Main Board Public

Thu 09 November 2023, 13:00 - 16:00

Room 10, Sandford Education Centre, Cheltenham General Hospital

Agenda

13:00 - 13:00
0 min

Agenda

00_Public Trust Board - 9 Nov 2023 v1.pdf (1 pages)

13:00 - 13:00
0 min

1. Chair's welcome and introduction

Deborah Evans

13:00 - 13:00
0 min

2. Apologies for absence

Deborah Evans

13:00 - 13:00
0 min

3. Declarations of interest

Deborah Evans

13:00 - 13:00
0 min

4. Minutes of previous meeting(s)

Deborah Evans

04.1 - 2023-09-14 - Public Board of Directors minutes 14.09.2023 DRAFT (For board).pdf (10 pages)
04.2 - 2023-09-28- Public Board of Directors minutes 28.09.2023 v2 SFLS.pdf (3 pages)

13:00 - 13:00
0 min

5. Matters arising

Deborah Evans

05 - Matters - Reply to Mr M.pdf (2 pages)

13:00 - 13:00
0 min

6. Patient story

Katherine Holland

06 - Patient Story.pdf (2 pages)

13:00 - 13:00
0 min

7.
Chief Executive's report

Deborah Lee

07_CEO Board Report_November 2023.pdf (3 pages)

13:00 - 13:00
0 min

8.
Board Assurance Framework (BAF)

Sim Foreman

8.1.
BAF summary

Board Assurance Framework Summary_October SIM DRAFT.pdf (3 pages)

8.1.1.
SR01

BAF summary SR1 aug 11 9.pdf (2 pages)

8.1.2.
SR02

BAF summary SR2 Quality governance Oct 2023 v0.2 (1).pdf (3 pages)

8.1.3.
SR03

8.1.4.
SR04

8.1.5.
SR05

BAF summary SR5 Quality improvement methodologies August 2023 11 9.pdf (2 pages)

8.1.6.
SR06

BAF summary SR6 OCT 2023.pdf (2 pages)

8.1.7.
SR07

BAF summary SR7 Community engagement and participation - Sept 2023.pdf (2 pages)

8.1.8.
SR08

BAF summary SR8 Staff engagement and participation.pdf (2 pages)

8.1.9.
SR09

BAF summary SR9 Financial Sustainability - 19 Oct 23.pdf (4 pages)

8.1.10.
SR10

BAF summary SR10 Capital_Sept2023_IQ.pdf (3 pages)

8.1.11.
SR11

BAF summary SR11 Sustainable healthcare_Sept2023_IQ.pdf (2 pages)

8.1.12.
SR12

BAF summary SR12 Cyber security.pdf (2 pages)

8.1.13.
SR13

BAF summary SR13 Digital systems functionality - Septemberr.pdf (2 pages)

8.1.14.
SR14

BAF summary SR14_Sept 23 Draft.pdf (3 pages)

13:00 - 13:00
0 min

9.
Trust Risk Register

Kate Hellier

9.1 - BoT Risk Report Nov 2023.pdf (2 pages)
9.2 - Trust Risk Report - November 2023.pdf (1 pages)
9.3 - Appendix A - Trust Risk Register Summary.pdf (5 pages)

13:00 - 13:00
0 min

10.
Quality and Performance Committee (QPC) report

Alison Moon, Matt Holdaway and David Coyle

10.1.
KIAR

Alison Moon

10.1 - 2023-09-27 - KIAR QPC September 2023 SFAM.pdf (3 pages)

10.2.
Quality performance report

10.02- QPR Sept 23.pdf (46 pages)

13:00 - 13:00
0 min

11.
Learning from Deaths Report

Kate Hellier

11.1.
Coversheet

11.1 - Cover sheet - Learning from Deaths BoT Nov 2023.pdf (1 pages)

11.2.
Learning from deaths report

11.2 - Learning From Deaths - Q4 (Jan to Mar 23 v0.6.pdf (13 pages)

11.3.
Appendices

11.3.1.
Appendix 1 Mortality quarterly dashboard

11.3 - Appendix 1 - Mortality Quarterly Dashboard Jan-mar 23 updated Aug 23.pdf (8 pages)

11.3.2.
Appendix 2 - Bereavement feedback report

11.3 - Appendix 2 - bereavement feedback report jan-mar 2023.pdf (5 pages)

11.3.3.
Appendix 3a - Q&P NOF report July 2023

11.3 - Appendix 3a - Q&P NOF Report July 2023.pdf (13 pages)

11.3.4.
Appendix 3b - Hip fracture analysis

11.3 - Appendix 3b - Hip fracture analysis at GRH.Jan 2023 to August 2023.pdf (4 pages)

13:00 - 13:00
0 min

Break

13:00 - 13:00
0 min

12.
People and Organisational Development Committee (PODC) report

Balvinder Heran

12 - PODC KIAR Oct 2023 SF.pdf (2 pages)

13:00 - 13:00
0 min

13.
Guardian of Safe Working

Shyam Bhakthavalsala

13.1 - Coversheet - GOSW Report - Board July 2023.pdf (1 pages)
13.2 - Quarterly report of GOSW Apr - Jun 23.pdf (5 pages)

13:00 - 13:00
0 min

14.
WRES/WDES Annual Reports

Claire Radley

14.0 - WRES WDES Reports and Action Plans Coversheet 2023.pdf (3 pages)
14_WRES WDES Annual Reports.pdf (15 pages)

13:00 - 13:00
0 min

15.
Finance and Resources Committee (FRC) report

Jaki Meekings Davis and Karen Johnson

15.1.
KIAR

- 15.1b_Finance and Resources Committee KIAR_October.pdf (3 pages)
- 15.1a_Finance and Resources Committee KIAR_September.pdf (3 pages)

15.2.
Financial performance report

- 15.2_COVER SHEET - Finance Report M6.pdf (1 pages)
- 15.3_M06 Financial Performance Report.pdf (12 pages)

13:00 - 13:00
0 min

16.
Audit and Assurance Committee (AAC) report

John Cappock

- 16 - 2023-09-26 AAC KIAR SF.pdf (3 pages)

13:00 - 13:00
0 min

17.
Any Other Business

13:00 - 13:00
0 min

18.
Governor Observations

NHS
Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
13:00, Thursday 9 November 2023
Room 10, Sandford Education Centre, Cheltenham General Hospital

AGENDA

REF	ITEM	PURPOSE	REPORT	TIME
1	**Chair's welcome and introduction**			13:00
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of previous meeting**	Approval	Yes	13:05
5	**Matters arising**	Assurance		
6	**Patient story** *Katherine Holland, Head of Patient Experience*	Information	Presentation	13:10
7	**Chief Executive's report** *Deborah Lee, Chief Executive*	Information	Yes	13:25
8	**Board Assurance Framework** *Sim Foreman, Trust Secretary*	Review	Yes	13:40
9	**Trust Risk Register** *Kate Hellier, Deputy Medical Director and Director of Safety*	Assurance	Yes	13:45
10	**Quality and Performance Committee (QPC) Report** *Alison Moon, Non-Executive Director, Matt Holdaway, Chief Nurse and Director of Quality, and David Coyle, Interim Chief Operating Officer* • **Quality Performance Report**	Assurance	Yes	13:55
11	**Learning from deaths,** *Kate Hellier, Deputy Medical Director and Director of Safety*	Assurance	Yes	14:15
	Break (14:25-14:35)			
12	**People and Organisational Development Committee (PODC) Report** *Balvinder Heran, Non-Executive Director*	Assurance	Yes	14:35
13	**Guardian of Safe Working,** *Shyam Bhakthavalsala, Consultant Paediatrician and Neonatologist*	Assurance	Yes	14:45
14	**WRES/WDES annual reports,** *Claire Radley, Director for People and OD*	Assurance	Yes	15:00
15	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director, Karen Johnson, Director of Finance* • **Financial Performance Report (Month 6)**	Assurance	Yes	15:15
16	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	Yes	15:35
17	**Any other business**			15:45
18	**Governor observations**			15:55
	Close by 16:00			

Due to the meeting room capacity, people wishing to attend the meeting are asked to email the Corporate Governance team on ghn-tr.corporategovernance@nhs.net no later than noon on Wednesday 10 November 2023 so that the appropriate arrangements can be made.

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST DRAFT Minutes of the Public Board of Directors' Meeting 14 September 2023, 14:30, Sandford Education Centre, Cheltenham General Hospital			
Chair	Deborah Evans	DE	Chair
Present	Helen Ainsbury	HA	Interim Chief Digital Information Officer
	Vareta Bryan	VB	Non-Executive Director
	John Cappock	JC	Non-Executive Director
	David Coyle	DC	Interim Chief Operating Officer
	Matt Holdaway	MH	Chief Nurse and Director of Quality
	Karen Johnson	KJ	Director of Finance
	Kaye Law-Fox	KLF	GMS Chair/Associate Non-Executive Director
	Deborah Lee	DL	Chief Executive Officer
	Jaki Meekings-Davis	JMD	Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Director of Safety/Deputy CEO
	Ian Quinnell	IQ	Interim Director of Strategy and Transformation
	Claire Radley	CR	Director for People and Organisational Development
Attending	James Brown	JB	Director of Engagement, Involvement and Communications
	Becky Fell	BF	Associate HCSW Educator (item 6)
	Sim Foreman	SF	Interim Trust Secretary (minutes)
	Becky Hall	BHa	Specialist Nurse Organ Donation (item 17)
	Mark Haslam	MH	Clinical lead, Organ Donation (item 17)
	Dickie Head	DH	Head of EPRR (item 19)
	Katherine Holland	KH	Patient Experience Manager (item 6)
	Louisa Hopkins	LH	Freedom To Speak Up (FTSU) Guardian (item 13)
	Ian Mean	IM	Chair of Organ Donation Committee (item 17)
	Juwairiyia Motala	JM	Community Outreach Worker (item 14)
	Lisa Stephens	LS	Midwifery
Observers	Two governors, a CQC representative and Kevin McNamara (incoming CEO) observed the meeting in person.		
Apologies	Marie-Annick Gournet	MAG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director

REF	ITEM
1	**CHAIR'S WELCOME AND INTRODUCTION** DE welcomed all to the meeting, in particular JC, SF and Kevin McNamara (the latter joining as CEO in January 2024). The minutes would reflect changes to the agenda running order.
2	**APOLOGIES FOR ABSENCE** Apologies from MAG, BH and SM were NOTED.
3	**DECLARATIONS OF INTEREST** There were no declarations of interest.
4	**MINUTES OF PREVIOUS MEETING** **RESOLVED:** The minutes of the meeting held on 13 July 2023 were **APPROVED**.
5	**MATTERS ARISING** There were no matters arising.

Unconfirmed

6	**STAFF STORY** KH introduced BF who shared her story as an Associate Health Care Support Worker (HCSW) Educator outlining the background to her role and the difficulties, challenges and delays faced in trying to implement reasonable adjustments. BF also provided constructive suggestions based on her own experience as to how the experience for staff with disabilities could be improved with CR confirming that BF was part of the Staff Experience Task Force. The Board also heard the staff Disability Network had had difficulty in finding a chair and work was underway to refresh the group. Board members were inspired by BF's story and her willingness to help and they commended her transparency and vulnerability. **RESOLVED:** The Board **NOTED** the staff story and thanked BF for sharing.
7	**CHIEF EXECUTIVE'S BRIEFING** The Board was briefed on the following: • Operational performance had deteriorated and required a return to boarding of patients to release ambulances • Industrial action impacting on care with three patients expected to breach 78 weeks waiting time. Elective activity cancelled for next industrial action and would be stood back up based on staffing available. The Trust was doing everything possible to protect cancer patients, and these were being prioritised alongside long waiters. • Gloucestershire was top performing system nationally for CT / MRI / Ultrasound performance • Continued work to make improvements for colorectal and urology cancer patients. • The national rationalisation of cancer standards from nine to three, simplifying for patients and staff. DL expressed a view that the right three had been selected. • Staff survey to be launched between 20 September 2023 and 3 October 2023 with the Trust held in queue nationally. DL had recorded a vlog with colleagues to discuss the importance of the survey and different reasons to support and encourage uptake and engagement. • The Trust has been shortlisted for a number of national awards and the community outreach programme had engaged over 17,000 local people. Discussion then focused on reflections post-Letby and the immediate sense of the impact this had on the Trust, colleagues and patients; • All nursing colleagues, not only those in neonatal, had been touched by this. • Two key themes were noting that this could happen anywhere and if it happened here, would it be detected, would the Trust have acted differently. • Continued work on Freedom to Speak Up (FTSU) and responding to concerns, alongside the analysis and review of mortality outliers and neonatal deaths which provided insights which could be triangulate. • The Quality and Performance Committee (QPC) had looked at the new Patient Safety Incident Reporting Framework (PSIRF) that was being introduced and noted the work had been carried out and additional resources in the Quality and Safety team had been implemented. • The Mortality Group had met the previous day and looked at safeguards in respect of data completeness, receiving a verbal update and a report scheduled for the next meeting. Non-executive colleagues welcomed the harm review meeting alongside the Good Governance Institute (GGI) deep dive on quality and sought to understand how these would fit into existing work.

	CR responded from a cultural perspective reporting that the FTSU Guardian, Louisa Hopkins, was focused on closing the loop on concerns raised and undertaking retrospective review of all anonymous concerns to 2020 and non-anonymous back to 2018/19 to follow up with individuals as required. The Executive Strategic Priorities were appended to the report and sat alongside the Trust's three strategic objectives (reduced from ten previously). In response to a non-executive director (NED) question, the Board was assured that some activities were stopping to allow the focus on the three objectives and to prepare for winter challenges and NEDs could ensure this focus remains targeted. **RESOLVED:** The Board **NOTED** the update from the CEO.
8	**BOARD ASSURANCE FRAMEWORK (BAF)** The Board received the BAF and SF advised scores were unchanged from the last report in July 2023. Executive leads were in the process of reviewing and updating strategic risks and actions and these would be going through the committee assurance process. SF would be scheduling regular catch ups with executives to support the BAF update and review process. **RESOLVED:** The Board **NOTED** the BAF.
9	**TRUST RISK REGISTER (TRR)** MP reported that the usual activities continued with the following items highlighted and discussed: • Datix Cloud was almost ready to launch following a major review of risks. Timetable for the transfer of risks would be agreed and monitored through the Risk Management Group (RMG) and AAC. • Progress made on water and fire and safety risks. In response to a request for assurance that the 116 actions on the water safety action plan had been prioritised and tracked to mitigate against critical actions being missed in the quantum, it was confirmed they were and good progress had been made with a full plan going to Audit and Assurance Committee (AAC). Quality and Performance Committee (QPC) had also requested more detail on this, as well as the ophthalmology risk. • Air handling risk has been downgraded following works to replace the units. • The impact on backlog maintenance on risk with the Board reminded that whilst it only saw the top risks on TRR they could appeared siloed, other risks were assessed at divisional level, with investment risks usually forming part of the business planning cycle. The Board development session earlier in the day would help progress this work and this could be a potential separate future item for the Finance and Resources Committee (FRC). **ACTION.** **RESOLVED:** The Board **NOTED** and **RECEIVED** the Trust Risk Register.
10	**UPDATE ON PACS IT ISSUE** HA outlined the background to IT issues related to the Picture Archive Communication System (PACS) following a provider system upgrade in May 2023. Performance issues were identified shortly after "go live" and it became clear the system was not robust enough as more issues emerged. However, the Board was assured that clinicians were able to access PACS via the Electronic Patient Record (EPR) system from day one albeit more slowly and not as easily; the major issues were localised to radiologists' reporting and breast screening. 25 different changes had been applied and although greater stability has been achieved, difficulties continued. Service levels had been maintained throughout by outsourcing reporting to maintain radiology provision. The Breast Screening Programme was ahead on performance before" go live" and

	so we remained complaint with the screening intervals at present. HA reported a loss in breast screening productivity of 35% requiring clinical colleagues to run longer clinics to maintain capacity and keep 100% on Two Week Suspected Cancer Waits. A Datix data review showed no Serious Incidents (SIs) and no known harm but not wanting to be complacent these checks continued. DL and HA had both met senior personnel to express the Trust's disappointment and notified intent to trigger contractual recompense for costs incurred to date and have retained legal advice. The process to monitor this going forward was confirmed as Finance & Resources Committee (FRC) with additional reporting into the Quality and Performance Committee (QPC) to maintain overview of the impact of patients, harm and flow. **RESOLVED:** The Board **NOTED** the update on the PACS system.
11	**GLOUCESTERSHIRE MANAGED SERVICES (GMC) GOVERNANCE MATTERS** The papers, previously supported by the GMS Board and FRC, proposed recommendations to help strengthen GMS governance and reduce the burden of this work. These covered Delegated and Reserved Matters schedule (final page to be updated by Trust Secretary – **ACTION**), updated GMS Board Terms of Reference to reflect replacement of Trust appointed directors with independent NEDs and address quoracy issues. The Board also considered options related to the appointment of an additional executive on an interim basis pending the arrival of new GMS Managing Director. JMD asked when the organisation would revisit the GMS interface i.e. Contract Management Group and was advised this formed part of work being progressed by DL. **RESOLVED:** The Board **APPROVED**; • the revised GMS Schedule of Matters Reserved and Delegated. • the revised GMS Board Terms of Reference. • an additional executive company director to the GMS Board of Directors, and • the role of Director of Strategic Assets Director as the additional executive company director on an interim basis, and for up to six months post appointment of the substantive GMS Managing Director • the update GMS company documentation in the routine cycle of review.
12	**FINANCE AND RESOURCES COMMITTEE REPORT** Matters highlighted from July 2023 included GMS and early discussions on the capital programme with a short meeting in August 2023 to review financial performance year to date and receive on update on the red rated PACS issue as reported earlier. Month 4 (M4) performance was under pressure and if the trajectory continues the Trust would not achieve its breakeven control target. £1.7m deviation from plan was a result of industrial action costs, with additional pressures from inflationary costs on PFI contract and a shortfall on pay increase costs (common NHS pressure). The net position related to concerns in Medicine (largely pay) and Surgery (largely non-pay) with increased oversight implemented with support from DC. The Trust itself was under scrutiny from the System and Region on the financial position due to the risk of £21m deficit (£11m financial sustainability target and £10 additional pressures) if trajectory not corrected. KJ described the actions in place to mitigate the position and notably address the run rate going in to next year. AM asked what increased oversight would feel like for the divisions and it was explained that the approach was intended to be supportive but with clear expectations and timelines in respect of the recovery plan. The Divisions welcome the support and guidance. AM also asked

