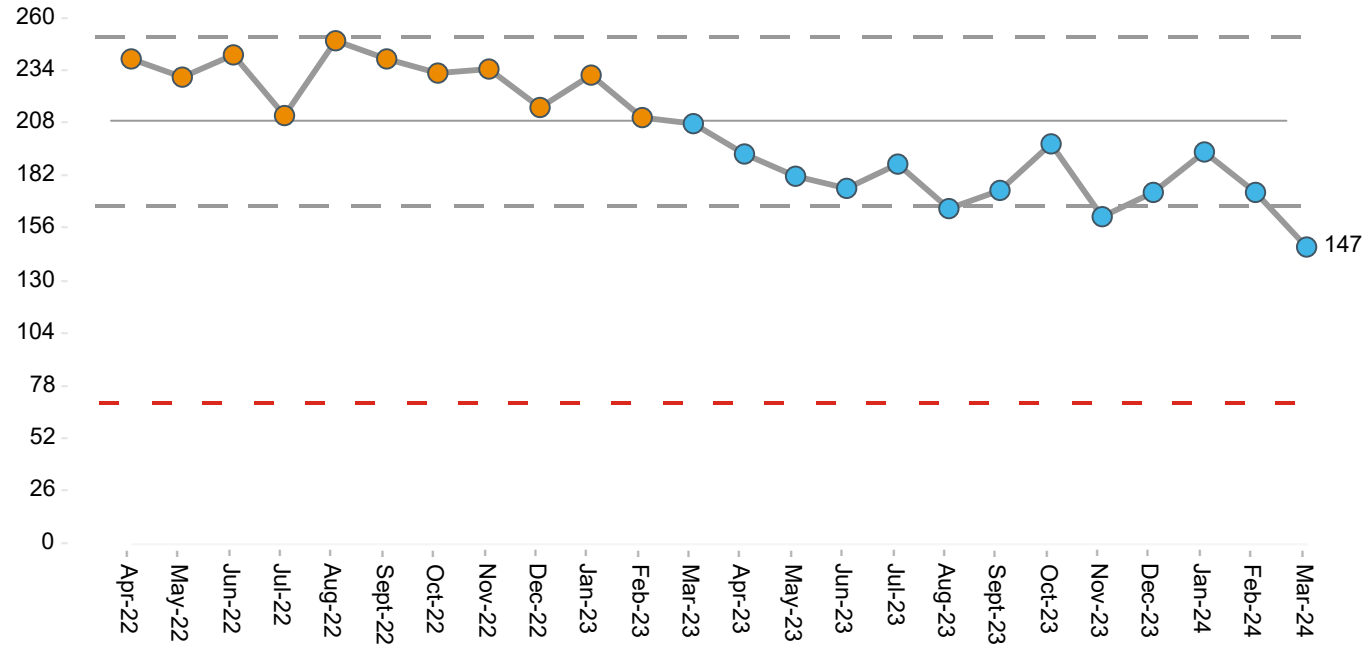
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[186] Number of patients stable for discharge

- - - Target: ≤ 70



Data Observations

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[4] 2 OF 3

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Commentary

The number of nCTR patients continues to show a downward trend in line with the multiple workstreams supporting a reduction in LOS and nCTR numbers. We remain some way off the 70 target set previously, which has again been agreed as the appropriate target within the planning submission for 24/25. As part of the resolution to this gap and to support the ongoing downward trend, the integrated flow hub has been extended for a further 4 months based on the success seen within the pilot. This will enable the solidifying and progression of work that is ongoing to reduce both process and capacity delays within pathways 1-3.

Head of Therapy & OCT

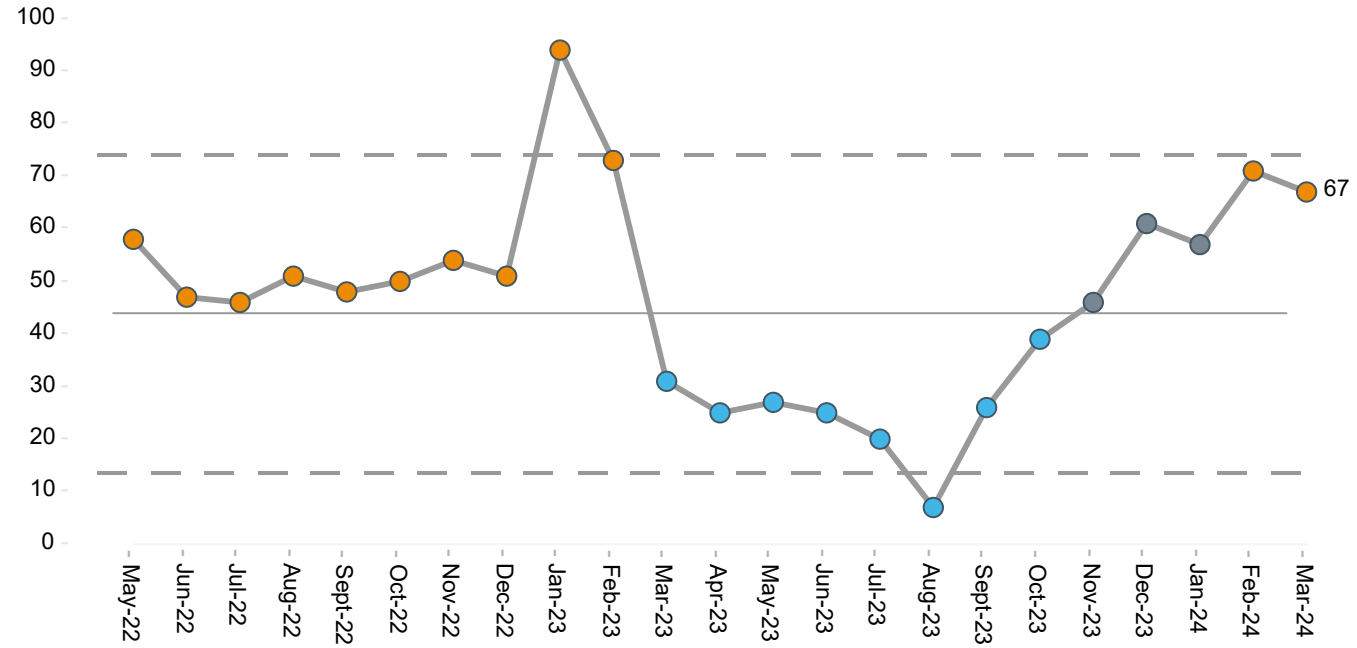
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[608] Number of patients waiting over 104 days without a TCI date

- - - Target: No Target



Commentary

Data to be reviewed and validated
General Manager - Cancer

Data Observations

[1] SINGLE POINT

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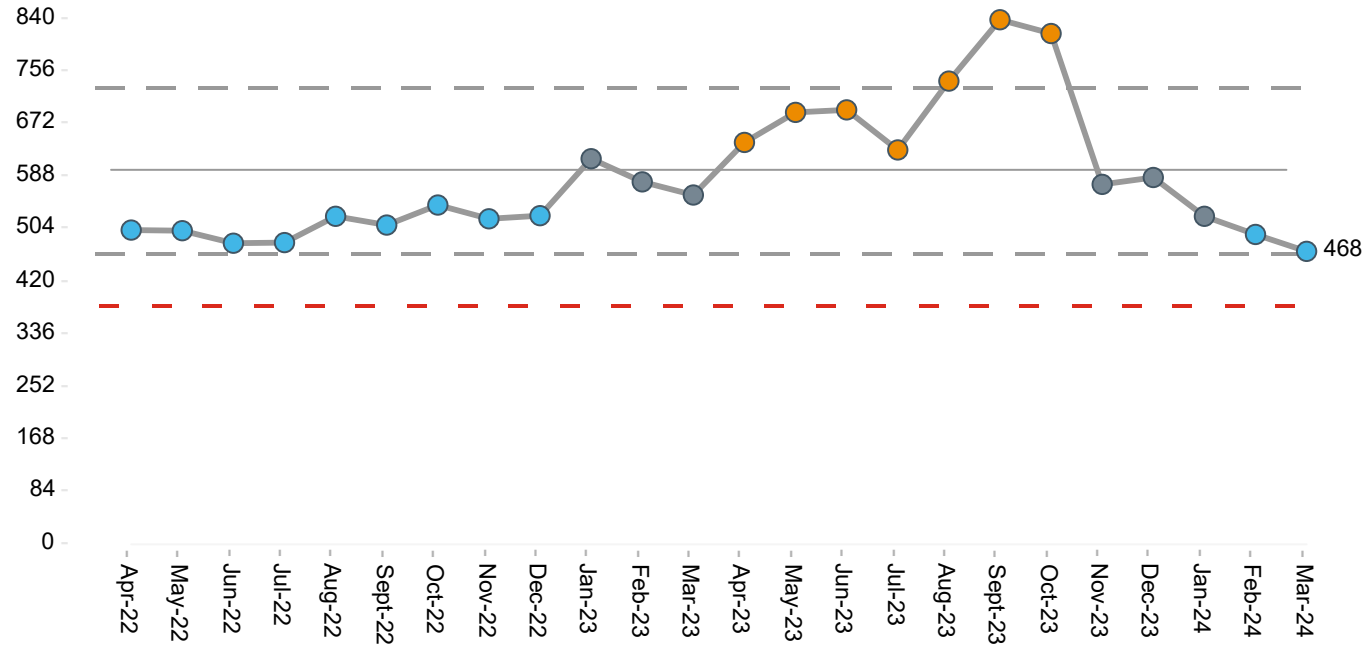
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≤ 380



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

March saw further month on month significant improvements in this metric, but remains some way above the target figure set some time ago. Lined strongly to the nCTR numbers, ongoing work is focused on both the processes, capacity and escalation approach to patients with a LOS of 7, 14 and 21+ days LOS. As a key outcome measure of the WasO programme and the integrated flow hub, further work to strengthen the internal reviews of 21+ day patients deemed CTR has been identified to help further reduce the number of patients stranded within the hospital.

Deputy Chief Operating Officer

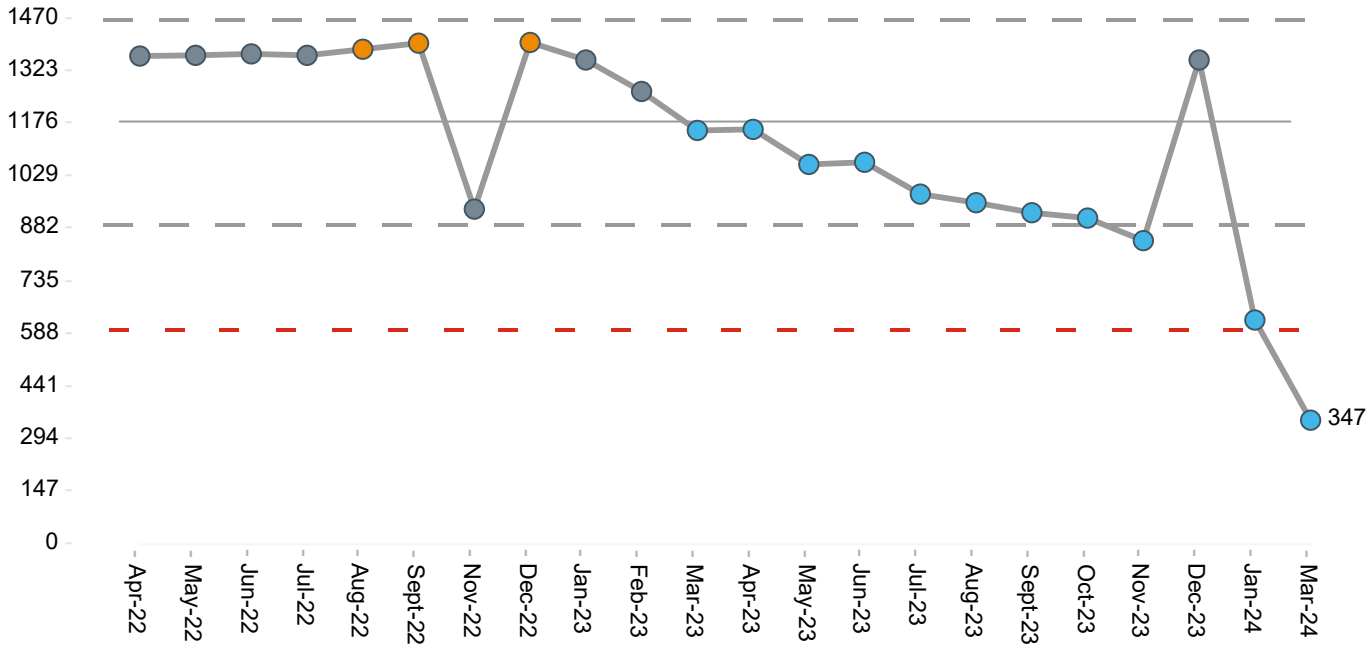
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≤ 600



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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

Utilising the NHSE £480k Recovery Monies for empty list back fill and weekend working, the service has managed to reduce the number of surveillance patients significantly along with improving the DM01 Performance. of the 1021patients on the 2023 Surveillance Waiting list, there are 85 remaining. DM01 performance went from 61% in January to 46.7% in February (the target is 1%). This position is only due to the extra activity we have been putting on using these monies. They are expected to run out end of May. ERF submissions have been submitted to enable continued improvement, however, if these are not successful, the position will start to deteriorate again as there is insufficient workforce to meet the status quo.

General Manager of Endoscopy

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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	Mar-24	76.8%	
	Inpatients % positive	No Target	Mar-24	93.5%	
	Maternity % positive	No Target	Mar-24	81.4%	
	Outpatients % positive	No Target	Mar-24	94.3%	
	Total % positive	No Target	Mar-24	92.2%	
Health Inequalities	Smoking Status Compliance	No Target	Mar-24	87%	
Infection Control	C. difficile - infection rate per 100,000 bed days	↓ Lower	Mar-24	40.8	
	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target	Mar-24	25	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target	Mar-24	195	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target	Mar-24	44	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target	Mar-24	133	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower	Mar-24	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7	Mar-24	9.1	
	Number of E. coli bacteraemia cases	No Target	Mar-24	4	
	Number of Klebsiella bacteraemia cases	No Target	Mar-24	1	
	Number of MSSA bacteraemia cases	≤ 8	Mar-24	5	
	Number of Pseudomonas bacteraemia cases	No Target	Mar-24	0	
	Number of bed days lost due to infection outbreaks	↓ Lower	Mar-24	292	
	Number of community-onset healthcare-associated C. difficile cases per month	≤ 5	Mar-24	3	
	Number of hospital-onset healthcare-associated C. difficile cases per month	≤ 5	Mar-24	5	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Infection Control	Number of trust apportioned C. difficile cases per month	< 10	Mar-24	8	
	Number of trust apportioned MRSA bacteraemia	= 0	Mar-24	0	
Maternity	% PPH >1.5 litres	< 2.00%	Mar-24	5.45%	
	% breastfeeding (discharge to CMW)	= 0.0%	Mar-24	0.4%	
	% breastfeeding (initiation)	≥ 81.00%	Mar-24	74.63%	
	% of women smoking at delivery	< 7.00%	Mar-24	6.93%	
	% of women that have an induced labour	≤ 33.00%	Mar-24	25.79%	
	% stillbirths as percentage of all pregnancies	< 0.200%	Mar-24	0.412%	
	Number of births less than 27 weeks	No Target	Mar-24	5	
	Number of births less than 34 weeks	No Target	Mar-24	15	
	Number of births less than 37 weeks	No Target	Mar-24	49	
	Number of maternal deaths	No Target	Mar-24	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target	Mar-24	2.1%	
	Total births	No Target	Mar-24	487	
Mortality	Number of deaths of patients with a learning disability	No Target	Mar-24	2	
	Number of inpatient deaths	No Target	Mar-24	162	
	Summary hospital mortality indicator (SHMI) - national data	No Target	Nov-23	1.135	
MSA	Number of breaches of mixed sex accommodation	≤ 10	Mar-24	9	
Operational Efficiency	Daily Average of Boarded Patients	No Target	Mar-24	8	
Patient Advice and ..	% of PALS concerns closed in 5 days	No Target	Mar-24	75%	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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	Mar-24	257	
Patient Safety Incidents	Medication error resulting in moderate harm	↓ Lower	Mar-24	2	
	Medication error resulting in severe harm	↓ Lower	Mar-24	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Mar-24	36	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Mar-24	1	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Mar-24	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Mar-24	13	
	Number of falls per 1,000 bed days	↓ Lower	Mar-24	6.90	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Mar-24	3	
	Number of patient safety incidents - severe harm (major/death)	No Target	Mar-24	13	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Mar-24	5	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target	Oct-23	58.08%	
	Number of DoLs applied for	No Target	Mar-24	128	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Mar-24	89	
	Total admissions aged 0-17 with DSH	↓ Lower	Mar-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	Mar-24	61	
Serious Incidents	Number of never events reported	= 0	Mar-24	0	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Mar-24	69.9%	

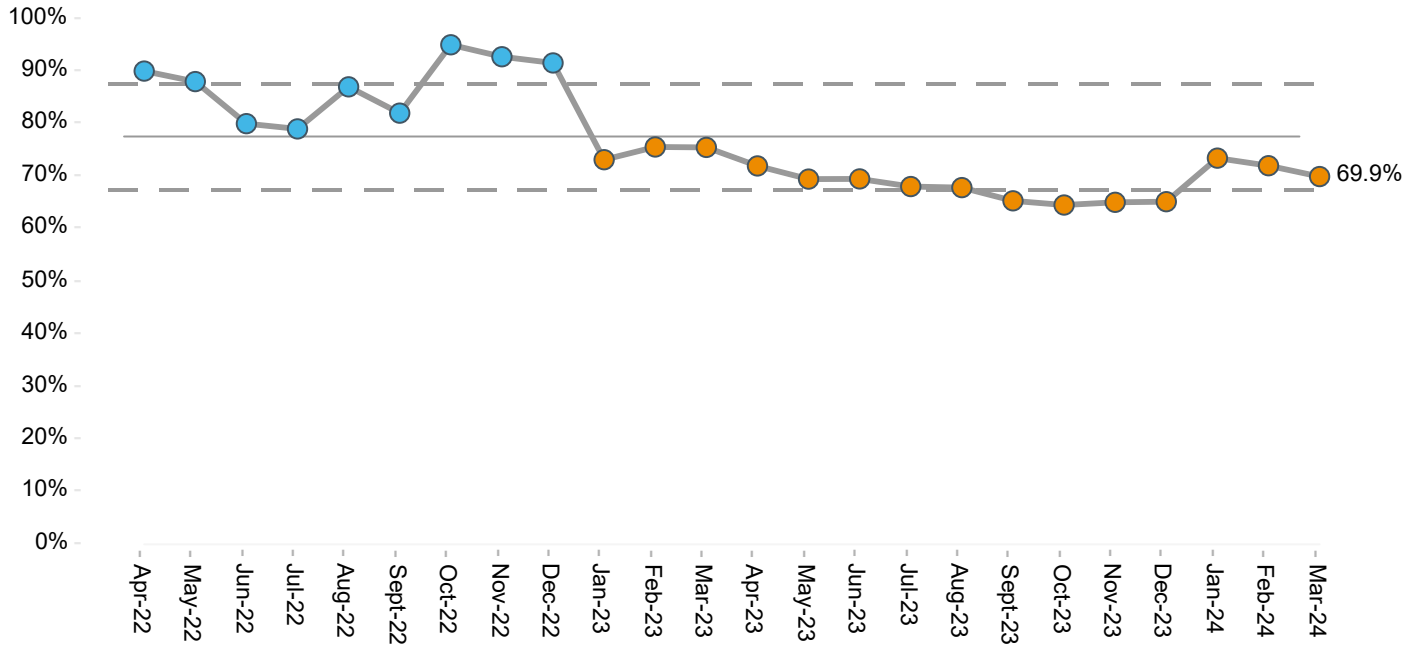
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



Commentary

Data check in progress; if issue is not related to data then changes will be considered to EPR to make completion mandatory.
Quality Improvement & Safety Director

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.

[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.

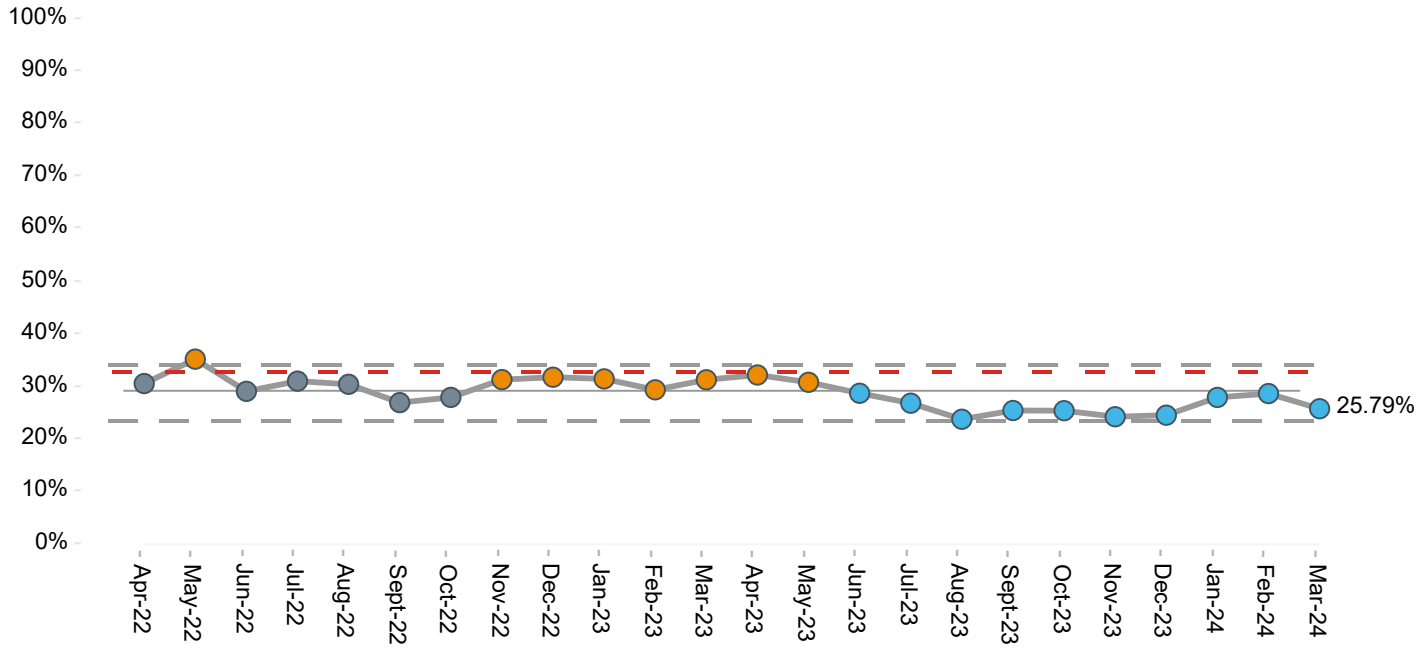
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[479] % of women that have an induced labour

Target: ≤ 33.00%



Commentary

QI project monitoring IOL delays ongoing
Divisional Director of Quality and Nursing and Chief Midwife

Data Observations

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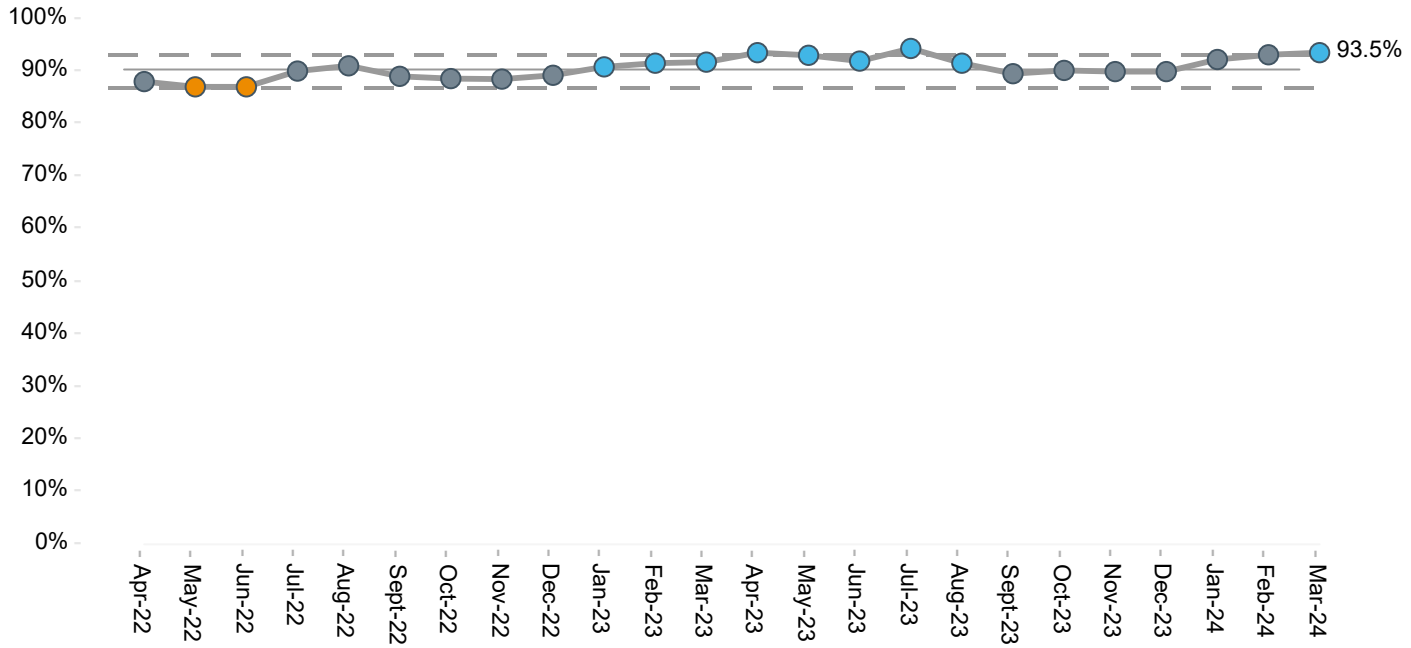
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[153] Inpatients % positive

- - - Target: No Target



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Commentary

The current positive FFT score for Inpatient and Daycase is at 93.5%, which is an increase from 92.1% in February. The score is just above the newly adjusted upper control limit (93.4%).
The scores for inpatient areas (88.9%) and acute care assessment areas (87.1%) are less positive than for daycase (97.7%) but all areas have seen increases in scores. Inpatient and acute care assessment areas are more directly affected by the challenges in flow which has continued to be challenging. Patients report that staff are overall kind and caring with acknowledgement that there are significant pressures due to staffing and resources. Poor experiences of discharge continue to be reported. Updates and monitoring will be reported through Quality Delivery Group via divisional reports and the monthly Patient Experience Report.
Head of Quality

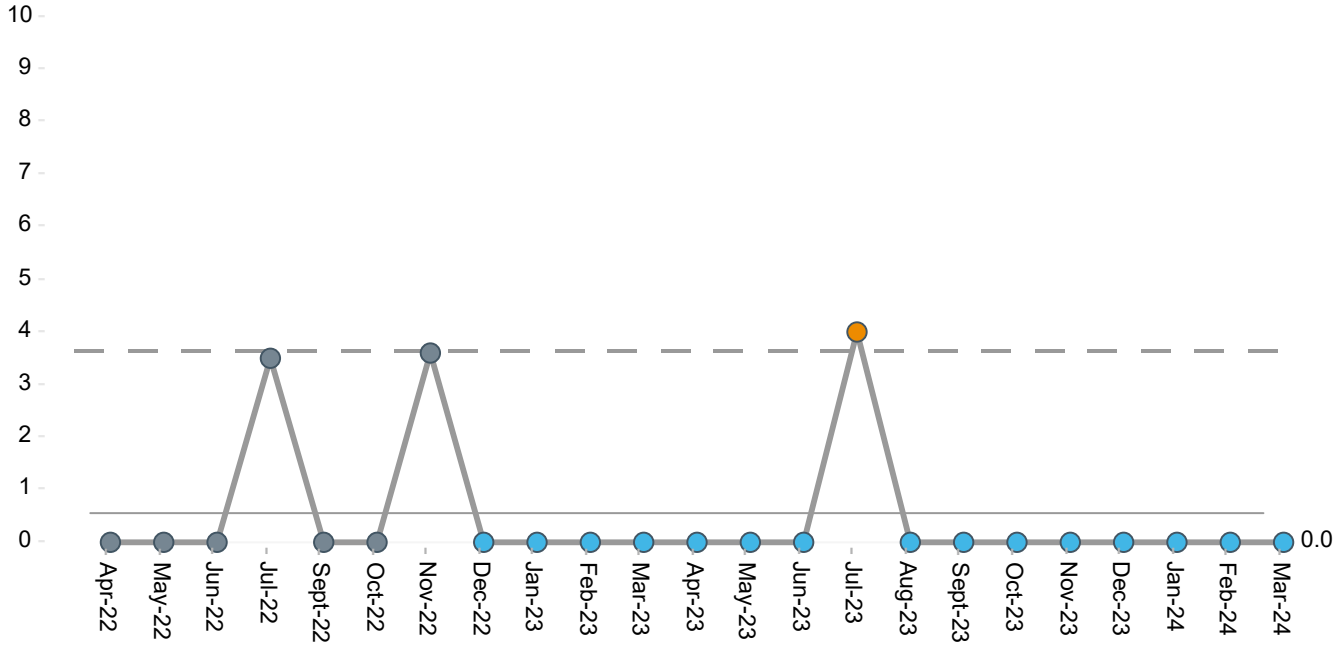
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[445] MRSA bacteraemia - infection rate per 100,000 bed days

- - - Target: ↓ Lower



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Commentary

There were no trust apportioned MRSA bacteraemias reported during March 2024. There has been one trust apportioned MRSA bacteraemia this financial year. The Infection Prevention and Control Team (IPCT) have included a programme of activities within the annual plan to support the reduction of blood stream infections, specifically for high-risk patient groups and those associated with invasive devices. The IPCTs across the system are currently reviewing all cases of MRSA and MSSA bacteraemias from this financial year, with a particular focus on exploring sources of these infection and risk factors, which will be used to develop a targeted quality improvement programme to reduce bacteramias across the system. This work is being fed into the regional SW IPC network improvement collaborative.

Director of Infection Prevention & Control

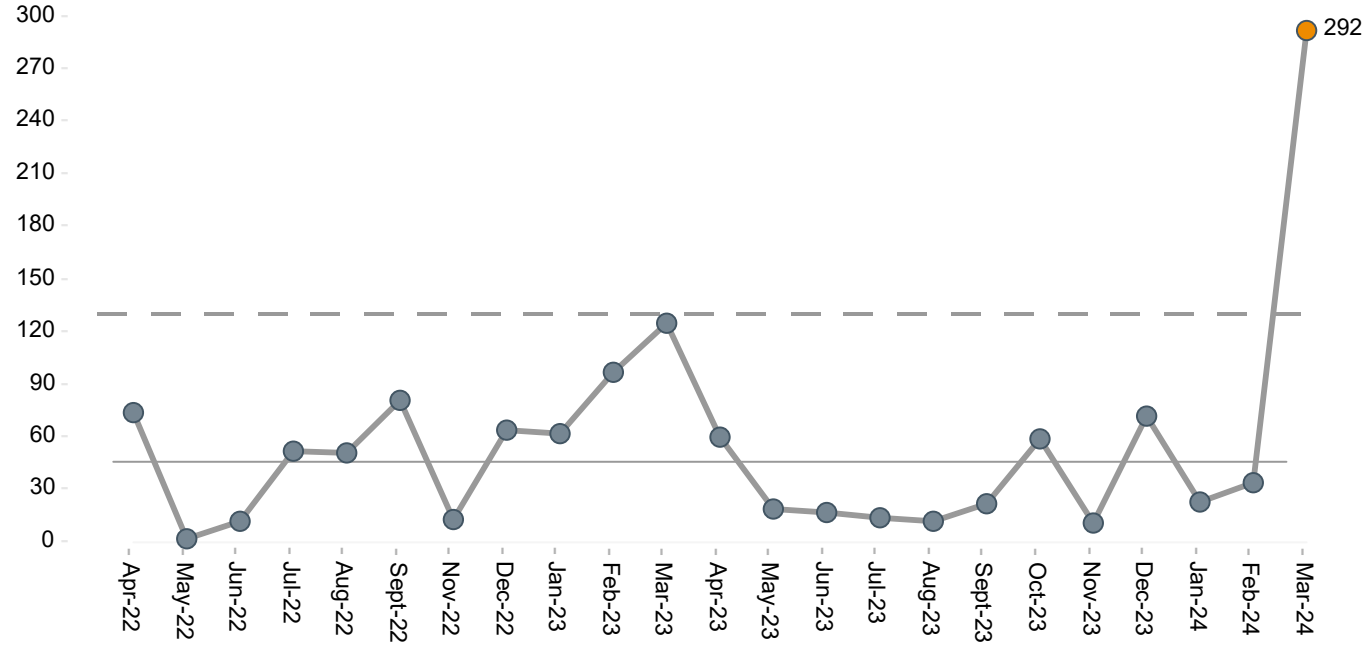
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Data Observations

[1] SINGLE POINT

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Commentary

During March 2024, 292 bed days were lost due to outbreaks associated with transmission of COVID-19 and Norovirus. The trust in response to several outbreaks of Norovirus went into BCI and met daily with stakeholders to support outbreak management via the IMT. The IPCT reviewed all outbreak affected areas and supported use of empty beds where possible for patients who were deemed safe to use them. 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 Norovirus was sent out/ displayed across the trust (posters & screensavers and public facing comms was sent out (intranet page, switchboard messages and social media). The IPCT supported with a 7 day service.