	about the implementation of recruitment and retention work and it was explained that this was progressing well and leading to improved performance. CR confirmed that that a new system to show shifts covered by agency and bank staff had seen 280 additional shifts had been covered by bank staff as opposed to agency as a result of this work. A workshop of HR business partners was taking place to look at consistency of grip and control measures across divisions **RESOLVED:** The Board **NOTED** the updates on the deficit, balance sheet deficit and capital plan and applauded the work to improve the position.
13	**FREEDOM TO SPEAK UP (FTSU) UPDATE REPORT** LH reflected on her first 100 days in post as the full time FTSU Guardian since April 2023 and commended the energy from colleagues and support given to her. FTSU cases had doubled since her arrival and LH confirmed there had been no barriers to hearing cases or following up on them. Following deep reflection on the staff survey findings on speaking up, tools from the National Guardian's Office (NGO) were being used to realign the Trust service with national guidance. Progress was being made with a reduction in the number of anonymous cases from 34% to 14% as staff become more confident in the process. The size of caseload prevented LH and her team from being as proactive as they would like and the Board was asked to confirm continued support for FTSU. Questions and discussion points were: • GMS was included and fully signed up to this work. • Hope that line managers and supervisors could play role in this work at a critically important time for the Trust. • In relation to regulatory requirements, LH as a full time Guardian had protected time and was working through the impact on other members of the team who had other "day jobs". • The policy was out of date but expected to be addressed within six weeks. • In response to a question on whether she had seen or observed anything that surprised her (in a good way or otherwise), LH advised on the challenges of implementing NGO guidance and recommendations in very different organisations, when the model had evolved. • CR updated that the staff experience improvement programme was building confidence for staff to raise concerns and in the FTSU Guardian as an advocate for speaking up, rather than the individual. • FTSU is a responsibility of the organisation and rather than FTSU Guardian alone. **RESOLVED:** The Board **DISCUSSED** and **NOTED** the Freedom to Speak Up update and **SUPPORTED** on going work to ensure an open and transparent culture of speaking up is achieved in the organisation. *Break at 14:25*
14	**ENGAGEMENT AND INVOLVEMENT ANNUAL REVIEW** JB and JM presented in the report and highlighted the first publication of the engagement tracker showing partnership working delivered over 17,000 contacts all of which had a story behind them. JM also shared highlights from work since starting in May 2022; • Initially focused on Gloucester and Forest of Dean areas due to higher levels of deprivation, the team was now starting to make inroads into other areas. • Community engagement had enabled and led to conversations with communities not usually in contact with healthcare services. • Membership recruitment continued with attendance from governors and board members at events encouraged.

	JB outlined the next steps for this work which included a clear community engagement plan, capturing colleague experience and greater focus on membership and service users. The Board commended JM for her nomination for two awards and noted that what was described goes to the heart of keeping people well at home and that this was part of the Integrated Care Board (ICB) agenda. **RESOLVED:** The Board **NOTED** the report and provided comments and feedback on the review.
15	**MATERNITY STAFFING** LS presented the report up to the end of June 2023 to provide assurance on the effectiveness of the system of safe staffing in maternity highlighting: • Work on the audit reports • Monitoring tool via the Maternity Incentive Scheme • 20 safety risks report • BirthRate plus (BR+) review completes and shows requirement for specialist nurse and clinical midwives • One to one care in labour – action plan to achieve 100% and currently at 97% with staffing being reviewed daily and weekly • A further update on obstetric workforce would be presented later in the year. • Quarterly reports on audits were proposed. The Board recognised this detailed and important report with the following points being raised or discussed; • How 97% for one-to-one care compared to other trust? LS stated that very few Trusts consistently achieve 100% and last month GHNHSFT reached 99%, but that was not enough for that one woman in 100 not getting one to one support, however midwives know the means through which to escalate concerns about safety and/or staffing levels. • Prompt training for obstetric emergency – Rates were high but the performance not rated GREEN. LS explained Prompt training starts at zero then uplifted each month rather than using rolling data which would better explain the position • Did all the new staff coming into specialist posts have clearly defined objectives? LS confirmed this varied depending on individuals and time in the role. There was always a risk that specialists (usually part time roles) were pulled into clinical work but appraisal compliance remained a key focus. • Noting a further review in October 2023, what considerations were needed in respect of reopening the Aveta birth unit in CGH and the level of confidence that this would happen? LS affirmed this depended on confidently deploying staff into the centre on a 24/7 basis and she did not anticipate it opening in October 2023. 28 new whole-time equivalents were joining to fill some of the 35 vacancies and would make a huge difference in this regard and she was hopeful that by November we would be in a position to confirm the date for Cheltenham reopening. • JMD asked if there were financial implications of meeting or missing the maternity scheme? KJ advised this was provided for in the accounts if not achieved and LS added the submission took place in February and was worked on daily with an action plan in place for years missed. • A number of the red flags were not known 18 months ago, which demonstrated the huge achievements of the Maternity Delivery Group in progressing understanding and planning resolution of issues. **RESOLVED:** The Board **RECEIVED** the report and update presented by the Director of Midwifery.

Unconfirmed

16	**QUALITY AND PERFORMANCE COMMITTEE REPORT** AM highlighted several of the issues from July 2023 had featured in performance discussions during the meeting, and although the report was at a point in time, performance was improving. Key points highlighted and discussed were: • Risk Register discussion led to additional assurance requested on the management of emerging risks, capacity to manage water safety processes and capacity to implement the next phase of PSIRF. • Significant discussion on maternity noting that things felt different with more clinical leadership in the specialty and consideration a Maternal Death Review commission by MH. • Learning from Deaths report. • MH followed up to add details of the CQC reinspection of maternity services resulting in a fresh report issued with a 29A. Although the initial 29A had been lifted following representation a review meant this continued to stand due to ongoing overdue incidents and safeguarding training compliance. • Maternity Support Programme – The next governance review received the previous Friday identified much to consider. • Incident response safety huddle trial due to start at the end of the month with report • Patient Experience and PALS repots contain lots of knowledge and work underway to maximise this learning. ***Quality and Performance Report*** Other key points were highlighted as follows: • Accessibility of report reviewed based on feedback to change metrics on quality and show all priorities in the quality account. • CQC action plan and trajectory to achieve compliance coming to QPC for oversight ahead of 10 November deadline. • Elective performance 67.7% for diagnostics in June 2023 to be validated with the number of endoscopy and gastro referrals challenging capacity. • Urgent emergency care at c.72.1% in the Top 40 nationally was a stepped improvement (although slower than hoped for) • Ambulance handover issues continued however cohort areas staffed by SWASFT staff allowed seven immediate offloads. • Cancelled elective activity on strike days impacting outpatients and procedures • Emergency Department (ED) attendances at over 500 per day. DC challenging the number of frailty cases presenting from care homes that don't warrant coming in hospital and could be better supported at home. • Recognition and support for the Newton work coming. DC leading flow and discharge work supported by a national expert. **RESOLVED:** The Board **RECEIVED** the update from the Quality and Performance Committee including noted the quality and performance report.

Unconfirmed

17	**ORGAN DONATION ANNUAL REPORT** IM, MH and BHa updated on the highlights from another successful year in relation to organ and tissue donation, with Gloucestershire being upgraded to a level 2 centre and nominated for three national awards, winning one. The team expressed thanks and gratitude for the consistent support from the Board and management. Key discussion points were: • Organ Donation week taking place from 18 – 24 September with a campaign message of "two minutes to sign up could save up to nine lives" • 7000 people awaiting transplants nationally (250 under 18 years old) mainly for heart, lung and liver. • 494,334 of the 643,000 (c80%) Gloucestershire population registered as organ donors on 3 September 2023, one of the highest in the country at a time of national decrease in other areas. • Challenges continue to register donors from diverse communities, with further need to concentrate on young people and particularly involve schools. • Falling consent is a national issue and being addressed through collaboration with partners i.e. Go Gloucestershire volunteer platform. • Excellent year in the quality and number of transplants with high levels of referrals, families supported by specialist nurses. • The team aim for 100% with all missed opportunities reviewed to identify any learning and keep up the work to train remind refreshed junior doctors and colleagues. Board members recorded their formal thanks to all colleagues in the team and MN offered to provide a connection to the Cheltenham Cricket Festival to host the annual cricket match. In response to a question on whether "opt in or opt out" was better, BHa explained there was negative perception of opt out as considered by some to be a "pursue at all cost" approach and reminded that in all cases the family had the ultimate say. DL also advised that there was not a strong correlation between higher rates and "presumed consent". **RESOLVED**: The Board **RECEIVED** the report as a source of assurance regarding the quality of organ and tissue donation activities in the Trust.
18	**AUDIT AND ASSURANCE COMMITTEE REPORT** JC has observed a couple of meetings prior to taking office and since joining had met with KJ and colleagues from Internal Audit and Counter Fraud as well having a handover with Claire Feehily. The annual accounts process was flagged as a RED item with a number of issues highlighted by the external auditors about the 2022/23 process. It was not clear whether the escalation processes (both Trust and auditors) were used appropriately and a working group has been established to produce a better outcome next time. Internal follow up was an AMBER item due to auditors' concerns about engagement from executives on draft findings and actions from audit reports. The CEO had taken action to improve this but the Committee would maintain pressure to ensure collective responsibilities were upheld. **RESOLVED:** The Board **NOTED** the Audit and Assurance Committee report.
19	**EMERGENCY PLANNING RESONSE AND RESILIENCE (EPRR) COMPLIANCE** The Trust had self-assessed compliance against 67/73 standards (92%) demonstrating substantial compliance. The assessment had taken a prudent approach and the Board was updated on the six partially compliant standards which included evacuation and shelter, business continuity and impact assessments, Data Protection and Information Governance (94.7% compliance against 95% target) and decontamination capability. It was reported that: • 12 months of industrial action and the impact in terms of planning and meetings has limited time available for EPRR

	• Teams are well-rehearsed and practiced at contingency planning and "what ifs" despite an element of fatigue creeping into requests for more working groups • CBRN remains very important at time of global tensions and high-risk sites nearby. • The Major Incident in August 2021 provided opportunity to drive forward top-level learning but there remained a reliance on WhatsApp as communication tool which needed to be addressed. • DH, MP and colleagues were thanked for their work to mitigate the impact of industrial action and DH was congratulated on his non-clinical leader nomination in the staff awards. Questions related to how the Trust linked to non-NHS bodies and whether exercises were improving and learning arising from these. In response it was advised NHS bodies met monthly through the ICB and with other responders through the Gloucestershire Local Resilience Forum (LRF). Exercises in an acute trust were hard to do as everyone was busy and generated a lot of work for a small number of people, so the Trust had shifted the approach to smaller, low level desktop exercises to provide more opportunities to educate staff through a "walk and talk" through plans and responses. **RESOLVED:** The Board **RECEIVED** the EPPR update report for assurance and thanked DH for his continued work in this area.
20	**ANY OTHER BUSINESS** A public question had been submitted about the telephone system for contacting the Emergency Department at GRH. As this was received after the deadline for questions, a formal response would be provided with a copy of this shared at the next Board meeting. There were no items of any other business
21	**GOVERNOR OBSERVATIONS** Mike Ellis (ME) and Peter Mitchener (PM), Public Governors for Cheltenham, both commended the staff story, the support provided to BF and the follow up on lessons learned. ME appreciated the PACs feedback and maternity update particularly in context of the Aveta birth unit. PM was the lay member on the Hospital Mortality Group and confirmed discussions had taken place the previous day on mortality reporting in the context of the Letby case. PM added the community outreach work was inspiring for governors and offered to support organ donation promotion in schools through his network.
Close 16:12	

ACTIONS/DECISIONS			
Item	**Action**	**Owner / Due Date**	**Update**
9. Trust Risk Register	Backlog maintenance risk as potential separate future item for the Finance and Resources Committee	SF	Added to work planner topics. **CLOSED**
GMS governance matters	**APPROVED**; • the revised GMS Schedule of Matters Reserved and Delegated. • the revised GMS Board Terms of Reference. • an additional executive company director to the GMS Board of Directors, and		

Unconfirmed

	• the role of Director of Strategic Assets Director as the additional executive company director on an interim basis, and for up to six months post appointment of the substantive GMS Managing Director • the update GMS company documentation in the routine cycle of review.
FTSU update	**NOTED** the Freedom to Speak Up update and **SUPPORTED** ongoing work to ensure an open and transparent culture of speaking up is achieved in the organisation.
Maternity update	**RECEIVED** the report and update presented by the Director of Midwifery.
Organ donation annual report	**RECEIVED** the report as a source of assurance regarding the quality of organ and tissue donation activities in the Trust.
EPRR	**RECEIVED** the EPPR update report for assurance and thanked DH for his continued work in this area.

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST DRAFT Minutes of the Public Board of Directors' Meeting Held on 28 September 2023 at 12:00 via MS Teams			
Chair	Deborah Evans	DE	Chair
Present	Vareta Bryan	VB	Non-Executive Director
	David Coyle	DC	Interim Chief Operating Officer
	Balvinder Heran	BH	Non-Executive Director (from 12:21)
	Matt Holdaway	MH	Chief Nurse and Director of Quality
	Karen Johnson	KJ	Director of Finance
	Kaye Law-Fox	KLF	GMS Chair/Associate Non-Executive Director
	Deborah Lee	DL	Chief Executive Officer
	Jaki Meekings-Davis	JMD	Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Director of Safety/Deputy CEO
	Claire Radley	CR	Director for People and Organisational Development
Attending	Sim Foreman	SF	Interim Trust Secretary (minutes)
	Lisa Stephens	LS	Director of Midwifery
Apologies	Helen Ainsbury	HA	Interim Chief Digital Information Officer
	John Cappock	JC	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Ian Quinnell	IQ	Interim Director of Strategy and Transformation

REF	ITEM
1	**APOLOGIES FOR ABSENCE** Apologies from HA, JC, MAG, BH and IQ were NOTED.
2	**DECLARATIONS OF INTEREST** There were no declarations of interest.
3	**MATERNITY SERVICE - MONTHLY QUALITY REPORT** MH thanked the Board for convening the meeting and explained that due to the bi-monthly meetings and no Quality and Performance Committee (QPC) in August there was a need for this single item meeting. The Board was reminded of the Trust's focus on maternity care following a re-review of the Maternity Incentive Scheme years 2 to 4 having shown non-compliance. The Trust had been transparent on this with NHS Resolution (NHSR) and was addressing this, and as part of this work LS as the Director of Midwifery was able to have direct access to report to the Board. It was confirmed the report had been considered by the Quality and Performance Committee (QPC) the previous day following standard governance process. LS presented the report and focused on three areas: ***Maternity dashboard (to end of July 2023)*** • The dashboard is presented to QPC ahead of Board. • No maternal deaths but two incidents graded moderate harm or above (therefore RED). Ongoing work on the Trust's approach to review and improve classification of incident It was expected that we would see an increase in reporting. • Two HSIB referrals in July following a period of no referrals, linked to identifying a cluster of term admissions. • Maternity incidents previously showed a significant number of overdue incident closures; however, the 166 in July had reduced to 70 at present. A thorough thematic analysis of

incidents was being carried out to provide assurance on learning and investigations with this supported by the instigation of daily safety review meetings with senor midwives.

- Risk register shows 19 risks with three having overdue actions, although these were being addressed.
- Scorecard completion at 100% but RED. LS assured this was GREEN and would update the document: **ACTION - LS.**
- Ockenden was AMBER. Work had been mapped but unable to progress– AMBER – mapped but unable to progress action report to QPC in October. **ACTION – MH/LS.**

Serious incidents

- Details of both cases outlined and the immediate and follow up safety actions.
- Other Healthcare Safety Investigations Branch (HSIB) cases covered in the report alongside progress on other cases.

Maternity Incentive Scheme (includes saving babies lives)

- Programme manager now leading on this work and update via dashboard.
- Board was reminded that it had been told in February 2023 that it was not possible to achieve 10 safety actions. Following resource being put into this the Trust was now in a better position to be able to meet these.
- Ten safety actions rated as RED but these were expected to change and the Trust was receiving significant support from the NHS England maternity safety advisor.
- Maternity Delivery Group oversee the RAG rating and LS explained the rationale for current RED rating and when this was expected to change. Key to this was the work to review all aspects of the five-year MIS journey.
- Maternity Service Data Set reported as RED in July was now resolved.
- Transitional Care data being collated.
- Expect GREEN on two elements – (Workforce – Element 4 and Element 5) as result of quarterly reporting from Director of Midwifery to mitigate the previous gaps shared with the Board within the bi-annual workforce report. Progress on the outstanding audits will be captured within the next Quarterly Workforce report.