Director of Infection Prevention & Control

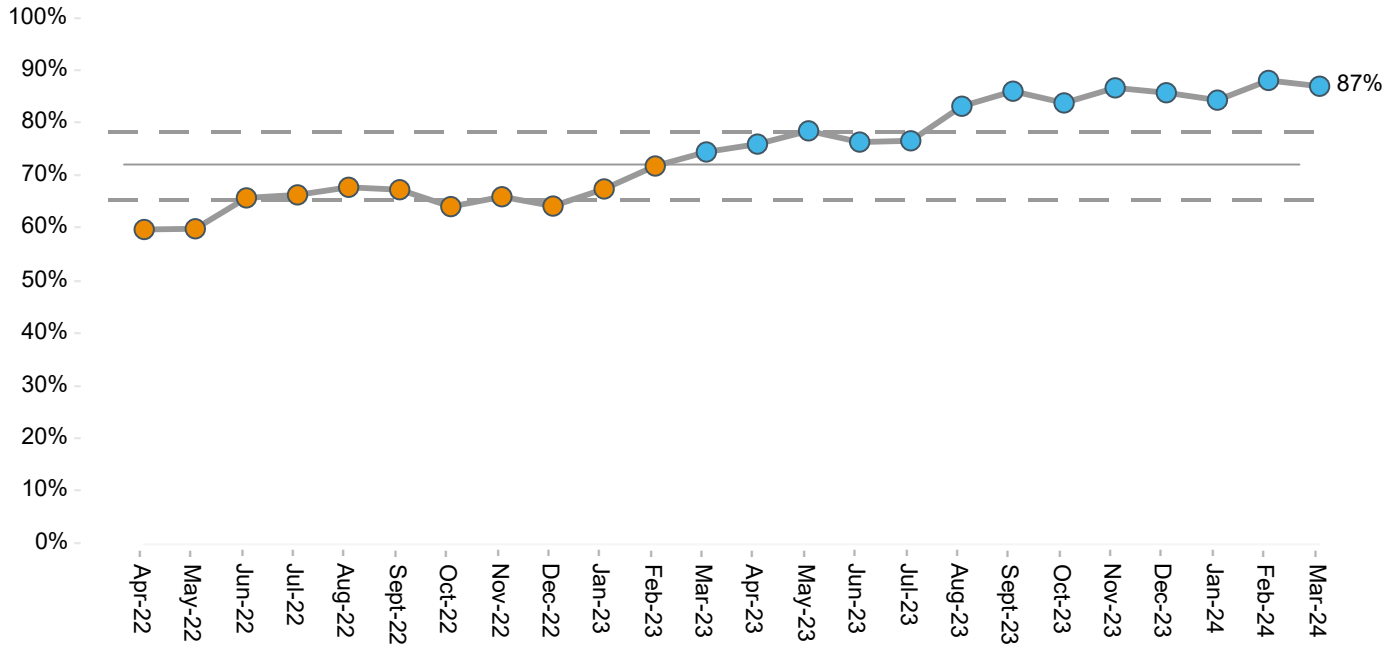
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[610] Smoking Status Compliance

- - - Target: No Target



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Commentary

Recording smoking status compliance is at 87% in March. Further interventions have been agreed with wards.
Head of Inequalities, Health Improvement

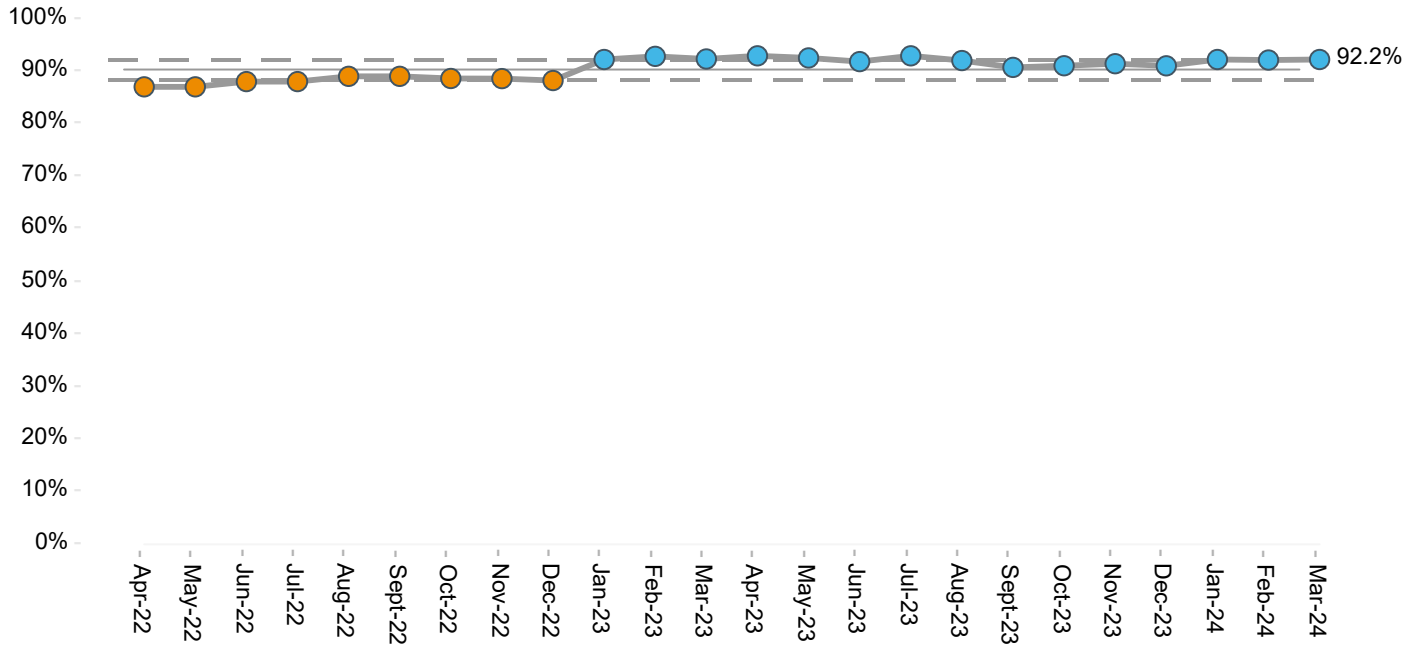
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[156] Total % positive

- - - Target: No Target



Commentary

The overall Trust FFT positive score has remained fairly static this month at 92.2% compared to 92.1% in February 2024.

Our overall
score sees us remain above just above the newly revised upper control (92.2%). The stable score is as a result of increases in scores across within Inpatient and Emergency Department care types. The slight decrease in the score for Maternity services and Outpatients remaining static has countered the slight increases in the other areas.
Head of Quality

Data Observations

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Gloucestershire Hospitals
NHS Foundation Trust

Integrated Performance Report (IPR)

Operational Performance Only (March 2024)

Guidance: SPC Charts

Gloucestershire Hospitals
NHS Foundation Trust

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:

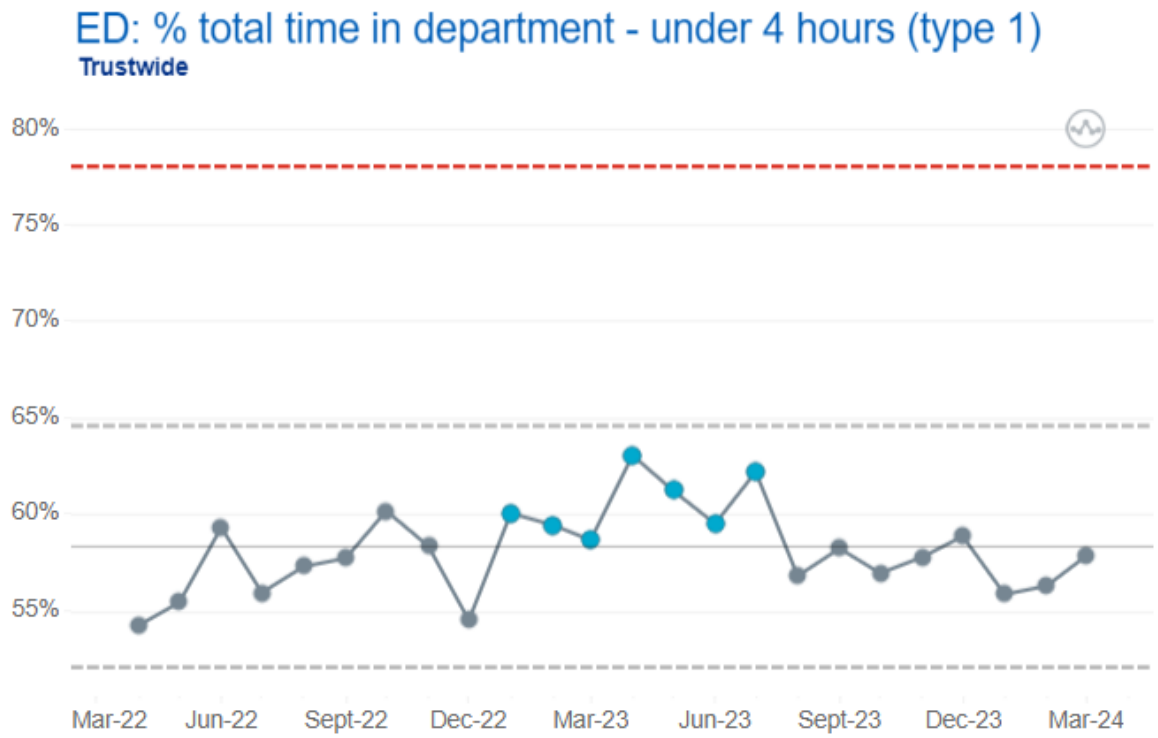
- Assurance results show whether a target is likely to be achieved, and is based on trends in achieving the target over time
- **Blue icons** indicate that you would expect to **consistently achieve a target**
- **Orange icons** indicate that you would expect to **consistently miss a target**
- **Grey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

- The **red lines** on the charts show the **target** for that performance metric.
- The **black lines** on the charts show the **mean** for that performance metric.

UEC: Seen within 4hrs (%)

Standard: *a minimum of 78% of patients seen within 4 hours in March 2025*

Gloucestershire Hospitals NHS Foundation Trust



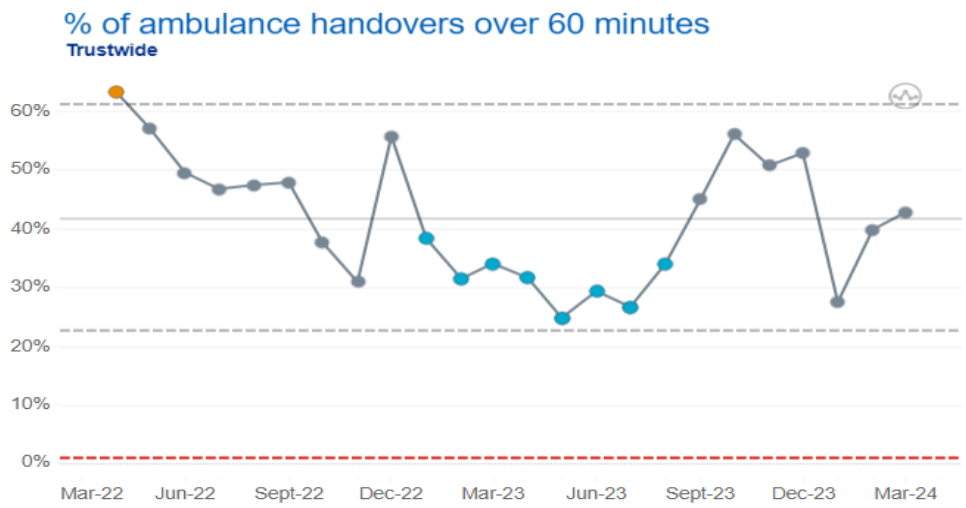
Commentary:
Four-hour performance across the Trust improved by 2% to 58% compared to February's position. The UEC team have also completed validation of all 4 hours breaches on a daily basis and are implementing live validation in April.

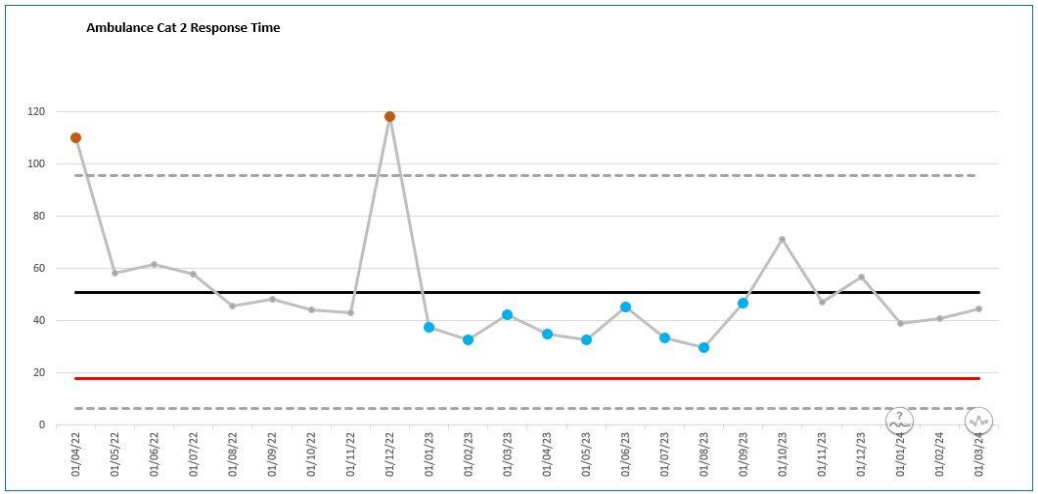
Planned Actions:
Real-time validation of four-hour breaches built into day-to-day working of ED Team from mid-April. During 12 days of spring initiative there will be additional focus on this issue at CGH with a view to capturing Trust-wide learning.

Expected recovery:
The current performance of 57.8% in April (up to 14/4) is in line with the trajectory to deliver 58% in April.

UEC: Average Handover Time (over 60 mins)

Standard: *Improve Cat 2 ambulance response times to an avg of 30 mins across 24/25*





Commentary:
Handover delays deteriorated very marginally in March, from 66 mins to 79 mins. Dialogue with SWAST in place to address anomalies with XCAD system underway

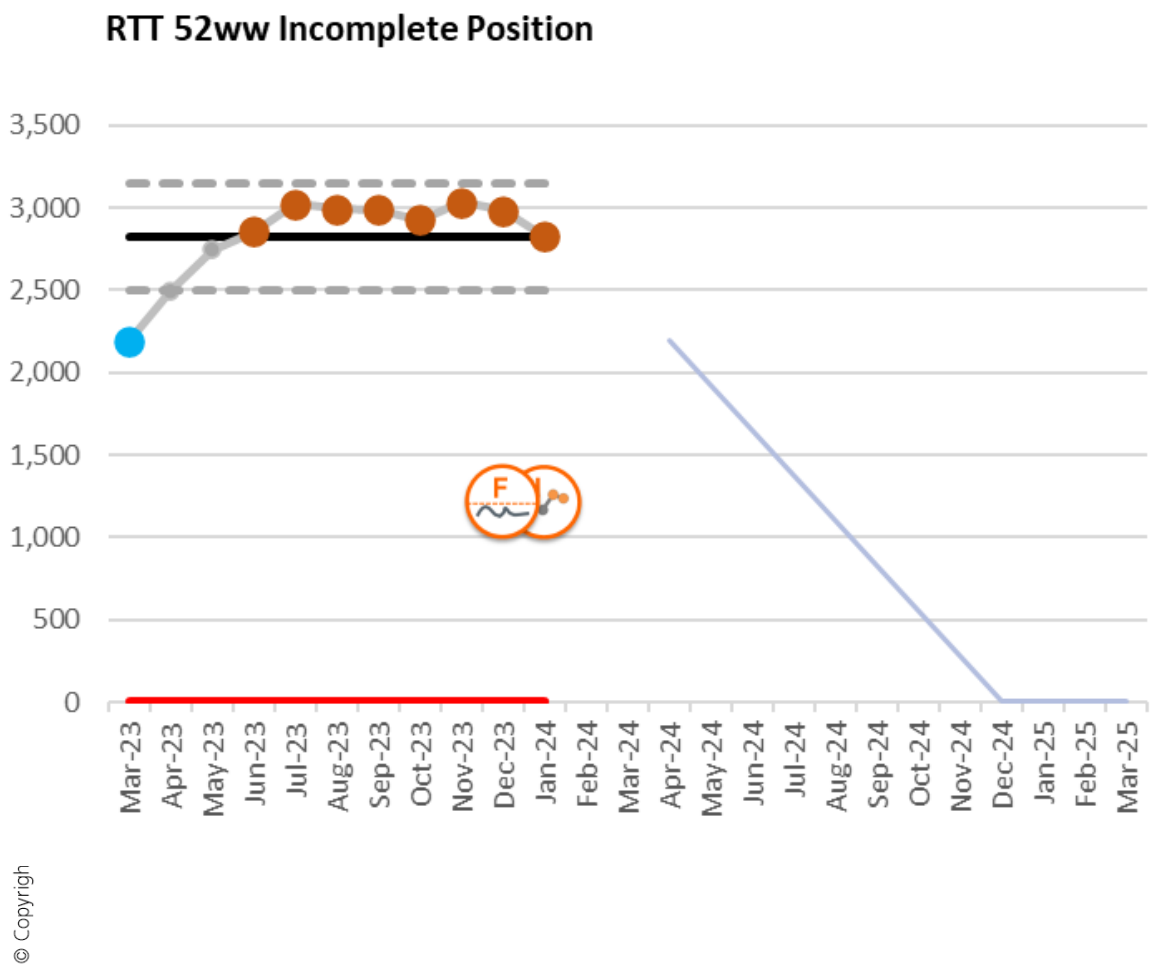
Planned Actions:
As part of the 12 days of spring initiative, 6A audit of ambulance hand-overs will take place. In addition, the Red-to-Green model in Pit-Stop will be introduced.

Expected recovery:
During the first half of April, ambulance handover performance has remained at roughly the same level as in March; with the implementation of actions above through the 12 days of spring, we expect to move the dial positively.

Elective: 52 week waits

Standard (Local): *Eliminate all over 52ww by September 2024*

Gloucestershire Hospitals
NHS Foundation Trust



Commentary:
The March position is unvalidated at this stage until submission later this month. The number of over 52 ww is expected to be at around 2,890 breaches.

The main specialties contributing to this position are oral surgery, ENT and T&O.

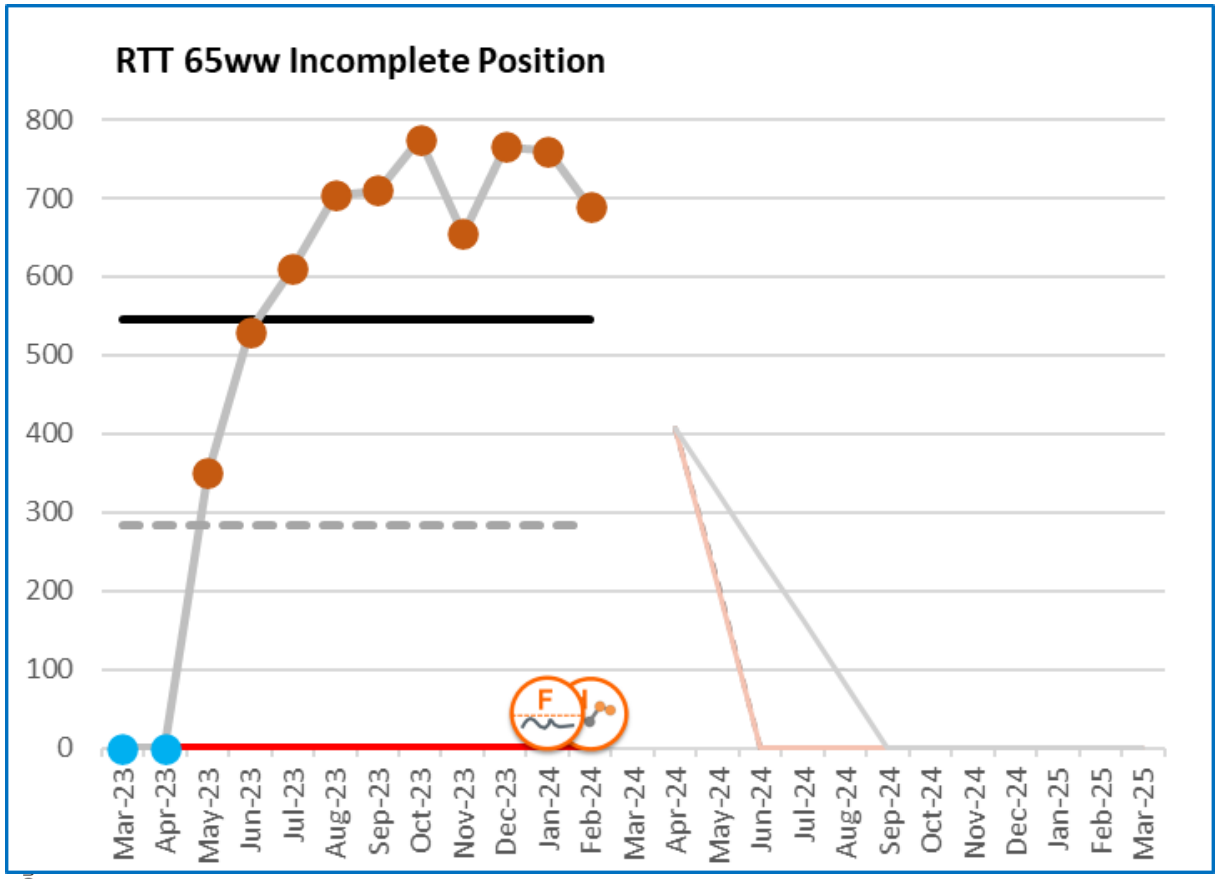
Planned Actions:
Delivery of the 2024/25 operational plan aims to ensure the 52 ww is met by December 2024. However, this will be reliant on sufficient resources and supported with ERF funding.

Expected recovery:
The trajectory submitted as part of the 24/25 operational plan showed the volume of over 52 ww reduce to 2,517 in April and the local target shows all 52ww being eliminated by September 2024.

Elective: 65 week waiters

Standard: *Eliminate waits of over 65ww by Sept 2024 (national target), local stretch to eliminate over 65ww by June 24*

Gloucestershire Hospitals NHS Foundation Trust



Commentary:
The number of patients waiting over 65 week waiters is expected to be 454 patients.
The notable specialties contributing to this position are Oral Surgery, ENT, Orthopaedics, Cardiology, & Upper GI.

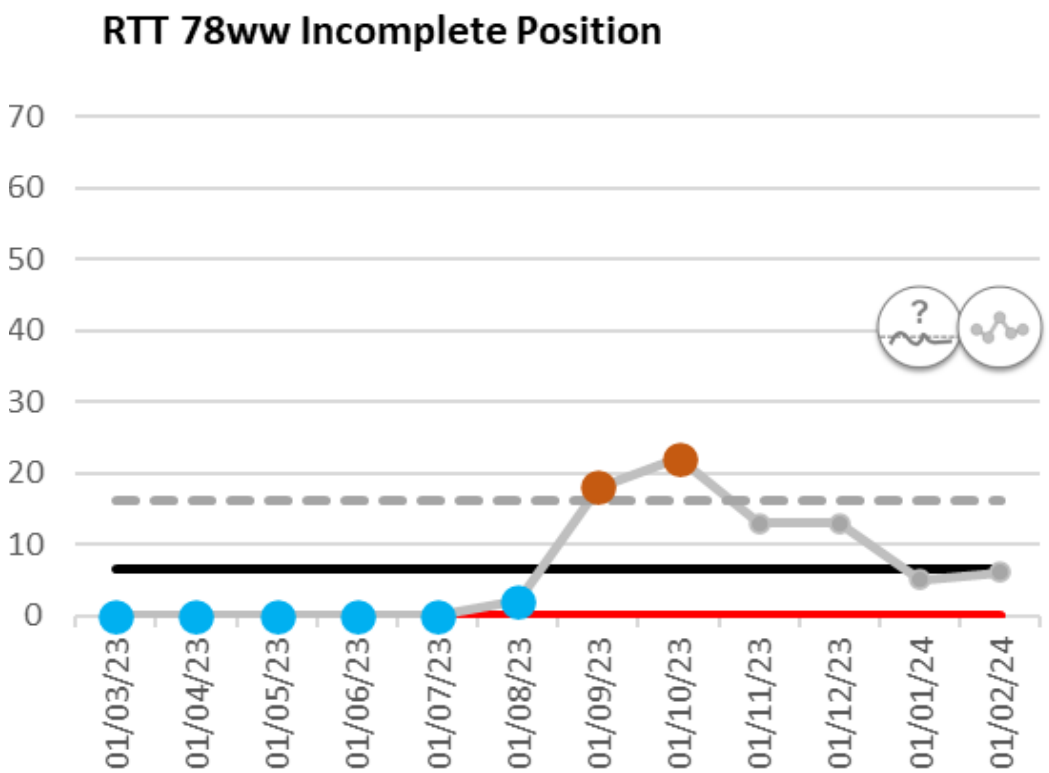
Planned Actions:
A service by service line review of ability to deliver against the 65 week target is underway as part of the planning round. This will also include ERF schemes required to secure delivery of no patients >65 weeks by September 2024

Expected recovery:
All 65ww are to be eliminated by the end of June 24. The agreed operational plan trajectory is to reduce waits to 406 in April, 206 in May and zero by June 24.

Elective: 78 week waiters

Standard: *Eliminate all over 78ww by March 2024*

Gloucestershire Hospitals NHS Foundation Trust



Comments

The number of patients waiting >78 weeks at the end of March will be reported as 5 patients.

These consist of 2 x Oral Surgery; 1 x Cardiology; 1 x Surgical Endoscopy and 1 x Upper GI.

Looking further ahead to April position, currently suggests 53 risks in total. This position remains very fluid with steps actively being taken to treat patients prior to month-end

Planned Actions:

Greater levels of focus on predicting patients who may get to 78 weeks. The focus on patients at 65 weeks will drive fewer patients getting to 78 weeks.

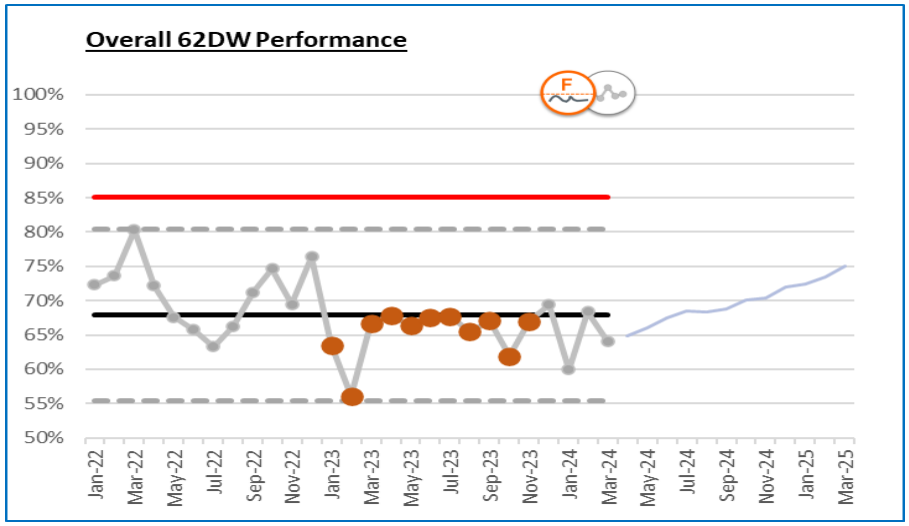
Expected recovery:

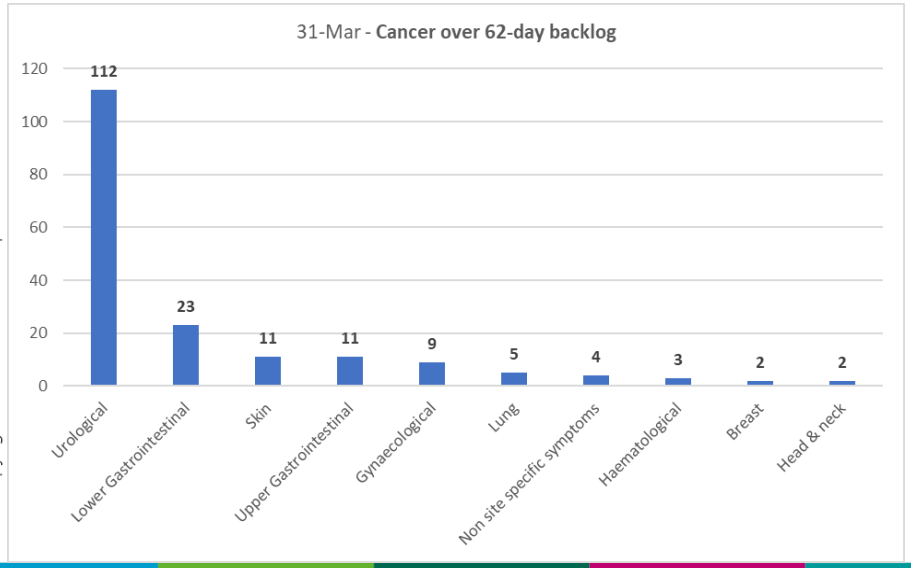
All 78ww are to be eliminated by the end of March 24.

Cancer: % Patients seen within 62 Days (with trajectory)

Standard: *85%*

shire Hospitals
NHS Foundation Trust





Commentary:

Unvalidated 62 Day Upgrade standard for March is currently at 64.8% and we will miss this target

62 Day reportable backlog is 185 (8.2%) as of 31/03/2024

Planned Actions:

Focus on specialty level recovery and diagnostic pathways :Urology improvement plan agreed by Trust to support additional LATP and treatment capacity. Local LGI recovery plan being developed with focus on minimising patient delays. Radiology project manager in place to review TATs and improvement plans for diagnostic testing; Review of access policy to support operational decision making and mitigating and performance risk . Review of Cancer Alliance funding for 24/25 with focus on operational delivery against this standard

Expected recovery:

Trajectory has been submitted to ICB for recovery of 62Day at a sustained position of 75% by March-25

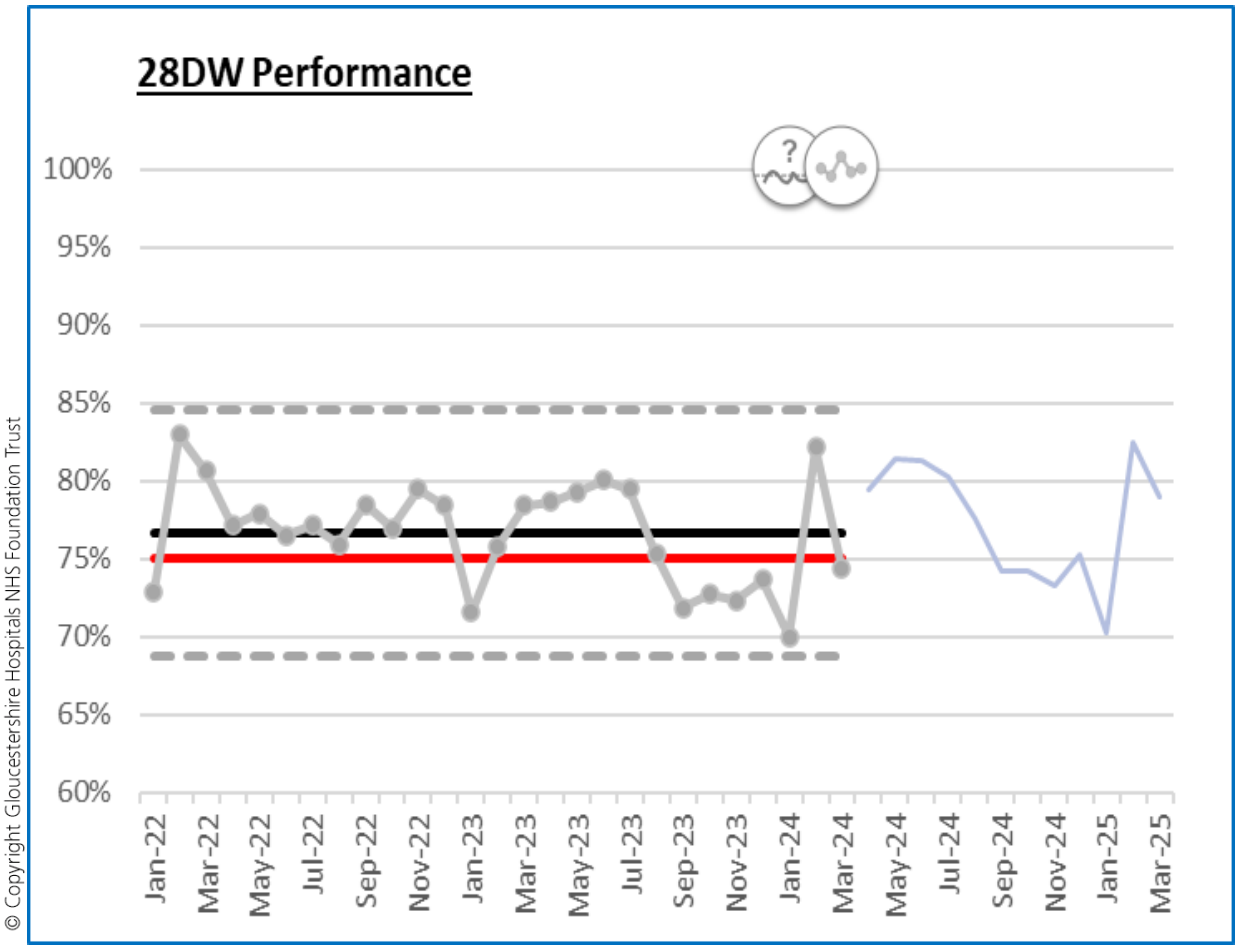
Sustained backlog recovery of no more than 6% of our PTL expected March-25

Current backlog of patients waiting longer than 62 days is currently at 8.7% of our PTL size. As good practice, a manageable backlog size should be no more than 5-6% of the PTL and our aim by (date to be agreed) is to sustain a maximum of 6% backlog moving forward

Cancer: Faster Diagnosis Standard (FDS) %

Gloucestershire Hospitals
NHS Foundation Trust

Standard: *Improve performance against the 28 day FDS to 77% by March 2025 towards the 80% ambition by March 2025*



Commentary:
Unvalidated 28 Day standard for March is currently at 74.4% and with validation we are expected to meet this target in March

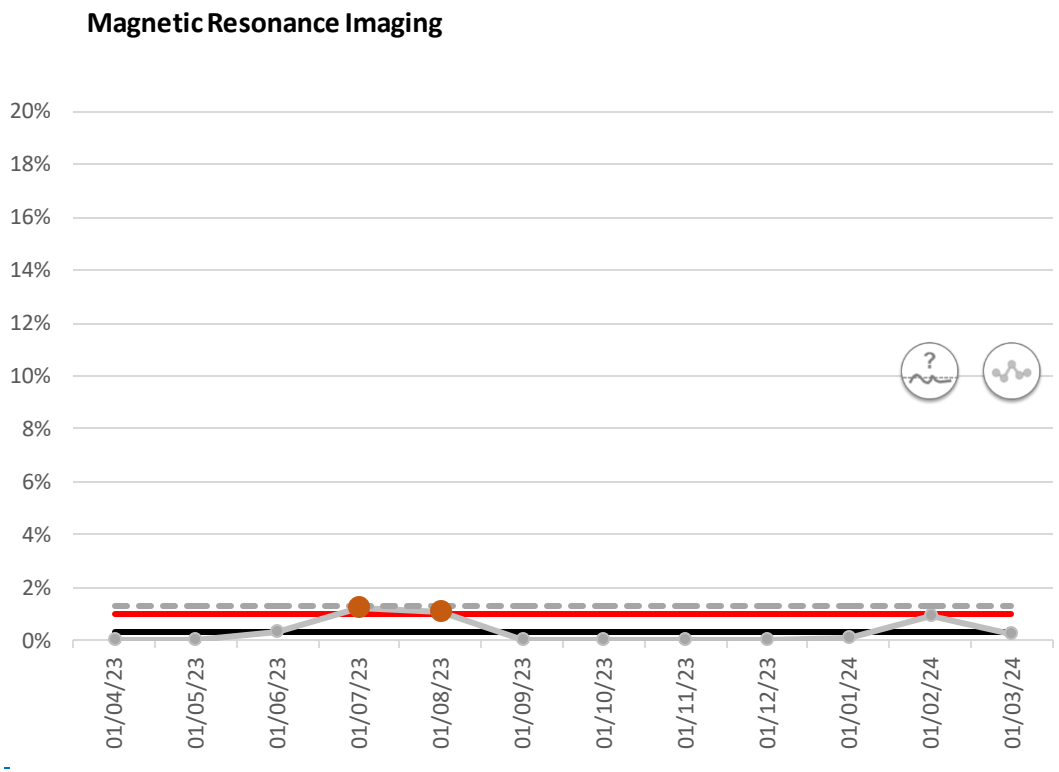
Planned Actions:
In order to maintain this standard of 75% and achieve the new target of 77% FDS, some of the planned actions include :
Focus on BPTP implementation on key specialties
New Escalation policy to support earlier identification of bottlenecks and concerns
Review of 2WW booking date and aim to bring this in line with 7 days or less
Review of non-cancer and cancer FDS to look at opportunities to improve FDS for cancer patients

Expected recovery:
Recovery and sustained achievement of the FDS standard is expected by March-25, however is dependent on all services which support the cancer pathways supporting the actions agreed

Diagnostics: MRI

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*

Gloucestershire Hospitals NHS Foundation Trust



Commentary:
The only breaches are in Paediatric GA MRI, caused by high demand in anaesthetics. All other areas of MRI are fully compliant.