Questions and discussion related:

- Availability of benchmarking data and it was explained that this was not as readily available as Gloucestershire was a single site for Local Maternity and Neonatal System (LMNS) linked to Integrated Care Board (ICB) geography. Whereas most organisations were included with three or four other provider sites. However, the benchmark information that was available related to challenging priorities, governance and moderate harm incidents and this had been discussed at QPC the previous day particularly to learn from others related to staff vacancies (currently 14%). [*BH joined the meeting at 12:21]*
- QPC had also discussed incidents the previous day and how the data could be triangulated in relation to safety and legal cases and the next paper would help to navigate this.
- The QPC Chair requested that future dashboards show both the in-month and target positions: **ACTION – MH/LS**.
- How outcomes of assessments interplay with clinical negligence scheme premiums, either annually or over the five years. Submissions to NHSR were made in February each year and following their assessment of the evidence, the Trust received a lump sum targeted to deliver outputs (not fund bottom line) and this would be repaid if aspects not achieved (as

	had happened in Month 6). This was set aside so did not form an additional financial pressure. **RECOMMENDATION:** The Board **RECEIVED** the maternity services report and **NOTED** the contents and update from the Director of Midwifery.
4	**ANY OTHER BUSINESS** There were no items of any other business.
Close 12:28	

ACTIONS/DECISIONS			
Item	**Action**	**Owner / Due Date**	**Update**
Scorecard completions	Scorecard completion at 100% but shown as RED. LS to update.	LS Oct 2023	
Ockenden	Progress action report to QPC in October 2023 on AMBER rating.	MH/LS Oct 2023	
Maternity dashboard	Future dashboards reporting to show in-month and target position.	MH/LS Oct 2023	
MATERNITY SERVICE - MONTHLY QUALITY REPORT	The Board **RECEIVED** the maternity services report and **NOTED** the contents and update from the Director of Midwifery.		

9 NOVEMBER 2023 – BOARD MEETING - ITEM 4 – MATTERS ARISING

Board question submitted by Mr Main in September 2023. This was received too late for the 14 September 2023 but reply provided below:

Question for the next Board meeting. I would like to share my frustration and that of my sister over the poor and inadequate telephone system going into your AE at the Royal Gloucester. This is no way a criticism of the medical staff who you should be proud off and are first class. My brother-in-law was admitted to your AE department this Wednesday late Pm. I drove down from Surrey to support her.

We tried for over an hour to connect with AE using two phones to no avail. After an hour we gave up and drove to the hospital a round trip of 57 miles to seek information and reassurance on the condition of my brother-in-law. We arrived at AE and were treated with respect and we got the information and location for him.

My Question to the executive is this why did this happen? Why no Q system to tell the relatives time scale of the waiting times, you display AE waiting times.
What action are you going to take to improve the situation so as other patients' relatives do no suffer the stress of trying to get through and it was stressful.
Can I suggest the Board at their next meeting try to contact AE.

I require an assurance that the system will be reviewed.

Mr Main

REPLY

Dear Mr Main,

Apologies for the delay in sending this over to you. Please find below the response to your questions that you raised to our Trust Board. As I have previously noted, this was taken to Board in September. Dr Gregson, Director Change and Governance at Gloucestershire Managed Services has been able to support the responses to your questions.

You raised a concern about being unable to reach the Emergency Department at Gloucestershire Royal Hospital despite trying for a hour. You then took the decision to drive to the department in order to obtain an update on your brother-in-law. In answer to your question about why did this happen,

"Our Emergency Department have a limited number of lines, calls handled via our switchboard will be passed to these extensions as part of a hunt and return process. This means all extensions will be tried by the system and if not answered will be returned back to the switchboard.

Calls unanswered in ED only happens when resources in ED are deployed responding to demands placed on the department.

Responses from the Switchboard can be delayed at peak times, again when resources are deployed to meet urgent demands.

The direct line to the ED will either be answered, engaged or ring out, again as a result of resources responding to demands placed on it. The line should always connect and if hasn't then this would be classed as a fault and remedial action would be taken to restore the service if we are made aware. We have reviewed our records and no fault has been reported, but we would encourage anybody to report faults to us at the switchboard"

You also asked why we do not have a queue system to advise relatives of the waiting times. You note that we are able to display the waiting times in the Emergency Department.

"The switchboard system does not provide the capability to advise queue position or wait times."

Lastly, you asked what action we are going to take to improve the situation so as other patient's relatives do not have the same experience as you and Pamela did.

Our Unscheduled Care team are currently in the process of recruiting a Patient Experience lead, this post previously was an important role in ensuring relatives and carers were kept informed of the care of patients. Previous feedback has been very positive from relatives about the difference this post made to their experience we found that this is in part is due to this role being non-clinical.

"Gloucestershire Managed Services also suggests the process for updating patient location is reviewed to identify if more UpToDate ward information can be supplied to switchboard/ED, to assist relatives in contacting patients."

Thank you, Roger, to both you and Pamela for taking the time to raise this important issue.

With kind regards,

Katherine Holland

Head of Patient Experience

Gloucestershire Hospitals NHS Foundation Trust

Report to Trust Board

Date	9 November 2023
Title	**Patient Story – Sophie's story**
Author / Sponsoring Director/ Presenter	Sophie Dawe, Oncology Patient Katherine Holland, Head of Patient Experience Sponsor: Matt Holdaway, Director of Quality and Chief Nurse

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

To provide a patient story for consideration by the Board.

Background

This patient story provides the perspective from just one of our oncology patients to bring to life some of the data of the National Cancer Patient Experience Survey (NCPES).

The National Cancer Patient Experience Survey 2022 report was published July 2023. We achieved a response rate of 61% which was above the national average. We achieved above expected range in 9 questions. The results can be found here https://www.ncpes.co.uk/wp-content/uploads/2023/07/CPES-2022-Trust-Gloucestershire-Hospitals-NHS-Foundation-Trust-RTE-1.pdf

Sophie's Story

Sophie is sharing her story of her experience of Hodgkin's Lymphoma relapse. The journey she has had, the emotions she has felt and the ways she has found to help her manage her condition and recovery.

Her relapse diagnosis was made in December 2022 following a routine follow up appointment. Sophie underwent both chemotherapy and stem cell treatment with her treatment concluding in June 2023.

Sophie has turned to art as a means of being able to tell her story and support her recovery, some of which she will be using to share her story.

Positives from this story:

- The input and support from the Clinical Nurse Specialists
- The benefits of peer support
- The use of art to support recovery

Learning from this story:

- Delivery of bad news over the telephone
- Health psychology resourcing

• Importance of the physical environment
Risks or Concerns
Patient experience data can carry reputational risk. This story highlights areas where we have provided positive care and areas for improvement for patients, carers and relatives, to improve experience of our services.
Financial Implications
None.

Approved by:	**Date:**

Recommendation
The Board is asked to receive this story and note the points for learning.
Enclosures

Gloucestershire Hospitals
NHS Foundation Trust

CHIEF EXECUTIVE OFFICER'S REPORT TO THE BOARD OF DIRECTORS NOVEMBER 2023

1 Operational Context

1.1 Following a period of sustained improvements in operational performance we are currently facing a number of challenges, most notably in urgent and emergency care where we are once again experiencing significant ambulance handover delays with the consequent impact of ambulance community response times; this picture has been replicated across the South West and driven by a number of factors including an increase in ambulance conveyances and a reduction in acute beds secondary to building works.

1.2 Inevitably, recent industrial action by medical colleagues has introduced a number of additional operational challenges but our teams and leaders have worked incredibly effectively to maintain safe care. Regrettably, due to high numbers of staff on leave and many staff, most notably consultant colleagues, experiencing significant fatigue we were unable to maintain the same levels of routine planned care as previously. Since industrial action by the British Medical Association began in mid-March we have cancelled 1,520 operations and 5,350 outpatient appointments and, for the first time, this included the cancellation and re-scheduling of a small number of cancer patients; whilst this was considered clinically acceptable for them to wait, we do not underestimate the impact this has on them and their families.

1.3 Despite this backdrop, the Trust continues to perform well in respect of elective waiting times and Gloucestershire remains the only system in the South West achieving the national standard of no patients waiting more than 78 weeks at the end of August. However, it is likely that this month, for the first time since February 2023, we will be reporting a small number of 78 week breaches (24) arising from cancellations related to industrial action. The numbers of patients waiting more than 65 weeks has increased from 80 at the start of the year to 775 at the end of October. The biggest impact has been felt in the 52+ cohort where the number of patients waiting more than 52 weeks has risen from 1265 at the start of industrial action (both BMA and RCN) to 3050 currently which is broadly comparable to the number waiting at the end of March 2021 when backlogs peaked, post pandemic.

1.4 In respect of diagnostic performance for CT / MRI / Ultrasound we are the top performing system nationally out of the 42 ICSs. Delays remain for patients accessing endoscopy, angiography and echocardiography; oversight of their recovery plans remains through the Elective Recovery Board chaired by the Chief Executive.

1.5 The very significant focus on cancer has seen a deterioration in the number of patients waiting more than 62 days for their treatment. The 62 day waiting time standards remains the cause for most concern with the Trust continuing to meet the 2 week-wait and 28-day Faster Diagnosis Standard. The number of patients waiting more than 62 days for treatment following GP referral was 223 at the end of October, compared to 403 at the outset of the year however an increase on September's position (178). This represents 8.4% of the total cancer waiting list, an improvement from 14% against a target of 6%.

1.6 As a Trust overall, at the end of October 64% of patients were treated within 62 days of referral against a standard of 85%; nationally the average stands at 59%.

2 Key Highlights

2.1 Last month we hosted our first face-to-face Annual Members Meeting (AMM) which was a great opportunity to connect with our local communities. It is always a difficult balance when considering the merits of in person, over virtual meetings and sadly we didn't get the same level of engagement and participation as in recent years. This is something to think about for the future. It was a great opportunity to welcome outgoing governors for their service and welcome new governors - public, appointed and staff.

2.2 This month we have launched our staff survey and our teams have been working hard to ensure staff understand the value in them completing the survey. Last year half of our staff completed the survey and this year we have set ourselves the target of 60%. To date, an impressive 41% staff have responded compared to 30.2% as the same point last year. Many staff tell us that they simply do not have time in their working day to complete the survey or they do not have access to a computer. In response to this, our staff experience team will once again be out and about and offering drop-in sessions to staff who do not have ready access to a work station. Additionally in recognition of many staff doing this in their own time, they will also receive a £5 gift voucher as a small thank you. We have many tangible examples of the way in which staff feedback has led to tangible improvements and yesterday I was delighted to meet colleagues working in our Staff Experience Task Force who came along to the Executive Team to present. Special thanks to Josh Penston, Culture and Patient Experience Project Coordinator for his fantastic efforts in leading this year's staff survey work.

2.3 Preparations are in full-swing for this year's Staff Awards and, with a record-breaking 700+ nominations, we are set for a huge treat. 52 shortlisted individuals and teams will come together over two nights (8th & 9th November) with 14 winners announced on the nights. For those not lucky enough to be able to join the evening's celebrations, both nights will be web-cast live and teams are being encouraged to come together and celebrate alongside their colleagues, albeit virtually!

2.4 Last month, I was delighted to join members of the Staff Experience Task Force who, in response to feedback from staff, are distributing free meals as part of a pilot to evaluate the success. This was a key theme that came from the follow up to last year's staff survey in response to asking staff the one thing that would make them more likely to recommend the Trust as a place to work or receive care. We visited eight different areas including maternity, paediatrics, Tower wards, switchboard, sterile services, porters and the site team. The reception we received was phenomenal. The food was prepared by GMS colleagues and the quality, the presentation and the varied menu was remarked upon by everyone. In return for a free meal, staff were asked to complete an evaluation which will be used to inform whether the pilot continues. If successful the meals would be available to staff at an expected cost of £2.25; as part of the survey staff were asked to confirm whether they would be willing to pay this amount.

2.5 Last month we had a number of ward-moves with an increasing number of teams now in their final "home" including Care of the Elderly who are now settling in to the newly refurbished Gallery Wing Ward and the General Surgery Team who are now settled in to 4A. Later this month, we see the culmination of building works which will see our new expanded Emergency Department at Gloucestershire coming back together as a single department. Schemes such as these, where we need to continue to run services whilst

doing major building works, are some of the most challenging and we are all looking forward to seeing the benefits of a single, expanded department. We will be arranging visits to the new department over the coming months and would welcome the opportunity to show Board Members.

2.6 As part of our commitments under our strategy *Fit For The Future*, we committed to track the benefits associated with service centralisation and establishment of our two *Centre of Excellence.* This month I was delighted to see an early evaluation of stroke services following their centralisation at Cheltenham General. Despite many staffing challenges – both medical, nursing and therapy, the service has transformed itself and its outcomes for patients. Crucial to good outcomes is a service that enables safe and rapid imaging to enable access to life transforming treatments and specialist staff. Since the centralisation of stroke services at Cheltenham General Hospital the team has improved access to imaging within an hour (gold standard care) from 54% to 74% (52 minutes median time to 11 minutes) and 71% of patients were admitted to a specialist stroke unit within four hours of a stroke being confirmed compared to just 32% previously (383 minutes median to 15 minutes). We know from the evidence that achieving these care goals significantly reduces both mortality and morbidity from stroke; hospital mortality has been consistently less than expected for the last 12 months with 27 fewer deaths than expected. We are now rated 'B' overall in the Sentinel Stroke National Audit Programme from a previous rating of 'E'. There is still more to do, particularly in respect to access to therapy services, but this is truly transformational.

2.7 This month the Three Counties Medical School (TCMS) (hosted by the University of Worcestershire) has achieved a significant milestone following the announcement that they have secured nationally funded training places for 50 post-graduate medical-students which, alongside 22 self-funded international students, will lead to the first cohort of 72 students commencing in September 2024. A proportion of these students will be on placement with the Trust. TCMS is also seeking our support to bid for a further 104 funded places for the 2025 intake. The Trust has currently committed to support a cohort of 100 students and will be working with TCMS to explore the implications and opportunities associated with a larger cohort.

2.8 I am not often surprised but a letter from the Secretary of State for Health, Stephen Barclay took the vast majority of recipients by surprise. I was both shocked and dismayed by the letter and was delighted to see my views were shared by all those who commented. Read here the letter from the three Chairs in Gloucestershire's health system.

2.9 Plans for my transition are now confirmed which will see Kevin McNamara join the Trust on the 2nd January and after a period of handover resume the reins as Chief Executive on the 11th January making this my final public board meeting. There will be time for speeches but I would like to acknowledge my gratitude for the opportunity to lead such a great organisation and for the support of all the Board members, past and present.

Deborah Lee
Chief Executive Officer

1 November 2023

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	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	Oct 2023	CNO/MD/COO	QPC	3x3=9	N/A	5x5=25
SR2	Failure to implement the quality governance framework	Dec 2022	Oct 2023	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**							
SR3	Inability to attract and recruit a compassionate, skilful and sustainable workforce	Mar 2022	Oct 2023	DFP	PODC	3x4=12	N/A	5x4=20
SR4	Failure to retain our workforce and create a positive working culture	Dec 2022	June 2023	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	Oct 2023	MD/CNO	QPC	2x3=6	N/A	4x4=16
4.	**We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners**							
SR6	Individual and organisational priorities and resources are not aligned to deliver integrated care	Dec 2022	Oct 2023	COO/DST	QPC	2x3=6	5x3=15	4x3=12
5.	**Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services**							
SR7	Failure to engage and ensure participation with public, patients and communities	Dec 2022	Sep 2023	DFP	PODC	1x3=3	3x3=9	3x2=6
SR8	Failure to ensure opportunities and capacity for staff to engage and participate	Jan 2023	April 2023	DFP	PODC	2x3=6	N/A	4x3=12
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	Oct 2023	DOF	FRC	4x3=12	N/A	4x4=16
8.	**We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact**							
SR10	Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.	July 2019	Oct 2023	DST	FRC	4x3=12	N/A	4x4=16

Board Assurance Framework Summary

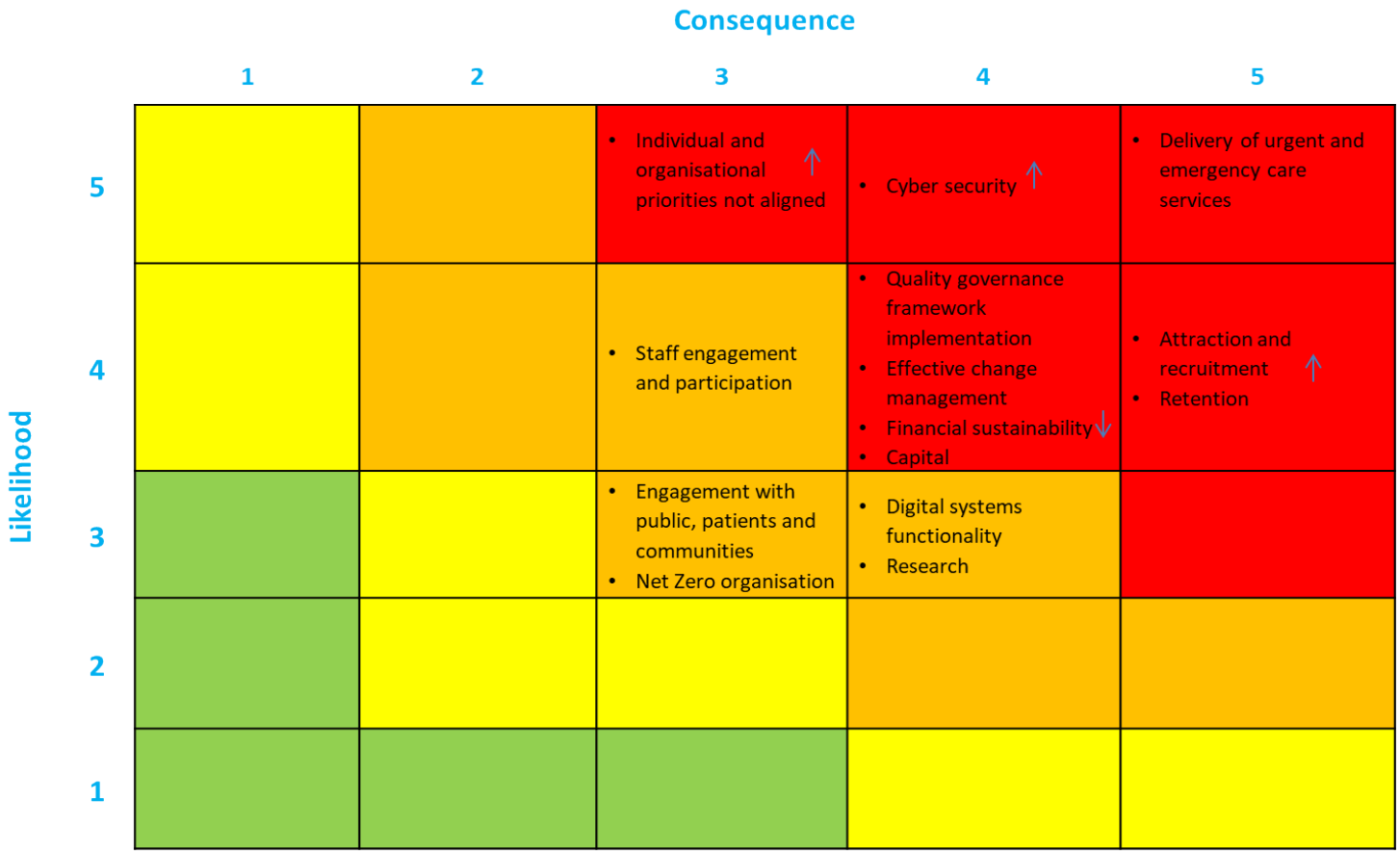
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Dec 2022	Oct 2023	DST	FRC	3x3=9	N/A	3x3=9
9.	**We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care**							
SR12	Failure to detect and control risks to cyber security	Dec 2022	Sep 2023	CDIO	FRC	5x3=15	N/A	5x4=20
SR13	Inability to maximise digital systems functionality	Dec 2022	Sep 2023	CDIO	FRC	2x3=6	N/A	3x4=12
10.	**We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK**							
SR14	Failure to invest in research active departments that deliver high quality care	Feb 2023	Sep 2023	MD	CIRG	2x3=6	N/A	3x4=12

Archived Risks (score of 4 and below)

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

Board Assurance Framework Summary

Heat Map



BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR1: Urgent and Emergency Care OCT 2023

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 well being. • Potential for increased moderate and serious clinical incidents • Potential for delay related harm • Poor patient experience • Unacceptable numbers of 12 hours breaches • Reduced flow leading to longer waiting times for ED • Failure to adequately support patients in the community be ensuring ambulances are offloaded in an effective manner. • Higher numbers of patients receiving care in non-ward environments	Quality and Performance	TRI	SR2 SR3 SR4 SR5 SR8 SR9

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Range of work programmes to support with managing demand internally and with system partners.	• 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.