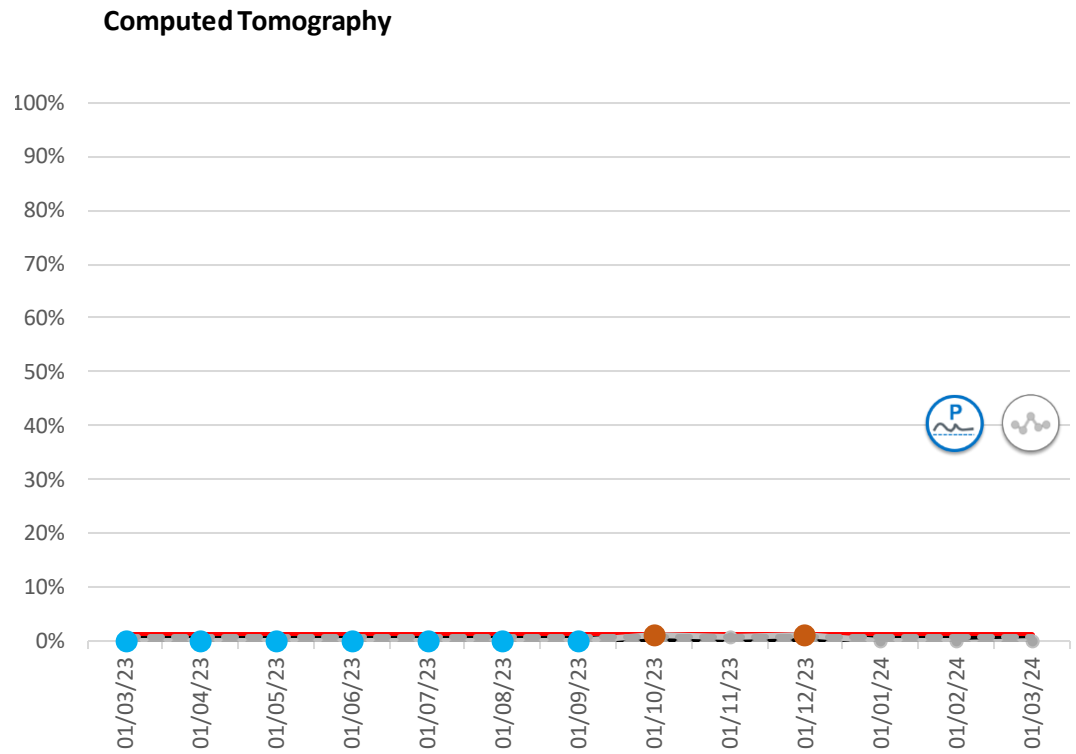
Planned Actions:
Paediatrics Service are writing a business case to support an increase in anaesthetic capacity.

Expected recovery:
D&S MRI have capacity to accommodate Paediatric demand. Once additional anaesthetic capacity is identified standard expected to be compliant.

Diagnostics: CT

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*

Gloucestershire Hospitals NHS Foundation Trust



Commentary:
Fully compliant, zero breaches in March 2024

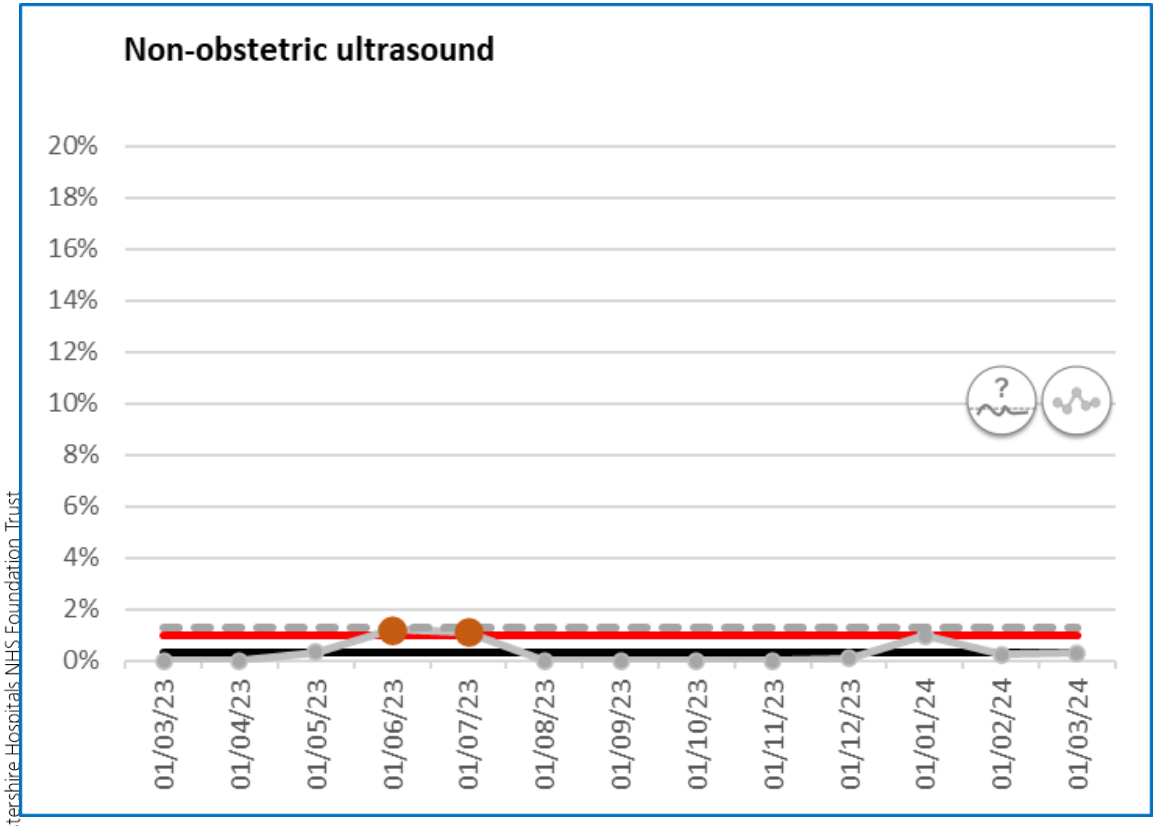
Planned Actions:
No additional planned actions required at present.

Expected recovery:
Not applicable

Diagnostics: Ultrasound

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*

Gloucestershire Hospitals
NHS Foundation Trust



Commentary:
MSK is the only area of Ultrasound that has had breaches. Due to Radiologist changes to job plans. All other areas of US are fully compliant.

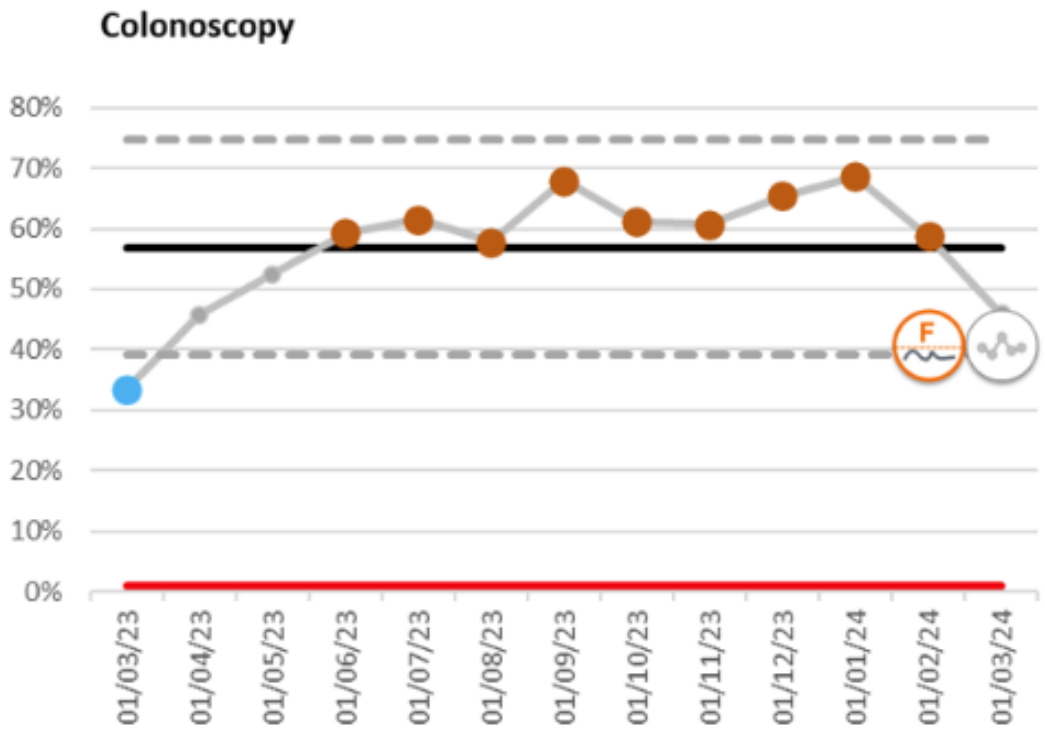
Planned Actions:
Review of Radiology Job Plans has commenced in order to resolve the capacity gap.
One additional US session has already been implemented

Expected recovery:
Review over next 2 months to identify if this has resolved the capacity issue.

Diagnostics: Colonoscopy

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*

Gloucestershire Hospitals NHS Foundation Trust



Commentary:
A previous focus on the cancer pathway and also capacity vs demand issues impacted DMO1 performance. Renewed focus on DMO1 and extra funded activity has significantly improved performance.

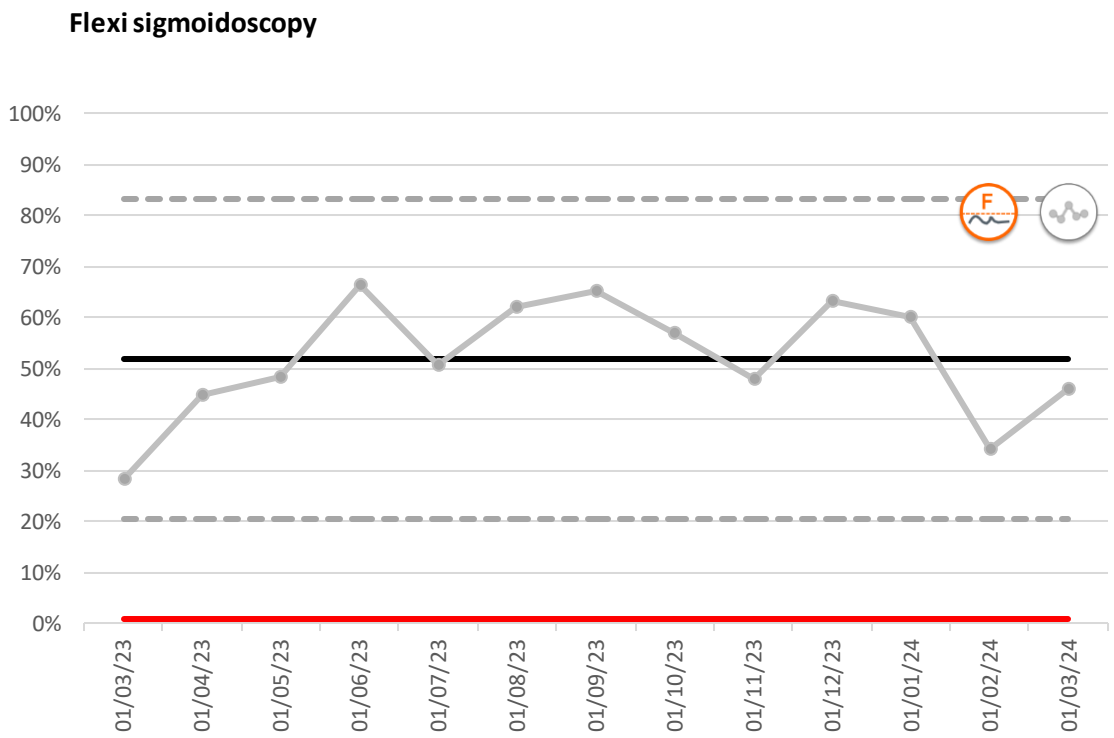
Planned Actions:
Utilise funds to back fill in-week lists, estimated to run out end of May.
Implement ERF schemes which will increase capacity
Continue to work with Four Eyes Insight
Deliver on the Endoscopy Recovery and Improvement Programme Plan including development of 3-5-10 year strategy (1st development day 15/04/25)
Continue to work with Four Eyes Insight and recruitment of Service Recovery Programme Manager (starts 1st May) to oversee delivery of recovery project.

Expected recovery:
Expected DM01 and surveillance recovery by March 25

Diagnostics: Flexi Sigmoidoscopy

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*

ershire Hospitals
NHS Foundation Trust



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Deliver on the Endoscopy Recovery and Improvement Programme Plan including development of 3-5-10 year strategy (1st development day 15/04/25)
Continue to work with Four Eyes Insight and recruitment of Service Recovery Programme Manager (starts 1st May) to oversee delivery of recovery project.

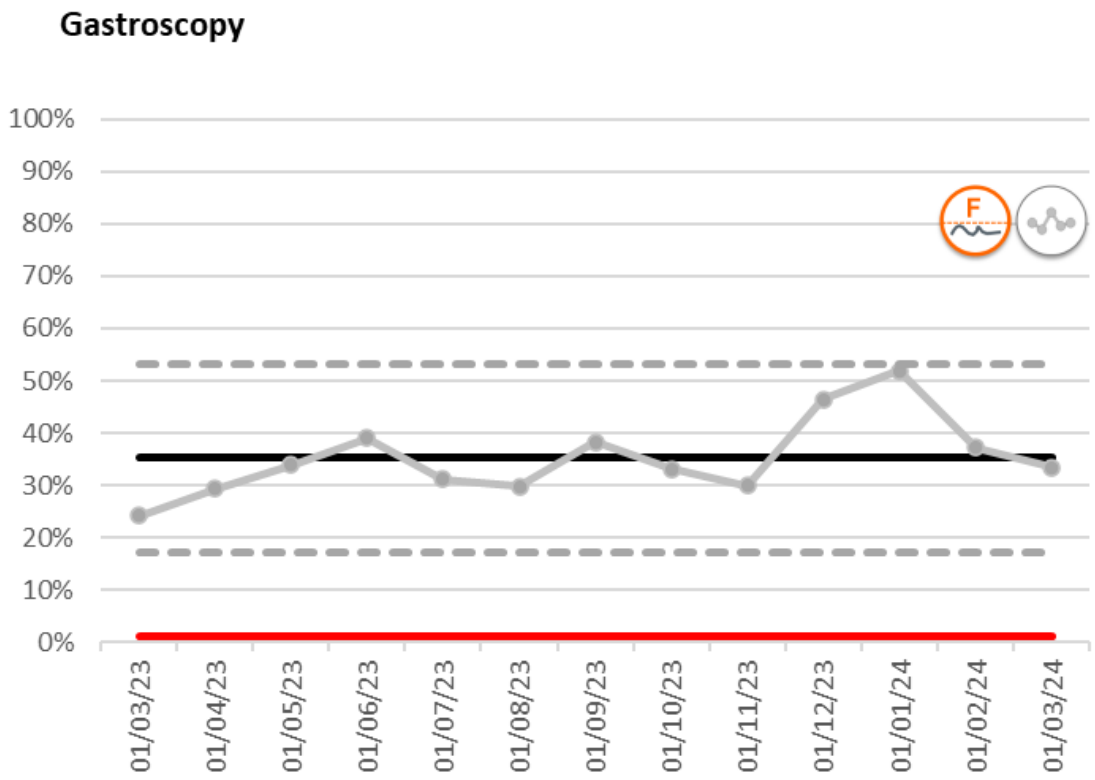
Expected recovery:

Expected DM01 and surveillance recovery by March 25

Diagnostics: Gastroscopy

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*

Gloucestershire Hospitals NHS Foundation Trust



Commentary:

A previous focus on the cancer pathway and also capacity vs demand issues impacted DMO1 performance. Renewed focus on DMO1 and extra funded activity has significantly improved performance.

Planned Actions:

- Utilise funds to back fill in-week lists, estimated to run out end of May.
- Implement ERF schemes which will increase capacity
- Continue to work with Four Eyes Insight
- Deliver on the Endoscopy Recovery and Improvement Programme Plan including development of 3-5-10yr strategy (1st development day 15/04/25)
- Continue to work with Four Eyes Insight and recruitment of Service Recovery Programme Manager (starts 1st May) to oversee delivery of recovery project.

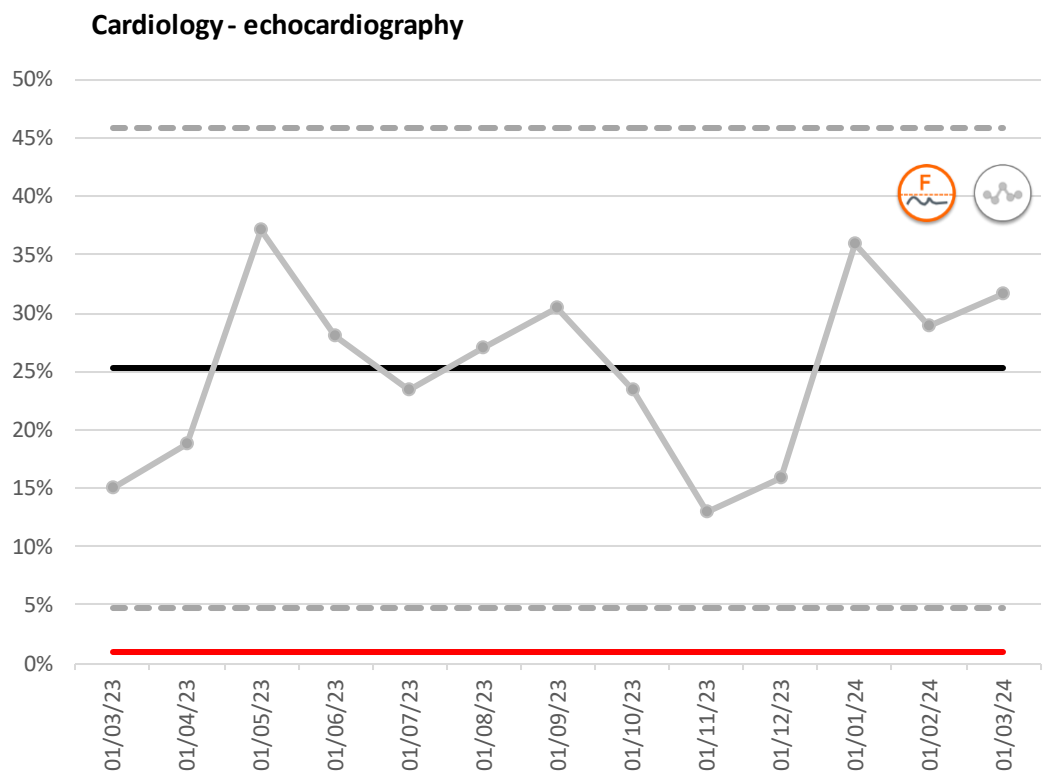
Expected recovery:

Expected DM01 and surveillance recovery by March 25

Diagnostics: Echocardiography

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*

Gloucestershire Hospitals NHS Foundation Trust



Commentary:

Backlog and breaches due to staffing gaps within the service. National shortage of echo physiologists making recruitment significantly harder than in other areas. Recruitment is further impacted by the difference in the enhancement payments that are received within the echo service compared to the pacing service. These discrepancies will be addressed as part of the financial sustainability work.

Planned Actions:

Recruitment delayed due to no sign off by HR, this is now rectified recruitment will begin.
Additional clinics where possible
New rota in place to utilise staff more efficiently.
Echo support workers would enable more efficient working practices and would support the DMO1 target, business case pending.
ISCV implementation and CDC activity

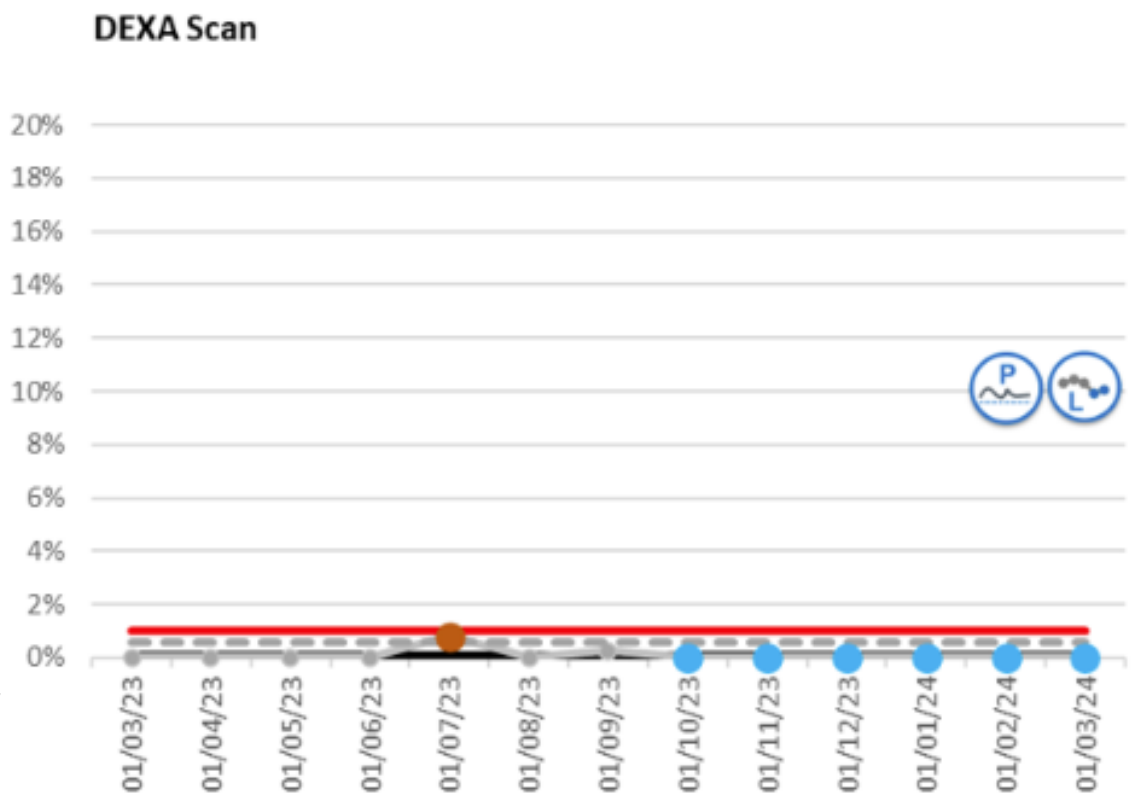
Expected recovery:

Dependent on recruitment timelines.

Diagnostics: DEXA

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*

Gloucestershire Hospitals NHS Foundation Trust



Commentary:
No breaches in DEXA

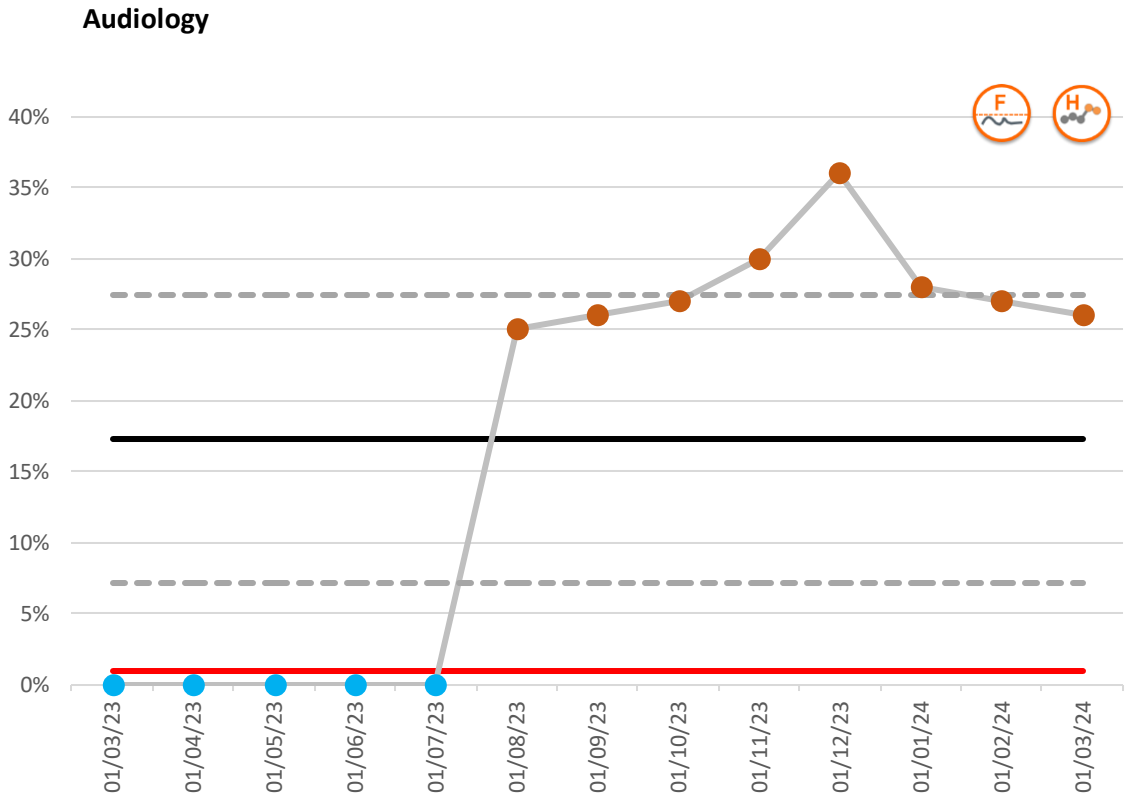
Planned Actions:
No additional actions required at present.

Expected recovery:
Not Applicable

Diagnostics: Audiology

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*

Gloucestershire Hospitals NHS Foundation Trust



Commentary:

Change in DM01 Reporting definitions commenced in August 2023 which affected historic 100% DM01 Compliance. Phasing of reporting changes led to gradual increase in breaches from July-December. Carrying 2.0 WTE B5 Audiology vacancies which were recruited to in January and February 2024. National shortage of audiologists and local private opportunities has led to difficulty in recruitment and retention.

Planned Actions:

Continued offer of overtime for staff
Approved VCP for locum Band 5 opportunity but unable to recruit at this level currently.
Ongoing review of process efficiencies for ENT clinical cover to ensure audiologists are utilised appropriately.

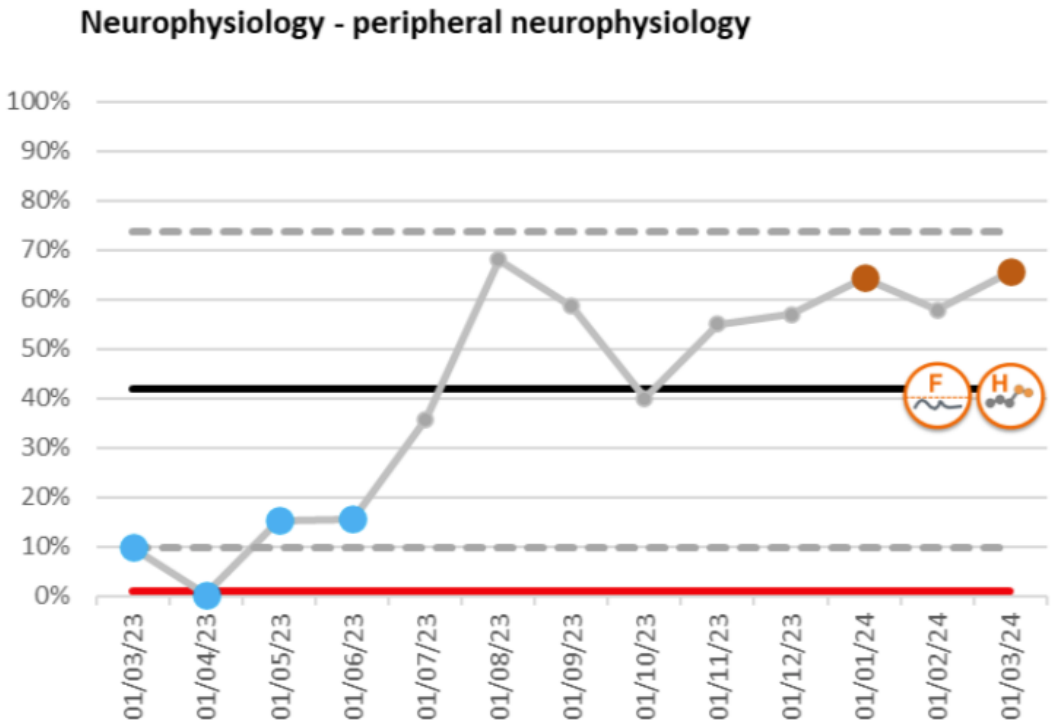
Expected recovery:

Dependent on above action plan, which is being managed in conjunction with focus on paediatric audiology. Predicted recovery for March 2025.

Diagnostics: Neurophysiology

Gloucestershire Hospitals NHS Foundation Trust

Standard: *Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%*



Commentary:

2.72WTE vacancies in neurophysiologists.
Consistent increase in referrals since pre-covid and GP referrals have doubled from 21/22 (209 referrals to 412 referrals.
Issues in December with Synertec resulted in 2 weeks lost capacity due to DNA rates, these have been resolved.

Planned Actions:

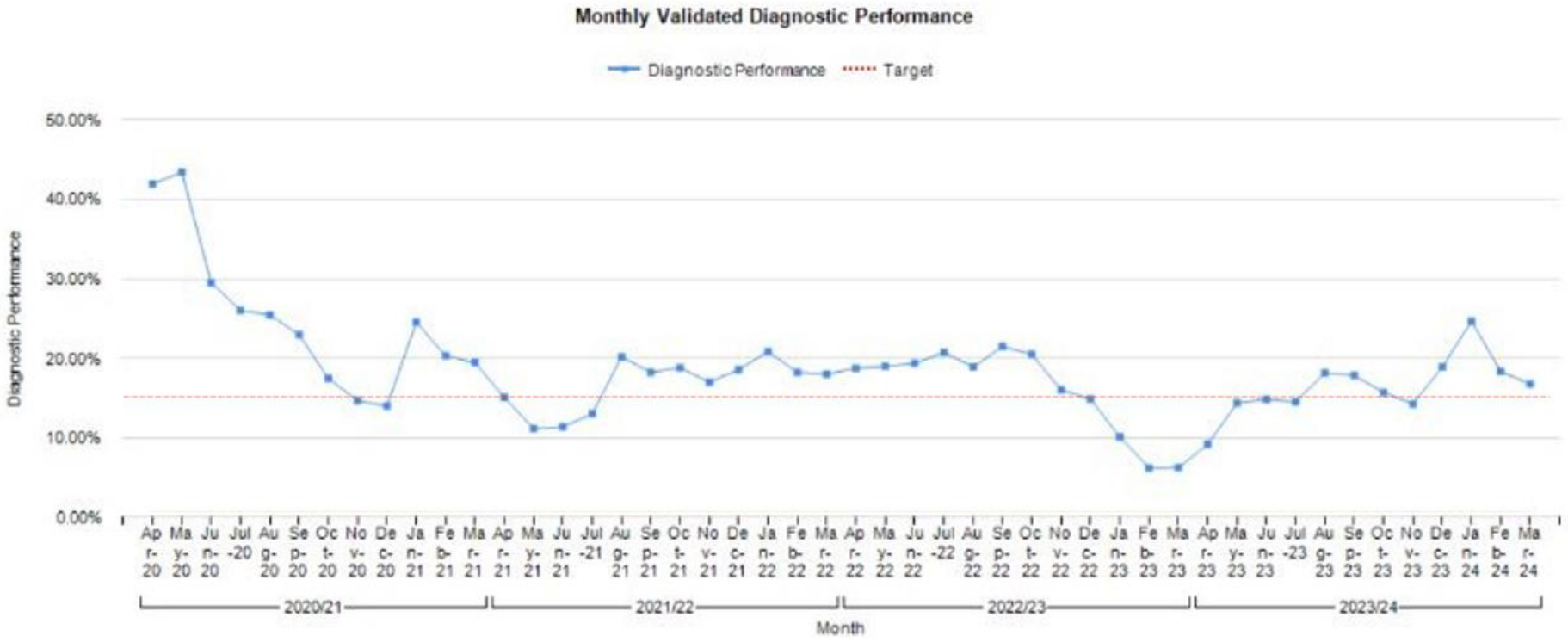
Recruiting apprentice (sept 24)
Recruit to vacancies – these are difficult to recruit areas. Currently out for advert.
Maternity due to return July 24
New GP referral form live
Administrative validation due to start April 2024
Aim to develop education programme for GP's and trainees

Expected recovery:

April 25 pending recruitment.