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

• Boarding and Pre-empting and Trust Flow and Escalation Policies revised and operational • Establishments of CADU and Discharge Lounge supporting earlier capacity. • UEC System Programme Board chaired at ICB level • UEC Improvement Board established and Chaired by CEO • Standardised Data set and Operational Dashboard now BAU • Quality & Performance Committee Report to Board.	• Non-compliance with National operational standards and KPIs • Ongoing impact of IA predicted to continue. • Service Changes more frequently applied (Closure of CGH ED during JUNIOR Doctor IA)

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Friends and Family scores continue to be positive • De-escalated from Tier 1 to Tier 3 monitoring with SW Region **KIAR** Stabilised performance was also reported in Urgent and Emergency Care. A patient improvement plan had been established to review further opportunities and achieve the 80% performance target as set out in the Operational Plan. Reduced incidence of Boarding; now pre-empting frequently but excellent controls in place. Trust Risk Register An improvement programme had been established to coordinate all discharge improvement activity, with an aim to support congestion in Emergency Departments. De-escalation from corridor care in ED.	• Delivery of operational standards remains non-compliant (64.2% 4hr; Handover time greater than 15mins) Significant improvements overall. • Continuation of IA resultant from dispute between BMA and HM Govt requiring significant service changes, loss of capacity and increased time to recover Emergency and Planned care.	Continued monitoring by SW Region at Tier 3 escalation Internal audit reviews 2022-2025

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Quality governance framework — October 2023

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
4x4=12	A refresh of the quality governance framework is being implemented. CCQ inadequate ratings for maternity and surgery Well led requires improvement rating for Trust and a MUST DO action to improve governance 1 service (maternity) has second CQC Section 29A warning notice related to same issues identified at previous S29a (clinical incidents and children safeguarding level 3 training) Additional unannounced focused CQC inspection children's services	**2022/23 Q3** **3x4=12**	Implementation and embedding of the quality governance framework and CQC Requires improvement rating and no inspection until Autumn 2023.	Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee Report to Board • Trust Risk Register Report to Board • Quality and Performance Report (QPR) to Board - Key Issues and Assurance Report (KIAR) • Quality and Performance Committee oversees progress of risks, safety, experience, access/performance and outcome improvement plans in areas where significant issues/concern highlighted • Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board • 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	New CQC Inspection Framework to be delivered awaiting timeline No control of when CQC inspections will happen

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

• 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 Q2
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	CNO	End Q2 2023/24	Delivery of the Quality Plan has been paused whilst meetings take place with Good Governance Institute (GGI). Workshop held with GGI and Executive Leads for Quality/Safety in early October
Work in progress to deliver all the actions against the CQC S29A warning notice	CNO	End Q2 2023/24	2nd section 29a warning notice received by maternity service 8 September 2023 with rapid improvement required by 10 November 2023. Awaiting final report from CQC for Surgery and Maternity services. CQC have carried out an unannounced focused inspection in children's services. BBraun report has been published with an increased rating to requires improvement.
Work to improve the ratings of the core services rated as inadequate to improve governance	CNO	End Q2 2023/24	MDG and QDG have oversight of the CQC improvement plan for the S29a, Must do and Should do improvement action plans for Surgery and Maternity and awaiting final CQC report to review plans.
Formal governance review, focusing on quality ward to Board processes	CNO/DOF/ Trust Sec	August 2023	Workshop held in October to review Quality reporting structures and second workshop to be held by end of Oct 2023.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
Prevention of future deaths report Infection Prevention and Control Report Annual Patient Experience Report GIRFT Report Regulatory Report SI report – no new never events	Quality and Performance Report - There are currently 2745 patients on the 52 week wait list which is anticipated to increase with industrial action. - Increased demand for cancer services. Maternity - NHSE Maternity Safety Support Improvement Programme is still in place and will continue until the service is re-rated to good. - Maternity Governance Review being undertaken. - Thematic review of maternal deaths undertaken and there were EDI/health inequalities raised within the analysis of the data. Water contamination incident - CQC have indicated that they will be investigating.	• 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.

	CQC Awaiting the reports from the April 2023 inspections.	

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR5: Quality improvement methodologies — October 2023

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 2023** **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	Q1 2023/24 - Overdue	Progress delayed because of Trust wide governance review. In progress, revised Divisional focus QDG piloted in August 2023, September QDG to pilot corporate agenda and October to pilot QDG agenda for specialty committees. Further developmental workshops planned for November 2023
Introduction of PSIRF	MD	Q3 2023/24	In progress. Business case and VCP approved, to introduce additional resource to support the introduction of PSIRF. Role now advertised. Aiming for November for Board approval of PSIRP, prior to ICB approval in December 2023. The PSIRF programme is under considerable pressure due to resources for initial implementation. This is detailed in the Safety Report submitted to Q&P Committee.
Establish A3 thinking approach to establish a recognised planning and monitoring approach for improvement	CN\MD\IQ	Q3 2023/24	Meeting scheduled 18 September 2023 VC/IQ to review progress and next steps.

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

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 OCT 2023

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 (2023/24)
- Systemwide STRATEGIC and TACTICAL escalation Groups (SEG, TEG) established as BAU
- Quality and Performance Committee oversees progress of improvement plans in areas of significant concern.
- Delivery Group exception reporting (Maternity, Quality, Planned Care and Cancer)
- Urgent and Emergency Care Board as BAU
- Monitoring of key performance metrics via Quality and Performance Report (QPR)
- Quality Strategy, Risk Management and Executive Review processes in place as BAU
- Efficiency Board in place
- Key issues and assurance reporting (KIAR)
- ICB attendance at Q&P Committee
- Triumvirates in place for the Operational/Clinical Divisions
- Continued delivery of Estate Strategy on both GRH and CGH

GAPS IN CONTROL

- Operational Plan 2023/24 not fully compliant in every domain (Activity agreed to delivery 105%; Financial gap identified and not fully mitigated).
- Operational Performance Delivery but with system ownership and buy in

ACTIONS PLANNED

Action	Lead	Due date	Update
~~BAF planned to assure Trust Board of Elective Priorities 2023/24~~	~~COO~~	~~Jul 2023~~	~~Paper to Q&P on 28/06/2023 recommending Monthly Assurance Paper~~
~~Winter Planning schedule in place following reflection and prioritisation workshop (ICB, GHC and Trust)~~	~~COO~~	~~Sep 2023~~	~~Reflection and System wide workshops already taken place and key schemes being developed and delivered via the Operational Plan 2023/24~~

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

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Elective Recovery Board in place – delivery continues to be strong • Regular 'systemwide' planning meetings in place • KPI (Cancer performance, diagnostics etc) monitoring meetings are fully established • UEC Performance moved from Tier 1 to Tier 3 escalation (Positive) • Operational Plan 2023/24 monitored via Executive Reviews and Efficiency Board on a BAU basis	• Operational Plan 2023/24 not fully compliant in all domains against National KPIS (Ambulance handover time) • Trust CQC Rating "Requires Improvement" • Deterioration of National Staff Survey Results • Ongoing Industrial Action between BMA and HM Govt reducing capacity and ability to deliver key operational standards	• 'Flow' focussed strategy and delivery group planned • Internal audit reviews 2022-25: ○ Outpatient Clinic Management ○ Discharge Processes ○ Cultural Maturity ○ Clinical Programme Group ○ Patient Safety: Learning from Complaints/Incidents ○ Patient Deterioration ○ Equalities, Diversity and Inclusion ○ Infection Prevention and Control

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

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

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

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

CONTROLS/MITIGATIONS

- 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 SR8: Staff engagement and participation — April 2023

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR8	**Failure to ensure opportunities and capacity for staff to engage and participate**	Staff tell us that they feel involved in the planning, design and improvements of services. Staff are proud to work at the Trust and in the quality of care.	Insufficient engagement and involvement approach, methodologies or timing.	Colleagues reflect that they would not recommend Trust as a place to work or receive care.	Quality and Performance / People and OD	DoST	SR1 SR5 SR6 SR7

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		June 2023	Jan 2024		Feb 2023	4x3=12
4x3=12	Internal engagement and involvement and approaches requires more work. Staff Survey scores show significant deterioration in net promoter scores	3x3=9	2x3=6	• Leadership and Team Development programme builds capacity and opportunity for staff engagement • Improvements within key Staff Survey and NQPS Scores, including Net Promoter.	March 2022	3x3=9
					Aug 2021	3x2=6
					Nov 2021	3x2=6

CONTROLS/MITIGATIONS

- Staff Experience Improvement Programme Board established
- Board approved Engagement and Involvement Strategy – with key milestones for staff engagement
- Monthly Team Brief to cascade key messages
- NHS Staff Survey and NHS Quarterly Pulse Survey
- Colleague Experience and Internal Communications Manager recruited.
- Engagement and Involvement programme in place with local communities.
- Leadership and Team Development presented to TLT and specification finalised ready to publish to marketplace for competition.

GAPS IN CONTROL

- Objective measurement of how well key messages are being cascaded to and understood by colleagues.
- Resources to develop new approaches and tools to help reach and actively engage colleagues
- Data analysis and insights to ensure the Trust understands the experience of colleagues and what matters most to them
- Anonymous reporting tools/systems for staff to raise concerns
- Ensuring 'people' are at the heart of our stories

ACTIONS PLANNED

Action	Lead	Due date	Update
Staff Experience Taskforce to evaluate feedback from Staff Survey and lead change on key priorities emerging	Claire Radley	April 2023	Taskforce being recruited and programme of induction and project support in place
Development of Staff Experience Improvement Programme Board	Claire Radley	March 2023	Structured review and approach to culture and staff engagement, including Leadership and Teamwork; Restorative Just Principles and Practice; Colleague Communications and Engagement.
Review internal communications channels and opportunities for engagement. Team Brief now well established.	DEI&C	March 2023	Feedback on Team Brief cascade, review of communication channels aimed at colleagues who do not use email/digital systems regularly. Exploring face-to-face and virtual engagement events with leaders.
Back to the Floor programme now part of each Exec PA portfolio with a plan to increase activity and include TLT.	DEI&C/ DfP	May 2023	70+ Back to the Floors completed between Aug 2022-Feb 2023 and a further 90+ planned. Wider scope to involve all Divisions.
Development of Staff Survey engagement programme, including a review of engaging services and back to the floor.	DEI&C	Oct-Dec 2022	Working Group established and plan developed. Key interventions and resources developing to support all divisions.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

• Staff Experience Improvement Programme Board established • Review of Communications and Engagement – Our Brilliant Basics • Staff Experience and Internal Communications Role in place	• Engagement score from 2022 NHS staff Survey dropped to 6.3 - 0.3 point reduction on 2021 score and our lowest in 6+ years. • Significant drop in net promoter scores within Staff Survey: Only 43% would recommend the Trust as a place to work (down from 58%) and only 44% as a place to receive care (down from 53%).	Internal audit reviews 2022-25: • Staff Experience Improvement Programme Board review • Internal Communication and Engagement approaches • Cultural Maturity and managing incivility and discrimination • Staff Engagement and experience • Recruitment and Retention

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR9: Financial sustainability OCTOBER 2023

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR9	**Failure to deliver recurrent financial sustainability**	We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources. We are a Trust with minimal backlog maintenance and fit for purpose equipment.	• The inability to deliver recurrent financial savings creating a financial gap. • Lack of financial accountability within the organisational culture. • Recruitment and retention challenges leading to high-cost temporary staffing. • Current economic crisis around cost of living, inflation and supply chain challenges. • External demands resulting is lack of flow of patients driving escalation costs and reducing productivity. • Conflict between clearing backlog demand v financial sustainability. • The level of resources to support the trust is not sufficient, including the need to maintain our buildings. • Service pressures and risk appetite leading to rostering above funded levels	• The Trust and ICS continues to have an underlying financial baseline deficit which may grow in size. • Higher sustainability targets for the following year. • Creating an adverse impact on patient care outcomes. • Inability to deliver the current level of services. • Impact on future regulatory ratings and reputation; regulatory scrutiny/intervention/reporting leading to increased risk of reduced autonomy. • Prevention of investment to enhance services and inability to achieve the strategic objectives • Decommissioning of services to operate within means	Finance and Resources	DOF	SR1 SR3 SR4 SR6 SR10 SR14

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
4x4=16	• 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 spend 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**~~ **4x4=16**		July 19	
		Jan 2024	**3x4=12**			
		Feb 2024	**3x4=12**			
		Mar 2024	**2x4=8**			
		Target risk shifted out to 16 in				

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

	• Pressure on operational capacity, limiting the focus on how to drive out efficiencies whilst improving patient outcomes. • Productivity information is showing a reduction in activity but not a corresponding reduction in costs to match.	December, 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.	• 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	

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. • 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	• ~~Draft accountability framework to be launched~~ • Robust benefits identification, delivery and tracking across major projects • Controls on the approval of WLIs/overtime payments needs strengthening – in some areas segregation of duties needs review. Update: Additional paid activities (APA) panel in place with clear terms of reference with clear links to productivity. performance. Monitoring will be within each division and controls monitored through FSP. Medical Grip & Control meeting meets bi-weekly to review all aspects of medical workforce spend. • The approval process for ad-hoc additional medical shifts needs review; increased the controls in Locums Nest to stop ad hoc shifts being approved retrospectively. • 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 • ~~System deficit agreement and system financial framework yet to be implemented –~~ in place • Current rostering rules do not provide prior approval to over roster where applicable - This is now in place as the templates have been uploaded onto ESR where controls are now in place. Any over roster requests have to have Chief Nurse sign off. • No central medical rostering system in place - TLT approved e-Roster procurement on 17 October 2023.

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

• 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	

ACTIONS PLANNED

Action	Lead	Due date	Update
Robust benefits identification, delivery and tracking across major projects	DOS	Oct 23	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).
Trust wide communication is being developed and sent out to inform the organisation of the financial position to get the message understood	DOS/PMO	Aug 23	Development of Trust wide workshops to gain more traction on ideas for medium term plan during the financial year. CEO provided an update to staff on the pressures and concerns to our financial position via a VLOG in August with a clear message that everyone plays a role to resolve. **These actions have been completed. CLOSED**
Drivers of the pressures understood and communicated to system and regulator partners (UNDERLYING POSITION)	DOF	Monthly	This would form part of the regular monthly monitoring, if the financial position starts to move into a deficit then more formal plans will be developed. This is in place. **CLOSED.** This was underlying position – new ask to repeat for run rate (below).
Drivers of the pressures understood and communicated to system and regulator partners – Based on RUN RATE	DOF	Monthly	Forms part of the regular monthly monitoring, if the RUN RATE starts to move into a deficit, then more formal plans will be developed.
HFMA self-assessment recommendations to be implemented	DOF	Sept 23	HFMA self-assessment tool completed, Report presented to Audit Committee in November. Action plan now being addressed. This is in place **CLOSED.**
WTE growth from 19/20 actuals to 22/23 establishment understood and challenged	DOP	Jul 23	WTE growth was presented to F&D in Sept 22 but further work needed to understand whether WTE growth is still required. Updated to reflect 22/23 WTE growth impact which continues to show WTE increase since 19/20. Exec team peer review and discussion to challenge this.
Implementation of system deficit agreement and financial framework	DOF	Jul 23	Draft presented to FRC and has full engagement of CEO. The framework has been formalised **CLOSED.**
Relaunch of business planning for 23-24	DOS	Oct 23	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.
Implementation of divisional governance	DOF/COO	Nov 23	The efficiency Board, chaired by the COO, now includes a session on financial recovery and oversight. The initial meeting of this refreshed format is in September. A draft accountability framework has been developed and will provide a structure to move divisions into increased oversight as applicable. This is being rolled out by the Executive. This is focused on the Executives holding divisions to account, with escalation of issues up to Trust Leadership Team

			(TLT) for escalation, as appropriate to relevant Board committees. An update will be provided to Audit and Assurance for information linked to internal controls.
Greater focus on productivity opportunities within theatres and OPD	DOF	Dec 23	Clear governance and reporting in place to focus on greatest opportunities with input from system colleagues.
Determine and assess output from Recovery Action Plan	DOF	Nov 23	Initial reporting to FRC in October 2023.

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 • Improved and co-ordinated system working. • Development of productivity analysis at divisional level • Robust financial reporting highlighting key pressures in a timely manner	• 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. • Continuing under-delivery of recurring efficiency programme. • ERF achievement for 2023/24is a cause for concern • Lack of benefit realisation on schemes that should be delivering financial improvement • No real consequences of financial deviation • No review on whether to continue to stop a project if overspending	• Internal Audits planned 2022-25: ○ Cross health economy reviews ○ Shared Services reviews ○ Risk Maturity ○ Data Quality ○ Budgetary Control ○ Charitable Funds ○ Payroll Overpayments • NHSE/I scrutiny of Trust/system finances. • ICS accountability and assurance on system wide transformational changes.

UPDATE

September 2023: The risk to the Trust's financial position remains high for 2023/24 with the main drivers of pressure being linked to workforce levels being above funded establishments, and the non-delivery of sustainability schemes. Currently recovery plans are having minimal impact on the forecast outturn position. The Trust has secured additional resource targeted at the medicine division to support their recovery as this is our greatest risk area. No formal deviation to the Trust's year end breakeven position has been made at this time – system partners and NHSE are fully aware of this position.

October 2023: Development of FRP and in place. Oversight meeting enacted and embedded M6 position has shown improvement to run rate due to review of accruals which was part of FRP programme of work (showing impact)

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR10: Inability to secure capital — October 2023

REF.	STRATEGIC RISK	GOAL / ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR10	**Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.**	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact.	• National Capital Department Expenditure Limits (CDEL) • Age, condition and inefficiency of GHFT buildings & infrastructure • Previous equipment purchase profile resulting in peaks in end-of-life equipment • Scale of backlog maintenance: £72M 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 • 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	
		Jan 2023	Jan 2024			
4x4=16	One Gloucestershire CDEL results in an annual capital budget of c£24M per year for GHFT. This is split across estates, digital and equipment. This allocation is insufficient to address the scale of backlog maintenance (£72M) risk within an appropriate timescale as well as a refurbishment, equipment replacement & digital programme.	**4x4=16**	**4x3=12**	• CDEL limits constrain the level of capital investment One Gloucestershire can commit to • 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. • 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 backlog maintenance element.	Sept 2023 Apr 2023 Feb 2023 Sept 2022 July 2022 April 2022 April 2021 Oct 2020	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Trust Board and ICB sighted on the scale of GHFT estates backlog and Critical Infrastructure Risk	• 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

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

• All NHSE/I capital bids include costs of address backlog maintenance risks in immediate and/or linked development areas • Improved risk reporting of estates risks through GMS, RMG, Committee, Board & ICS • Transition to develop 5 year estates capital programme to provide assurance & timescale of when highest risks will be addressed • Exploring options to dispose of estate with capital receipt used to address backlog risks • Emerging ICS CDEL prioritisation process that is starting to recognise the level of risk being carried by each organisation • Developing 'library' of GHFT & ICS estates schemes, some with supporting Strategic Outline Case and feasibility studies to ensure GHFT is well placed to respond to NHSE national capital programmes	• Lack of clarity on scale of national funding and application route for New Hospital Programme post 2025.

ACTIONS PLANNED

Action	Lead	Due date	Update
Review equipment MES business case learning from how other Trusts/ ICSs have managed IFRS16	DoF/ DST	Q3 23/24	Project to be re-launched in 2023/24. Will require project resource. Pathology MES business case underway, LINAC and Imaging MES being considered.
Improve awareness across ICS partners of level of risk GHFT is carrying across estate and equipment	DoF/ DST	From Q3 22/23	ICS capital group established with DoF and DST. Improved awareness of risk is already influencing CDEL prioritisation decision making Movement to a 5 year capital Programme from 24/25
Review scope, function, priorities and resourcing of ICS Estates Strategy Group	DST	Q1 23/24	Raise via ICS Strategic Executive
Explore partnership opportunities to develop GHFT estate and/or adjacent sites	DST/ GMS	From Q3 22/23	Opportunities in progress/ being explored with GCC and other potential partners.

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

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

Sept 2023: actions updated to reflect progression and new actions for 2023-24

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR11: Sustainable healthcare — September 2023

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	Finance and Resources Committee	DoST	SR9 SR10

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		Jan 2024	Sept 2023		Sept 2023	
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	**3x3=9**	**3x3=9**	GHFT has been successful in securing external grants	Apr 2023 Feb 2023 Dec 2022	

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

ACTIONS PLANNED

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

Action	Lead	Due date	Update
Progress on delivery against GHFT Green Plan reported through F&R Committee	DST	Ongoing	Process established. Last update in July 2022
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
Engage in ICS/ Gloucestershire County Sustainability groups to make linkages and pursue joint initiatives	GMS (JC)	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
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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• SSD Programme progressing to plan at BREEAM '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 — Sep 2023

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.	**Dec 2023** **5x3=15**		Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Cyber Security action plan in place, reviewed annually and gaps in security and investment identified • Monitoring systems in place and dedicated cyber security team • Backup systems and disaster recovery in place and regularly updated • Cyber security delivery workstreams – monitoring safety and access • Investment in cyber tools and software • Regular phishing tests and firewall tests (planned system hacks) • Regular security updates and patches	• Insufficient in-house expertise in cyber security team • Inability to recruit specialist cyber staff because of cost (market forces) • Disaster recovery planning around support systems (out of IT control) not consistently in place • Operating model of cyber-technical & cyber-governance currently not optimal • Backlog of cyber-security issues requiring resolution • Device estate – assets not adequately recorded and maintained • ICS-wide incident response processes not operational

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	

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	Dec 23	Since the last F&R actions have progressed to mitigate the recently raised cyber risk. An interim CISO (Chief Information Security Officer) has been appointed and started In August. There has been progress in bringing historic disparate actions plans together so there is one view of the cyber-programme. A review of tooling, monitoring and alerting has also been performed and it has been identified the tooling suite being used needs to be rationalised. In addition, the monitoring and alerting mechanisms in place at the Trust are not adequate to identify invasive attempts and these are being rewritten and implemented. An asset register for end-point user devices has been established but is yet to being fully completed site-wide. It is being expanded to contain medical devices and IoT. The Trust is working with the wider ICS on developing a cyber-security strategy in line with the new National Cyber-Security Strategy.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
Cyber Action Plan in place and regularly monitored/updated	Difficulty in recruiting enough experienced staff to support our cyber security needs	Internal Audits External Audit (annual) 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	• Inconsistency of approach and not following digital strategy • Implementing new systems without digital approval – that don't integrate with clinical record (EPR) • Lack of required investment in digital skills, resources and infrastructure • ICS wide strategy not operationalised and/or financial gap to deliver. Poor clinical and operational engagement in what is new developments or optimisations	• Reduced ability to innovate, use clinical intelligence and data effectively and plan. • Unable to reach Govt requirements to become a HIMSS level 6 organisation; impacting reputation as well as safety. • Inability to work effectively across the care system, providing poor joined-up care. • Inefficient operational practice and planning/flow. • Inefficient systems/poor data can contribute to clinical errors and poor safety • Unable to meet expectations of patients, commissioners and regulators.	Finance and Resources Committee	CDIO	SR9 SR12

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
3x4=12	The government requires that all hospitals reach a required digital standard of HIMSS level 6 to ensure safety and consistency across the NHS. Digital hospitals are safer hospitals, are better places to work and provide better patient care and outcomes. Improved data leads to better operational and clinical planning, as well as opportunities for innovation. The five-year strategy has seen the trust move from a digitally immature organisation to almost HIMSS level 5 and this must continue if we are going to reach our target of 2024.	**Feb 2024** **2x3=6**		Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Electronic Patient Record (Sunrise EPR) becomes single source of clinical information, implemented to HIMSS level 6- and five-year plan by 2024. • Joining Up Your Information (JUYI) implemented in partnership with external partners and available to access through EPR • Data Warehouse providing one version of the truth supporting clinical and operational dashboards used for planning across the ICS.	• 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.

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

• Delivery workstreams including clinical/business and IT leads with sufficient seniority and oversight/awareness of wider Gloucestershire strategy and requirements • All projects must meet existing Digital Strategy and contribute to the journey to HIMSS level 6 • Implementations must provide significant patient care and/or safety benefits – and reduce risk • Optimisation of EPR for users as part of a continuous improvement, responding to clinical demand • Support wider organisational journey to outstanding • Development of new Digital Strategy 2024+ aligned to Trust Strategy 2024+ building on delivery of Digital Strategy 2019-2024	

ACTIONS PLANNED

Action	Lead	Due date	Update
PACS | Radiology system replacement		May 2023	This system has now been implemented albeit remaining work to stabilise and optimise
Maternity EPR		June 2023	This system has now been implemented
Blood Transfusion onto EPR (resulting)		July 2023	This system has now been implemented
Internal-referral Rollout/expansion		October 2023	Internal medical referrals to deploy in first phase. This is ready to go live but a time to deploy is being considered given Industrial Action.
Paper-lite Outpatients – Order Communications		Q4 2023/24	Order comms deployment as first phase by end of FY23/24. Paperlite and clinical pathways to follow.
NHS at Home		July 2023	Initial rollout of virtual ward platform for Respiratory delivered in July followed by surgery in August. Frailty is due in October.
Clinical Documentation Expansion		Ongoing	Regular drops of documentation continues with prioritisation done by the Clinical Design Authority.
Sunrise Mobile		Autumn 2023	
Patient Portal Implementation		September 2023	Procurement by September 2023, implementation leading into next financial year. Procurement nearing final stage.

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

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

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

Report to Board of Directors

Date	9 November 2023
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 31 October 2023 the following changes were made to the Trust Risk Register.

Key issues to note

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

For further details see enclosed report.

Transfer of Risks to DATIXCloud

All risks were transferred from DatixWeb to DatixCloud in preparation for Go Live of the new system. Prior to Go Live significant issues became apparent that prevented Go Live. These sit with the external Datix supplier and cannot be resolved locally and are not unique to us. A temporary manual solution is in place that has been cascaded to Divisions which involves emailing a form to the Risk Team who are currently maintaining both registers on DATIX Web and Cloud manually. Several options including a roll back or manual work-arounds are being considered. Following discussion at Risk Management Group on Oct 31st the digital and risk teams are meeting with the Divisions in w/c Nov 6th to consider some worked examples of the various options and agree the next steps.

Revised Risk Management Framework

The Risk Management Framework and associated documents were currently being realigned to the processes on DATIX Cloud. This is currently on hold pending a decision.

Water Safety Risk & Fire Safety Risk

RMG noted the significant progress in recruitment and training of the technical staff required to be compliant with HTMs 4 & 5. Independent Authorised Engineers (AE) have been appointed for

each of the disciplines who provide guidance and advice whilst also conducting audits/action plans which are monitored through the various groups and committees. RMG sought further assurance of progress against requirements and will continue to do so until the new governance arrangements are in place.	
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	

Gloucestershire Hospitals NHS Foundation Trust

RISK MANAGEMENT GROUP

TRUST RISK REGISTER

November 2023

1.0 RISKS PROPOSED FOR ESCALATION TO TRR

None

2.0 RISKS WITH AGREED TRR SCORE FOR HOLDING AT DIVISIONAL LEVEL

None

3.0 DOWNGRADE OF TRR RISK TO DIVISIONAL / SPECIALTY RISK REGISTER

None

4.0 PROPOSED CLOSURE OF RISKS ON TRR

None

5.0 OVERDUE REVIEWS OF TRR RISK

A number of TRR risks have gone overdue for review in the last month. Risk owners are currently unable to access the risks until a decision is made to continue with DATIX Cloud or to revert back to Web. A transition period of one month is proposed following the opening of either system, to allow all risks to be reviewed.

6.0 OVERDUE ACTIONS ON TRR RISKS

There are no overdue actions for TRR risks. Actions can be viewed in DATIX web on each individual risk. Actions can be updated by carrying out a search for any action within the action module, which is still accessible, and updating the action as normal.
A copy of the TRR as of 25 October 2023 is provided in Appendix A

Appendix A Trust Risk Register

Risk Ref	Risk Description	Risk Category	Sub Category	Previous score	Current Score (Date changed to current score)	Risk score Change	Target Score	Review Date
WC3845 Obs	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.	Quality	Recruitment & retention	**8**	**16** **(June 2022)**		12	19.9.23
D&S2404 Haem	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	**9**	**16** **(Aug 2021)**		6	2.10.23
C1437 POD	The risk of being unable to recruit and retain 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	**8**	**20** **(June 2022)**		12	19.9.23
S2976 BIMA	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Quality	Recruitment & retention	**15**	**16** **(Nov 21)**		4	12.10.23
S3968 Oph	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.	Safety	Staffing & Competency	**9**	**12** **(June 2023)**		6	2.10.23
C3963	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	**15**	**15**		4	9.10.23
C3941 EFD	The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal hospitals	Statutory	Breach of legislation	**15**	**12** **(Feb 2023)**		2	30.9.23

Appendix A Trust Risk Register

C3930 EFD	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	Safety	Estates	**10**	**15** **(Jan 2023)**		5	5.12.23
C3876 EOL	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	**16**	**16**		2	9.10.23
C3767 COO	The risk of harm to patients and staff due to being unable to discharge patients from the Trust.	Quality	Integrated Care Board	**16**	**16**		6	21.9.23
C3743 Haem	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.	Quality	Recruitment & retention	**12**	**15** **(Feb 2022)**		4	9.10.23
M3682 Emer	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	**15**	**16** **(April 2022)**		6	31.10.23
WC3536 Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Workforce	Recruitment & retention	**15**	**20** **(July 2022)**		6	31.10.23
S3481 Obs	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 minimum staffing requirements.	Workforce	Staffing & competency	**9**	**16** **(Dec 2022)**		4	9.10.23
S3337	The risk to quality of continued poor patient experience on SAU for patients requiring admission to a ward	Quality	Integrated Care Board	**15**	**16** **(Dec 2022)**		10	30.11.23

Appendix A Trust Risk Register

D&S3103 Path	The risk of total shutdown of the Clinical Chemistry Pathology laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Statutory	Breach of legislation	**12**	**16** **(May 2021)**		4	11.10.23
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Quality	Digital risk	**20**	**15** **(Dec 2019)**		6	16.11.23
C3034N	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 Royal Hospital and Cheltenham General Hospital.	Workforce	Recruitment & retention	**15**	**20** **(May 2022)**		9	30.11.23
F2895	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/or deliver key strategic schemes, resulting in interruption in clinical services impacting on patient care and outcomes and overall, Trust performance.	Environment	Breach of legislation	**8**	**16** **(April 2023)**		6	6.9.23
C2819N	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	**8**	**12** **(Aug 2019)**		6	29.9.23
M2815 Stroke	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	**16**	**12** **(March 2023)**		6	27.9.23

Appendix A Trust Risk Register

C2803 POD	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	**4**	**16** **(July 2022)**		6	9.9.23
C2669 N	The risk of harm to patients as a result of inpatient falls	Safety	Clinical Assessment	**15**	**12** **(April 2018)**		6	30.11.23
C2667 IC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C. difficile infection.	Safety	Infection Control	**16**	**12** **(Aug 2020)**		6	23.11.23
M2631 Card	The risk to patient safety as a result of laboratory failure due to ageing imaging equipment within the Cardiac Laboratories.	Safety	Equipment	**16**	**12** **(Feb 2020)**		4	4.12.23
D&S2517 Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Quality	Facilities	**8**	**10** **(Oct 2022)**		4	23.10.23
S2424Th	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	**4**	**16** **(May 2020)**		6	3.8.23
M2268 Emer	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	**16**	**16**		4	6.11.23
C1945 TV	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	Safety	Infection Control	**9**	**12** **(Feb 2021)**		6	30.11.23

Appendix A Trust Risk Register

C1850 N Safe	The risk of ineffective care, prolonged stay and harm of a child or young person (12-18yrs) with significant emotional dysregulation or mental health needs at Children's Inpatients Gloucestershire Royal Hospital. This risk of harm to other patients, staff and visitors caused by abusive or violent behaviour of a child or young person whilst on the ward.	Safety	Abuse and Violence	**9**	**12** **(Oct 2019)**		4	29.9.23

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 27 September 2023		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
There were no RED items.		
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Regulatory Report	• Human Tissue Authority inspection 'red' actions progressed and escalated, but plan remained incomplete. • DBS checks and rechecks for mortuary staff (particularly GMS staff) escalated to the Deputy Director for People. • CQC - Final reports for surgery and maternity awaited. • Inspection of children's services had been requested due to children in care with nowhere to go.	• Organisation wide policy, with a particular focus on GMS staff to be implemented. A report was awaited.
Maternity Exception Report	• The maternity dashboard associated with perinatal quality and safety showed improvement. • Two incidents in July eligible for HSIB, following a period of no HSIB investigations. • 14% vacancy rate challenged • Areas of training and overdue incidents improving. • GIRFT neonatal update given and staffing figures noted with issues of skill mix.	• Team undertaking a cluster review in response to the governance deep dive. • Verbal update on workforce plan given.
Quality Delivery Group Exception Report	• Picture Arching and Communication System (PACS) implementation continued to be challenged. • W&C division had reported that mental health amongst children was increasing significantly, in particular eating disorders. • Frequency of Business Continue Incidents (BCI) in the Trust – becoming part of daily life.	• Mental health issues on daily escalation calls, which were attended by ICB colleagues. • Review of BCI needed and Newton work would link to this.
Cancer Care Delivery Group Exception Report	• Five of 10 standards had been met in July along with 2WW and 28-day standards. Lower GI was the only service not achieving the 2WW standard at 92.2%. • Report on gynae oncology cancer service and action plan for improvement. • Emerging risk to the breast service due to workforce sickness which was negatively impacting on 2WW delivery.	Requested that clinical harm review reporting included figures. Deep dive requested for October Committee To include updated report and mitigations at next committee.