Diagnostic: Performance Trend

Gloucestershire Hospitals NHS Foundation Trust



Diagnostic overview

The below table shows the current areas that are seen as priorities to support recovery and cancer delivery.

System	DMO1 15%	13wks total	13ww colon	FDS 75%	DM01 bottom 20 *	Surveillance risk	CDC activity (off track/on track)	CDC opening dates	Histo (70% 23/24)*4	Imaging Utilisation	Reporting TAT - % (by 28 days) **
BSW	26.6%	5656	487	66.2%	4/5	Yes	-14000	1 April 23 2 8 Mar 24 3 1 Mar 24	64%	mobiles	89.9
BNSSG	10.3%	893	80	72.4%	NOUS	No	-3380	1 April 24** 1 April 24**	57%		93.2
CIOS	21.4%	1025	0	76.0%	2/5	No	-13848	1 Sep 22 2 April 22 3 Aug 24***	35%	mobiles	98.4
Devon	26.7%	5765	296	75.0%	5/5	No	-21592	1 Jul 21 2 Aug 24*** 3 Mar 25***	83%	UHP & mobiles	99.1
Dorset	13.6%	150	34	71.9%	CT	No	--21258	1 April 23 2 Nov 21 3 Jun 23 4 Feb 24*** 5 April 23	64%		99.1
Gloucester	18.4%	833	378	70.3%	Endo/Echo	Yes	-7184	1 Sept 21	44%		100 (May 2023)
Somerset	21.8%	1563	268	70.8%	Endo/CT/MRI	No	-99	1 Sept 21 2 July 21 3 July 21 4 July 21 5 July 21 6 July 21 7 Nov 24***	79%		95.0

*reviewed nationally against 5 modalities: CT, MRI, NOUS, Echo and Endo (grouped – including cystoscop3
** Reporting TAT new target (100% of examinations reported within 28 days), some inconsistencies with data that need to be reviewed, including reporting status not known
*** Whilst building not open, accelerator activity is taking place in temporary facility either on or off site. Note some sites appear five but are RAG rated amber due to delayed phasing of build for additional modalities.
*4 Histopathology services to achieve 70% or higher histopathology turnaround times within 10days by Mar 24; 80% or higher by September '24; 98% by March '25.

Diagnostic: DM01 Performance

Gloucestershire Hospitals NHS Foundation Trust

Data as at: 31/03/2024 23:59.59

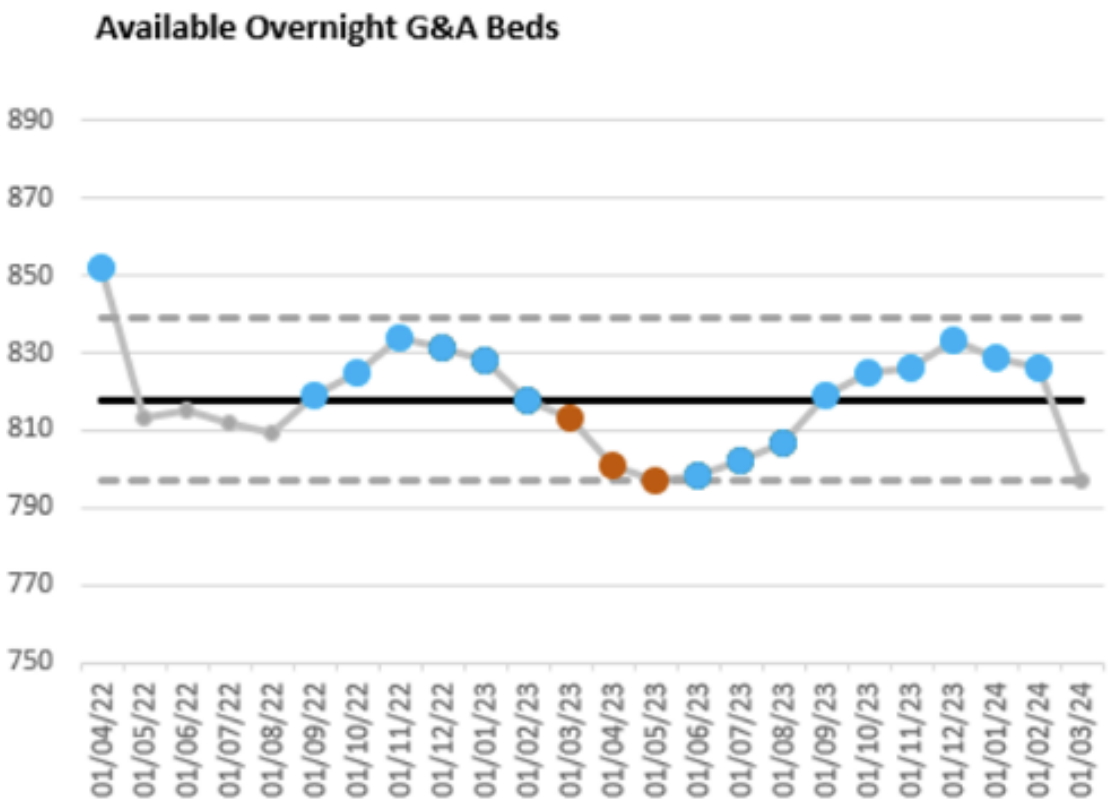
RAG Rating:	<= 1.0%	1.1% to 50.0%	>= 50.1%

Diagnostic Group	Diagnostic Modality	2020/21	2021/22	2022/23	2023/24											
					Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Endoscopy	Colonoscopy	59.51%	7.18%	16.80%	45.77%	52.42%	59.27%	61.60%	57.78%	67.94%	61.18%	60.67%	65.47%	68.62%	58.67%	45.92%
	Cystoscopy	16.30%	8.93%	21.37%	13.68%	22.08%	67.16%	33.85%	32.88%	27.42%	32.31%	32.08%	36.59%	79.72%	76.99%	43.87%
	Flexi sigmoidoscopy	65.10%	10.81%	18.59%	44.75%	48.41%	66.33%	50.66%	62.15%	65.26%	57.11%	48.06%	63.34%	60.29%	34.30%	45.84%
	Gastroscopy	65.38%	14.19%	11.94%	29.25%	33.86%	39.06%	31.19%	29.76%	38.29%	33.06%	29.94%	46.41%	51.88%	37.14%	33.44%
Imaging	Barium Enema	3.53%	0.00%	0.18%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Computed Tomography	3.44%	1.84%	0.01%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.90%	0.52%	0.99%	0.00%	0.00%	0.06%
	DEXA Scan	0.92%	0.00%	0.02%	0.00%	0.00%	0.00%	0.81%	0.00%	0.24%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Magnetic Resonance Imaging	0.25%	0.05%	0.02%	0.15%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	5.16%	4.54%	3.36%
	Non-obstetric ultrasound	7.42%	2.72%	0.85%	0.00%	0.31%	1.20%	1.11%	0.00%	0.00%	0.00%	0.00%	0.07%	0.96%	0.22%	0.29%
Physiological Measurement	Audiology - Audiology Assessments	16.75%	0.00%	0.13%	0.00%	0.00%	0.00%	0.00%	24.77%	25.89%	27.76%	29.60%	35.59%	27.52%	26.55%	25.81%
	Cardiology - echocardiography	49.38%	66.50%	68.56%	18.73%	37.10%	28.01%	23.35%	27.04%	30.37%	23.34%	12.95%	15.81%	35.86%	28.95%	31.68%
	Neurophysiology - peripheral neurophysiology	0.82%	1.16%	1.56%	0.31%	15.36%	15.63%	35.74%	68.13%	58.69%	40.07%	55.06%	57.06%	64.42%	57.98%	65.63%
	Respiratory physiology - sleep studies	12.99%	20.23%	2.45%	1.16%	2.75%	2.23%	2.33%	0.49%	5.24%	13.21%	15.94%	40.00%	35.00%	14.92%	15.41%
	Urodynamics - pressures & flows	46.40%	23.77%	2.20%	4.92%	6.90%	0.00%	2.90%	29.09%	4.23%	6.67%	1.33%	1.52%	1.64%	0.00%	0.00%
Total		**22.88%**	**16.47%**	**16.66%**	**9.20%**	**14.40%**	**14.84%**	**14.54%**	**18.19%**	**17.86%**	**15.74%**	**14.28%**	**18.93%**	**24.69%**	**18.37%**	**16.79%**

G&A Beds: Available Overnight

Standard: maintain acute G&A beds as a minimum at the level funded and agreed through operating plans in 2023/24

estershire Hospitals
NHS Foundation Trust



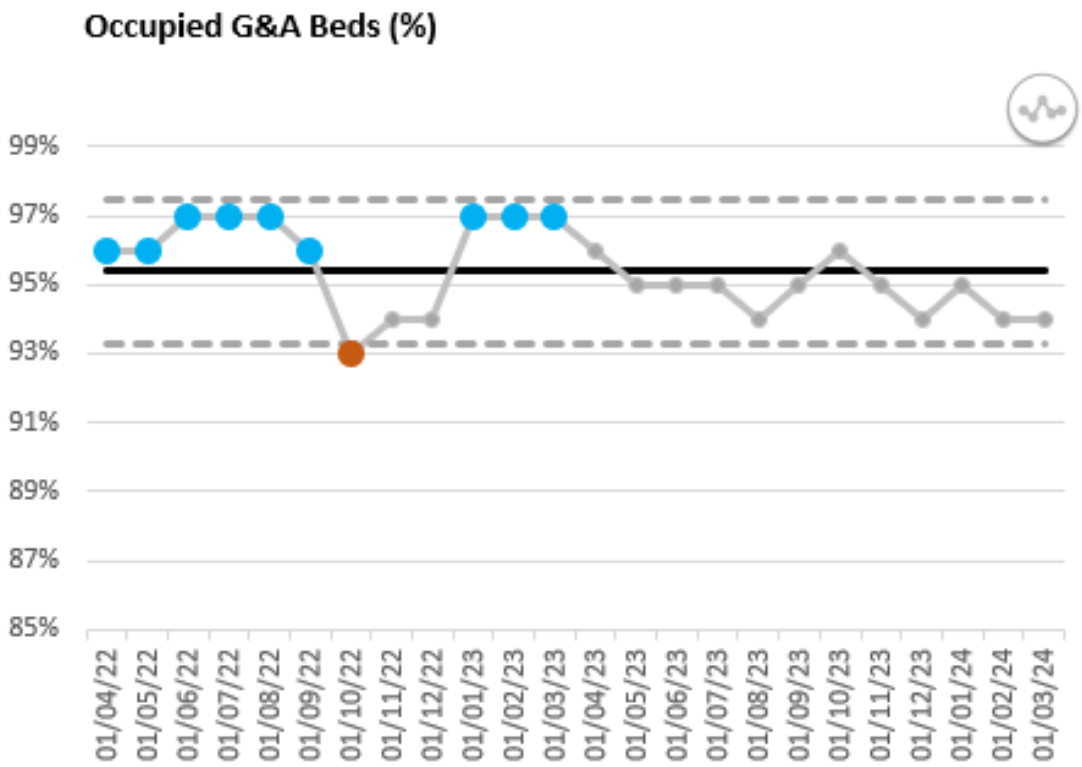
Commentary:
Data within this metric still relates to prior to making recent changes to the governance around our bed stock.

Planned Actions:
A bed base reconciliation process has now taken place, which has confirmed our bed stock and ensured all reports have been rectified against that number. Alongside this we have introduced a new governance process for any changes to our bed stock to ensure understanding and awareness across the various teams.

Expected recovery:
In terms of accuracy of data, this will be evident within the April data set. In terms of bed stock availability, this is dependent on multiple factors such as Infection outbreaks or estates work. What we do now have is much better understanding of impact and recover timelines within each episode. There are currently no issues affecting our bed stock

G&A Beds: Occupied G&A Beds

Gloucestershire Hospitals
NHS Foundation Trust



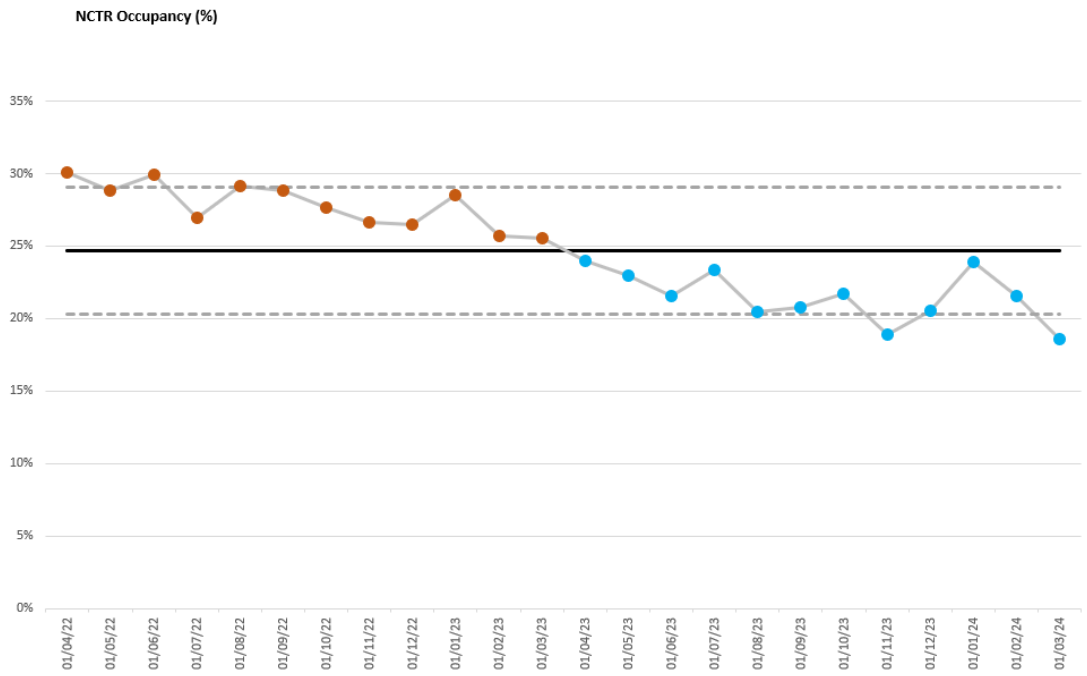
Commentary:
This data has still got limitations linked to issues we have been resolving through within our bed stock reconciliation. This should be resolved within the April data set. Our lower occupancy is driven through bed utilisation within our elective orthopaedic wards predominantly.

Planned Actions:
As part of our bed stock reconciliation, the surgical division is considering the elective orthopaedic beds and how best to capture and manage these beds. This is expected to be taken through the new governance process for agreement and ratification.

Expected recovery:
It is expected within the April data, the accuracy and validity of data will be improved. We will then need to work through and set what our expected bed occupancy should be whilst we support and work through other improvements such as ED performance and putting a stop to corridor boarding.
What we do have now is a daily sign off process to we can be accurate around available bed stock and subsequent occupancy.

G&A Beds: % Beds occupied with NCTR

Gloucestershire Hospitals
NHS Foundation Trust



Commentary:
Overall the nCTR numbers continue to show a positive downward trend. There was a slight increase post Easter holidays, but this has now been recovered.

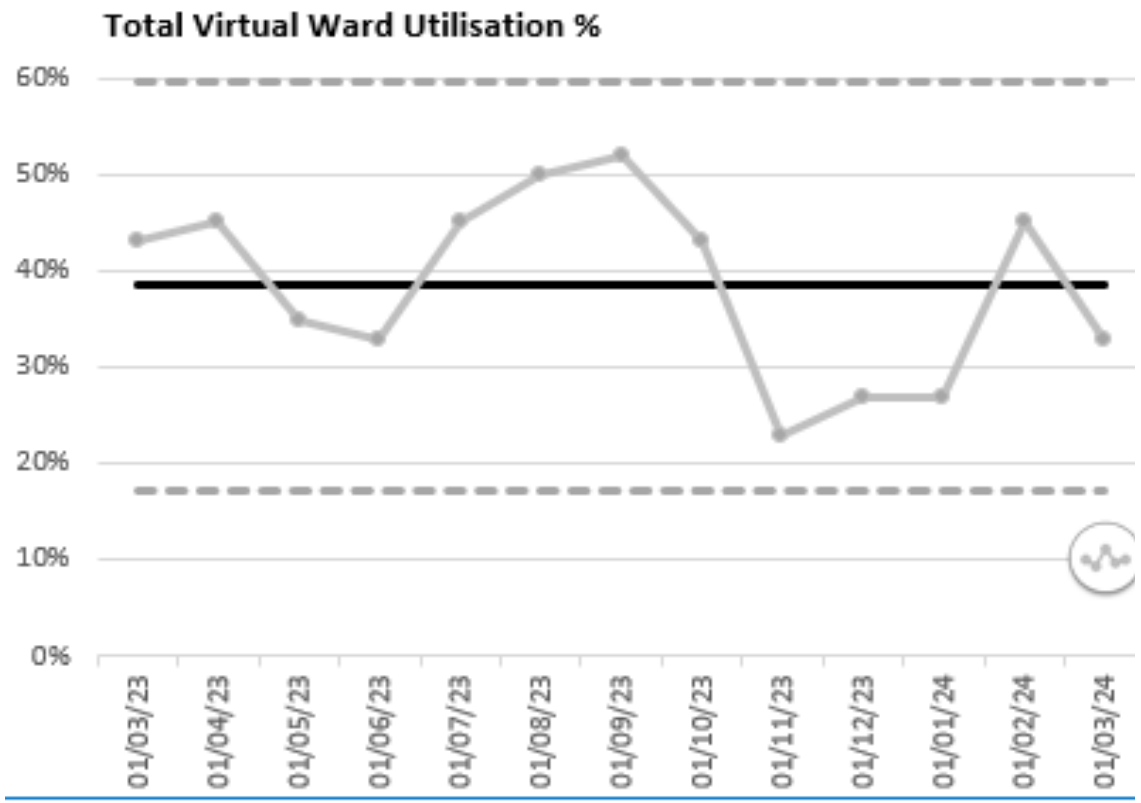
Planned Actions:
Multiple actions in train as part of the development of the Intergrated Flow Hub, WasO programme and challenge within the wider ICS.
This covers a range of internal actions around process improvement and driving 21+ day reviews, to driving flow within P1 & P2 predominantly, aiming for same day/next day discharges.

Expected recovery:
In line with planning for 24/25, the expectation is that the nCTR number is less than 80 by the end of the year, being maintained through our winter months

Virtual Wards: Utilisation

Standard: 80%

Gloucestershire Hospitals NHS Foundation Trust



Commentary:
Reporting based on snapshot data (fortnightly national reporting). Gloucestershire systemwide occupancy has been above 80% since Jan 24. The GHFT led respiratory, frailty and surgical virtual wards are at an earlier stage of development. Activities to maximise utilisation are focussed on these wards.

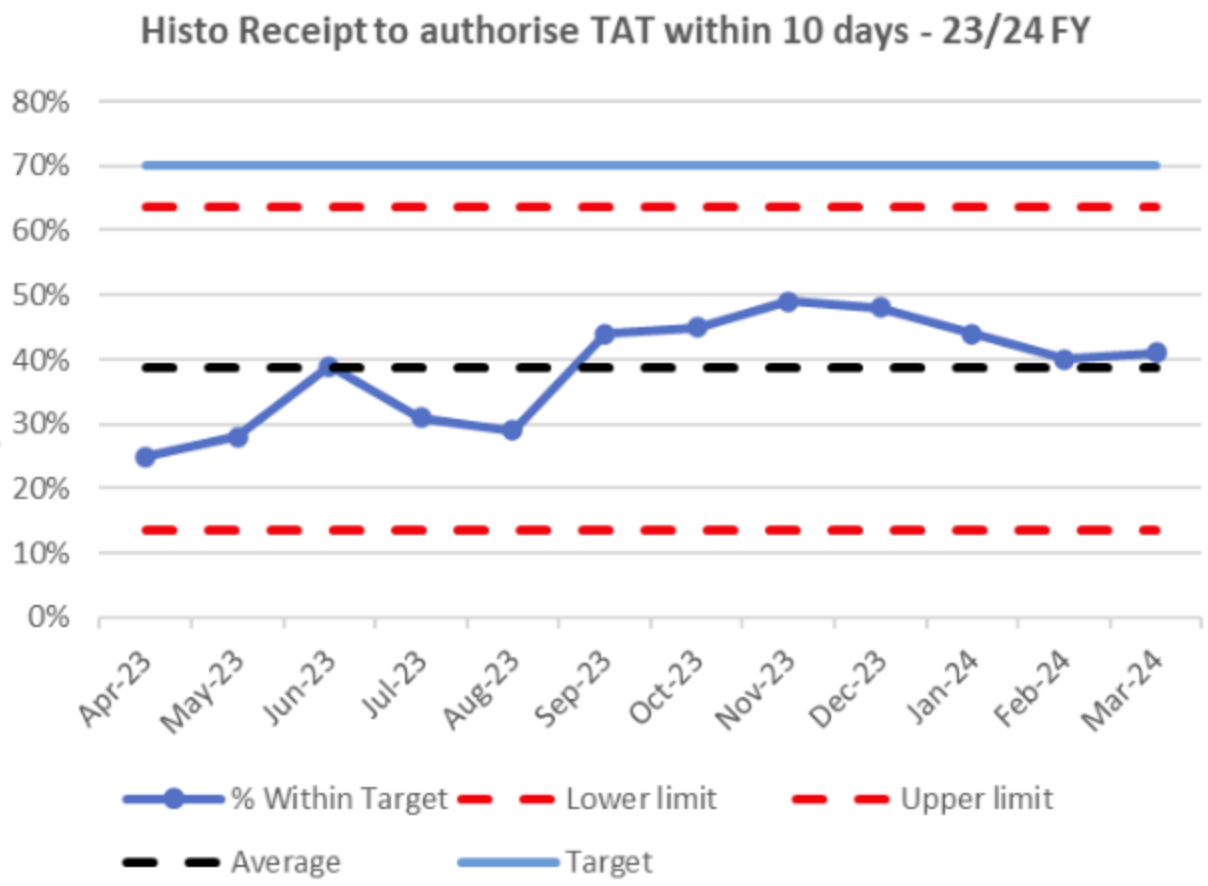
Planned Actions:
The Virtual Ward Programme continues to support the growth in capacity and occupancy across pathways. Programme activities include building awareness with system clinical teams, increasing referral routes and operational hours, as well as embedding virtual wards within the system flow processes. The virtual ward medical hub, due to go live May 2024, will be a key enabler by providing 12-hour support 7 days a week.

Expected recovery:
The Virtual Wards Programme delivery plan will continue the development and growth of virtual wards across Q1 and Q2 with an intent to consistently achieve 80% occupancy ahead of winter 24/25.

Diagnostics: Histopathology 10-day reporting

Gloucestershire Hospitals NHS Foundation Trust

Standard: *Delivering 70% turnaround times*



Commentary:
There is a national shortage of Histopathologists and this comes at a time of a 30% increase in Histopathology requests. The department has old, end of life equipment which is becoming increasingly unreliable. The Department is reliant on outsourcing and locum reporting

Planned Actions:
We are increasing capacity for Scientist dissection. This together with new tissue processors will increase capacity and efficiency.
The department is implementing Digital Pathology and this will improve efficiency around reporting.
Recruitment of new Histopathologists is also ongoing
Trial of six day working to increase capacity

Expected recovery:
Dependent on recruitment and procurement of new equipment

REPORT TO TRUST BOARD

Date	**9 May 2024**
Title	**Integrated Performance Report (Operational Performance)**
Author / Sponsoring Director/ Presenter	Al Sheward – Chief Operating Officer

Purpose of Report (Tick all that apply ✓)

To provide assurance	✓	To obtain approval	
Regulatory requirement		To highlight an emerging risk or issue	
To canvas opinion		For information	
To provide advice		To highlight patient or staff experience	

Summary of Report

The enclosed report is an Operational Performance report. It is a detailed report on elements of operational performance that may not have been shared with the members of the Q&P committee. It is suggested future reporting takes place with a reduced number of slides i.e., summary of DM01 performance.

Key Headlines

- The number of patients seen within four hours has remained largely static with a small improvement seen in March 2024
- There was a deterioration in % of Ambulance handovers over 60 mins.
- Improvements seen in the number of patients on an RTT pathway > 52 & 65 weeks.
- The target for cancer patients being seen within 62 days was missed. The number of patients >62 days reduced to 185 from 230 in February.
- The 28day faster diagnostic standard was met.
- DM01 performance of 85% of patients <6 weeks was narrowly missed with 16.79% of patients not being seen within six weeks.
- There has been a sustained improvement in beds occupied by patients with No Criteria to Reside (NC2R)

As part of the 2024/25 operational plan a number of additional measures will be added.
The year ended with some positive assurances which will need to continue. These are supported by transformation, productivity, and operational planning initiatives.

Risks or Concerns

Current risks to performance are linked to some external pressures. The number of patients attending ED where a more attractive alternative would been preferable. Poor community flow for patients who no longer need to remain in the Trust. The impact of Industrial action has resulted in a 4-5% impact on RTT data. Some areas have not previously had measures in place or the required governance to monitor them. We will use this planning round to confirm the monitoring of key performance indicators.

There remain residual risks around IA and wider political and economic uncertainty but our priorities remain the delivery of high quality and timely access to diagnostic and treatment to patients.

Financial Implications

There is a clear impact of Trust finances when we do not achieve our annual plan. Overcrowding in our wards and departments results in a cost pressure related to additional staff to ensure patients safety. Some investment requests are pending, and until the 2024/25 Operational Plan is fully confirmed there remains a degree of residual risk. There is a financial cost pressure to the ICB for Ambulance Delays.

Recommendation
The Board is asked to NOTE this report in conjunction with the Trust Quality and Performance Report (QPR). The Board is also asked to note the progress being made to the development of an IPR in the coming weeks.
Enclosures
Integrated Performance Report (IPR) – Performance only.

Report to Board of Directors				
Date	9 May 2024			
Title	Annual Equality Report 2022/23			
Author **Sponsoring Director**	Coral Boston, Equality, Diversity & Inclusion Lead Claire Radley, Director for People & Organisational Development			
Purpose of Report		Tick all that apply ✓		
To provide assurance			To obtain approval	✓
Regulatory requirement		✓	To highlight an emerging risk or issue	
To canvas opinion			For information	✓
To provide advice			To highlight patient or staff experience	

Summary of Report

Purpose

This paper presents the Annual Equality, Diversity and Inclusion (ED&I) 2022 – 2023 Report to Board to provide assurance about the Trust's commitment to ED&I.

There is a requirement on NHS Trusts to annually publish an Equality Report as part of the Public
Sector Equality Duty. This must be available to download from the Trust website.

The report details:

- Context of our organisation – our mission, vision and values and how this links to the Equality
- Diversity & Inclusion (EDI) agenda
- Overview of legal and regulatory frameworks
- Summary of progress against our equality objectives in the last 12 months (March 22-April 23)
- An overview of planned activities for the year ahead to improve our services and meet the
- needs of our patients and colleagues

Key issues to note

- Following on from last year's feedback received from the People and Organisational Development Committee we have continued with the same style and format of the Equality Report, highlighting areas where we have made positive progress.
- We have included a new section in the report, highlighting our International Educated Nurses and our Cultural and Religious celebrations.
- Due to unexpected team absence, there has been a delay in completion of this report. 2023/24 Annual Equality Report is already in progress and is on track to be signed off by the 14 November 2024.

Conclusion

The Report not only highlights our key achievements made in 2022/23 but for the year ahead our plans to create a culture where we all feel a sense of ownership and shared responsibility for improving equality, diversity and Inclusion.

The appendices contain the Trust's WRES and WDES reports which show key racial and disability workforce indicators together with concise narrative regarding planned action to tackle areas of concern. The report is presented to Board for assurance ahead of presentational support from the communications team prior to the report being released on the Trust's website.

Implications and Future Action Required Once ratified and finalised, this report will be published on the Trust's internet and shared with the Commissioners.
Recommendation
The Board is requested to **ACCEPT** the 2022/23 Equality Report and **AUTHORISE** its publication on the Trust website. If the report is not accepted and authorised, the Board is asked to grant the People and OD Committee the power to approve it at their next meeting, ensuring that any board members' comments and feedback are addressed.
Enclosures
Report

Gloucestershire Hospitals
NHS Foundation Trust

Equality Annual Report 2022–2023

the **Best Care for Everyone**
care / listen / excel

Contents

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0300 422 3563 / 3120

ghn-tr.comms@nhs.net

Executive foreword

It has been a year of transition, with a significant shift of focus towards our staff and the value we place in each and every one of them. This agenda is wide-ranging and goes to the heart of staff and patient experience.

We know from what staff and patients tell us, and from our data, that colleagues and patients who identify with minority groups continue to have a worse experience than their counterparts. The investment we are making into improving staff experience is substantial, with work underway into team and leadership development, building confidence in raising concerns, and a focus on discrimination. There is much to do, but by having relationships, curiosity, humility and courage at the foundations of all our cultural work, we are hearing people express hope and optimism.

Cultural work is not easy; it takes time and can create instability as we navigate habits and patterns that exist across the organisation. It is also exciting!

Our annual Equality Report highlights the actions we have been taking. Successes, even small ones, build energy and momentum and are creating a great platform for future activity that will create a compassionate and inclusive culture.

Working on this together, we will make it even better.

Claire Radley,
Director for People & OD

EDI Lead

As discussed earlier, the NHS has a vision that all staff should be made welcome, to feel that they belong, are valued and respected.

The NHSE Improvement Plan includes six new high impact actions that the Trust must demonstrate progress, however, whilst the Senior Leadership Team, supported by the new Associate Director of Education, Learning and Culture are responsible and accountable for delivery, a positive outcome will require that all staff take responsibility for change. This new culture must become business as usual for the trust.

As the Trust enters the final year of the 2023/24 EDI Action Plan, work to complete actions, review the wider Inclusion Vision and develop equality objectives has commenced. Priorities include developing an anti-racism strategy and improving support for international recruits. In line with the NHSE improvement plan the Trust is working to develop a discrimination strategy and improve overall staff experience.

The Trust benefits from the strength of its diverse teams who deliver outstanding patient care but it acknowledges that there is always scope to do more.

Coral Boston,
Equality, Diversity & Inclusion Lead

This report

The purpose of this report is to use the best available data, to gain a clearer picture of possible gaps and identify possible patterns of inequality in relation to access to services and workforce activities.

The principles of equality, diversity and inclusion are fundamental to the successful delivery of patient care and underpin our vision of "best care for everyone". Of course, along with patients and families, 'everyone' includes the staff and volunteers who deliver a wide range of services – equality, diversity and inclusion are key enablers for an engaged, productive and safe workforce.

This annual report outlines our activity over the past 12 months and provides an update on progress against our equality objectives in line with the requirements of the Public Sector Equality Duty and the Equality Delivery System 2022 (EDS22).

The Equality Act 2010 replaces previous anti-discrimination laws with a single Act. It simplified the law, removing inconsistencies and making it easier for people to understand and comply with. It also strengthened the law in important ways, to help tackle discrimination and inequality.

The Public Sector Equality Duty (PSED) 2011 is made up of a general overarching equality duty supported by specific duties intended to help performance of the general equality duty. Trust must capture a range of equality related information and report on it. By analysing this information, the Trust can identify possible issues of inequality and seek to address them; specifically for people who have personal protected characteristics as defined by the Equality Act 2010.

The previous 12 months we have been working hard to embed the Equality Objectives set out in our 2022 - 2024 Action plan. One of our greatest strengths this year is the work we are doing at a system level. We recognise that we cannot achieve our ambitions in isolation and that we are stronger working collaboratively with our partners.

As our work continues to evolve and the profile of EDI activity increases, we look ahead to 2024 when new Equality Objectives will be established. The Trust recognises that there will be challenges ahead but remains firmly committed in making a difference to the workforce and the community of Gloucestershire.

Protected characteristics as defined by the Equality Act 2010

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

Equality Delivery System

The Equality Delivery System (EDS) is the foundation of equality improvement within the NHS. It is an accountable improvement tool for NHS organisations, in active conversations with patients, public, staff, staff networks, community groups and trade unions, to review and develop their services, workforces, and leadership. It is driven by evidence and insight and all NHS commissioners and providers are required to implement the EDS which is part of the NHS Standard Contract.

The EDS comprises eleven outcomes spread across three domains, which are:

Domain 1)
Commissioned or provided services

Domain 2)
Workforce health and well-being

Domain 3)
Inclusive leadership

Each domain has a number of outcomes that key stakeholders evaluate, score, and rate using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement and required actions. The Trust held our Workshops where evidence was provided for each of the domains. Attendees reviewed and discussed evidence and gave the outcomes ratings.

For domain 3, EDS requires this to be independently tested, that is, by a third party with no direct involvement in managing or working for the organisation, Gloucester Health and Care Trust rated us alongside Staff Side.

Domain 1: Commissioned or Provided Services		
Outcome		Score
1A	Patients (service users) have required levels of access to the service	1
1B	Individual patients (service users) health needs are met	2
1C	When patients (service users) use the service, they are free from harm	2
1D	Patients (service users) report positive experiences of the service	1
Overall Rating		6

Domain 2: Workforce Health and Wellbeing Outcome		
Outcome		Score
2A	When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health condition	1
2B	When at work, staff are free from abuse, harassment, bullying and physical violence from any source	0
2C	Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	1
2D	Staff recommend the organisation as a place to work and receive treatment	0
Overall Rating		2

Domain 3: Workforce Health and Wellbeing Outcome		
Outcome		Score
3A	Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	1
3B	Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	1
3C	Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	1
Overall Rating		3

Scoring criteria: 0 = underdeveloped activity, 1 = developing activity, 2 = achieving activity, 3 = excelling activity

Once all assessments had been completed, the overall ratings for the 3 domains were calculated together to give a total of 11 which means the Trust's overall EDS Organisational Rating is 'Developing'.

NHSE Improvement Plan

In June 2023 the national NHSE EDI Team launched an additional improvement Plan. The improvement plan sets out targeted actions to address the prejudice and discrimination whether direct and indirect that exists through behaviour, polices, practices and cultures against certain groups and individuals across the NHS workforce.