Planned Care Delivery Group Exception Report	• Assurance received on systems in place to understand and monitor Trust position. • RTT performance for July was 66.9%, with 2855 two week waits; August had 3052. • Zero 78-week breaches at the end of July and two for August. • Long waiters had reduced.	Weekly review of 78-week patients underway due to increase; low and medium risk patients well managed, but higher risk patients increasing in numbers. Committee requested continued visibility on elective priorities and impact to patients. Committee requested update on previously noted ophthalmology issues, to come via regular elective care reporting.
Emergency Care Delivery Group Exception Report	• Patterns of late evening congestion in ED noted. • Further evidence of boarding seen, control of boarding required due to the profound effect on quality, • Early discharge and discharge planning challenges continue. • Business Continuity Incidents very challenging with significant impact to workflow.	Newton work was ongoing, but sporadic. ICB agreed to fund an external review and progress update would come back to Committee.
Annual Complaints report	• 2022/23 989 complaints were received with an average of 82 a month; an average increase of 10 per month, main themes known of communication and waiting times. Examples of learning within the report.	Response rates raised as a concern and asked how clinicians responding to complaints as a priority was maintained.
Serious Incidents Report	• No Never Events reported since last report. • 12 new SIs had been reported since the last report to Committee, as detailed in reporting; eight SIs were declared in July, with five new to Committee. Four referrals in August related to concerns with radiology reporting and three referrals were HSIB investigations. • Five actions plans had been closed. • Complaints totalled 102 in July and 101 in August. Monthly average of 89 higher than previous years (82 in 2022/2023 and 72 in 2021/2022). • Evidence of harm and investigation delays under review.	• Challenges within complaint team being mitigated with recruitment and a plan for additional investigation time. • Upcoming quality summit focused on radiology and pathology issues with update from this to Committee. Reintroduction of 72hr immediate action reports also requested.

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.

Patient Safety report	• Progress with implementation of national safety strategy noted, challenges with resourcing capacity continue. • Incorrect version of water safety plan included	• Executive oversight clear • Committee to receive correct version, reassurance given of progress.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Cancer services annual report	Noted for INFORMATION.	Report was commended.
Quality and Performance Report	Noted for INFORMATION.	
Safeguarding Adults & Children annual report	• Reassurance given that sufficient safeguarding arrangements in place in the organisation to meet regulatory responsibilities across all five safeguarding pathways. • External recognition of work on homelessness.	Assurance required for committee of potential gaps in services identified in 22/23 report and progress in 23/24. More focus on organisational learning encouraged for future reports.
Items not Rated		
System feedback		
Impact on Board Assurance Framework (BAF)		
All risks had been updated since last reporting, although progress for each of these were at different stages and further scoring reviews would take place.		

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.

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period September 2023

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

ELECTIVE CARE
Although the full September data is not confirmed, the Trust has for successive months been unsuccessful in delivery of the 78 week standard. Although unconfirmed, it is likely there will be 13 x 78 week breaches in September. These relate to Oral Surgery (6), ENT (4), Gastroenterology (2) and Cardiology (1) and although unwelcomed, this is still better than anticipated given the impact of Industrial Action. In addition, 4 of these patients are categorised as P6 meaning they have chosen to delay treatment during part of their pathway. The part-validated RTT position is anticipated to remain similar to last month, with an estimate of 64.5% compared to 64.8% in August. The factor influencing RTT recovery remains the impact of Industrial Action and the consequential loss of capacity. The positives for September are (a) that the total number of incomplete pathways have remained stable and (b) that the number of patients waiting over 52 weeks have decreased, which is the first time since November 2022. These achievements have primarily been made following the commencement of ENT Glanso clinics in September, and scheduled for October. The September position for 52 week waits remains unconfirmed at this stage but is anticipated to be around 2,950 (compared to 3,022 in August).

CANCER
Unvalidated Sept-23 performance shows overall delivery of 4 against the 10 national operational standards. The Trust are UNLIKELY to meet the 2WW Standard with performance of 90.9% in Aug. This has been due to staffing issues and capacity with the Breast service. A recovery plan is being generated. The Trust CONTINUED TO MEET 28d FDS standard in Sept with a performance of 77.1% and continues to be one of the highest performing Trusts in the SW ICS against the FDS standard. The Trust DID NOT meet the 31d FDT standard in Aug with data showing performance of 87.7%. The Trust DID NOT meet the 62d Standard at 63.3% with 70 breaches for 190.5 treatments. 19.5 of the patients treated were historic patients. The Trust back-log is continually reducing with an end of Sept reportable position of 196; Of the GHFT backlog, Colorectal and Urology due to complex pathways and diagnostic capacity. Industrial impact is continuing to have an impact on performance and patients' pathways and this is being monitored and recorded for understanding and analysis

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

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

	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
All electives (including day cases)	6,257	6,196	6,236	5,097	5,933	5,784	6,557	5,085	6,174	6,180	5,895	6,285	5,827
Day cases	5,214	5,178	5,317	4,284	5,133	4,937	5,655	4,346	5,277	5,270	5,007	5,426	4,998
ED attendances	11,888	12,630	12,290	12,726	10,947	10,706	12,511	11,616	12,993	13,176	12,764	12,300	12,813
FUP outpatient attendances	35,477	35,636	38,346	30,804	37,379	33,593	38,505	30,822	34,946	36,687	34,740	35,258	34,644
GP referrals	10,526	10,827	10,748	8,576	10,504	9,774	11,944	9,346	10,631	11,186	10,502	10,736	10,430
New outpatient attendances	17,448	16,991	19,245	15,099	18,394	16,975	18,868	14,916	17,278	18,320	17,657	17,493	17,737
Non elective (Incl. Assessment)	5,220	5,657	5,663	5,283	5,265	5,027	5,724	5,316	5,607	5,675	5,333	5,193	5,220
Outpatient attendances	52,925	52,627	57,591	45,903	55,773	50,568	57,373	45,738	52,224	55,007	52,397	52,751	52,381

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%		Sept-23	85.3%	
	Cancer - 28 day FDS (all routes)	≥ 75.0%		Sept-23	73.6%	
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%		Sept-23	86.9%	
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%		Sept-23	99.0%	
	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	≥ 94.0%		Sept-23	93.8%	
	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	≥ 94.0%		Sept-23	81.0%	
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%		Sept-23	87.4%	
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%		Sept-23	70.4%	
	Cancer - 62 day referral to treatment (urgent GP referral)	≥ 85.0%		Sept-23	61.8%	
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%		Sept-23	90.8%	
	Number of patients waiting over 104 days with a TCI date	No Target		Sept-23	10	
	Number of patients waiting over 104 days without a TCI date	No Target		Sept-23	26	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%		Sept-23	17.86%	
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600		Sept-23	927	
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%		Sept-23	94.9%	
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%		Sept-23	23.10%	
	% of ambulance handovers < 15 minutes	No Target		Sept-23	13.85%	
	% of ambulance handovers < 30 minutes	No Target		Sept-23	33.22%	
	% of ambulance handovers over 60 minutes	≤ 1.00%		Sept-23	44.91%	
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%		Sept-23	40.6%	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Emergency Department	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%		Sept-23	34.4%	
	ED: % total time in department - under 4 hours (type 1)	≥ 95.00%		Sept-23	58.23%	
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0		Sept-23	697	
	Number of ambulance handovers 30-60 minutes	↓ Lower		Sept-23	694	
	Number of ambulance handovers over 60 minutes	= 0		Sept-23	1,349	
Maternity	% of women booked by 12 weeks gestation	> 90.0%		Sept-23	90.4%	
Operational Efficiency	% day cases of all electives	> 80.00%		Sept-23	85.77%	
	Average length of stay (spell)	≤ 5.06		Sept-23	7.42	
	Cancelled operations re-admitted within 28 days	No Target		Sept-23	74.36%	
	Intra-session theatre utilisation rate	> 85.00%		Sept-23	91.45%	
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40		Sept-23	2.98	
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65		Sept-23	8.40	
	Number of patients stable for discharge	≤ 70		Sept-23	175	
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380		Sept-23	578	
	Urgent cancelled operations	↓ Lower		Sept-23	0	
Outpatient	Did not attend (DNA) rates	≤ 7.60%		Sept-23	6.24%	
	Outpatient new to follow up ratio's	≤ 1.90		Sept-23	1.86	
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%		Aug-23	8.13%	
Research	Research accruals	No Target		Feb-23	141	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower		Sept-23	296	

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 35+ Weeks (number)	No Target	Sept-23	10,154	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target	Sept-23	5,543	
	Referral to treatment ongoing pathways over 52 weeks (number)	= 0	Sept-23	2,994	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%	Sept-23	65.23%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	No Target	Sept-23	74.20%	
	% patients receiving a swallow screen within 4 hours of arrival	No Target	Sept-23	77.90%	
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target	Sept-23	82.4%	
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%	Aug-23	96.0%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	≥ 65.00%	Sept-23	0.00%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%	Sept-23	100.0%	

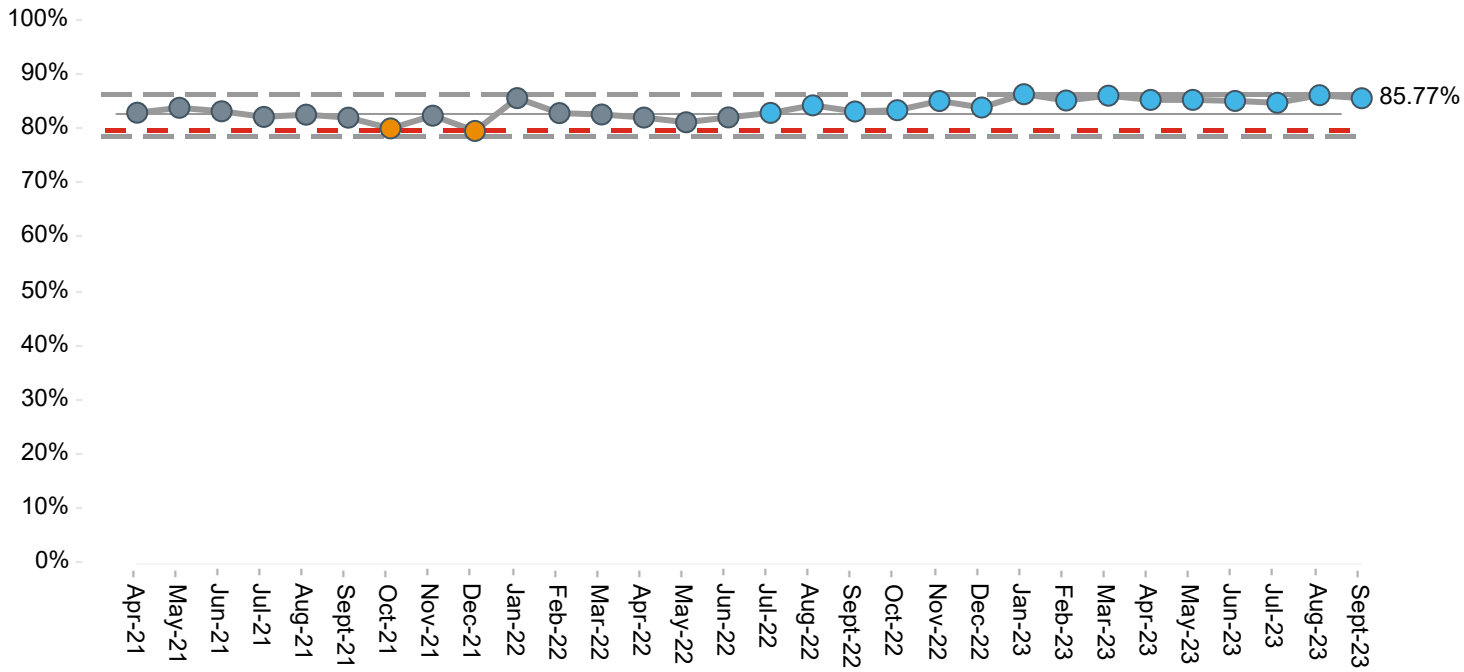
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[487] % day cases of all electives

- - - Target: > 80.00%



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.

[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

Daycase rate of 82.7% has been achieved for August 2023.
Divisional Director - Surgery

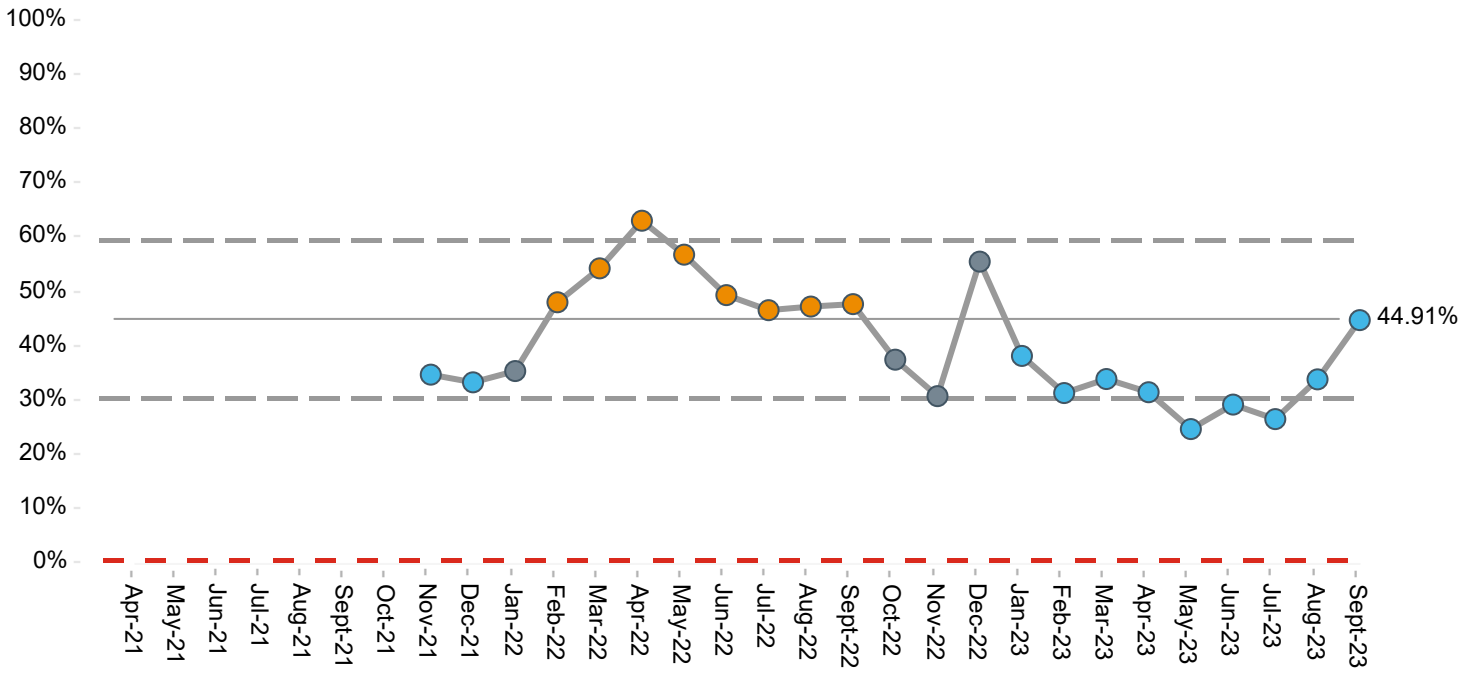
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[482] % of ambulance handovers over 60 minutes

Target: ≤ 1.00%



Commentary

Significant increase in longer ambulance handover delays in September - largely a consequence of the reduction in the level of discharges across the hospital. Overall hours lost to ambulance delays are at their highest since early last year.

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.

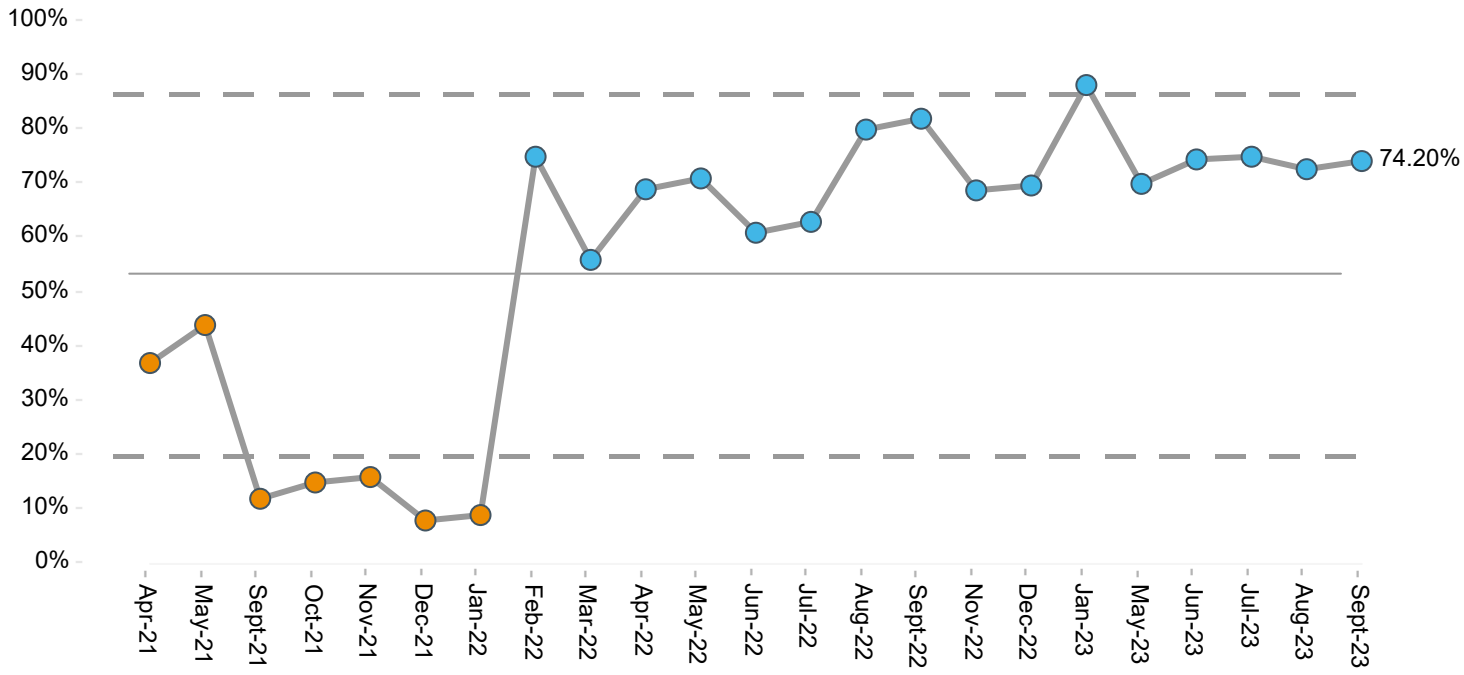
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

[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

There has been a sustained improvement in this metric since the start of the direct to CT stroke pathway has been formed and the successful ringfencing of a stroke bed. Any impact on performance is driven by stroke attendances at GRH

General Manager - COTE, Neuro and Stroke

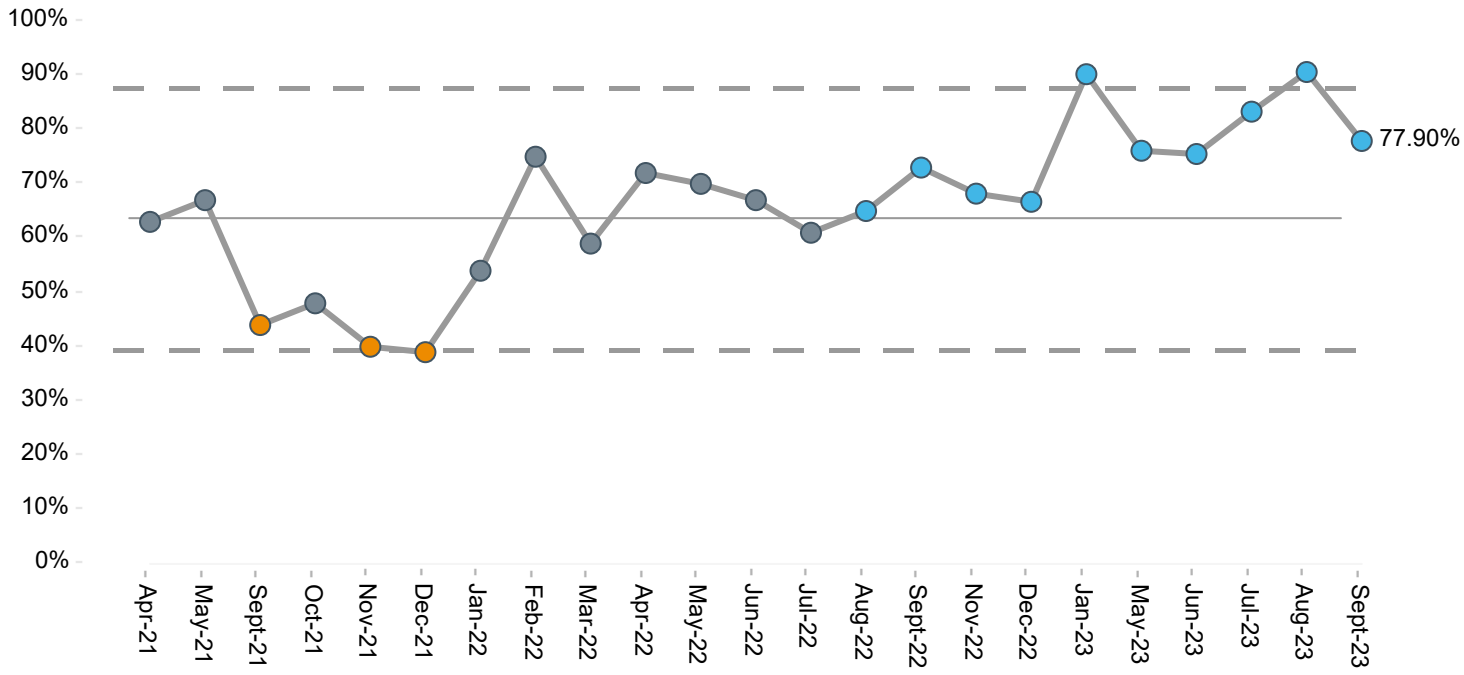
Access

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

[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.

Commentary

The new Stroke pathway ensures that a SSN or HASU nurse meets the patient on admission and performs the swallow screen. We now have swallow screen trained nurses working on HASU overnight.

General Manager - COTE, Neuro and Stroke

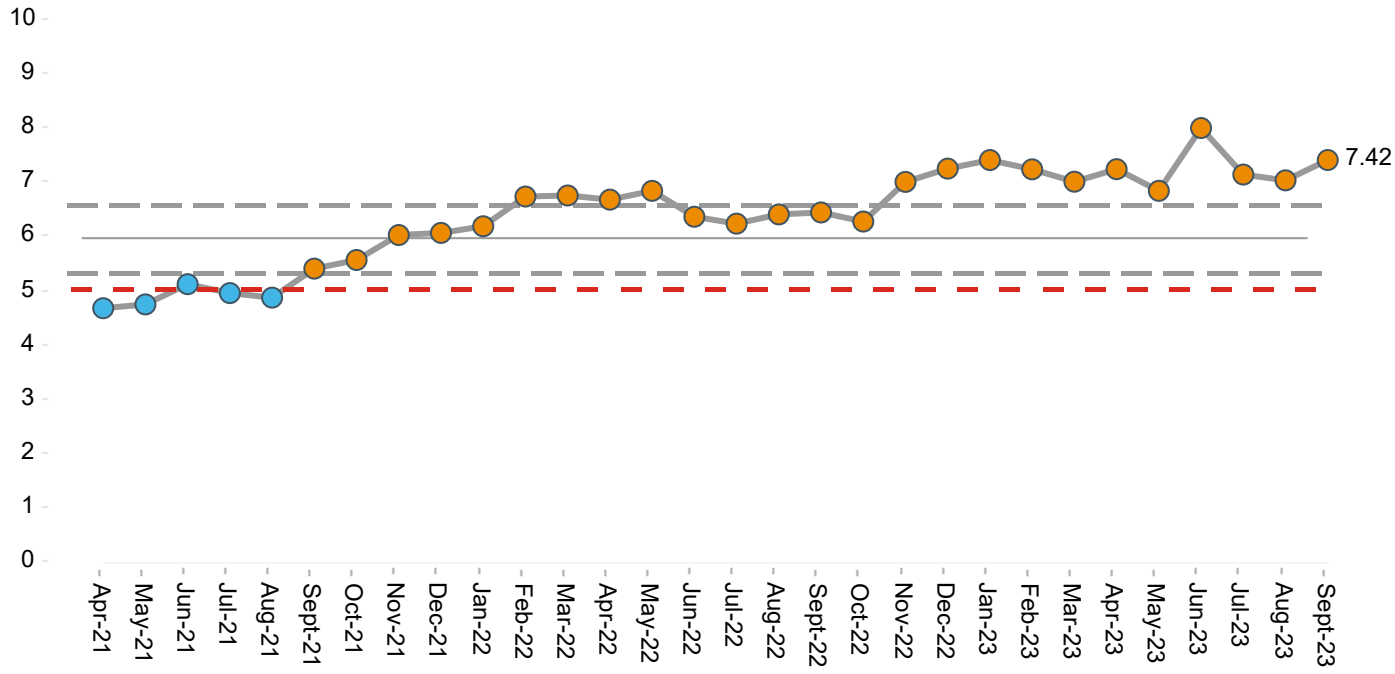
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[188] Average length of stay (spell)

- - - Target: ≤ 5.06



Commentary

Average LOS rose again in Sept with average of 7.41 days. There are ongoing data issues relating to the timely completion of EPR, but also correlates with an increased delay within our longest nCTR patients, and generally within our simple discharge pathways.
Deputy Chief Operating Officer

Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

[3] RUN

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

[4] 2 OF 3

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

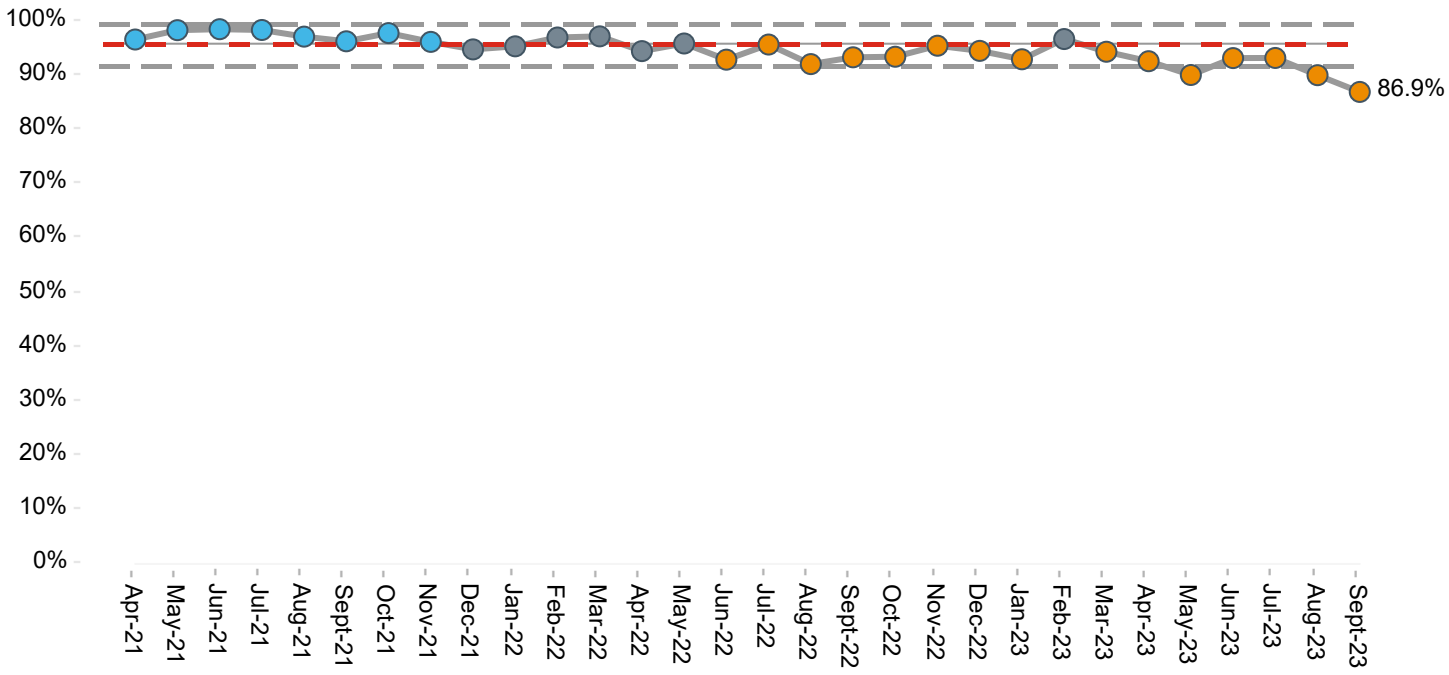
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 96.0%



Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

[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

Unvalidated Sept performance of 86.9% with 44 out of 335 patients breaching. An analysis is underway of each breach to look at themes which caused delay, and actions plans to be created with specialties to mitigate this and increase performance. While Cancer capacity was continued where possible, recent IA has had an impact on planning treatments

Divisional Director of Operations

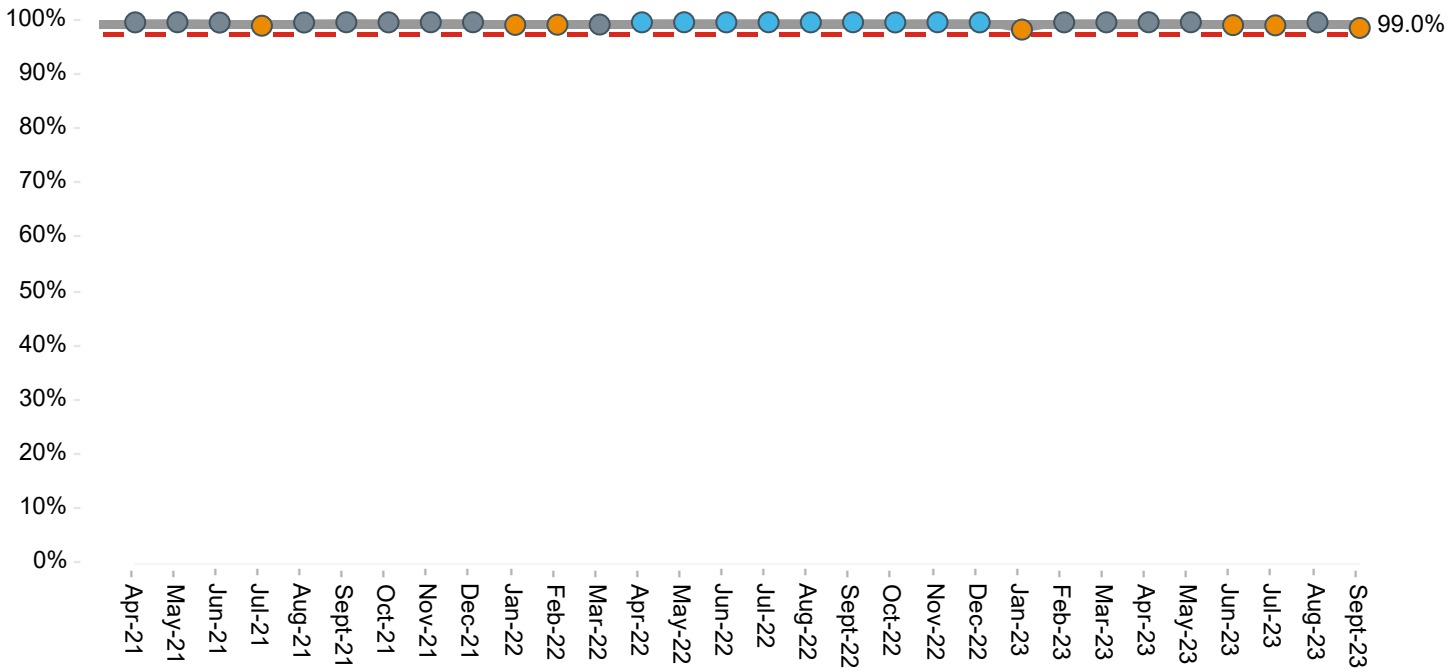
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 98.0%



Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

Commentary

Achievement of 31 day subsequent treatment anti-cancer drugs at 99%
Divisional Director of Operations

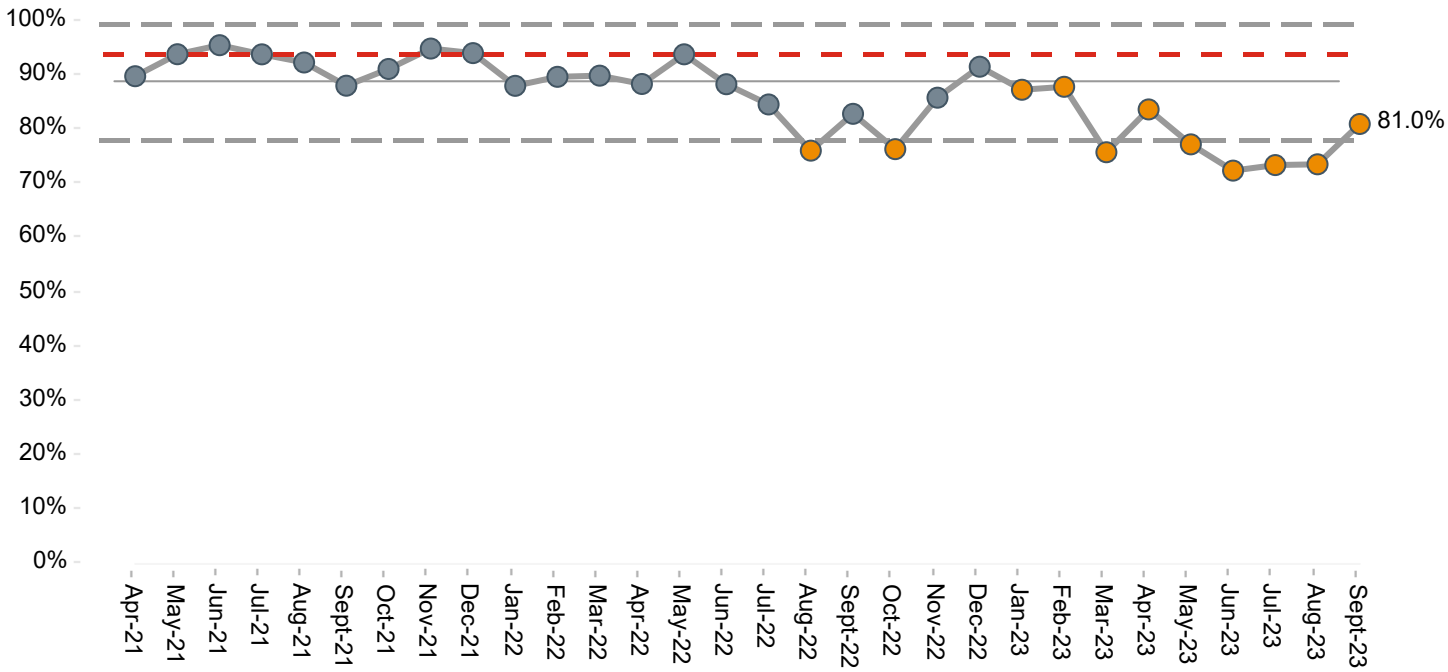
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 94.0%



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.