The plan contains the following:

- **High Impact Action 1:**
  Measurable objectives on EDI - Chief Executives, Chairs and Board members. Must have specific and measurable EDI Objectives to which they will be individually and collectively accountable.
- **High Impact Action 2:**
  Embed and Inclusive recruitment processes and talent management strategies that target under – representation and lack of diversity.
- **High Impact Action 3:**
  Develop and implement an improvement plan to eliminate pay gaps.
- **High Impact Action 4:**
  Develop and implement an improvement plan to address health inequalities within the workforce.
- **High Impact Action 5:**
  Implement a comprehensive induction, onboarding and development programme for internationally recruited staff.
- **High Impact Action 6:**
  Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur.

Our Trust Population

Black Asian and Ethnic Minority Population

In 2022, 88.9% of staff declared their ethnicity on our ESR, this figure has increased over the past year. The total number of staff employed in the Trust as at 31st March was 8097, 18.1% (1466) of staff identify as being from a BME background.

Annual reports and submissions

Workforce Race Equality Standard

Since 2015 The Workforce Race Equality Standard (WRES) has supported NHS organisations to close the gap in workplace experiences and opportunities between Black, Asian and Minority Ethnic staff and White staff. This measures the Trust's performance against 9 indicators, some of which relate to the workforce statistics, and others which are derived from the annual NHS Staff survey results. These metrics enable NHS organisations to measure their progress to reduce and eliminate the gap in experience between Minority ethnic staff compared to White staff.

In 2023 our performance against these indicators can be summarised, with comparisons made to our performance in 2022 are as follows. The Trust's WRES report for 2023 data, submitted in March and is due to be published in October 2023.

Key Highlights from this year's reporting

- Our Black & Minority Ethnic (BME) representation is 18.1%, (1466) this is a 1.6% improvement on our 2022 data 16.5% (1273)
- Relative likelihood of white candidates being appointed from shortlisting compared to BME applicants, the rate for 2023 is 1.46, this is consistent with last year (1.49)
- Relative likelihood of BME staff entering the formal disciplinary process compared to white staff – White staff are more likely to enter a formal disciplinary process.
- Relatively likelihood of BME staff accessing non-mandatory training and continuing professional development (CPD) compared to BME staff, the rate for 2023 is 1.28. This is an increase of 0.5 in comparison to 2022.
- Percentage of BME staff experiencing harassment, bullying or abuse from other staff in the last 12 months has continued to improve. Percentage rates for BME are now 22.25% (326) and was 34.6% (440) in the previous year. For white staff, it is now 16.5% (26.5% in 2021).

- Percentage of BME staff experiencing harassment, bullying or abuse from patient's relatives or the public in the last 12 months has continued to improve. Percentage rates for BME are now 31.8% (466), 37.6% (478 in 2021), and white are now 28.3% (1622), 29.9% (1755) in 2021.
- Percentage of staff that personally experienced discrimination at work from a manager, team leader or other colleagues - Both BME and white staff scores are in line with last year's scores; however, there continues to appear to be variance between scores from BME and White staff BME 24% (352), White 8% (458)
- Percentage of staff believing that their trust provides equal opportunities for career progression or promotion - The percentage rate has improved for BME staff (2021 - 35.7% (454) to 41.1% (602) in 2022. Whereas the figure for white staff has deteriorated slightly (2021- 56.4% (3311) to 51% (2922) in 2022.
- Total Board Membership by ethnicity is White 11 and BME 3 Unknown 4
- Voting board member by ethnicity is White 4 BME 2 and Unknown 4
- Non-Voting Board members by ethnicity White 87.5% BME 12.5% Unknown 0%
- Overall workforce by ethnicity White 5730, BME 1466, Unknown 901

Workforce Disability Quality Standard (WDES)

Implementation of the Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a set of ten specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of Disabled and non-disabled staff. NHS trusts use the metrics data to develop and publish an action plan.

It will enable us to demonstrate progress against the indicators of Disability equality. The WDES enables us to understand the experiences of our Disabled staff and support positive changes for all existing employees. The Trust is committed to creating a more inclusive environment for Disabled people working and seeking employment in our Trust.

Key Highlights from this year's reporting

- Disability Representation is 2.94% (238); this is an improvement from the previous year. 45.8% (3709) of staff have a disability status of unknown or not stated.
- The overall relative likelihood of non-disabled staff being appointed from shortlisted compared to disabled staff ratio is 1.39. This data indicates that disabled candidates are less likely to be appointed than non-disabled candidates.
- Staff who have not declared a disability are more likely to enter the formal capability process.
- 36.2% (86) of Disabled staff experienced harassment, bullying, or abuse from patients or the public in 2022. This compares to 27% (1120) of non-disabled staff experiencing incidents.
- Incidents of harassment, bullying or abuse from managers towards Disabled staff, have increased to 20.7% (49) compared to 20% in 2021/22. There is a gap between the experiences of disabled and non-disabled staff, non-disabled are 11.8% (489).

- 28.2% (67) of disabled staff had experienced harassment, bullying or abuse from colleagues – compared to 20.2% (838) of non-disabled staff experiencing an incident.
- Equal opportunities for career progression or promotion – 44.5% (106) of disabled staff (3.4% increase on 2020/21) believed they had equal opportunities for career progression or promotion. This compares to 51.9% (2153) of non-disabled staff.
- 35.9% (85) disabled staff (an improvement since the 2021/22 result of 39% said they felt pressure from their manager to come to work, even when they did not feel well enough to perform their duties. This compares to 24.7% (1025) for non-disabled staff.
- 27.2% (65) of Disabled staff feel that their work is valued, compared to 34.8% (1444) of non-disabled staff.
- Percentage of Disabled staff saying that their employer has made an adequate adjustment(s) to enable them to carry out their work. Staff experience has declined since last year (2021/22 – 71.5%) to 72.3% (172)
- Overall, 0% of board members have declared a disability; this compares to 2.94% of the total workforce. Disability unknown (61.1%).

Both reports can be accessed via the Trust website

We recognise that there is still more work to be done to improve our performance against the WRES/WDES indicators. The Trust will work with our Networks and colleagues to better understand the experiences of our ethnic minority/disabled workforce. We know we need to make significant changes to become a truly equal and supportive place to work and be cared for.

Attracting and recruiting a diverse workforce and Inclusive workforce has been the Trusts focus. Our EDI action plan sets out in more detail the priorities and programmes of work as part of the Trust's Equality, Diversity and Inclusion Strategy which will drive improvements against these indicators.

Below are some of the actions we have delivered in 2022/23

Refreshed the mandatory Equality Diversity Inclusion e-learning module launched which is highly interactive and includes real case studies and examples of patients and staff

Safe space events were held for Ethnic Minority colleagues, allowing them to have conversations with senior members of the Trust

A number of Cultural Intelligence Training workshops were delivered to staff and managers

A new Inclusion network with associated networks for ethnic minority, disability and LGBTQ+ staff relaunched and rebranded (from 'Diversity' network).

Delivered a further series of interview skills workshops and took positive action to encourage ethnic minority colleagues to apply

Worked with One Gloucestershire system partners to commission the delivery of an Inclusion Allies training programme

Commissioned a leadership development programme aimed at Speciality Directors and aspiring Consultant leaders. We took positive action when advertising and asked the provider to include content preparing colleagues from diverse backgrounds to apply for leadership roles in the future.

An Inclusion Ally intranet page was launched and promoted to staff which gives access to a range bitesize video on EDI and ally-related matters

A poster campaign was held to coincide with Black History Month to showcase our Ethnic Minority leaders as role models.

Next Steps

This coming year we will align our actions to the 2023, NHSE new EDI Improvement plan, which consists of 6 high impact intersectional actions that are recommended to address the negative experiences identified in the WRES and WDES report.

Using the High Impact Improvement plan we will ensure:

Measurable Objectives on EDI for Chairs and Executives and Board members

- Every Board and Executive team member have EDI objectives that are SMART and be assessed against these as part of their annual appraisal.
- Board Members demonstrate how organisational data and lived experience have been used to improve culture.
- NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework

Overhaul recruitment process and embed talent management processes.

- We will Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation
- Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes. Impact should be measured in terms of social mobility across the integrated care system (ICS) footprint.

Eliminate total pay gaps with respect to race, disability and gender

- We will Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce.
- Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.

- We will work to Implement an effective flexible working policy including advertising flexible work options on organisations' recruitment campaigns.

Address Health Inequalities within the workforce.

- Line managers and supervisors should have regular effective wellbeing conversations with their teams, using resources such as the national NHS Health and Wellbeing Framework.
- Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm length bodies, such as the NHS Race and Health Observatory. For example, local educational and voluntary sector partners can support social mobility and improve employment opportunities across healthcare.

Comprehensive Induction and onboarding programme for Internationally Recruited Staff

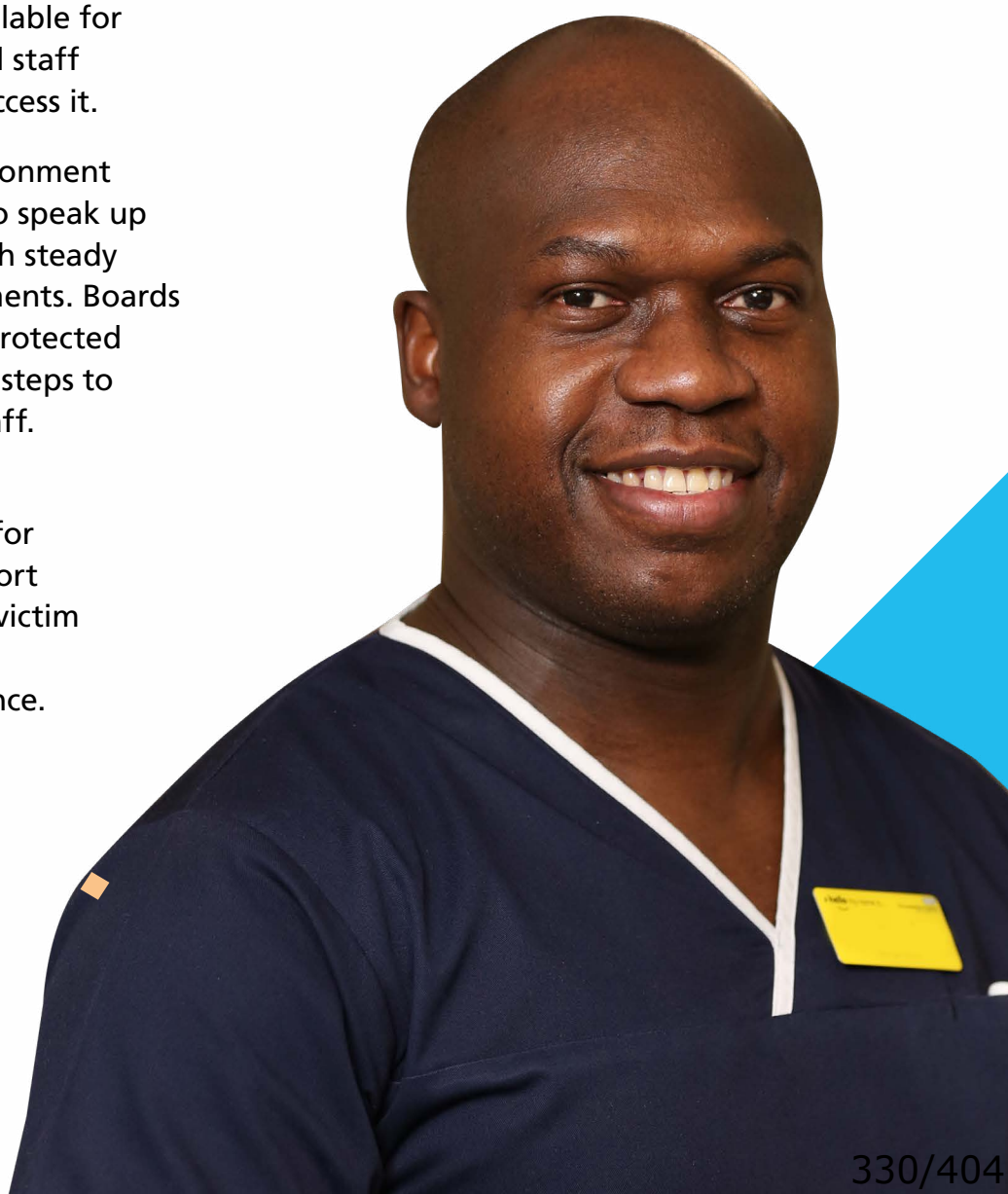
- Before they join, ensure international recruits receive clear communication, guidance and support around their conditions of employment: including clear guidance on latest Home Office immigration policy, conditions for accompanying family members, financial commitment and future career options.
- We will create comprehensive onboarding programmes for international recruits, drawing on best practice. The effectiveness of the welcome, pastoral support and induction can be measured from, for example, turnover, staff survey results and cohort feedback.
- Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures and embed psychological safety.
- We will give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. They should ensure that personal development plans focus on fulfilling potential and opportunities for career progression.

Eliminate Conditions and environment in which bullying, harassment and physical harassment occurs.

- We will review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year on year.

- We will review disciplinary and employee relations processes. This may involve obtaining insights on themes and trends from Trust solicitors. There should be assurances that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics. Where the data shows inconsistency in approach, immediate steps must be taken to improve this.
- Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available for those who need it, and staff should know how to access it.
- We will create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff.
- Provide comprehensive psychological support for all individuals who report that they have been a victim of buying, harassment, discrimination or violence.
- Have mechanisms to ensure staff who raise concerns are protected by their organisation.

  By 2028 we will complete an updated analysis of where racial disparity exists, with associated trajectory and recommendations for achieving ambition in line with Model Employer parity targets (by 2028)



Some of our local actions we also aim to achieve

- We will organise another series of speed coaching for our minority colleagues to explore how coaching can support further professional development.
- Following the success of the Trusts first Reciprocal Mentoring Programme, together with One Gloucestershire, we are delighted to be running the second cohort. The programme will provide insight, create transformational changes and assist in optimising the career development and talent pipeline of staff with a protected characteristic.
- The first Inclusion Allies programme was delivered in 2022/23. In Collaboration with One Gloucestershire system partners, we will be to commissioning the delivery of another cohort in 2024.
- To better enhance access to career progression, training, and development opportunities, we will be working with the Resourcing Team to further develop our positive actions processes to improve our Inclusive recruitment practices and achieve more parity of diversity in higher bands.
- To eliminate bullying, harassment, discrimination, and violence in the workplace, we will Continue to develop and implement the planned Staff Experience Improvement Programme. The programme includes workstreams focused on Discrimination, Teamwork and Leadership development, Speaking and Raising Concerns. To monitor progress, we will continue to review data through our staff surveys, Pulse surveys and Networks.
- To support year-on-year improvement in race and disability representation, we will actively analyse our staff survey data by comparing the experiences of our colleagues. The themes of bullying and harassment and discrimination have been identified as high priority areas for improvement and focus. As part of this Teamwork and Leadership Development workstream specific deliverables will include:
    - Workshops for leaders and teams across the Trust which include reflection and skills development on responding to inappropriate behaviours and building psychological safety
    - Executive and senior leadership workshops
    - Action Learning Sets for leaders which will have a specific focus on team culture

- We will continue to offer Buddy support for international recruits, to ensure they receive appropriate guidance and support on arrival. We recognise moving to a new country can sometimes be a struggle. In support of this we will be creating a fixed term EDI Pastoral post to help the new recruits settle into their ward environments and to help them adapt to life in Gloucestershire.
- In 2024 we will be recruiting a fixed term EDI Trainer, who will provide the necessary tools and strategies to support and progress the Trusts equality, diversity and Inclusion agenda.
- We will be collaborating with Gloucester Deaf Association to promote the awareness of colleagues and patients who have hearing loss and /or are deaf.
- We will continue to support our staff networks as a safe way for colleagues to have peer support and open conversations. Engagement with our staff networks provides the opportunity for the trust leadership to hear lived experiences of staff. This is turn will inform decision about how the trust supports our staff. We currently have three networks: Disability, Ethnic Minority and LGBTQ+ Networks. We will also support departments in developing EDI Ambassadors within their own areas of work to encourage local engagement and to feed into the trust wide networks. In 2024 we will work to create a further two networks: Women's Network and a Mens Conversation Network.

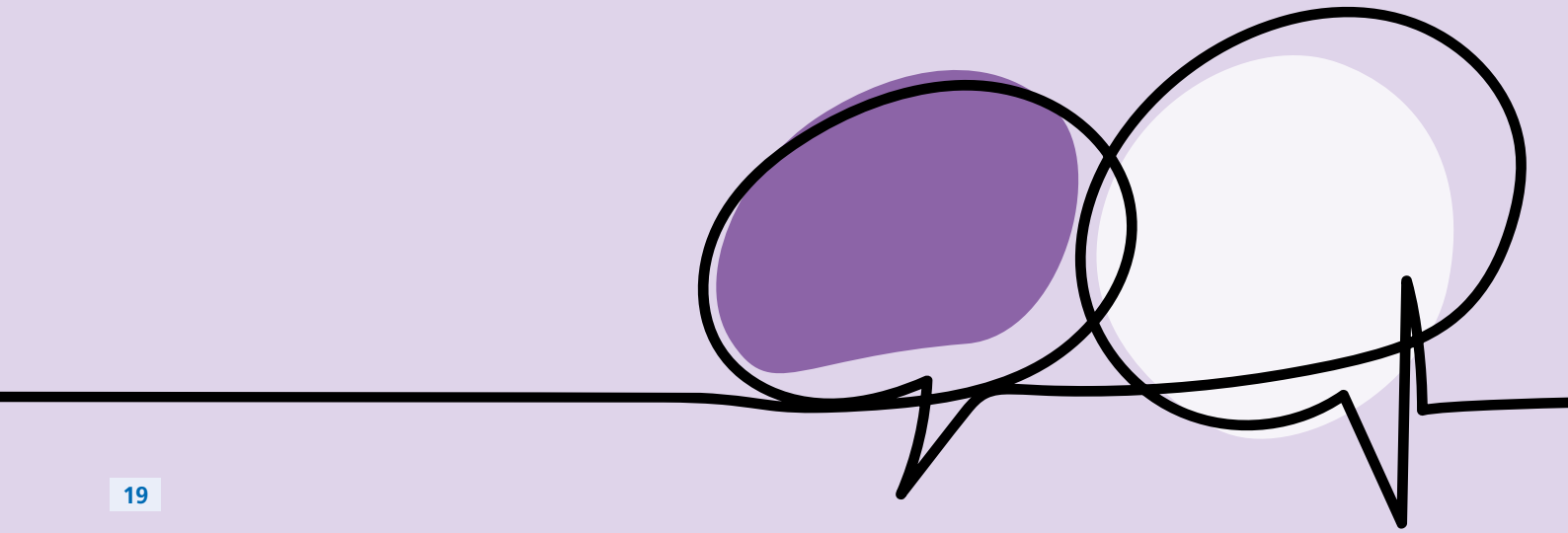
Staff Survey

The Trust participates in the national NHS Staff Survey on an annual basis. The survey was undertaken from October to November 2022. This year the response rate was 50% with over 4232 colleagues taking part, an increase of over 50% on the previous year.

The staff survey findings are reported in line with the 7 elements of the People Promise themes.

- We are recognised and rewarded.
- We are compassionate.
- We each have a voice that counts.
- We are safe and healthy.
- We are always learning.
- We work flexibly.
- We are a team.

The Staff Survey results have been communicated to Divisions and Departments across the Trust. The data was also shared with the Board, Equality, Diversity and Inclusion Steering group and Inclusion network where they can work together on actions to support the Trusts overall commitments to Equality, diversity and Inclusion.



Gender reporting pay gap

Equality monitoring is central to understanding the profile of our workforce and colleague experience. We need information about employers by protected characteristics to understand whether we are providing equality of opportunity and experience.

The Gender Pay Gap is one example of the Trusts equality monitoring, as a public sector organisation with over 8,000 employees. The Trust is required to publish a Gender Pay Gap report on an annual basis. The Trust gender Pay gap at 31 March 2022

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

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.

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 eventually lead to a reverse in the pay gap.

Disability Confident Employer Accreditation

The Trust maintains its "Disability Confident Employer – level 3 accreditation.

The Disability Confident scheme aims to help organisations successfully employ and retain disabled people. It shows applicants and employees who inform us they have a disability that we are committed to being an inclusive employer.

Patient experience

Demographic information on the population we served during 2022-23

Age group

Of the 754,252 Outpatients:

- The largest proportion: 31.4% were aged 41-65
- The next largest group: 29.6% were aged 66 – 80
- Followed by: 18.7% were aged 16 – 40

Of the 155,321 inpatients:

- The largest proportion: 27.1% were aged 41-65
- The next largest group: 25.1% were aged 66 – 80
- Followed by: 23.7% were aged 16 – 40

Ethnicity

Of the 754,252 Outpatients:

- The majority: 78.7% were White British
- The next largest group: 14.0% did not disclose or were not known
- Followed by: 2.6% Any other White background**Of the 155,321 inpatients:**
- The majority: 83.0% were White British
- The next largest group: 11.3% did not disclose or were not known
- Followed by: 3.5% Any other White background

Marriage and Civil Partnership

Of the 754,252 Outpatients:

- The majority: 36.6% did not disclose
- The next largest group: 35.3% were Married or in a civil partnership
- Followed by: 22.6% Single

Of the 155,321 inpatients:

- The majority: 39.9% did not disclose
- The next largest group: 31.4% were Married or in a civil partnership
- Followed by: 23.2% Single

Religious belief

Of the 754,252 Outpatients:

- The majority: 52.0% Religion unknown or no data collected
- The next largest group: 35.3% were Church of England
- Followed by: 7.1% Not religious

Of the 155,321 inpatients:

- The majority: 54.9% Religion unknown or no data collected
- The next largest group: 28.7% were Church of England
- Followed by: 6.9% Not religious

Sex

Of the 754,252 Outpatients:

- The majority: 56.5% Female
- Followed by: 43.5% Male

Of the 155,321 inpatients:

- The majority: 56.4% Female
- Followed by: 43.6% Male

Sexual Orientation

Of the 754,252 Outpatients:

- We do collect this information, however, for the majority of patients, 99.92% this information has been left blank followed by 0.08% identifying as heterosexual or straight.

Of the 155,321 inpatients:

- We do collect this information, however, for the majority of patients, 99.84% this information has been left blank followed by 0.15% identifying as heterosexual or straight.

Pregnancy and Maternity

Of the 754,252 Outpatients:

- The majority: 98.2% were not pregnant
- Followed by: 1.8% were pregnant

Of the 155,321 inpatients:

- The majority: 90.3% were not pregnant
- Followed by: 9.7% were pregnant

Gender Reassignment

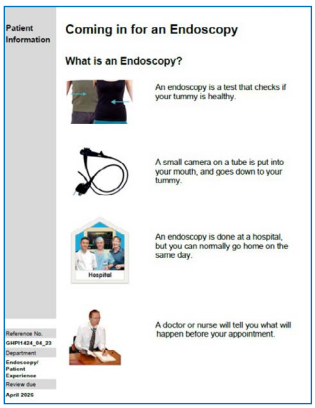
- We do not currently collect this data.

Patient Experience EDI improvements

We have implemented some changes which help to improve the experience of our patients.

Easy Read

We have been working with Inclusion Gloucestershire to support the development of easy read patient information leaflets. This has included supporting the prioritisation of which leaflets to translate and the translation of those. These leaflets are all available on our website. We are continuing to work with Inclusion Gloucestershire on the further translation of information.


Patient Information

Coming in for an Endoscopy

What is an Endoscopy?

An endoscopy is a test that checks if your tummy is healthy.

A small camera on a tube is put into your mouth, and goes down to your tummy.

An endoscopy is done at a hospital, but you can normally go home on the same day.

A doctor or nurse will tell you what will happen before your appointment.

We have also worked with Inclusion Gloucestershire to develop an Easy Read version of 'Ask 3 words' which is an initiative we have begun rolling out across our organisation. This enables patients to be more involved in the care and treatment.

Audio Guides

We have been working with the Sight Loss Council and Pocklington Trust to improve the wayfinding options available to our patients including co-producing an audio guide providing directions to several locations as identified by our patients. The finished guides will be available to patients later in 2023.

What Matters to Me Folders

We have been working with our Integrated Care Board colleagues to introduce the What Matters to Me folders across several clinical areas including the High Intensity User/ Homelessness team, Paediatric team, Care of the Elderly team, Homeward Assessment team and the Palliative Care team. The folders enable people to record their health needs and wellbeing wishes to enable delivery of more personalised care.

Arts for Our Community

We have worked collaboratively with our patients and staff to create bespoke pieces of art to enhance the experiences of our patients in our hospitals, many of which have been supported by the Cheltenham and Gloucester Hospital Charity. Stand out pieces include:

- The development of art for our mental health rooms in our Emergency Department at Gloucestershire Royal Hospital to offer a calming space to our patients.
- The installation of dementia friendly art work on the newly refurbished Gallery ward 2.
- The creation of a large mural outside of the Children's Centre at Gloucestershire Royal Hospital, kindly supported by the Pied Piper Appeal.

Planned future Patient Experience EDI improvements 2023–34

Accessible Information Standard

Working with community groups and people with lived experience to support the Trust to meet the requirements of the Accessible Information Standard.

Patient Portal

The PEP (Patient Engagement Portal) is in the final stages of tender and contract agreement. The basis of the PEP being that it allows the opportunity to communicate digitally with patients, with information being surfaced through the NHS App. One of the key features is the ability to send appointment letters digitally without reliance on paper/postage, and this will be one of the first initiatives to be rolled out. Recognising that not all patients are digitally enabled, both paper and digital solutions will be available with the decision down to patient preference. A phased approach will be taken in the rollout of digital appointment letters, starting with outpatient clinics and then progressing to elective procedures/ diagnostics, and ultimately clinic letters.

Patient portals will be rolled out to support patients being able to have more control over how they make, amend and cancel their appointments electronically.

Patient Letters

Further improvements to the format and content of patient letters. Work is ongoing with the Physiotherapy team to trial an amended letter, which is being developed alongside our Healthwatch partners.

EDS22

Our focussed area's following the EDS22 outcomes are accessibility of our services and translation and interpreting services.

Accessibility Experience Group

In order to support delivery of the accessible information standard and wider improvements to accessibility of our services we are establishing an accessibility experience group of people with lived experience.

Reducing Cognitive Deconditioning

We will be introducing a team of volunteers to support our older patients with reducing cognitive deconditioning. This team will be lead by a dedicated Volunteer Coordinator which has kindly been funded by Cheltenham and Gloucester Hospital Charity. This role will also look to build partnerships with other charities and community groups to provide support to our patients.

Arts in Our Community

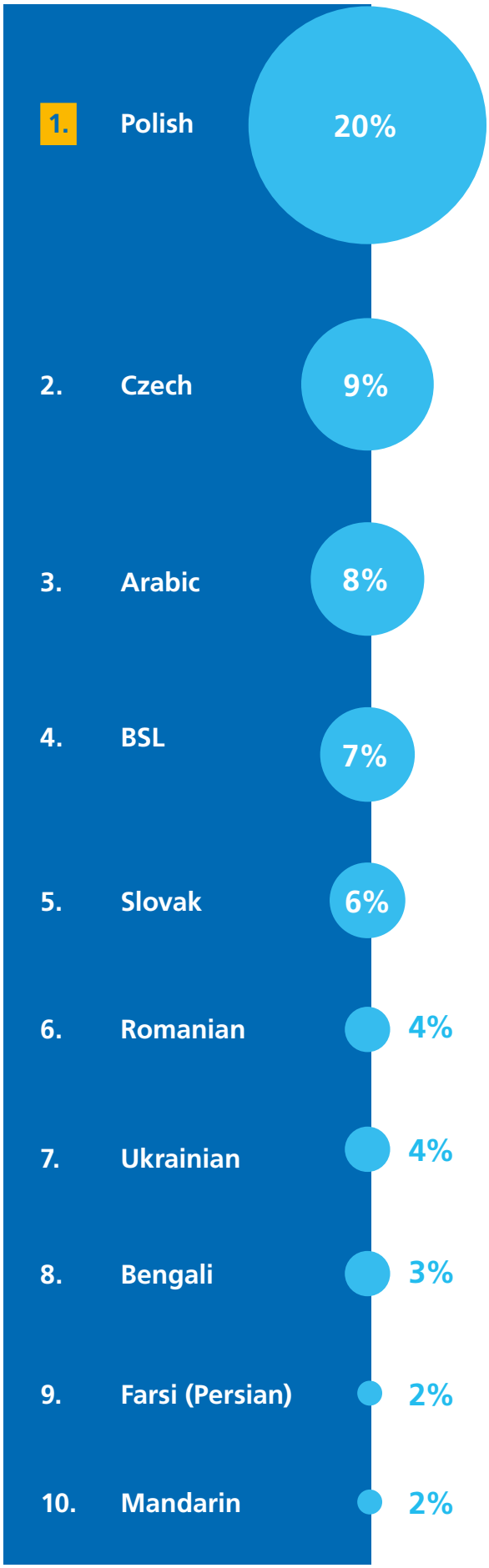
We have some exciting Arts projects planned including:

- Improving the experience of children and young people in our emergency department
- Baby memorial garden
- Dementia friendly art work at the new Community Diagnostic Centre
- Installation of Submergence, a light and sound immersive experience. This will be installed in both Oncology outpatients and Childrens Centre. It is hoped these installations will support wellbeing of patients in these areas.

Interpretation and Translation

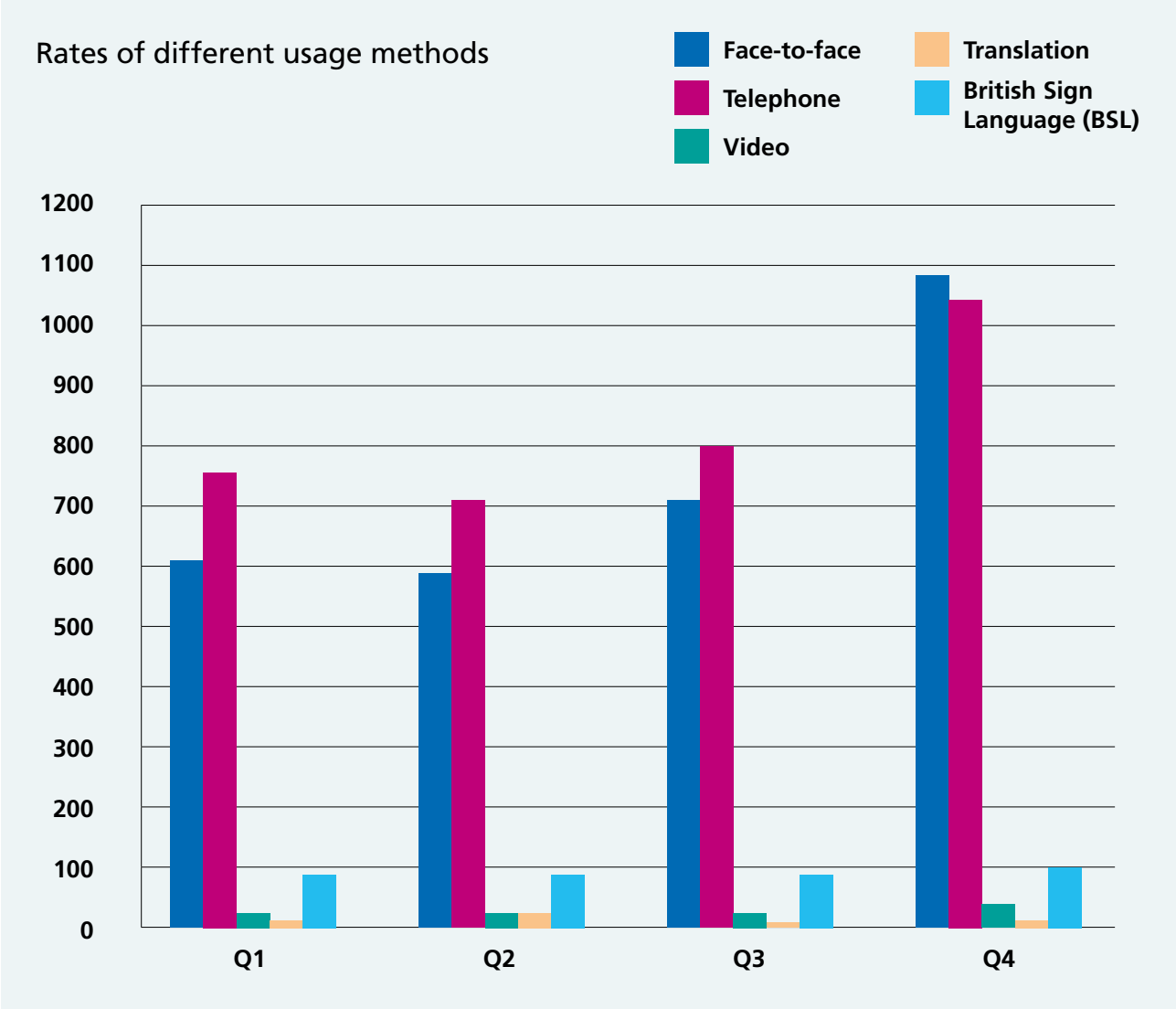
The following data shows the 10 most commonly requested languages for interpretation and translation in the Trust, including British Sign Language (BSL). The data is compared to 2021-22. Overall, the total number accessing this service has increased in all commonly requested languages.

We had 53 different languages requested during 2022/23.



Data: 2022–23

The following charts demonstrate the rates of different methods of interpreting, for example, face to face, telephone, video, British Sign Language and translation of written materials including Braille.



We are re-tendering our translation and interpreting contract collaboratively with our colleagues at Gloucestershire Health and Care, Gloucestershire Integrated Care Board and Gloucestershire County Council. This is to ensure people in Gloucestershire have a high quality, efficient translation and interpreting service available to them.

In addition, all four organisations will be working together to support the engagement of our patients and service users and increase awareness of the importance of interpreting and translation services.

We are working with our current provider for translation and interpreting services to offer a relay telephone service for our patients to be able to call an interpreter and then they will contact the department requested by the patient. This will enable patients to be able to make contact with the Trust to be able make, amend and cancel appointments but also to seek advice and support too.

Improvement work continues in maternity services including introducing the use of iPads for video interpreting and looking at how interpreting can be improved for those needing to go to theatre.

All interpreting and Translation services are available across all settings, however, some services may not be deemed appropriate by clinicians in every setting. There are national challenges in providing an interpreter as the demand is outweighing the supply across all providers. We are however, out to tender for a new interpreting and translation contract and we are undertaking this as an Integrated Care System with colleagues from NHS Gloucestershire Integrated Care Board, Gloucestershire Health and Care NHS FT and Gloucestershire County Council. As part of this partnership working, we will also embark on a community engagement programme not only to raise awareness of interpreting services but to also promote the role of an interpreter for those that may be interested in this as a role. This will hopefully build some resilience locally and support our local communities.

Equality Impact Assessment

The Equality Impact Assessment is a tool that helps to ensure decisions, practices and policies within the organisation are fair, and do not discriminate against the protected characteristics.

In order to meet the requirements of this duty, the Trust will use the Equality Impact Assessment process which has been developed to be compliant with the Equality Act 2010

The Trust has an obligation to:

- Evidence the analysis that has been undertaken to establish whether our policies and practices have (or would) further the aims of the general equality duty.
- Provide details of information that we have considered when carrying out an analysis.
- Provide details of engagement (consultation / involvement) that we have undertaken with people whom we consider would have an interest in furthering the aims of the general equality duty.

An equality impact assessment (EIA) is most effective when used at the primary stages of planning and is expected to be used for the following activities:

- Organisational change
- Considering any new or changing activity
- Developing or changing service delivery
- Procuring services
- Developing projects
- Developing a policy / procedure / guidance or changing or updating existing ones

Used to assess whether there may be any barriers or difficulties, harassment or exclusion, or any positive impact such as promotion of equality of opportunity, developing good community relationships, encouraging participation and involvement as experienced by service users, patients, carers, relatives, staff, the general public and key stakeholders.

Recruitment

This section identifies disparities of the likelihood of being appointed to a role based on identifying with a protected characteristic. A score of 1.0 means that there is no greater or lesser likelihood of someone being appointed over another. A score of more than 1.0 indicates a greater likelihood: the higher the score, the greater the likelihood.

Ethnicity

When comparing the data between White and Ethnic Minority groups, in line with our WRES submission our data indicates that White applicants are more likely to be appointed compared to BME applicants.

From application to appointment:

- White applicants are 15.47 times more likely to be appointed compared to Black Ethnic applicants, and 4.28 times more likely to be appointed compared to Asian Ethnic applicants
- Asian Ethnic applicants 3.62 times more likely to be appointed compared to Black Ethnic applicants

From shortlisting to appointment:

- White applicants are 1.60 times more likely to be appointed compared to Black Ethnic applicants, and 1.33 times more likely to be appointed compared to Asian Ethnic applicants
- Asian Ethnic applicants are 1.21 times more likely to be appointed compared to Asian Ethnic applicants

Disability

When comparing disabled and non-disabled applicants, in line with our WDES submission, the data indicates that disabled applicants are less likely to be appointed compared to non-disabled applicants. Applicants who have declared having a disability include those with mental health conditions, physical disabilities and impairments, and longstanding illness.

- From application to appointment, disabled applicants are 1.57 times more likely to be appointed compared to non-disabled applicants.
- From shortlisting to appointment, non-disabled applicants are 1.39 times more likely to be appointed compared to disabled applicants.

Gender

When comparing male and female applicants, the data indicates that females are more likely to be appointed than males. This may reflect that a large proportion of healthcare roles are historically filled by women.

When comparing male and female applicants, the data indicates that females are more likely to be appointed than males. This may reflect that a large proportion of healthcare roles are historically filled by women.

- From application to appointment, female applicants are 2.40 times more likely to be appointed compared to males.
- From shortlisting to appointment, female applicants are 1.35 times more likely to be appointed compared to males

Sexual Orientation

When comparing heterosexual and LGBTQ+ applicants, the data indicates a fair recruitment process for those who have declared their sexuality as heterosexual, non-disclosure, Gay or Lesbian, other sexual orientation and undisclosed. However, the data indicates a less equitable outcome for those who identify as bisexual. It is worth noting that the reliability of data for 'other sexual orientation' and 'undecided' is low due to very low number of applications for these groups.

From application to appointment, heterosexual applicants are:

- 2.33 times less likely to be appointed compared to Gay/ Lesbian applicants.
- 1.44 times less likely to be appointed than bisexual applicants
- 1.85 times less likely to be appointed than 'other sexual orientation' applicants.
- 1.96 times less likely to be appointed than undecided applicants.
- 1.13 times less likely to be appointed than undisclosed applicants

From shortlisting to appointment, heterosexual applicants are:

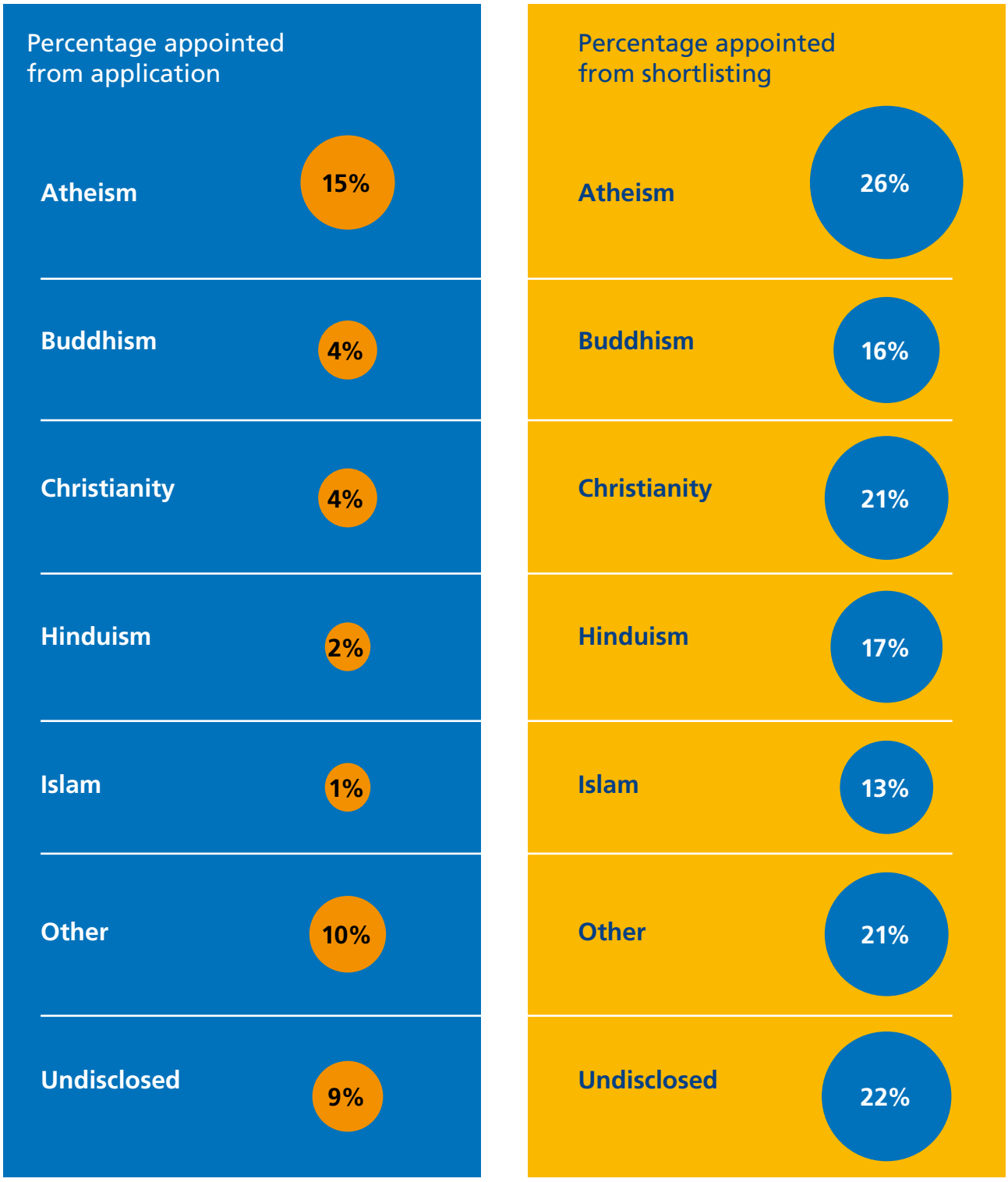
- 1.12 times less likely to be appointed compared to gay/ lesbian applicants. This means heterosexual applicants are marginally less likely to be appointed
- 1.06 times more likely to be appointed than bisexual applicants
- 1.08 times less likely to be appointed than other orientated applicants
- 1.39 times less likely to be appointed than undecided applicants
- 1.17 times more likely to be appointed than undisclosed applicants

Religion and belief

When comparing applicants with different religions/beliefs, those who identify as Hindu and Muslim are considerably less likely to be appointed from application compared to other religious/belief groups.

For some religions, the reliability of the data is low and should be viewed with caution. In 2022/23 we received 100 applications in total from the following: Sikhism; Judaism; Jainism.

For the other religions where application numbers are higher, the table below illustrates the percentage of applicants who were appointed from application, and from shortlisting:



Data indicates that those who are Atheist, Other, undisclosed or Christian are most likely to be appointed from shortlisting, and those who are Buddhist, Hindu or Islam are less likely to be appointed from shortlisting.

Age

Applicants in the age groups of under 20 years; 55-59 years and 60-64 years are more likely to be appointed than those in other age groups.

Recruitment remains a real focus for our Trust and we are committed to the principles of diversity and inclusion. Our recruitment processes encourage candidates from diverse backgrounds to apply for positions, and we are working to ensure that diversity and inclusion are taken into consideration when evaluating the skills, knowledge and experience needed for each candidate.

All Band 8a and above interviews have to have an Inclusion Champion on selection panels, and this is a mandatory requirement. The role of the inclusion champion is to monitor and challenge bias, and decision making to ensure fair recruitment practices and positive action are in place.

Workforce Data

The Trust is committed to treating all its patients and colleagues with dignity and respect. Embracing diversity supports the delivery of our Strategic vision and helps to ensure that we are providing effectives services that meet the needs of our community. We have an EDI strategy which is a public declaration of how we will demonstrate our commitment to ensure EDI is embedded within all aspects of the organisation.

This analysis gives an overview of the existing workforce in 2022/23:

Ethnicity

As per the Trust's annual WRES submission, BME staff as a proportion of the workforce has increased from 16.5% to 18.1% at the time the data was analysed. Additionally, 11.1% no longer disclose their ethnicity status to the Trust: this has increased by 3.4% since the previous year.

Overall representation across all ethnic groups has remained fairly stable since 2016/17.

8.93% of our workforce are Asian.

Asian colleagues are most represented in the following staff groups:

- Medical and Dental (15.95% of staff group)
- Nursing and midwifery (12.2%)
- Additional clinical services (6.88%)
- Estates and ancillary (5.68%)

4.07% of our workforce are Black.

Black colleagues are most represented in the following staff groups:

- Estates and ancillary (8.22%)
- Medical and dental (6.34%)
- Additional professional scientific and technical (3.99%)
- Nursing and midwifery (3.91%)

Disability

As per the Trust's annual WDES submission, 2.9% of the Trust's workforce have declared a disability.

This is an increase of 0.3% on the previous year. There remains a high proportion of colleagues (43.83%) for whom we do not know their disability status. We will continue to encourage colleagues to tell us if they have disability or long-term condition.

Gender

In 2022/23. 80.80% of the workforce were female, and 19.20% were male. This is a change of 3.2% decrease in males and 3.21% decrease in females.

Age

The majority of the workforce is made up of people in the age groups:

- 21-30 years (20.70%)
- 31-40 years (27.80%)
- 41-50 years (21.70%)
- 51-60 years (21%)

Collectively these groups represent 91.2% of the workforce

More recently we have seen an increase in representation in age groups 31–40 years (going from 27.8% in 2020/21 to 28.5% in 2021/22).

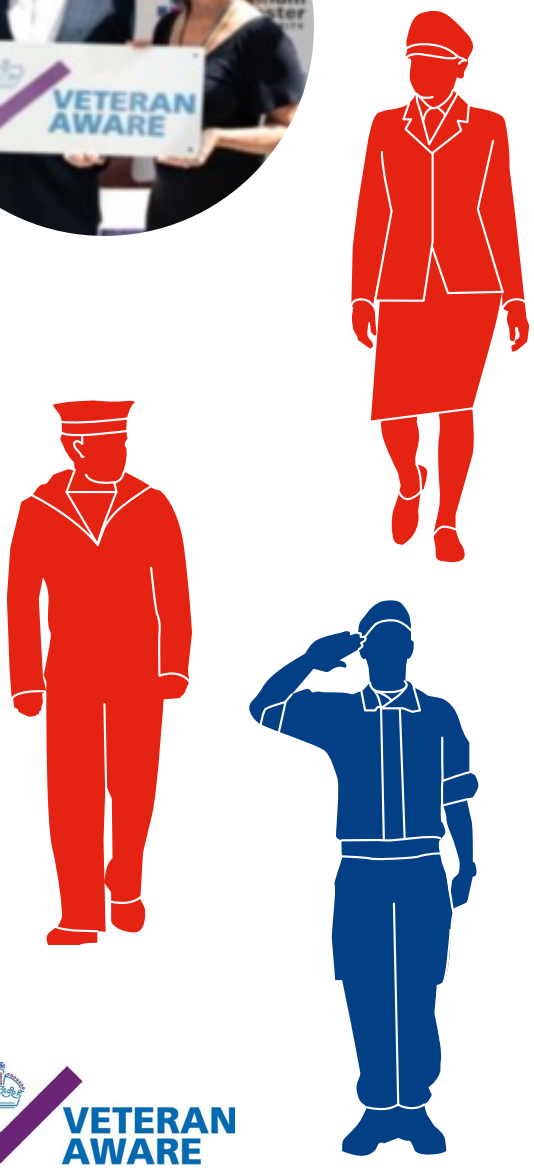
Key achievements in the last year

Through our equality, diversity and inclusion initiatives, we continue to promote our values and behaviours at every opportunity and specifically to engender a sense of belonging for all by creating an environment where we value unique differences. We strive to build a workforce which is representative of the communities that we serve and to create a work environment where colleagues are supported, treated fairly, which is free from discrimination and where there is psychological safety for all. While we acknowledge that there is much work still to be done to achieve our ambitious EDI objectives, we are proud of the progress we have already made over the past 12 months and still continue to make, they include:

Veteran

The Trust was reaccredited by the Veterans Convenance Healthcare Alliance (VCHA) in July 2022 in recognition for the work and relationships undertaken with the local Armed Forces Community. NHS Providers that have been accredited demonstrate themselves as exemplars of the best care for veterans, helping to drive improvements in NHS care for people who serve or have served in the UK armed forces and their families.

Veterans Aware award Presentation for the hospital and Armed Forces Community



Veteran Aware Trusts:

- Provide leaflets and posters to veterans and their families explaining what to expect and train staff to be aware of veterans' needs and the commitments of the NHS under the Armed Forces Covenant
- Inform staff if a veteran or their GP has told the hospital they have served in the armed forces
- Ensure that members of the armed forces community do not face disadvantage compared to other citizens when accessing NHS services
- Signpost to extra services that might be provided to the armed forces community by a charity or service organisation in the trust
- Look into what services are available in their locality, which patients would benefit from being referred to
- Veteran attendance in 2022-2023 is 1520
- Veteran EPR compliance from April 2022-2023 was 79%
- Armed Forces Breakdown by Month Year Month Armed Forces Admission Documents

Objectives 2023-2024

- Re-sign Armed Forces Covenant to acknowledge The Armed Forces Act 2021 was amended to include the Armed Forces Covenant as a Statutory requirement within the Private Sector
- Pledge support to Step into Health programme to actively recruit workforce from the Armed Forces Community
- Register with Forces Family Jobs to proactively engage with the Armed Forces Community
- Design and produce a Banner Scroll promoting the Trust as a Veteran Aware Hospital
- Increase compliance with the Electronic Patient Records System
- Work with Business intelligence to design a live Veteran portal for support
- Request a Veteran e-refer tab on the Trust intranet to accommodate Advocate Referrals out of hours
- Publication in Trust Newsletter, Twitter and local Press about the Armed Forces work in the hospital
- Publication in Armed Forces Journal
- Armed Forces Advocate uniform
- Remembrance Service attended by Veteran patients as able
- Armed Forces screen saver for Armed Forces Week
- Armed Forces Blog for Chief Exec weekly Blog during Armed Forces week

Health Inequalities

The NHS Long Term Plan set out clear commitments for NHS action to improve prevention by tackling avoidable illness, as the demand for NHS services continues to grow. Supporting patients, service users and staff to overcome their tobacco dependence will not only provide improvements in their health, but reduce health inequalities and also decrease demand on services by reducing the number of smoking related admissions and readmissions. The Global Burden of Disease (GBD) ranks tobacco as the top modifiable risk factor that drives deaths and disability, with 96,058 avoidable deaths associated with its use in England in 2019 (GBD, 2019).

Tackling smoking remains the leading modifiable cause of health inequalities. Tobacco dependence treatment is effective and improves the health and wellbeing of the person smoking and their family, as well as saving them money. Being in hospital is a significant event in someone's life and people can be more open to making healthier choices.

Adult Programme Update

Supporting patients, service users and staff to overcome their tobacco dependence will not only provide improvements in their health, but reduce health inequalities and also decrease demand on services by reducing the number of smoking related admissions and readmissions.

The recommended acute inpatient pathway is underpinned by published evidence on the Ottawa Model for Smoking Cessation and based on work undertaken in Greater Manchester as part of the CURE model. We are pleased to offer this to inpatients admitted to Gloucestershire Hospitals Trust.

By the end of 2023/24 every patient admitted to Gloucestershire Hospitals NHS Foundation Trust (GHT) who smoke will be offered NHS funded tobacco treatment:

- Screened for smoking status
- Opt-out referred to tobacco treatment advisor
- Provided personalised behavioural support and Nicotine Replacement Therapy (NRT)
- Provided discharge package including continued smoking support by community team.

Staff Psychology Service

The Staff Psychology Service was initially launched in October 2020. In 2021-22, additional investment, using NHS Charities Together funds, was secured to increase the number of Staff Psychologists and the addition of an Assistant Psychologist. In March 2023, the service went through a restructure and members of the service left before funding was made substantive. There will be a 1.0 WTE Staff Psychologist post going out to advert in the next couple of months.

The service offers a limited amount of 1:1 trauma focused intervention for colleagues who have experienced trauma at work. We provide access to a four-week online course provided by Balanced Minds which allows individuals to learn Compassionate Mind skills to help them access their soothing system. The service facilitates two online workshops, Compassionate Resilience and Managers, you matter: Supporting You and Your Supporting of Others.

There are a range of bespoke teaching sessions available for teams to request including 'what is compassion?'. The team can also join team aways days for one off teaching or can provide a whole day focused on Compassionate interventions and practices. Decompression sessions and a debrief training package can also be requested by teams. The service will be reinstating its lunchtime mindfulness sessions soon and they will be online to provide easier access.

The 2020 Hub continues to support the emotional, physical and financial wellbeing of staff throughout the organisation via a telephone, email and walk in advice and signposting service. The Hub also outreaches to disseminate information to staff through mobile hubs across Gloucester and Cheltenham sites.

Staff support services:

- **Salary Finance** – Assisting the financial wellbeing of staff through advance access to salary already earned; loans (with repayments made via payroll); savings and the Governments Help to Save Scheme; financial education resources
- **Salary Sacrifice** – Eligible staff have access to an online purchasing system, a bike-to-work scheme and a car lease scheme. These spread costs through monthly payments across at least a year, and payments are deducted directly from gross pay
- **Menopause at work** – The 2020 Hub runs monthly online menopause support sessions providing an informal safe space for colleagues to share experiences and provide mutual support
- **Peer Support Network** – Staff going through a difficult time at work or at home can be matched with a volunteer peer supporter via the 2020 Hub. Our trained peer supporters provide a confidential, non-judgemental and understanding ear when times get hard

The Chaplaincy Team

Our Chaplaincy department have been instrumental in ensuring everyone in the hospital community has the opportunity to access pastoral, spiritual or religious support when they need it. The service is for everyone - patients, visitors and our staff. Whether religious, spiritual or no faith, the team offer person centred, holistic and non-judgemental care for people experiencing any kind of traumatic, difficult, or life-changing situation in the hospital.

Admiral Nurse Service

The Admiral Nurse Service in our Trust is now in its third year. Admiral Nurses specialises in dementia care, by providing support to family carers and people affected by dementia, particularly during complex periods of transition. Admiral Nurses also provides education, leadership, development and support to other colleagues and service providers.

Some positive feedback from the service include:

"I was in hospital for 2 weeks before the dementia nurse was involved - everything changed when she saw me - staff respected her and care improved."

"Asma was involved in my care, and she was my lifeline."

"Asma helped staff to understand me, if she wasn't working, I would be scared and lonely,"

Asma is looking for additional staff who have a passion for caring for people with dementia or want to learn more about dementia.

Training and Development:

Specialist Equality Diversity & Inclusion (EDI) Training

In 2021, a fixed term EDI Training Specialist was appointed to deliver a range of training courses across the Trust. The emphasis being to support Colleagues and Managers, skills, address accountability and commitment to the Equality, Diversity and Inclusion agenda. The Specialist EDI trainer updated and relaunched the new e-learning package as well as deliver additional Disability Awareness training to managers to support their Colleagues with a disability or long-term condition.

Reciprocal Mentoring

In collaboration with One Gloucestershire the Trust Executive Team are taking part in their first pilot Reciprocal Mentoring Programme. Launched in April 2023 the programme is a positive action initiative designed to support staff members from underrepresented groups to develop the skills and confidence to move into more senior roles.

For the Pilot the decision was made that the Executive Team would be mentored by 8 BME colleagues from across the Trust. The aims being to raise awareness and appreciation of the lived experiences of racial inequalities, and factors that might negatively impact the experience of people from an ethnic minority group whilst working in the Trust.

An evaluation of the programme will be completed once the programme has ended. The Trust has decided that would be 2024 to extend its follow up programme to the second tier of managers and across a wider range of protected characteristic groups.

Training - Skill Boosters

In August 2022 the Trust launched a series of online training videos through Skill Boosters, an online platform where staff can preview and download courses and resources to train our workforce. Skill Boosters is designed for self-managed learning and to address the skills that many managers and leaders to give a better understanding of;

- the benefits of being an inclusive organisation
- the key traits of inclusive leadership
- the skills necessary to become an inclusive leader
- why inclusive leaders and inclusive teams are more effective
- how to build an inclusive culture
- the importance of building inclusive relationships
- how tackling the impact of unconscious bias in the workplace leads to better decision-making.

The training consisted of 5 mini-Videos;

1. Sexual Orientation
2. Disability Etiquette
3. Trans Non-Binary Awareness
4. Understanding Race bias at work
5. Unconscious Bias

International Educated Nurses

We positively embrace diversity and believe that a diverse workforce, that shares its knowledge and experience, facilitates the provision of high-quality patient care. In 2022, we welcomed 192 international nurses, (184 IENs, 2 Midwives & 6 Radiographers) from the Philippines, India, and the African Continent. Our new nurses will help us to deliver safe and timely care for our patients and provide a greater staff experience. Upon arrival, our new nurses commenced their intensive training for the Objective Structured Clinical Examination (OSCE) which will allow them to register with the NMC. Our international nurses are supported by an experienced team of OSCE trainers for international nurses alongside the On Boarding Team, EDI Team and Overseas Buddies supporters who ensures they receive the support they need to adapt in their new workplace and Gloucestershire.

Overseas Buddy System

We continue to work together to improve the transition and experience of our overseas nurses by providing a support overseas buddy support (OBS) for the first 3 months of their arrival. In addition to the OBS an International Council has also been established.

Interview skills workshops

The workshop continues to be popular with not just our Ethnic Minority colleagues but by all Colleagues. We are conscious of some of the gaps in development opportunities for some groups, in particular our ethnic minority groups. We have introduced supported initiatives to improve access to development opportunities. In 2021, we commissioned the design and delivery of a series of half-day Interview Skills workshops. The workshops were so successful, we continued to run them again in 2022/23. We have already begun to see progress in this area with a number of ethnic minority Colleagues seeking and gaining promotion.

The workshop explored the following:

- Overview of the recruitment and selection process
- Feedback from the CQC report, WRES data and Staff Survey
- Positive Action
- Answering Questions
- Presentations
- Feedback
- Actions and next steps

Feedback from the participants who attended the workshops

> *a big thank you to you for hosting the interview skills event! I attended the event because I have failed to bag the charge nurse role, my inexperience was exposed, and I waffled immeasurably during the interview. This time around, using the things I've learned in your lecture, I have managed to bag the band 6 charge nurse role in our ward.*

> *I invented the way I answered the question, to the mantra of the STAR technique, and I made sure I didn't open my mouth until I knew what was coming out. I also made sure the clothes I wore to the interview were something smart and that I commanded presence into the room when I came in. I walked out of that room yesterday, promoted.*

Safe Space Event

Colleagues from Ethnic Minorities were able to sit with a panel that consisted of Deputy Directors of Quality and Nursing, and the Chief Nurse. EM colleagues asked questions to the panel, and discussions were held around discrimination and racism within the Trust, and what changes attendees wanted to see to improve their experiences working here.

Exposed: Racism and the Pandemic Screening

An event was held for the screening of the documentary film 'Exposed: Racism and the Pandemic'. Around 40 colleagues attended, including many senior leaders in the Trust. Following the screening, a discussion was held with attendees to discuss how they felt following the screening and their experiences within our Trust.

Race Equality Week

In February the Trust took part in Race Equality Week by joining with Race Equality Matters in their continued effort to address the barriers to race equality. Over the five working days of Race Equality Week, our CEO asked everyone to take just 5-minutes each day to reflect and commit to action to drive change. The week included lots of online events and the opportunity to make a personal pledge.

Schwartz Round – Discrimination in our Workplace

Schwartz rounds are an opportunity through narrative to explore the impact of what happens at work on how we care and are cared for. The Schwartz round was an opportunity to listen to the personal experiences of colleagues who have been impacted by discrimination particularly in relation to racism. Colleagues were able to share their experiences in a supportive confidential forum or simply hear about the experience of other.

EDI Ambassador Pilot

The Equality, Diversity and Inclusion Ambassador (EDIA) pilot was launched to improve communication, promotion and awareness with hard-to-reach groups of colleagues in the Trust. 12 pilot areas were identified based on the results of the cultural barometer. Ambassadors were able to volunteer to take part with their managers approval. Some of the areas originally identified did not have any volunteers so did not take part, and some areas had more than one ambassador volunteer. The final number of ambassadors taking part in the pilot was 16. To ensure consistent communication to support ambassadors, share information and collect feedback, quarterly meetings were arranged and ambassadors were sent monthly emails. Ambassadors were encouraged to contact the Equality, Diversity and Inclusion (EDI) team at any point if they needed additional support or had queries or concerns.

There were a number of successes that emerged from having EDI ambassadors in the pilot areas. We found that for some of these areas there was an increase in problems and concerns being brought to the EDI team, allowing additional support to be given. An example of concerns is lack of perceived promotion opportunities in these areas. This enabled the EDI team to give additional information on initiatives in the organisation for the EDI Ambassadors to share with areas.

There were two areas that were particularly engaged in the EDI Ambassador pilot. Finance had three Ambassadors, each of whom have joined quarterly meetings, corresponded via email and joined other EDI related meetings including the EDI steering group and Ethnic Minority Council Meetings. The Finance Ambassadors had some fantastic successes including a series of Black History Month communications, and the introduction of department wide conversations during meetings around EDI related topics.

Partnerships and Collaboration

We are proud to be a diverse workforce and we want to make sure that our working environment welcomes all people to help serve and care for our local community and each other. One of the key actions for us to achieve our ambition of putting EDI at the heart of everything we do is building community partnerships. A great deal of work has been done by our Community Outreach Worker Juwairiyia Motala, who since taking on the role has been instrumental in bridging the gap between the Trust and the wider Community of Gloucester.

Examples of this include:

Attending a Women's Well-Being Group, being a Supporting body at the Gloucester Asylum Seekers Welcome Café and also along with a team of colleagues arranged a Iftar event, where the Colleagues and the Community were able to come together to break their fast.

Governance Structure for Equality Diversity and Inclusion

Whilst equality, diversity and inclusion is threaded across all structures and services in our Trust, we have a formal governance route which ensures that an overarching strategic and operational function is in place to both deliver and provide assurance on our progress. Colleagues from across the Trust can get involved in our umbrella Inclusion Network which is open to all.

We also have specific networks aimed at colleagues who identify with the following communities: Ethnic minorities, disabilities/long-term conditions, and LGBTQ+.

These all feed into our Equality Diversity and Inclusion Steering Group (EDISG) which formally reports into the Trust's People and OD Delivery Group (PODG). The People and OD Committee (PODC) seeks assurance of the Steering Group's activities on behalf of the Trust Board.

Inclusion Network

The Inclusion network has 3 sub networks, LGBTQ+, Ethnic Minority and Disability and we hope to establish 2 further networks (Women's network & Mens Conversation network) in the coming year. All of which support colleagues to have their voices heard, shared lived experience, raise awareness and provide a space for us to learn and improve how we do things

All three networks continue to be a source of peer-to-peer advice and support for colleagues. The Trust continues to improve awareness of the Freedom to Speak up Guardian, the EDI Team and Health and Wellbeing Hub who provide a confidential service for colleagues to reach out for advice where they feel they may have experienced harassment and bullying or discrimination.

It was identified that there were a number of improvements that could be made to the staff networks, in order to make them more inclusive, easier to access, to ensure a focus on the networks aims and to improve visibility. In order to do this, we relaunched what was previously the 'Diversity Network' as the 'Inclusion Network'.

This was done with a refresh of network branding, and a launch of our new 'Inclusion Council', which brings together our three sub-networks (Ethnic Minority, LGBTQ+ and Disability) and is chaired by the co-chairs of these subnetworks. This has allowed for a collaborative and inclusive way of working towards colleague-led change within the Trust, and has allowed more space for allyship and intersectionality.

We have worked tirelessly to address the issues of discrimination in particular racism by holding a number of events which has shone a light on the inequalities and inequity colleagues experience. We have worked incredibly hard to ensure those who work in our Trust feel valued, appreciated and safe to be who they are.

Disability Network

The Disability Network is for staff with a disability or long-term health condition and their allies who work for the Trust. The aim of the group is to discuss and improve issues that may affect members of staff with a disability. Unfortunately, despite our efforts we have not been able to recruit a Disability Chair, however we still continue to update our colleagues in the monthly Inclusion meetings, through social media platforms and the Inclusion network newsletters.

Ethnic Minority Network

Empowering Black, Asian, and Minority Ethnic Colleagues to achieve their potential through creating positive change. The Network aims to create an inclusive culture and environment to ensure all staff are able to thrive. The group strives to raise the importance of the cultural diversity agenda and facilitate improvement across the Trust

For **Black History Month** in October, we celebrated with posters around the Trust sites highlighting the stories of some of our senior nursing colleagues from ethnic minorities. We also asked colleagues who their Black historical role models were, why they were #Proud to be, and sent out an updated recipe book with colleagues favourite cultural recipes called 'Menu of Memories'. The library were busy promoting books related to Black History Month.

Race Equality Week February. The Trust took part in Race Equality Week by joining with Race Equality Matters in their continued effort to address the barriers to race equality. Over the five working days of Race Equality Week, our CEO asked everyone to take just 5-minutes each day to reflect and commit to action to drive change. The week included lots of online events and with the opportunity to make a personal pledge.

I am personally appealing to everyone to reflect on their own behaviours, your inherent bias – conscious or otherwise and to have the courage to talk to colleagues whose behaviours gives you cause for concern. Last month, a number of us attended a Schwartz Round where we heard the experiences of an international nurse and two doctors in training which will remain with me forever and my resolve to respond to their experience is stronger than ever. This was very powerful testimony and one which we intend to use as part of our efforts to raise awareness of the need for each and every one of us to play our part in making our Trust a place where everyone can thrive. We know that to make our hospitals a place that people want to work that we have to tackle, head on, the discrimination that many colleagues experience, day in day out. Make your promise online.

A new member of the Ethnic Minority network

I joined the Trust in May 2023 and was inspired by the honesty of the Chief Executive in our induction. In Deborah Lee's welcome speech, she not only highlighted areas of inadequacy and discontentment within the Trust, but called on each of us to be accountable and call out concerns and discrimination.

Tali Blake

Lesbian Gay Bisexual Transgender and Queer (LGBTQ+) Network.

The LGBTQ network comes together to celebrate difference. It provides an accepting, open and understanding community, and to make positive changes within the Trust. During September we celebrated Pride by asking colleagues to wear rainbow to show support for the LGBTQ+ community. We also had colleagues let us know what Pride means to them and sharing colleagues' LGBTQ+ role models. The library also did a spotlight on LGBQT+ library books. This was all communicated via our social media channels and a special pride themed newsletter.

The network is working to increase the awareness of our LGBTQ+ Colleagues and patients. Particularly those who are transgender. Transgender individuals can sometimes experience a cycle of vulnerability, discrimination and exclusion.

Our LGBTQ+ Chair has been working hard to educate colleagues and has been holding a number of 'Ask me anything' 'This is me' sessions to educate and increase awareness of the trans community.

This is me.

My name is Emma and I'm a transwoman. I work in the theatre department as an Operating Department Practitioner and came out as transgender in 2017.

I have received a massive amount of support but have equally have suffered discrimination due to misconceptions and poor education toward to trans community.

The EDI team has not only given me the support I need, but have also enabled me to educate and dispel falsehoods about the trans community, and the LGBTQ+ community as a whole. I hope to keep sharing information, educating and helping those who need support in the future.

By Emma

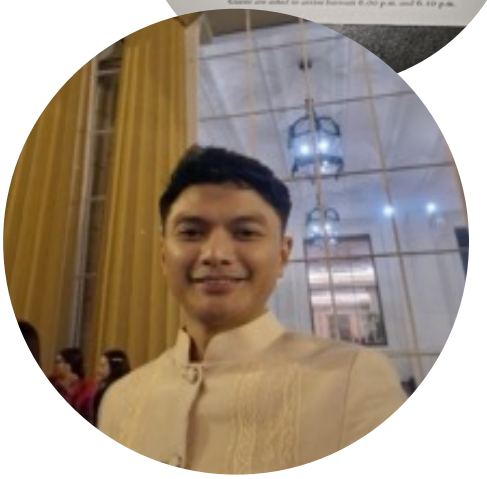
The Trust has hosted and celebrated a number of Cultural and religious events

Our events-based calendar is used to raise awareness of diversity and promote equality, inclusion, and acceptance across the wider NHS and locally here at the Trust. Events and celebrations 2022/23 have included: a number of events including. South Asian Heritage Month, Race Equality Week, LGBT History month, PRIDE, Black History Month and Disability Awareness Month.

- March to April 2023 was the Muslim holy month of Ramadan. Colleagues marking Ramadan are supported in breaking the fast, Iftar. Iftar is the breaking of the fast which is an essential part of a typical day during Ramadan. This can be done either with their families or for those who are working, can be part of their daily routine. At the hospital we incorporated this by having our own Iftar in Fosters restaurant

- We also celebrated 75 Years of the NHS with a celebration at Gloucester Cathedral. Staff from across the NHS and social care were invited to attend. The event included songs and readings NHS leaders and community partners offered their reflections on the significant contributions made by the county's dedicated health and care professionals over the years.
- There was an opportunity to visit an NHS 75 Exhibition in the Cathedral, which included images and items from across the local NHS as well as from Windrush.
- In July the NHS teamed up with parkrun UK to mark the 75th anniversary. NHS staff and volunteers, as well as local communities, were encouraged to take part.
- 75th anniversary of Windrush, was celebrated by the raising of the Windrush flag outside the Tower Entrance at GRH, followed by Readings, Cake, Refreshments and entertainment from Music works in the Memorial Garden in GRH and outside Sandford Education Centre.
- In December Coral Christmas Carols took place in the Atrium. Staff were asked to join us to celebrate the festive period. This proved to be extremely popular for both staff, visitors and patients. It increased staff morale and wellbeing and we hope to do this again in Dec 2023.

- Kyle Marasigan had a once-in-a-lifetime opportunity to go to Buckingham Palace to celebrate British East and South-East Asian Communities in February 2023.



It was truly a remarkable experience to meet His Majesty the King, the Queen Consort and members of the royal family to celebrate my heritage and for us to be recognised on our contributions to the United Kingdom. I got to meet senior NHS leaders and senior Filipino nursing leaders too!

I attended wearing our national Filipino attire, the Barong Tagalog, I have never been prouder being one of the many Filipino nurses working for the NHS.

Our vision, purpose and values

Purpose

Our Trust has a clear purpose which is to improve the health, wellbeing and experience of the people we serve by delivering outstanding care every day.

Vision

Gloucestershire Hospitals NHS Foundation Trust has a clear vision of the best care for everyone. This means that, regardless of who you are, we aspire that all patients will receive the best possible care and treatment. To truly achieve this, we must be able to adapt our services flexibly to meet the different needs of everyone.

Values

We have three core values of Listening, Caring and Excelling. These are interdependent with one another. We recognise that in order to excel in the delivery of our services we need to truly listen to our patients and colleagues, take action to remove barriers and make improvements to enhance the quality of care and overall experience. These are underpinned by compassion and we have launched our new compassionate behaviours framework which focus on four key elements:

- We are attentive
- We are understanding
- We show empathy and compassion
- We are helpful

Our values and behaviours help to articulate what the principles of equality diversity and inclusion look like on a day-to-day basis, and can be demonstrated by all members of the Trust when communicating with patients, families and one another.

Gloucestershire Hospital is committed to providing an environment in which diversity is valued and encouraged, and to ensuring patients, carers, families and staff are treated with dignity and respect, no matter their protected characteristics.

We strive to provide the best care and treatment we can, within the resources available to us, while ensuring everyone working in the NHS has the right training and skills for their job within a safe and clean environment. This cannot be achieved if there is prejudice, discrimination, alienation, or social exclusion. Services need to be accessible, appropriate and sensitive to the needs of all service users.

No-one should be excluded or experience particular difficulty in accessing and effectively using our services due to their age, disability, gender reassignment, marriage/ civil partnership, pregnancy/ maternity, race/ethnicity, religion or belief, sex or sexual orientation.

As an Equal Opportunities employer, we strive to have staff with the right skills to deliver equitable and quality services. We are committed to ensuring that our employees are not discriminated against and are appropriately supported in the workplace.

Report to Board of Directors

Date	May 2024
Title	Health and Safety Executive – Letter of Contravention
Author / Sponsoring Director/ Presenter	Lee Troake, Head of Risk and Safety Claire Radley, Director for People and Organisational Development

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

Key issues to note

The Health and Safety Executive carried out a statutory inspection over a three-day period in December 2023 and February 2024.

The Trust has received a Notice of Contravention Letter (Appendix 2). An NoC informs an organisation that the Inspector suspects or has seen something that is a breach of a regulation. It requires the Trust to respond and to outline what it will do to resolve any concerns highlighted. An NoC is not an Improvement Notice, the latter being a formal 'must improve' approach with a strict deadline.

The letter notes two material breaches:

- Section 2(1) and section 3(1) of the Health and Safety at Work etc. Act 1974 / The Management of Health and Safety at Work Regulations 1999, Regulations 3(1), 5(1) and 7 in relation to managing violence and aggression
- Section 2(1) and section 3(1) of the Health and Safety at Work etc. Act 1974 / The Management of Health and Safety at Work Regulations 1999, Regulations 3(1), 5(1) / The Manual Handling Operations Regulations 1992, Regulation 4 in relation to managing manual handling risks

Five key actions are required in order to achieve compliance. These are:

1. Ensure that the 'competent' advisers for violence and aggression risk that you use have the appropriate skills and experience in violence and aggression to be deemed competent
2. Implement the control measures that have been identified by: competent advisors; in violence and aggression policies; procedures and proposals and in risk assessments. This will include the implementation of controls to address the points listed in Appendix 1 (of the letter).
3. Identify doors that are broken and doors that do not hold open that present a manual handling risk and reduce it as low as is reasonably practicable e.g., no holds to doors in Resus area.
4. In relation to the TUR bucket, to demonstrate why manual handling cannot be eliminated by purchasing a Neptune machine.
5. Demonstrate that the Trust is now aware of the essential manual handling training that takes place within the surgical team and systems are in place to ensure all essential training records are accessible to the manual handling training team / others.

The Trust has an agreed action plan, which has been shared with the Executive Directors, Trust Health and Safety Committee and other key stakeholders (Appendix 3). This is a detailed action plan that addresses each point raised by the Inspector in their letter, including the main actions required to achieve compliance as outlined above. Further details regarding the actions are in the enclosed report (Appendix 1) and actions plan (Appendix 3). The Trust will progress the action plan and provide the HSE with an up-to-date copy by 31 May 2024. The Inspector noted that some control measures such as the ongoing security review and the identification of doors across the Trust that may require holds, will be implemented beyond 31 May 2024. The letter confirms that the Trust may demonstrate compliance with a robust action plan that identifies clear intentions and implementation dates. Appendix 3 provides the timeline for the security review. The letter also states that the HSE intend to write separately to GMS regarding PPE and manual handling training for their staff. GMS are, for the purposes of health and safety legislation, the legal duty holder in relation to their staff.
Risks or Concerns
Risk of an Improvement Notice if the Trust fails to comply with the NoC.
Financial Implications
Unknown, actions will be costed as part of the action plan

Approved by: Director of Finance / Director of Operational Finance	**Date:**

Recommendation
The Board is asked to **NOTE** the report.
Enclosures
Appendix 1 - HSE Update Report Appendix 2 - HSE Letter – NoC Appendix 3 - Trust Action Plan Appendix 4 - Security review timeline

Gloucestershire Hospitals NHS Foundation Trust

Board Report - HSE Inspection Update

May 2024

1. Summary

In November 2023, the Health and Safety Executive (HSE) announced an inspection of the Trust under two themes - violence and aggression (V&A) and musculoskeletal disorders (MSD).

2. Inspection Planning

Prior to the inspection, work was undertaken to prepare the Trust for the Inspection which included:

- A gap analysis and a RAG rating to highlight of areas of risk, which was shared with divisions and key stakeholders as part of the pre-inspection briefings
- Instructions to all departments detailing how to prepare for the inspection, and including specific actions to take
- Prioritised work within high-risk areas and specialist teams to reduce the gaps in compliance
- Briefings with key staff, managers and key Board members
- Evidence folders were prepared

3. Inspection Visits

The Inspection was conducted over 3 days, commencing on 6 December 2023 when the Inspectors interviewed key staff, reviewed the Trust's management system and assessed the commitment of the Board to managing the risks.

Three Inspectors returned on 6 February 2024 to conduct an on-site inspection in Gloucestershire Royal Hospital (GRH), predominantly looking at V&A in the Emergency Department and again on 7 February to conduct an on-site inspection in Cheltenham General Hospital (CGH) focussed on MSDs in Theatres and the GMS portering role.

4. Informal feedback

Verbal, informal, feedback was provided to the Trust after each inspection day and this included in reports to the People and Organisational Development (OD) Delivery

Group, the People and OD Committee, the Trust Health and Safety Committee, and to the Executive for People and OD.

Between February and April 2024, the HSE followed up various lines of enquiry with GMS in order to finalise their opinion.

5. Letter of Contravention

A Notice of Contravention (NoC) letter was sent to the Trust on 4 April 2024 (Appendix 2).

An NoC informs an organisation that the Inspector suspects or has seen something that is a breach of a regulation. It requires the Trust to respond and to outline what it will do to resolve any concerns highlighted. An NoC is not an Improvement Notice, the latter being a formal 'must improve' approach with a strict deadline.

The letter notes two material breaches:

- Section 2(1) and section 3(1) of the Health and Safety at Work etc. Act 1974 / The Management of Health and Safety at Work Regulations 1999, Regulations 3(1), 5(1) and 7 in relation to managing violence and aggression

- Section 2(1) and section 3(1) of the Health and Safety at Work etc. Act 1974 / The Management of Health and Safety at Work Regulations 1999, Regulations 3(1), 5(1) / The Manual Handling Operations Regulations 1992, Regulation 4 in relation to managing manual handling risks

The letter also states that the HSE intend to write separately to GMS regarding PPE and manual handling training for their staff. GMS are, for the purposes of health and safety legislation, the legal duty holder in relation to their staff.

6. Trust Action Plan

The Trust has an agreed action plan, which has been shared with the Executive Directors, Trust Health and Safety Committee and other key stakeholders (Appendix 3). This is a detailed action plan that addresses each point raised by the Inspector in their letter, including the main actions required to achieve compliance as outlined below.

6.1 V&A

Key observations highlighted by the HSE led to two main actions to achieve compliance for V&A.

- **Action Required:** Ensure that the 'competent' advisers for violence and aggression risk that you use have the appropriate skills and experience in violence and aggression to be deemed competent

This action relates to contractual requirements for GMS under the Service Level Agreements (SLA) for Security and /or the Violence and Aggression Response. The SLA requires a suitably qualified security manager to be in place within GMS. The interim post holder in GMS does not hold sufficient qualifications, and GMS have been unable to provide evidence to the HSE of the qualifications of the substantive post holder who has been away from the business for some time.

The Trust has included a specific action within the action plan for GMS to address this and for the Trust to reassure itself that this has been satisfied.

- **Action Required:** Implement the control measures that have been identified by: competent advisors; in violence and aggression policies; procedures and proposals and in risk assessments. This will include the implementation of controls to address the points listed in Appendix 2 (of the letter).

This action relates to a number of well-documented issues with the current security / V&A response model. These include, but are not limited to, the portering and site team having insufficient resources to respond in a timely way to incidents, a lack of security presence in the Emergency Department, a lack of PPE for responders, the impact on patient flow and critical services, and lack of proactive CCTV monitoring.

It was acknowledged by the HSE that at the time of the inspection the Trust had been presented with a proposed new security model in August 2023, which has been rejected by the Director of Operations Group (DOAG). Following increased concerns about safety, the Trust commissioned an external consultant in early 2024 to carry out an independent security review. The final report with recommendations is due by the end of May. The review will consider the security structure, governance, resources and skills required by the Trust. A timescale for the review is enclosed in Appendix 4.

As a result of the review, the training tender for restraint training was placed on hold and review will encompass the training requirements for the organisation to align with any proposed new security model. These actions are captured in the Trust's action plan (Appendix 3).

6.2 Manual Handling

Key observations highlighted by the HSE led to three main actions to achieve compliance for manual handling:

- **Action:** Identify doors that are broken and doors that do not hold open that present a manual handling risk and reduce it as low as is reasonably practicable e.g., no holds to doors in Resus area.

At the time of the inspection, there were number of locks on doors in the new build area of the Emergency department which had repeatedly broken and a request had

been made by staff to change the type / quality of the lock. There were also concerns about the number of doors across the entire Estate where door hold mechanisms were not in place, leaving staff to manually hold doors while moving beds and patients through.

Busy areas like resuscitation in the Emergency Department did not have door hold mechanisms factored into the new build. This has led to fire doors being propped open to aid handling in some areas. A hold mechanism is required for these doors which will auto-release on the activation of the fire alarm. Some doors, such as ward entrances, must remain secure and a hold device may introduce a tailgating or wandering patient risk.

This action has been captured in the Trust's action plan (Appendix 3).

- **Action:** In relation to the TUR bucket, to demonstrate why manual handling cannot be eliminated by purchasing a Neptune machine.

Theatres had a long-standing specific handling issue relating to surgical waste fluid where the fluid was collected into a TUR bucket and manually disposed of. This created a handling and splashing risk. This risk had already been reduced prior to the inspection by the introduction of a carrousel device. The carousel reduced the weight of the fluid to be moved by splitting it into smaller loads for disposal. However, staff reported to the HSE that a Neptune machine could be purchased that would further reduce the handling requirements.

The Neptune is a closed waste management system that collects, transports and disposes of surgical waste fluid. This would protect staff from exposure to the waste via splashes and spillages. Further work is necessary as to ascertain how the waste is emptied from the Neptune and whether the handling is reduced, as well as to establish the number of machines that would be necessary to support the number of Theatres in use, and the cost-effectiveness of the machines (purchase, maintenance and servicing) based on the number of operations carried out where this could be used. This action has been captured in the Trust's action plan (Appendix 3).

- **Action:** Demonstrate that the Trust is now aware of the essential manual handling training that takes place within the surgical team and systems are in place to ensure all essential training records are accessible to the manual handling training team / others.

During the inspection, Theatres provided the Inspectors a folder of paper-based manual handling training records. The HSE noted they had not been recorded centrally alongside other manual handling training records and were not visible to the central Manual Handling team. Whilst keeping paper-based records is not in itself a material breach, the inability to centrally monitor training records is not good practice. This action has been captured in the Trust's action plan (Appendix 3).

7. Next Steps

The Trust will progress the action plan and provide the HSE with an up-to-date copy by 31 May 2024. The Inspector noted that some control measures such as the ongoing security review and the identification of doors across the Trust that may require holds, will be implemented over time. The letter confirms that the Trust may demonstrate compliance with a robust action plan that identifies clear intentions and implementation dates.

Author: Lee Troake
May 2024

INSPECTION

Sarah Reilly

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Regulatory Inspector
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Gloucestershire Hospitals NHS Foundation Trust
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GL53 7AN

Ref: 4774456

For the attention of Kevin McNamara - Chief Executive

4th April 2024

Dear Sir,

HEALTH AND SAFETY AT WORK ETC ACT 1974

I visited the A&E Department at Gloucestershire Royal Hospital (GRH) on 6th February 2024 and the Surgical Department at Cheltenham General Hospital on 7th February 2024 to assess how well you were managing health and safety (violence and aggression and manual handling). I met several staff during my time on site including, Mrs Lee Troake (Head of Corporate Risk, Health and Safety).

I identified contraventions of health and safety law. This letter explains what was wrong, why it was wrong and what you need to do to put things right. Please e-mail or write to me confirming that you have acted on each of these matters by 31st May 2024.

It is important that you deal with these matters to protect people's health and safety. If you do not understand what action to take then please contact me or my Principal Inspector and we will explain further.

You will have to pay a fee because I have identified contraventions of health and safety law which are material breaches. The enclosed section on Fee for Intervention provides further information.

Section 28(8) of the Health and Safety at Work etc Act 1974 requires me to inform your employees about matters affecting their health and safety. As such, I have sent a copy of this letter to Mrs Lee Troake (Head of Corporate Risk, Health and Safety) as a representative of your employees and to circulate this letter to health and safety committee representatives (including union representatives).

You will find information and advice about health and safety on our website http://www.hse.gov.uk/

Yours faithfully,

Sarah Reilly
HM Inspector of Health and Safety

MATERIAL BREACHES – NOTIFICATION OF CONTRAVENTION

1. The Health & Safety at Work etc. Act 1974 (HASWA), Sections 2(1) and 3(1)
The Management of Health and Safety at Work Regulations 1999, Regulations 3(1), 5(1) and 7
Violence and aggression

Key observations

The key observations and findings are summarised below. Appendix 1 contains detailed lists of my observations relating to the management of violence and aggression and manual handling on both sites. Key observations and material breaches:

- CCTV is not proactively monitored. Staff reported feeling unsafe and were concerned about the Trust's reactive approach to violence and aggression whereby CCTV is only used to investigate incidents after people or materials/equipment have been injured or damaged.
- Absence of control measures in GRH Emergency Department and Paediatric Department to eliminate or reduce staff exposure to violence and aggression whilst at work. This includes those hazards identified in the departmental risk assessment where further action/control measures have not been carried out and in the Trust's Abuse, Violence and Unacceptable Behaviour Policy.
- The role of security manager within the GMS management structure is being covered by the Head of Facilities. GMS were unable to provide exact details of the job holder's qualifications and competence as the individual is away from the business. The Head of Facilities does not appear to hold the specific security specialist knowledge that the job role requires, thus resulting in a lack of specialist security advice being available to the Trust from GMS.
- The Service Level Agreement between the Trust and GMS refers to the provision of an accredited security management specialist (ASMS) to provide security advice and support to the Trust. From the information I have received, I am of the opinion that competent specialist security advice is not available.
- Staff resource issues were reported in relation to: attendance of site managers (clinical staff) to V&A incidents; the compatibility of techniques used by Registered Mental Health Nurses and porters to carry out safe holds/restraints and the ability of security to respond to multiple calls at the same time.
- Security/portering staff have raised concerns over the suitability of their PPE. There were reports of not feeling safe due to unsuitable PPE.

Reason for opinion

The Trust has failed to adequately manage violence and aggression risk within the A&E Department of Gloucester Royal Hospital. Sections 2(1) and 3(1) of HASWA place general duties on employers to ensure the health and safety of employees and those not in their employment. This duty extends to the risk associated with incidents of violence and aggression on Trust premises.

The Management of Health and Safety at Work Regulations 1999 require employers to make and give effect to appropriate arrangements for the effective planning, organisation, control, monitoring and review of preventative and protective measures. They also require employers to carry out suitable and sufficient risk assessments and seek competent advice to assist with the compliance of health and safety law. This applies to violence and aggression.

The range and number of material breaches identified during the inspection indicate that there are failings within the Plan, Do, Check, Act approach to violence and aggression prevention and reduction within the Trust. Violence and aggression control measures have not been fully implemented and monitored within the A&E Department and competent security specialist advice does not appear to be available to assist the Trust with these matters.

Appendix 1 lists several of the issues that I identified whilst on site and whilst reviewing your policies, documents and procedures.

Action Required:

I am aware that management have taken steps to further tackle violence and aggression within the Trust as indicated in the Security Services Proposal 2023 and Trust risk assessment, however, there is no clear indication of implementation timescales.

As a minimum and to achieve compliance you should:

1. Ensure that the 'competent' advisers for violence and aggression risk that you use have the appropriate skills and experience in violence and aggression to be deemed competent.

2. Implement the control measures that have been identified by: competent advisors; in violence and aggression policies; procedures and proposals and in risk assessments. This will include the implementation of controls to address the points listed in Appendix 1. I understand that some control measures will be implemented over time, therefore, you may demonstrate compliance with an action plan that identifies clear implementation dates.

Please send evidence of compliance 31st May 2024.

I shall also be writing to GMS as they need to address the issue of staff PPE (portering staff) and competent specialist security advice.

2. The Health & Safety at Work etc. Act 1974 (HASWA), Sections 2(1) and 3(1)
The Management of Health and Safety at Work Regulations 1999, Regulations 3(1) and 5(1)
The Manual Handling Operations Regulations 1992, Regulation 4
Manual Handling

Key observations

- Theatre staff explained that all staff undertake mandatory e-learning manual handling training but there are additional, unique manual handling requirements for theatre staff (essential to carry out theatre functions). Recording of this training is not on the main Trust electronic system, it is in paper format.
- Staff reported limited or no input into new build designs in terms of health and safety e.g. no staff input into new theatre design in relation to eliminating or reducing manual handling; there are no holds on doors into the resus area.
- Staff reported difficulties with: storage space; broken doors; doors holding open; distance travelled whilst moving patients and difficulty negotiating inclines and narrow areas of the corridors within Cheltenham General Hospital.
- Manual handling difficulties with the TUR bucket (13 litre bucket used during urology surgeries) have been reported by staff. The Neptune machine will eliminate manual handling associated with this task, however, the Trust has chosen to use control measures further down the Manual Handling Operations Regulations 1992 hierarchy to reduce the manual handling risk.
- The level of compliance for Level 2 mandatory manual handling training completion is poor in that overall Trust compliance is 81% (based upon December 2023 data issued to HSE) and no division has achieved green compliance.
- At the start of HSE's intervention, there were porters working within the Trust (not new starters) who had never received the mandatory manual handling training and they had carried out manual handling and patient moving activities.

Reason for opinion

The Management of Health and Safety at Work Regulations 1999 require employers to make and give effect to appropriate arrangements for the effective planning, organisation, control, monitoring and review of preventative and protective measures.

The systems that you have in place to monitor and review manual handling preventative and protective measures have failed in that:

i) There are two different types of recording systems being used by theatre staff to record important and mandatory manual handling training. One of these is recognised Trust wide and is a computer-based system used to record mandatory manual handling learning and the other is a paper lever arch folder used to record manual handling training that is considered essential for theatre staff. Your monitoring systems had not identified this practice and the manual handling team were not aware of this training and paper recording activity until it was raised by HSE;

ii) Staff have reported manual handling difficulties with hospital facilities (doors are broken or do not hold open) and equipment (TUR bucket).

I understand that a significant amount of work has recently taken place to examine the TUR bucket used in urology surgeries, however, this manual handling issue has been present for some time (pre 2019) and the assessment process does not appear to follow the manual handling hierarchy of control measures: avoid; assess; reduce and train. The Manual Handling and Operations Regulations 1992 state that if manual handling cannot be avoided, appropriate steps should be taken to reduce the risk of injury to the lowest level reasonably practicable.

Appendix 1 lists details of the issues that I identified.

Action required

To achieve compliance you must now investigate the issues identified above and take action to prevent a reoccurrence. Specifically:

i) Identify doors that are broken and doors that do not hold open that present a manual handling risk to employees and others who use them (usually when transporting patients and equipment) and implement control measures to either eliminate or reduce manual handling risk to as low as is reasonably practicable. E.g no holds to doors in Resus area may lead to manual handling injures because of the awkward positions the user has to achieve to hold the door open whilst transporting a patient. An action plan with timescales may be used to demonstrate compliance.
ii) In relation to the TUR bucket, you will need to demonstrate why manual handling cannot be eliminated (use of Neptune machine).
iii) Demonstrate that the Trust is now aware of the essential manual handling training that takes place within the surgical team and that systems are now in place to ensure that the recording of all essential staff training is in a location that is known and easily accessible to all employees who require it, including the manual handling training team.

Please provide written evidence to demonstrate your compliance (including action taken to address issues highlighted in Appendix 1) by 31st May 2024.

I shall also be writing to GMS in relation to porters carrying out patient handling duties without training.

Appendix 1

The following points were noted either during the inspection of the A&E Department and Paediatrics Department at Gloucester Royal Hospital and the Surgical Department at Cheltenham General Hospital:

Gloucestershire Royal Hospital (GRH) – Violence and aggression (V&A)

I have listed my observations from the site visit to GRH's A&E Department. These observations have formulated my opinion and demonstrate the material breaches listed in the main text of this letter:

Staff/resource issues

- Staff reported that they do not feel safe.
- Staff reported that additional training is required in relation to safer holding/restraint so that it is appropriate to the situation e.g. child specific training.
- GMS staff reported that clinical staff do not always attend incidents in their site manager role as they assume that someone else is in attendance.
- There is a difference in restraint techniques between portering staff and Registered Mental Health Nurses due to different training. Porters have reported that the do not like body mapping and that their technique is incompatible with the Registered Mental Health Nurse technique.
- Porters cannot respond to V&A calls when they are attending other calls. Porters reported having to spend longer periods of time with some patients which leaves them unable to respond to other calls. I have requested data from GMS to determine whether the minimum number of porters are attending all violence and aggression call outs.
- Staff reported that there is a psychological impact associated with the restraint of certain patients (e.g. eating disorders) and that they do not feel appropriately trained to manage these situations.
- Staff reported that the limited resource available in terms of porters used in V&A situations does not necessarily meet the variety of patients' needs and that this action may be detrimental to the health of all persons involved in the intervention.
- Safer Holding training – this is ad hoc and not focused on the high risk areas. Training needs analysis is required in high risk areas and training should be tailored to the specific needs of the patient type/department/site.
- The role of security manager within the GMS management structure is being covered by the Head of Facilities. GMS were unable to provide exact details of the job holder's qualifications and competence as the individual is away from the business. The Head of Facilities does not appear to hold the specific security specialist knowledge that the job role requires, thus resulting in a lack of specialist security advice being available to the Trust.
- The violence and aggression group requires a Chair and Director presence.

Inadequate or missing control measures

- CCTV is not monitored and is therefore not proactive. Staff have reported feeling unsafe as the CCTV is only used after a violent or aggressive incident has happened.
- Security/porters have reported feeling unsafe due to the lack of suitable PPE available to them. Staff reported incidents where members of the public have been carrying knives and that they are concerned as they do not wear appropriate security PPE (e.g. stab vests).
- A&E is not staffed with SIA.
- The pinpoint alarm system to be worn by Trust staff within A&E is not worn by all staff. Reports were made that Bank staff do not receive pinpoint cards.
- Staff were concerned about the safe ingress and egress of night shift staff, including junior doctors.
- Staff reported that some alarm locations were difficult to identify.
- The lighting and signage to the outside of A&E is poor, thus leading to patient frustration when trying to locate the department.
- Insufficient seating - The main A&E waiting area only has 17 seats. The department may have 30 patients per hour. A lack of seating in A&E for patients and people accompanying patients may trigger V&A behaviours.
- There was no visible waiting time information in triage or minors at the time of the inspection.

- There is a blind spot (no CCTV) in the main A&E waiting area, by the toilets and outside the reception area entrance/exit.
- The reception area door is left unlocked due to the number of staff entering and exiting to use facilities such as the photocopier.
- Insufficient seating – There are 40 seats in the minors area. Staff have reported that there have been 92 patients and 1 nurse located in this area. The lack of seating may trigger V&A behaviour.
- Lock broken to treatment room.
- Staff locker area in majors did not have a functioning lock. This is an area that many people pass to leave the building after 8pm.
- After 8pm the ambulance doors are the only available exit for all people leaving the hospital (includes members of the public). This means that everyone must exit via the majors' cubicle area.
- No CCTV to the refurbished area of paediatrics department because the new doors block the corridor CCTV camera.
- The panic alarm to the mental health room was located behind the chair, making it difficult for someone to reach in an emergency situation.
- Doors broken to the courtyard area.

Cheltenham General Hospital – Manual handling

I have listed my observations from the site visit to Cheltenham General Hospital. These observations have formulated my opinion and demonstrate the material breaches listed in the main text of this letter:

Clinical theatre staff

- A number of theatre staff reported manual handling issues associated with the lifting of a metal fluid bucket (13 litres) during urology surgeries (TUR bucket). The elimination of this particular manual handling risk by the use of Neptune was recognised in 2019, however, it took until August 2023 for a risk assessment to firstly identify that staff should not allow the bucket to fill and that they should empty it more often and secondly to examine alternative methods of transport to reduce but not eliminate manual handling. Mitigation measures were introduced in November 2023 to reduce the risk of manual handling injury and aid infection control by the use of suction canisters. This approach does not follow the manual handling hierarchy.
- Theatre staff explained that whilst all staff undertake mandatory e-learning manual handling training, there are additional, unique manual handling requirements for theatre staff. Training in these unique manual handling requirements is recorded in a lever arch folder (paper record) and is considered mandatory for theatre staff. New theatre staff are not allowed to carry out all functions until this training is complete. The manual handling team were unaware that this procedure was being followed until it was flagged by HSE. The use of two systems for recording manual handling training makes monitoring of corporate compliance difficult, especially when the department responsible for manual handling was unaware of the essential training and paper recording activity.
- There are a number of construction works taking place within the Trust, including the construction of a new theatre. Staff reported that they had little or no say in this process and therefore they are unable to identify health and safety issues that could potentially be designed out e.g. request that door holds are installed to prevent manual handling injuries whilst moving patients through doorways.
- Theatre staff explained that limited time due to staff resource and the nature of theatre work leads to training difficulties.
- Equipment sets can cause problems as they are heavy to lift, especially during hip and knee replacement operations.
- Several staff expressed manual handling issues when trying to manoeuvre through doors. They said that doors were too heavy, closed too quickly and were broken or did not hold open.
- It was reported that the availability of storage space played a huge part in controlling manual handling risk. Staff explained that overstacking of equipment and trying to squeeze items into limited space leads to manual handling injuries. It was noted that new construction works did not take account of the additional storage requirements. This may lead to future manual handling issues.

- Bed pushers have now been purchased and introduced to the surgical department, however, HSE noticed several beds being moved around the hospital during the inspection without the new bed pusher devices.

Porters

- Data from December 2023 shows that there were porters (not new starters) who had not received the mandatory manual handling training carrying out patient moving activities.
- Porters reported that they found moving through doors difficult as only 10% hold open due to slow close mechanisms.
- Staff reported that they found it difficult to manoeuvre patients past the pharmacy area because the corridor narrows and it is on an incline.
- Concerns were raised over footwear, in particular, the lack of comfort whilst wearing the compulsory steel toe capped shoes. Porters easily cover 20,000 steps per day but they have no say or choice in relation to the type of PPE footwear that they have to wear.
- Concerns were raised in relation to infection control as porters do not wear any additional protection to prevent their clothes from being contaminated by some of the waste products that they are expected to move. The same individuals will be utilised to move patients.

Other observations

- Trust documents identify that some high risk areas within the Trust do not have manual handling risk assessments
- The level of compliance for Level 2 mandatory manual handling training completion is poor in that overall Trust compliance is 81% (based upon December 2023 data issued to HSE) and no division has achieved green compliance.
- HR are unable to breakdown the figures for sickness absence data to check for manual handling RIDDORS.

Health and safety issues raised by Trade Unions

Violence and aggression

- Concerns were raised over the control that GMS has over health and safety issues (asbestos, fire, legionella and portering services) and the lack of Union input due to GMS not being part of the Trust.
- There is no security manager at present. Union representatives believe that the security response on site is inadequate
- Allege that near misses are not reported due to time constraints.
- The Datix reporting system is difficult to use and time consuming. This leads to under reporting. Anecdotally, staff do not feel that there is any point reporting V&A via Datix. Staff feel that V&A is “part of the job.”
- New builds have not been inspected for health and safety matters prior to opening e.g. signs had been located in front of CCTV cameras in the new A&E Department.
- Reports of violence and aggression between staff employed by GMS and Trust employees due to different pay scales.
- Concerns raised over the lack of time assigned to Union input during health and safety committee meetings.
- Bespoke training is required in high risk areas.
- Multiple incidents may be reported as one incident if the perpetrator is the same.

Manual handling

- Reports that access to specialist manual handling advice can take days when a quick response is required.
- Shortage of staff leads to short cuts being taken and training not being followed.

- Manual handling issues increased during construction works at GRH.
- Doors should be fit for purpose. There are reports of doors being propped open.

FEE FOR INTERVENTION

Health and Safety and Nuclear (Fees) Regulations 2022, Regulations 23 and 24

HSE will recover the costs that it incurs for the work it does in relation to contraventions of health and safety law which are material breaches. A material breach is something an Inspector considers is serious enough that they need to inform you of it in writing.

The fee is based on the amount of time that the Inspector has had to spend identifying the breach, helping you to put it right, investigating and taking enforcement action. This includes the cost for the whole visit, along with other associated work. The current cost recovery rate can be found on this page of our FFI website pages: https://www.hse.gov.uk/fee-for-intervention/what-is-ffi.htm.

Sometimes an Inspector may decide to write to you about matters which are not material breaches. Ts includes any matters listed as 'Advice'. HSE will not recover costs for the time it takes to do this.

We send out invoices every two months and you will have 30 days to pay. You may receive more than one invoice if the work done by the Inspector covers more than one invoicing period.

If you disagree with anything on your invoice, HSE operates a query and dispute process. You can query your invoice (within 21 days from the date of the invoice), and if you are not satisfied with the response, you can dispute it. You can find further information about fee for intervention and details of the query and dispute process at https://www.hse.gov.uk/fee-for-intervention/i-dont-agree-with-my-invoice.htm.

Further information is also available in the leaflet HSC14 – *When a health and safety inspector calls – What to expect when we visit your business*, at http://www.hse.gov.uk/pubns/hsc14.pdf.

More detailed information is given in HSE 47 - *Guidance on the application of Fee for Intervention* at http://www.hse.gov.uk/pubns/hse47.pdf.

Key	
	Action will be address as part of Security Review
	Action to be addressed by Gloucester Managed Services (GMS)
	Action to be addressed by Trust

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NHS Foundation Trust

HSE NOTICE OF CONTRAVENTION ACTION PLAN

V&A Issues

No.	Issue identified	Proposed Action	Owner	Target Date	Update / comments	Status	Supporting Evidence in folder
1	CCTV is not proactively monitored. Staff reported feeling unsafe. Trust's reactive approach to V&A whereby CCTV only used to investigate incidents	Security review in progress to include recommendations on proactive CCTV monitoring station	Ian Quinnell	15/05/24	The SLA with GMS does not require proactive monitoring of CCTV, although this was recommended to the Trust some time ago by the V&A Group. The Trust does not currently proactively manage security	**OPEN**	Security review SLA / Timeline
3.	Security manager GMS is being covered by the Head of Facilities. GMS were unable to provide exact details of the job holder's qualifications and competence as the individual is away from the business. The Head of Facilities does not appear to hold the specific security specialist knowledge that the job role requires, thus resulting in a lack of specialist security advice being available to the Trust from GMS.	GMS to confirm to the Trust how competent security advice will be sought in order to manage security on a daily basis	Simon Wadley / David Sass / Steven Grantham	15/05/24	5.4.24 – SLA in place which requires an accredited security management specialist who is competent 19.4.24 – SG confirmed that process with current postholder almost at an end. GMS have made contact with number of security specialists to hire a consultant 1 day per week. **HSE plan to write separately to GMS**	**OPEN**	GMS SLA for security and portering response
		The Trust must satisfy itself that 'competent' advisers for violence and aggression are place either within GMS or the Trust	Bernie Turner / Dickie Head (as Chair of Security Group)	20/05/24	19.4.24 – await update from GMS as above	**OPEN**	

4.	The ability of security to respond to multiple calls at the same time. Porters cannot respond to V&A calls when they are attending other calls. Porters reported having to spend longer periods of time with some patients which leaves them unable to respond to other calls.	GMS to provide data to the Trust to establish how many times the correct number of staff (4) have (or not) attended an incident with the agreed attendance time	Simon Wadley/ David Sass	01/02/24	5.4.24 – HSE have requested further data from GMS. It was provided by GMS on 9.4.24. GMS recorded less than 4 in attendance 82 times (out of 1117 (7.3%) in GRH and 26 (of 56 times 46.4%) in CGH in 2023	**CLOSED**	**Email 9.4.24 from DS and spreadsheet LT email to BT and RH to include this into the reporting for security group or contract management group**
		Security review in progress to recommendations on resources needed to respond to multiple calls / prolonged calls	Ian Quinnell	15/05/24	8.4.24 - The ineffectiveness of the current response model is a primary driver for the security review. The review will result in recommendations in relation to the security response model in the Trust	**OPEN**	Security review SLA / Timeline
5.	Security/portering staff have raised concerns over the suitability of their PPE. There were reports of not feeling safe due to unsuitable PPE	GMS is the duty holder for the provision of PPE to GMS staff. GMS to explore the options of PPE as part of the wider security review	Simon Wadley/ David Sass	15/05/24	5.4.24 – HSE will write to GMS separately on this point as the duty holder 19.4.24 – SG confirmed that it was agreed at GMS SLT this week that they will consult with Gary Ross on PPE e.g., high vis/stab vests, and how this can be located on site for collection on the way to an incident	**OPEN**	Security review SLA / Timeline
7.	Staff reported that additional training is required in relation to safer holding/restraint so that it is appropriate to the situation e.g., child specific training. There is a difference in restraint techniques between portering staff and Registered Mental Health Nurses due to different training. Safer Holding training – this is ad hoc and not focused on the high-risk areas. Training needs analysis is required in high-risk areas and training should be tailored to the specific needs of the patient type/department/site.	Security review in progress includes a full review or our training needs and will take into account the Trust's requirements for Paediatric-specific training	Garry Ross / Maria Smith	15/05/24	5.4.24 – The techniques taught by the current safer holding provider apply to both children and adults. 5.4.24 – It was outlined to the Inspector that RMNs are not Trust employees. Our training is unlikely to align. 5.4.24- The effectiveness of the current training model is a primary driver for the security review. The review will result in recommendations in relation to the training content and model in the Trust	**OPEN**	(See existing actions 34 and 50 on the V&A action plan)
		Agree training model and identify funding source for future training	Maria Smith	15/06/24			
		Complete tender specification and implement tender process	Maria Smith	30/06/24			

10.	A&E is not staffed with SIA	Completion of the security review, including whether a security guard is required in ED GRH	Ian Quninnell	30/07024	5.4.24 – SIA is the Security Industry Authority. An SIA licence is required for anyone doing work as part of a contract for service involving licensable activities. GMS security staff hold an SIA licence but current model does not include security presence in ED. Await recommendations from review		(See existing actions 34 on V&A action plan)
11.	The pinpoint alarm system to be worn by Trust staff within A&E is not worn by all staff. Reports were made that Bank staff do not receive pinpoint cards.	ED matron to lead on the practicality of giving bank staff a pinpoint alarm	Sam James / Sean Alfane	30/04/24	19.4.24 – SJ confirmed pinpoints are available to all substantive staff in ED but they are not mandatory. 150 units were purchased at a cost of £15,000. They were issued to rotation doctors who did not return them when they left. A sign-out register is required It is not cost effective to issue pinpoints to bank staff but more units have been ordered to create a pool of alarms which bank staff when on shift (and return at the end of the shift). SJ to confirm once these have been received to sign off this action.	**OPEN**	Meeting recording 19.4.24
12.	Staff were concerned about the safe ingress and egress of night shift staff, including junior doctors. Staff reported that some alarm locations were difficult to identify	Matrons to discuss issues with staff to establish the factors that contribute to feeling unsafe e.g., lighting, security presence,	Sam James / Sean Alfane	30/04/24	5.4.24 – more detail needed as unclear what the specific safety issues are at present 19.4.24 – SJ will email ED staff to ask for more detail about this as there are no DATIX incidents and no concerns have been raised locally to SJ	**OPEN**	
13.	The lighting and signage to the outside of A&E is poor, thus leading to patient frustration when trying to locate the department.	GMS to review lighting outside new Paeds entrance – test lux level	Terry Hull / Fariha Khan	30/04/24	5.4.24 – poor lighting is a reference to entrance door (old ED entrance / now Paeds) 19.4.24 – FK will compete a lux test of the lighting by the end of April and will confirm to LT the outcome 30.4.24 Lighting reviewed by Apleona 25/4. Minimum levels measured were 62 lux against a CIBSE minimum guideline of 50 lux therefore statutorily compliant. Potential to remove some fencing to improve worst areas – being explored by Access & Egress Committee.	**OPEN**	**Email with survey results**

					Propose action closed		
		Patient experience and Comms to review external signage from Tower car park and other main carparks to ED and report into Trust H&S Committee on their findings	Katherine Holland / James Brown	30/04/24	19.4.24 – Patient experience not able to attend meeting.	**OPEN**	
14.	Insufficient seating - The main A&E waiting area only has 17 seats. The department may have 30 patients per hour. A lack of seating in A&E for patients and people accompanying patients may trigger V&A behaviours. Insufficient seating – There are 40 seats in the minors area. Staff have reported that there have been 92 patients and 1 nurse located in this area. The lack of seating may trigger V&A behaviour	Seating areas to be reviewed to explore whether additional seating can be added without compromising fire safety, disability access or causing undue trip hazards	Mike Keen, Faith Newrick / Matrons ED	30/04/24	5.4.24 – ED triage area is very small. Additional seating may prevent wheelchair access. 19.4.24 – Review has been conducted. Faith Newrick (patient experience contact for ED), along with SJ and Hollie Lucas have reviewed seating and are considering options for new seating. Emma (DDQN) is supportive of funding this. Group to follow these up and ensure Mike Keen in GMS Fire Safety is happy with option. Review concluded that there are limited options to increase seating space (vending machine, new seating and signage actions added below as a result of the review)	**CLOSED**	Meeting recording 19.4.24 Email 25.4.24 from MK
		Arrangement to be made for food and Cold drinks vending machines to be placed in the Entrance to Minors Triage/Ortho.	Sam James / Sean Alfane	31/07/24	19.4.24 - Food and Cold drinks vending machines to be placed in the Entrance to Minors Triage/Ortho. The mitigation for this would be that it is a 60 min fire rated fire compartment and has a detector fitted in the area. There are also additional alternative escape route away from this area. This will also make room for additional seating in the Minors waiting area and possibly 6 additional seats in the entrance corridor (cinema style drop seats).	**OPEN**	
		New seating to be agreed / ordered and installed	Faith Newrick / Matrons ED	31/07/24		**OPEN**	

		Signage to confirm one visitor per patient to reduce the number waiting in ED	Sam James / Sean Alfane	01/05/24	Sign has arrived and ED is waiting for this to be installed	**OPEN**	
15	The reception area door (ED triage) is left unlocked due to the number of staff entering and exiting to use facilities such as the photocopier.	Explore whether the lock type is suitable for the frequency of use of this door. Staff to be reminded to engage the lock on the reception door	Sam James / Sean Alfane	1/05/24	5.4.24 – this door has access control but was disabled as staff found it inconvenient 19.4.24 – SJ to confirm SVR has been submitted for swipe lock	**OPEN**	
16	There was no visible waiting time information in triage or minors at the time of the inspection.	TV screens to be installed in the wait areas and display wait times	Sam James / Sean Alfane / Faith Newrick /	20/05/24	19.4.24 – Jane Birch is responsible for ordering the screens. Has been given the funding by Emma (DDQN) and Al (COO)	**OPEN**	
17.	There is a blind spot (no CCTV) in the main A&E waiting area, by the toilets and outside the reception area entrance/exit. No CCTV to the refurbished area of paediatrics department because the new doors block the corridor CCTV camera	GMS to review and advise on options for blind spots	David Sass / Steve Grantham	03/05/24	5.4.24 – reference is to rear area of PAU (not Paeds inpatients) where mental health room is 19.5.24 – SG will discuss with contractor next week and provide costs to the Trust to move existing cameras	**OPEN**	
19.	Lock broken to treatment room Staff locker area in majors did not have a functioning lock. This is an area that many people pass to leave the building after 8pm.	Staff to ensure the locks have been reported	Sam James / Sean Alfane/	01/05/24	19.4.24 – SJ advised SVR submitted to Aishah for swipe access. TH unsure that it was supported by funding and will check with Aishah. 30.4.24 - A replacement digilock of a different style has been installed to this door and is currently working. We will continue to monitor. **Request to close at meeting on 3.5.24**	**OPEN**	**Photo of digilock in place**
		GMS (or contractor if under warranty) to repair the locks and /or progress SVR for swipe	Daniel Pike / Terry Hull	15/5/24	30.4.24 - Lock to staff locker room being taped open by staff. Tape removed, lock working **Request to close at meeting on 3.5.24**	**OPEN**	**Email with photo of taped door lock.**

20.	After 8pm the ambulance doors are the only available exit for all people leaving the hospital (includes members of the public). This means that everyone must exit via the majors' cubicle area.	ED to walk through with options with GMS	Steve Grantham	01/05/24	19.4.24 – SG will arrange a walk through with SJ, DS, CD (S&T), MK, SB and BC next week	**OPEN**	
		GMS implement required security / lock programme & timing requested by ED	Steve Grantham	15/05/24	19.4.24 – TH confirmed timings can be implemented once agreed following walk around	**OPEN**	
21.	Doors broken to the courtyard area.	GMS to confirm whether doors have been repaired satisfactorily and if not, provide timescale for repair	Daniel Pike / Terry Hull	18/4/24	5.4.24 – a roof leak caused an issue with the doors. Staff advised these had been broken for some time, despite reporting 19.4.24 – SJ confirmed the but still some leaks. TH advised work done earlier this week to prevent leak. SJ will check if still leaking 30.4.24 Leak fully repaired., external doors operational. Internal doors not operational on auto open. ASG as specialist provider have been to site and installed access control (not just wave access) to these doors. Faulty controller identified and part ordered to repair.	**OPEN**	Meeting recording 19.4.24
22.	The violence and aggression group requires a Chair and Director presence.	Board to decide on Chair for V&A Group	Executives	1/505/24	5.4.24 – Lee Troake has been chairing the V&A group since the retirement of the Quality and Safety director in June 2023. 2.5.24 - to be discussed at exec team meeting in May	**OPEN**	

Manual Handling Issues

No.	Issue identified	Proposed Action	Owner	Target Date	Update / comments	Status	Supporting Evidence
23.	Two different types of recording systems being used by theatres to record mandatory manual handling training. Computer-based system and a paper lever arch folder to record training bespoke to theatre staff. Your monitoring systems had not identified this practice and the	Ensure any paper-based records are transferred to the central recording system	Sam Brown	15/05/2024	5.4.24 – As yet Theatres have not identified the paper records being referred to by the Inspector 19.4.24 – folder relates to only one of the teams in Theatres. TK has QR code to record training on SharePoint. Will work with SB to establish what can be centralised.	**OPEN**	**Scan of paper records found in folder - are Moving & Handling CSTF**

	manual handling team were not aware of this training and paper recording activity until it was raised by HSE						**Mandatory training registers. Email of ESR check for those names that training recorded centrally and electronically**
24.	Staff reported limited or no input into new build designs in terms of health and safety e.g., no staff input into new theatre design in relation to eliminating or reducing manual handling	Capital Team to confirm the stages at which staff were consulted in the design of the new Theatres on manual handling	Terry Hull / Ian Quinnell	18/05/2024	19.4.24 – TH confirmed Ian Quninnell had arranged open sessions for Theatres as well as direct consultant with nominated people. IQ to provide the evidence 30.4.24 Extensive consultation was undertaken as part of this project. All final plans were signed off by the department representatives, staff Q&A sessions and divisional engagement sessions held, open forum Q&A sessions for all staff. **Request to Close**	**OPEN**	**Cof Ex Comms plan, theatre posters, ToR for DS and Theatres working group, FBS sign off sheets, examples of engagement sessions held, staff Q&A sessions**
		Capital Team to confirm the agreed process for ensuring H&S input from teams that will occupy a new area and from central H&S team to all design work from the outset	Terry Hull / Ian Quinnell	18/05/2024		**OPEN**	
25	Several beds being moved around the hospital during the inspection without the new bed pusher devices	Ensure all staff trained to use the bed pushers in CGH	Sam Brown	15/05/24	5.4.24 – Bed pushers were in place at the time of the Inspection and were demonstrated to the Inspector. However, as	**OPEN**	**Training record spreadsheet**

					these are fairly new, not all staff across CGH have been trained to use them. 02.05.24 - TL provided updated trainig list for bed pushers. Indicating that 5 members of staff have yet to be trained. Email and attachment saved as evidence. 19.5.24 – SB to provide confirmation of when all staff will have been trained		**Competency PDF outlining training objectives. Email confirmation of cleared corridors. Email confirming fourth bed pusher received at CGH Recovery**
		Ensure all staff have been reminded to use the bed pusher once trained	Tasha Long	05/04/24	5.4.24 – Reminder sent to all trained staff. Local line manager to monitor the use of the bed pushers day to day	**CLOSED**	**email**
26.	Storage issues for beds / trollies across the Trust	Seek confirmation from fire service that they are content with the management of beds on corridors	Mike Keen	01/05/24	12.4.24 – sort and sweep in place and warehouse but basement area still full and corridor storage still and issue 19.4.24 – MK confirmed Glos Fire Service are content we are managing this and that it is impractical to take beds (stored by ED) to and from basement due to turnaround times. MK does not have this in writing but will ask Fire Service to confirm in writing	**OPEN**	
27.	Broken doors seen	Identify any broken doors in ED GRH and Theatres CGH plus common routes for bed pushing and complete repairs	Daniel Pike / Terry Hull	01/05024	19.4.24 – LT to confirm to TH (GMS) which doors to be assessed first – ED and Theatres. GMS to develop a plan to review other doors. 29.4.24 In addition to those identified by Site team. Please also inspect all doors in: ED GRH (including court yard) and ED CGH Theatres GRH and CGH All external doors in GRH and CGH	**OPEN**	

					Please provide a report detailing any broken, malfunctioning doors and /or broken locks on doors and whether these will be repaired via normal maintenance process or require a SVR. Please include a timescale for repair on each door as appropriate. Please provide this by 25 May 2024		
28.	Doors across Trust that do not hold open and present a manual handling risk when moving patients/beds/wheelchair, cages and equipment	Identify doors in ED GRH and Theatres CGH plus common routes with no holds / stays and cost options to install holds on doors where this does not introduce a greater security and/or fire risk	Elizabeth Dawes / Terry Hull	30/05/24	5.4.24 – it was discussed with the inspector that ward doors may not be suitable for hold mechanism as this increases the risk of tailgating and wandering patients 5.4.24 Inspector confirmed that Trust should focus on A&E at GRH and Theatres at CGH (common routes) and where there are known manual handling issues (e.g., the resus door) and include rest of the Trust in a higher-level plan for auditing at some point 19.4.24 – LT to confirm to TH (GMS) which doors to be assessed first – ED and Theatres. GMS to develop a plan to review other doors. 29.4.24 - GMS instructed to identify any internal door that does not have a hold mechanism in the following areas: • ED GRH (including court yard) and ED CGH • Theatres GRH and CGH • Any internal corridor doors in GRH and CGH which are part of access routes for patients being moved in beds / wheelchairs Ward entrance doors and doors internal to the wards can be excluded from this. Please provide a report which identifies the door, the most suitable hold mechanism, plus estimated costs for either a time-hold	**OPEN**	

					device or a device that releases on activation of the fire alarm.		
29.	No holds on doors into the resus /pitstop areas ED, GRH	Provide costed options to Install suitable door hold mechanisms in resus / pitstop ED, GRH	Elizabeth Dawes / Terry Hull	30/05/24	5.4.24 – these doors are propped open with bins and linen to allow trollies with patients through. They are fire doors so will need release mechanisms 30.4.24 Apleona arranging for quote to provide hold opens to RATA doors.	**OPEN**	
30.	Staff reported that they found it difficult to manoeuvre patients past the pharmacy CGH	Review whether the platform area into Pharmacy CGH can be redesigned to provide additional space for beds to pass and / or whether this work is cost prohibited / planning prohibited	Terry Hull	30/05/24	19.4.24 – This platform is a ramp for disability access to the Pharmacy. TH will review the platform to advise whether there are any cost effective options to reconfigure it to create more corridor space	**OPEN**	
31.	Storage space in Theatres	Storage space in new Theatres	Terry Hull	01/04/24	Additional storage space now provided in new Theatres includes a storage room with racking and a large equipment room	**CLOSED**	
32.	TUR bucket (13 litre bucket used during urology surgeries). The Neptune machine will eliminate manual handling associated with this task; however, the Trust has chosen to use control measures further down the MHOR1992 hierarchy to reduce the manual handling risk.	Theatres to confirm whether the Neptune will *eliminate* manual handling (as this machine also needs to be emptied and moved) and if so, the reasons it was not considered the most effective solution	Caroline Swift / Kayzia Bertman	15/05//24	5.4.24 – Risk assessment already completed and Theatres had already introduced a carousel device to reduce manual handling to a minimum and was in use at the time of the Inspection. The Inspector did not wish to enter Theatres to observe it. Details of the current system already provided to Inspectors but they have queried where Neptune is cost prohibitive **02.05.24** The system is closed and uses a docking station for waste disposal. Neptune 3 is on wheels. I am unsure why it was not agreed in 2019. Holds up to 20 litre before movement and docking required New system also potential to mitigate use of current smoke extractors	**OPEN**	
33.	Theatre staff explained that limited time due to staff resource and the nature of theatre work leads to training difficulties (for manual handling).	Plan a programme of training to meet the needs of staff in Theatres for manual handling training	Tina Kowalewicz / Sam Brown	30/07/24	9.4.24 – Theatre training action plan provided. Training to be done by PD team 19.4.24 – TK is working with SB on e-learning and a training programme. TK has scheduled training in a Theatre in May to create 60 training places.	**OPEN**	**Email to MELs- only PD team to deliver mandatory training.**

					29.4.24 - on 24/04 TW discussed action with Matron/DDQN/Bridie. Following discussion with MEL trainers and SB, to ensure governance in relation to the MEL training and the requirement of the CSTF it has been agreed that only the PD team will deliver mandatory training moving forward. E-learning approved by Theatre Delivery Board & CCCG awaiting approval from SQB in relation to risk 728 Training continues with twilight sessions (18:00-20:00) have been offered to open 65 training spaces over May/June. E-learning to be developed via Theatre PD and Corporate team (weekly meeting commencing 28/04/2024 and aim to complete in 3 months)		**Theatre Moving & Handling mandatory lesson plan.** **Theatre Moving & Handling mandatory PowerPoint content.** **Theatre Moving & Handling Compliance Analysis.** **Proposal for eLearning update offering outline, including ESR learning path screenshot.** **Copy of Theatre training risk on Trust risk register** **Sign off from CSTF for training offering change.** **Sign off from**

							Divisional Surgical leads for training offering change.
34.	Equipment sets can cause problems as they are heavy to lift, especially during hip and knee replacement operations.	Manual Handling team to review the assessment for the equipment sets and consider whether any additional measures can be introduced	Kayzia / caroline Swift/ Maja Sam Brown	1/05/24	5.4.24 – these can be heavy. They are marked with the weights, assessment is available, heavy items to be placed on middle shelves and mid-height on trolley. Inspector did not enter Theatres to see measures in place. 19.4.24 – TK to ensure risk assessment for this take is up to date and risk is well controlled 29.4.24 - TW confirmed Discussed with Kayzia Bertman and Caroline Swift. Risk assessments to be completed with them in conjunction with Ortho Team Lead	**OPEN**	Risk assessment and controls Draft SBAR developed to support reduction in manual handling. Requirements still need discussion and including in SBAR Appropriate Storage solutions & current storage footprint require review
35.	The level of compliance for Level 2 mandatory manual handling training completion is poor in that overall, Trust compliance is 81% (December 2023 data issued to HSE as request before the inspections) and no division has achieved green compliance.	Review compliance data to identify any staff that should not be listed and remove from the list	Sam Brown / Divisional Tris	10/05/24	19.4.24 – Sarah will request SB to look at the staff on the list and remove staff that should not be there – query deanery staff	**OPEN**	Training Needs Analysis Email to all out of date staff Email to all Maternity out of date staff

							Email - out-of-date Porter bookings per site Email - bank staff affecting compliance to be removed Training compliance report as of 31/03/2024 Training compliance report as of 30/04/2024 Evidence from SBd relating to bank staff, deanery etc affecting compliance
		Produce a plan for ensuring staff who have not attended the training are booked on and attend	Divisional Tris	10/05/24	8.4.2024 – compliance data at 85% at end of Feb (90% and above its green)		
36.	Porters working within the Trust (not new starters) who had never received the mandatory manual handling training (level 1 or level 2)	GMS to respond to the Inspector and action any staff showing on the compliance reports	Simon Wadley / David Sass / Fariha Khan	01/05/24	9.4.24 – GMS have responded to the inspector confirming some porters have never been trained 19.4.24 – DS in GMS is addressing this	**OPEN**	**Emil from DS**
37.	Porters' footwear, in particular, the lack of comfort whilst wearing the compulsory steel toe capped shoes. Porters easily cover 20,000 steps per day	GMS to address as the duty holder. Review footwear quality and options for staff	Simon Wadley / David Sass / Fariha Khan	30/04/2024	19.4.24- DS in GMS is addressing this	**OPEN**	

38.	Porters do not wear any additional protection to prevent their clothes from being contaminated by waste products and may then go on to handle patients	GMS to address as the duty holder. Review availability of disposable aprons and gloves for waste tasks and spare uniform if become contaminated. All porters to the be directed they must not handle patients whilst contaminated with waste products.	Simon Wadley / David Sass / Fariha Khan/ Infection Control	30/04/2024	12.4.24 – email to DS and FK in GMS to request response 19.4.24 - DS in GMS is addressing this	**OPEN**	

TU Concerns

	Issue identified	Proposed Action	Owner	Target Date	Update / comments	Status	Supporting Evidence
41.	TU concerns were raised over the control that GMS has over health and safety issues (asbestos, fire, legionella and portering services) and	GMS/Trust governance, compliance and resources review is ongoing	Tracey Cottrell	31/07/24	GMS has its own TU reps. Trust reps have also carried out inspections in GMS areas Contract in place	**OPEN**	
42.	TU concerned by lack of Union input due to GMS not being part of the Trust.	GMS to confirm how TU reps can input into H&S in GMS	Terry Hull	10/05/24	12.4.24 – action set at Trust H&S Committee for TH to confirm how union can input into GMS GMS TU reps are invited to GMS H&S meeting **Request to close**	**OPEN**	**ToR for GMS H&S Group meeting**
45.	Allege that near misses are not reported due to time constraints The Datix reporting system is difficult to use and time consuming. This leads to under reporting. Anecdotally, staff do not feel that there is any point reporting V&A via Datix. Staff feel that V&A is "part of the job."	TU reps to provide details of any near misses relating to V&A that have not been reported	TU reps	30/04/24	Unable to follow up anecdotal information. Weekly work of the V&A Panel indicates that reporting is good, staff are responsive to follow up by the Panel and extensive work is carried out weekly in response to staff safety (Evidence already provided to the Inspector). If TU are alerted to staff that are not reporting incidents, please refer them to the V&A policy.	**OPEN**	

47.	TU concerned - new builds have not been inspected for health and safety matters prior to opening e.g., signs had been located in front of CCTV cameras in the new A&E Department.	TU to provide details to Comms (who deal with signage and way finding)	TU reps	30/04/24	ED was inspected before opening by fire safety, H&S, estates etc.	**OPEN**	
48.	TU concerned - Reports of violence and aggression between staff employed by GMS and Trust employees due to different pay scales.	TU to raise this with HR with specific details so this can be investigated and addressed	TU reps	30/04//24		**OPEN**	
50.	TU concerned - Reports that access to specialist manual handling advice can take days when a quick response is required.	Manual Handling team to confirm process and response times for urgent support requests	Sam Brown	15/05/24		**OPEN**	
51.	TU- Doors should be fit for purpose. There are reports of doors being propped open.	Fire team to send reminder to all staff about propping doors open (e.g., message in the Global)	Mike Keen	15/05/24		**OPEN**	

COMPLETED ACTIONS

No.	Issue identified	Proposed Action	Owner	Target Date	Update / comments	Status	Supporting Evidence
2	Absence of control measures in GRH Emergency Department and Paediatric Department to eliminate or reduce staff exposure to violence and aggression whilst at work. This includes those hazards identified	Update risk assessment in line with new ED opening	ED Matron	08/04/2024	08/04/2024 - Risk assessment updated – outstanding actions include security review, CCTV and body cam trial – all covered by actions elsewhere on this plan	**CLOSED**	ED Risk assessment

	in the departmental risk assessment where further action/control measures have not been carried out and in the Trust's Abuse, Violence and Unacceptable Behaviour Policy.						
6.	GMS staff reported that clinical staff do not always attend incidents in their site manager role as they assume that someone else is in attendance.	Site team to confirm whether they are always in attendance	Elaine Houghton (Site Manager)	15/04/ 2024	12.4.24 – Site team always attend but if there is a V&A trained member of clinical staff on the ward, they will take the clinical lead instead of site and site is released. Site Mangers will reiterate to the site team to confirm who is leading (clinically) on the ward before they leave to avoid any confusion amongst the porters. Security review in progress which will take account of the issues with the current model of response including Site Managers needing to attend incidents whilst managing operational activities	**CLOSED**	**Email 8.4.24**
8.	Staff reported that there is a psychological impact associated with the restraint of certain patients (e.g., eating disorders) and that they do not feel appropriately trained to manage these situations. Staff reported that the limited resource available in terms of porters used in V&A situations does not necessarily meet the variety of patients' needs and that this action may be detrimental to the health of all persons involved in the intervention.	GMS and Site to confirm wellbeing support / welfare checks in place for porters	Simon Wadley/ David Sass Elaine Houghton	20/04/ 2024	5.4.24 – Hot brief and cold debrief can be carried out post incident. The porters, site and clinical staff attended debriefing sessions following a recent eating disorder inpatient. Sessions led by Mental health and safeguarding, and H&S present Porters and Site also offered support via the EAP. The porters have received input from Health Psychology in the form of support sessions. The site team carry out an informal debrief with the team, porters or ward staff, then they are expected to follow up with their relevant managers. Site Manager or site matrons check in/debrief with own team, where is needed and refer onwards where appropriate. Resources under review in security review.	**CLOSED**	**Email 8.4.24**

9	Porters have reported that the do not like body mapping	NFA		08/04/2024	5.4.24 –Body Mapping is a legal requirement and was implemented following a CQC inspection. Porters have had training and briefings via the Safeguarding team and there is a policy in place. Inspectors were advised this verbally during the inspection.	**CLOSED**	**Restraint policy / body mapping/ training records**
18.	The panic alarm to the mental health room was located behind the chair, making it difficult for someone to reach in an emergency situation. (NB: this occurs if a patient moves the furniture)	Check whether pinpoint alarms operate in this room or area	Sam James / Sean Alfrane	18/4/2024	19.4.24 – pinpoint operates in this room but not all staff entering the room will have one e.g., external mental health liaison staff who work for GHC	**CLOSED**	Meeting recording 19.4.24
		Explore whether furniture be fixed to prevent it being moved by patients in front of the panic alarm	Sam James / Sean Alfane	18/4/2024	19.4.24 – SJ confirmed furniture cannot be fixed as it may need to be removed for the safety of patients who attempt to self-harm by impacting with furniture	**CLOSED**	Meeting recording 19.4.24
		Confirm controls for exiting the mental health rooms	Sam James / Sean Alfane	18/4/2024	19.4.24 – all rooms have two exits to allow safe egress. Staff can wear own pinpoint alarm or one of the pool pinpoint alarms. Staff attend in twos where there is a risk of V&A / security incident.	**CLOSED**	Meeting recording 19.4.24 and ED risk assessment updated
39.	Trust documents identify that some high-risk areas within the Trust do not have manual handling risk assessments	Ensure all high-risk areas have manual handling risk assessments	Lee Troake	30/4/2024	All high-risk areas in the Trust have manual handling risk assessments	**CLOSED**	**Risk Library**
40.	HR are unable to breakdown the figures for sickness absence data to check for manual handling RIDDORS	NFA		08/04/2024	5.4.2024 – HR have advised that the national team (who control the system) will not allow the work-related check box to be made. HSE were advised of this during their inspection.	**CLOSED**	Emails from HR
43.	Shortage of staff leads to short cuts being taken and training not being followed.	Incidents and near missed to be reported on DATIX. Workforce issues that impact in safety to be raised as a risk	N/A	08/04/2024	Risk management and incident reporting process already in place. All workforce risks raised on the risk register. National staff shortages in NHS	**CLOSED**	Policies

44.	There is no security manager at present. Union representatives believe that the security response on site is inadequate. Bespoke training is required in high-risk areas.	NFA			Will be addressed in security review. TU are part of the T&F Group and aware this is the driver for the review	**CLOSED**	Security review
46.	TU concerned multiple incidents may be reported as one incident if the perpetrator is the same.	NFA		8/04/2024	12.4.24 – if the incident is prolonged, only one incident report is required. If multiple incidents occur e.g., over several days these are reported separately. All V&A incidents (with capacity or unsure) are seen by the Panel weekly and any reporting issues flagged and aggressed	**CLOSED**	Panel weekly meeting
49.	Concerns raised over the lack of time assigned to Union input during health and safety committee meetings.	All members, including TU, are expected to provide of agenda items a minimum of 10 days prior to the meeting so that the agenda and timings can be factored into the meeting	Claire Radley	30/04/2024	5.4.24 TU have a standing agenda item but do not tend to table agenda items prior to the agenda setting. Late submitted items or items raised at the meeting can impact on timings. It's a full agenda so business must be succinct. TU to ensure that their items are added to the agenda at least 10 days prior to the meeting.	**CLOSED**	H&SC standing agenda items

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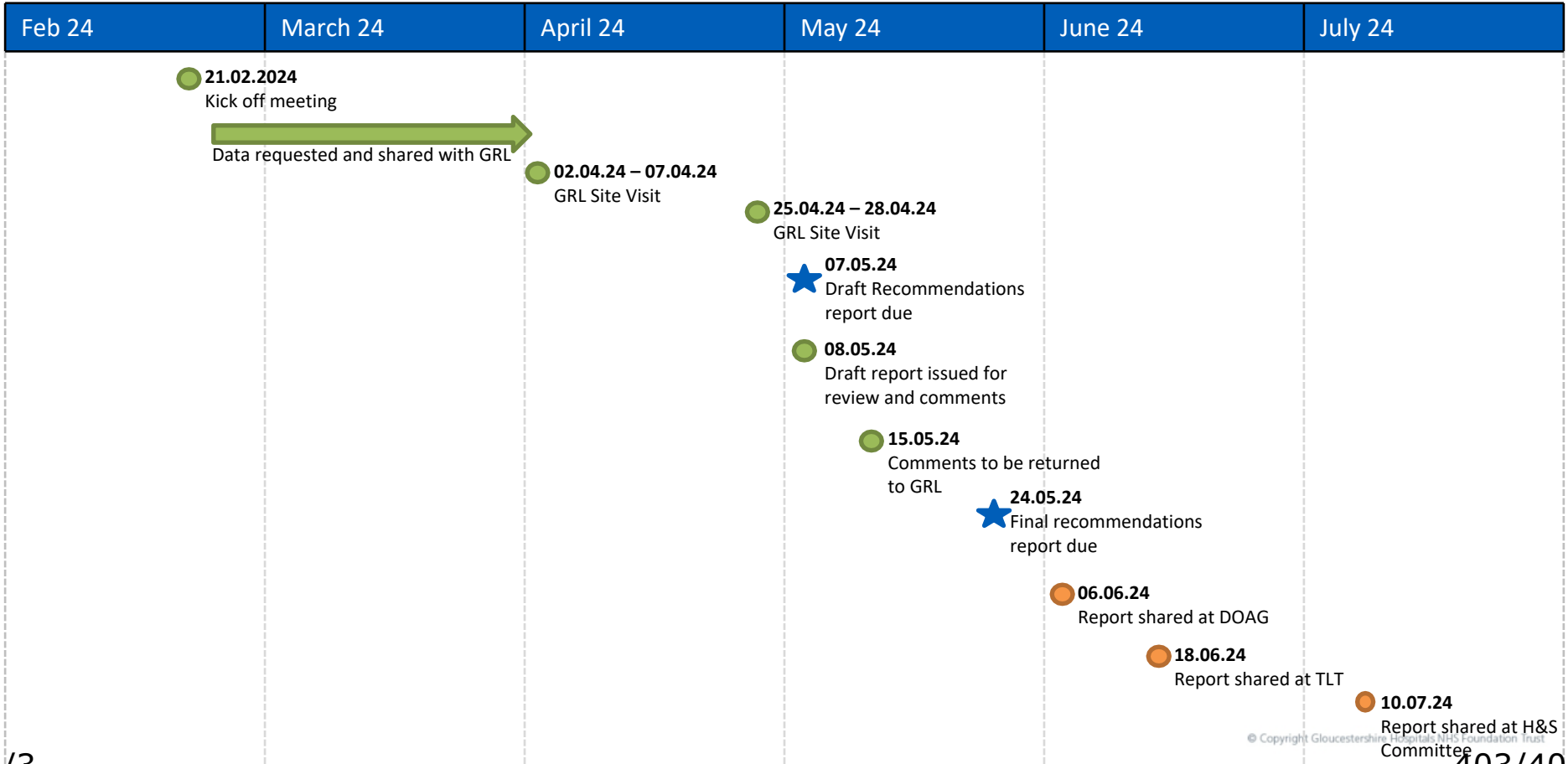
Security Review Timeline

the Best Care for Everyone
care / listen / excel



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Thank you