Commentary

Unvalidated Sept performance of 82.5% . An analysis is underway of each breach to look at themes which caused delay, and identify demand and capacity issues. While Cancer capacity was continued where possible, recent IA has had an impact on planning surgical treatments

Divisional Director of Operations

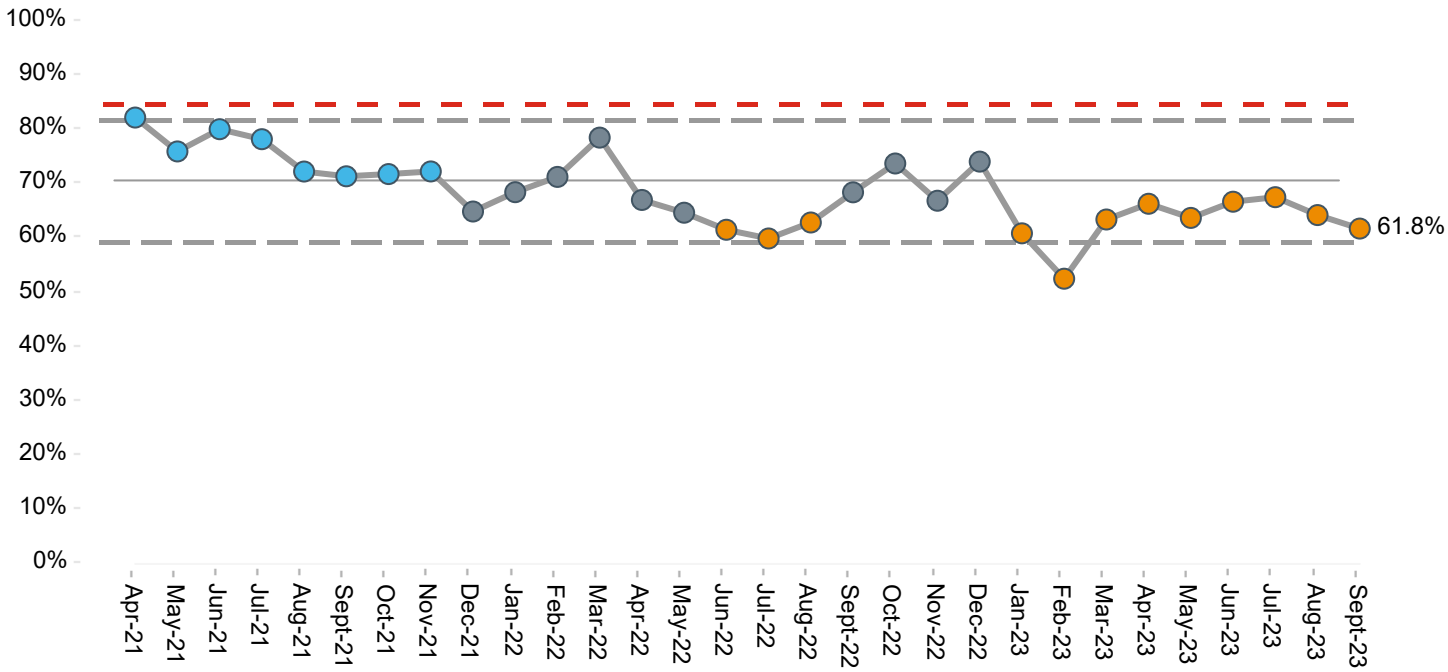
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 85.0%



Data Observations

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[4] 2 OF 3

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

Commentary

Unvalidated Aug position of 63% with 70 breaches for 190.5 treatments. 19.5 of the treatments were for patients waiting over 104 days. patients. Daily validation of future 62-day breaches is now firmly in place within Cancer Services and mitigating impact of industrial Action where possible

Divisional Director of Operations

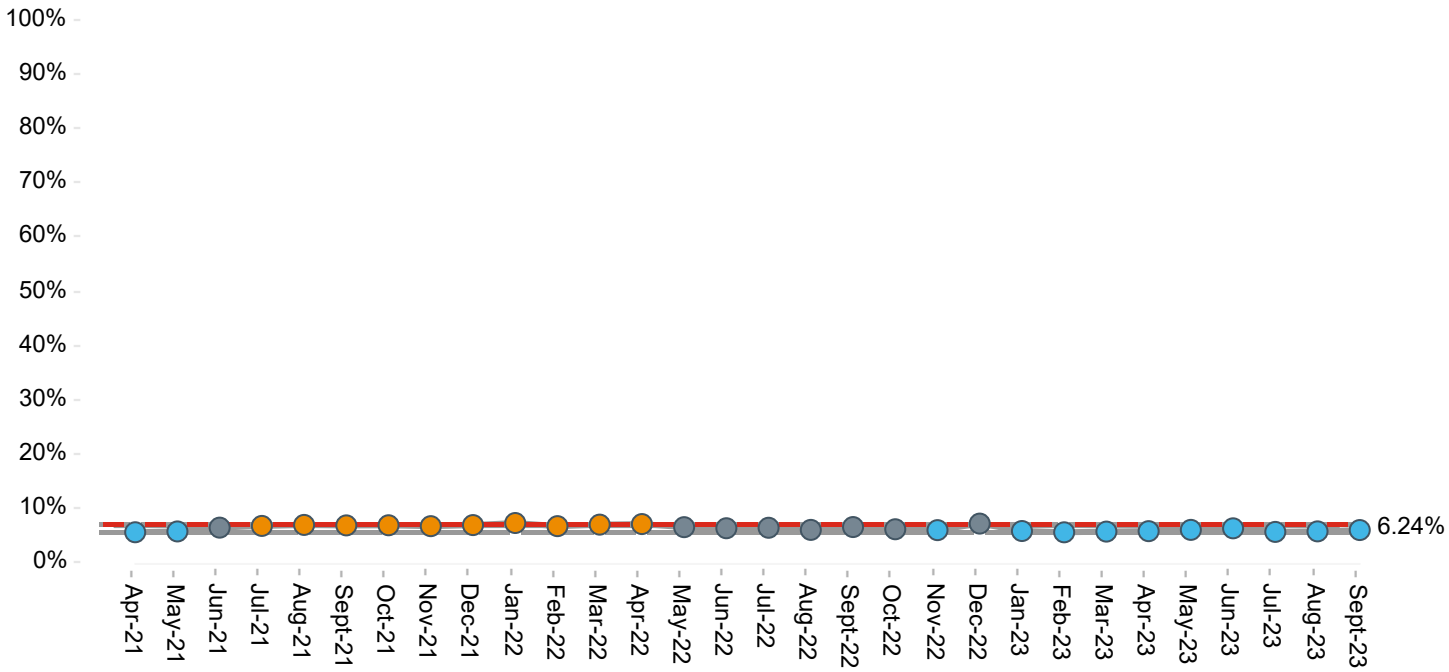
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[491] Did not attend (DNA) rates

- - - Target: ≤ 7.60%



Commentary

The DNA rate still remains fairly static over the past quarter fluctuating around 6-6.5%, with September position being reported as 6.25% (up 0.25% on last month)

Associate Director of Elective Care

Data Observations

[1] SINGLE POINT

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[4] 2 OF 3

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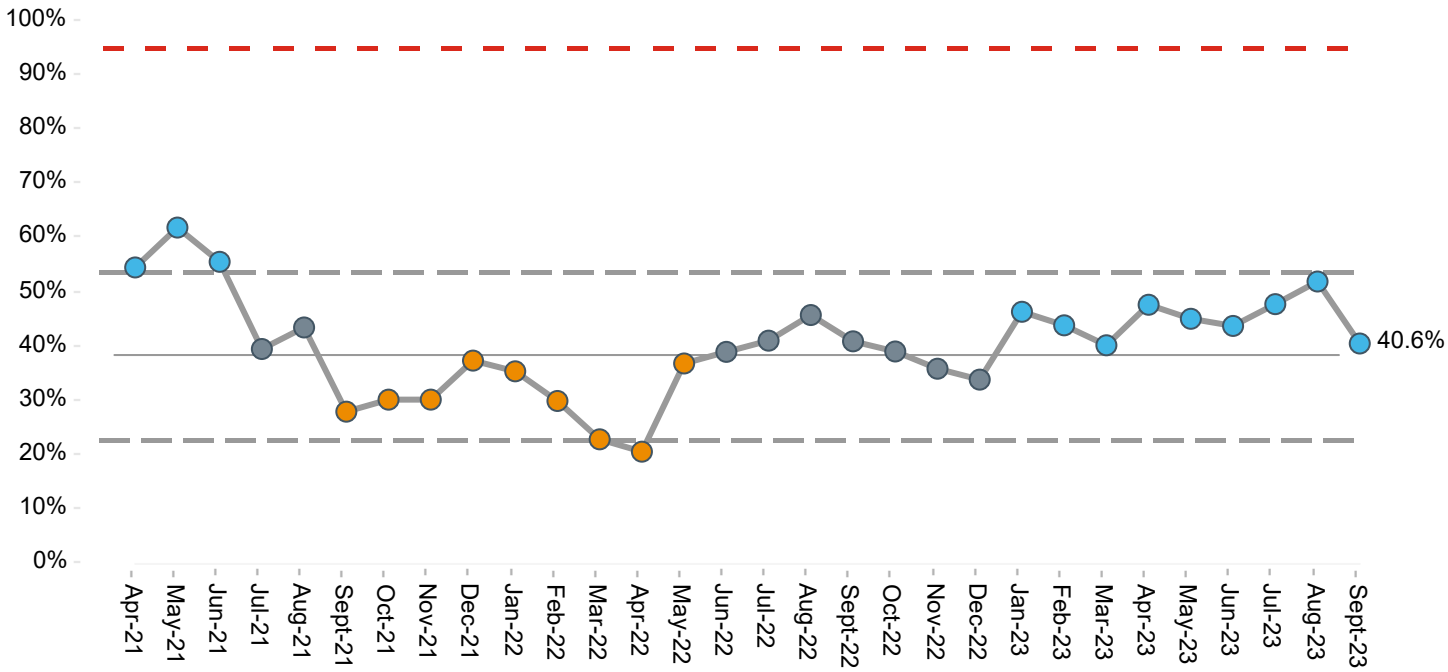
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 95.0%



Data Observations

[1] SINGLE POINT

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[2] SHIFT

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Commentary

Triage times were maintained at 30 minutes on average through September. This continues the trend of maintaining time to initial assessment at half an hour or less throughout the current year.

General Manager of Unscheduled Care

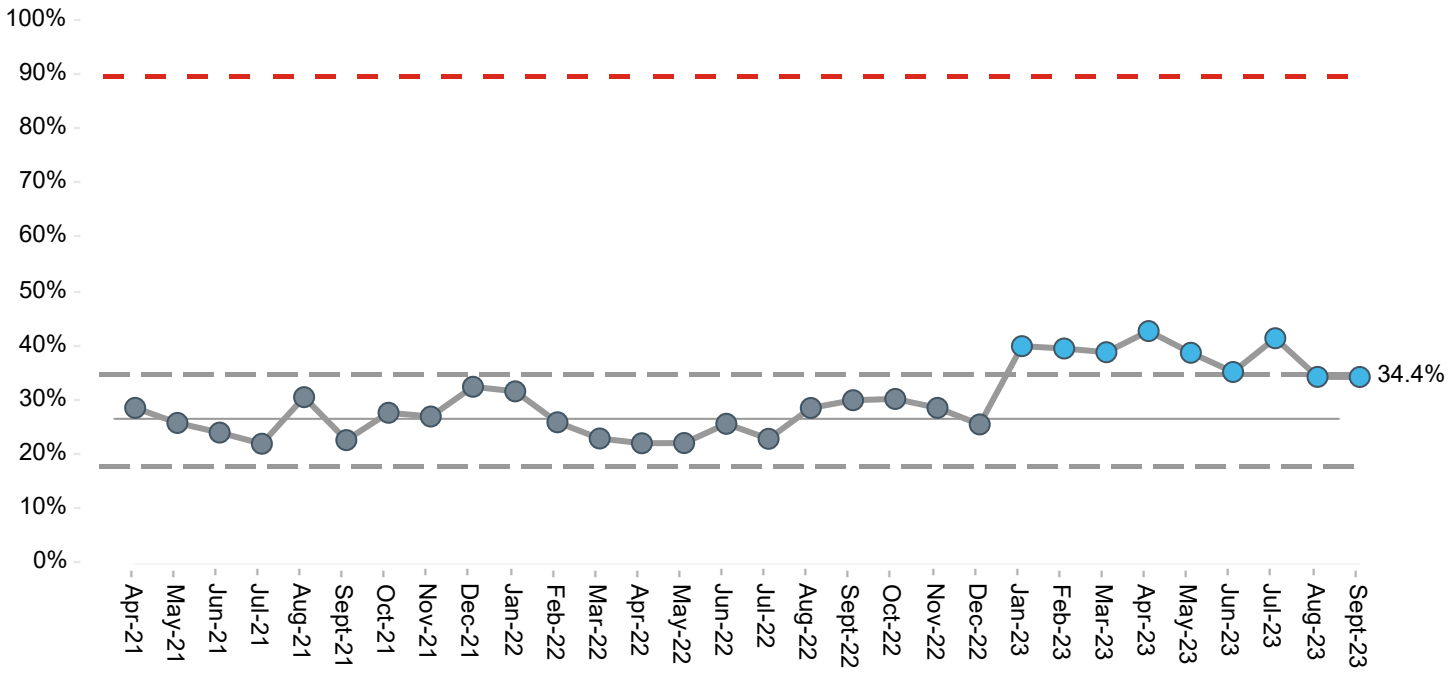
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 90.0%



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[4] 2 OF 3

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Commentary

Small month-on-month improvement achieved in September, from 118 minutes to 115 minutes. Improvements in performance during IAs is counter-balanced by adverse impact of higher attendances prior to, and immediately after, these IA periods.

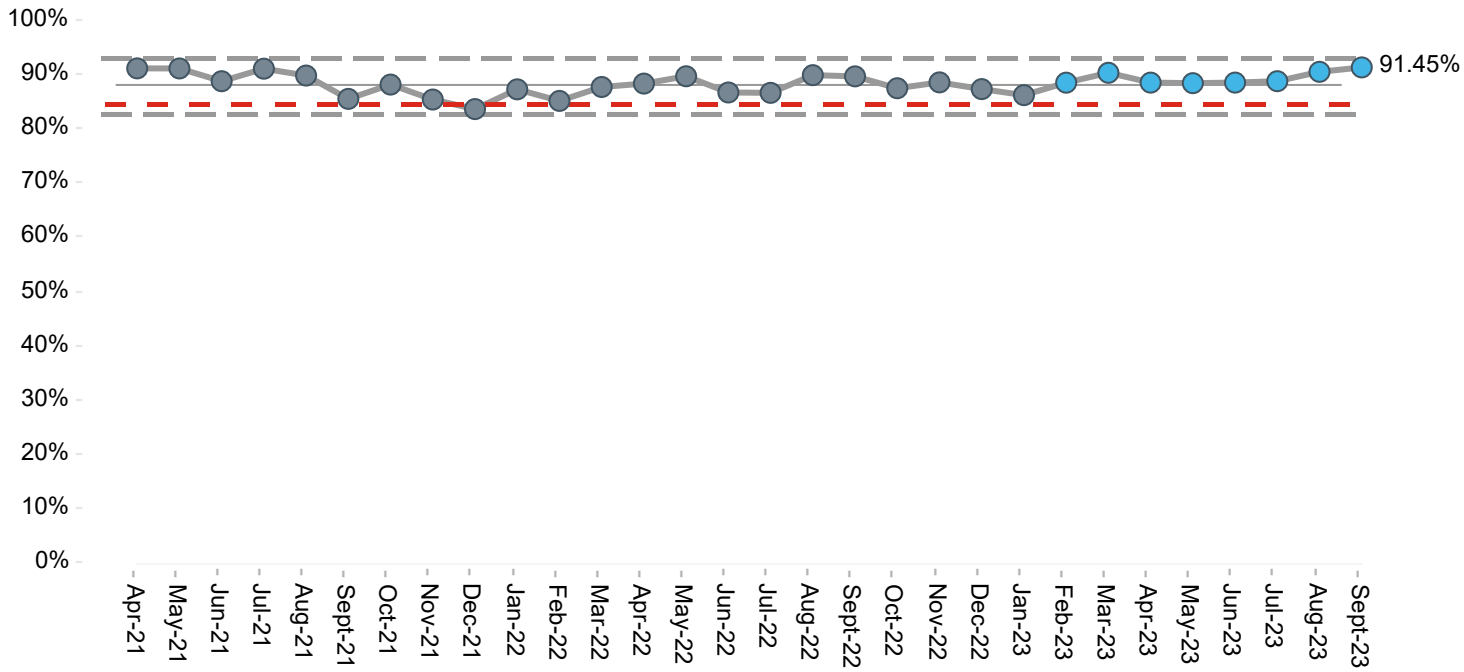
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[488] Intra-session theatre utilisation rate

Target: > 85.00%



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

Overall GHFT capped utilisation achieved 74% in August 2023. Uncapped utilisation rate for emergency theatre lists across all sites in the same period is 78%.

Director of Operations - Surgery

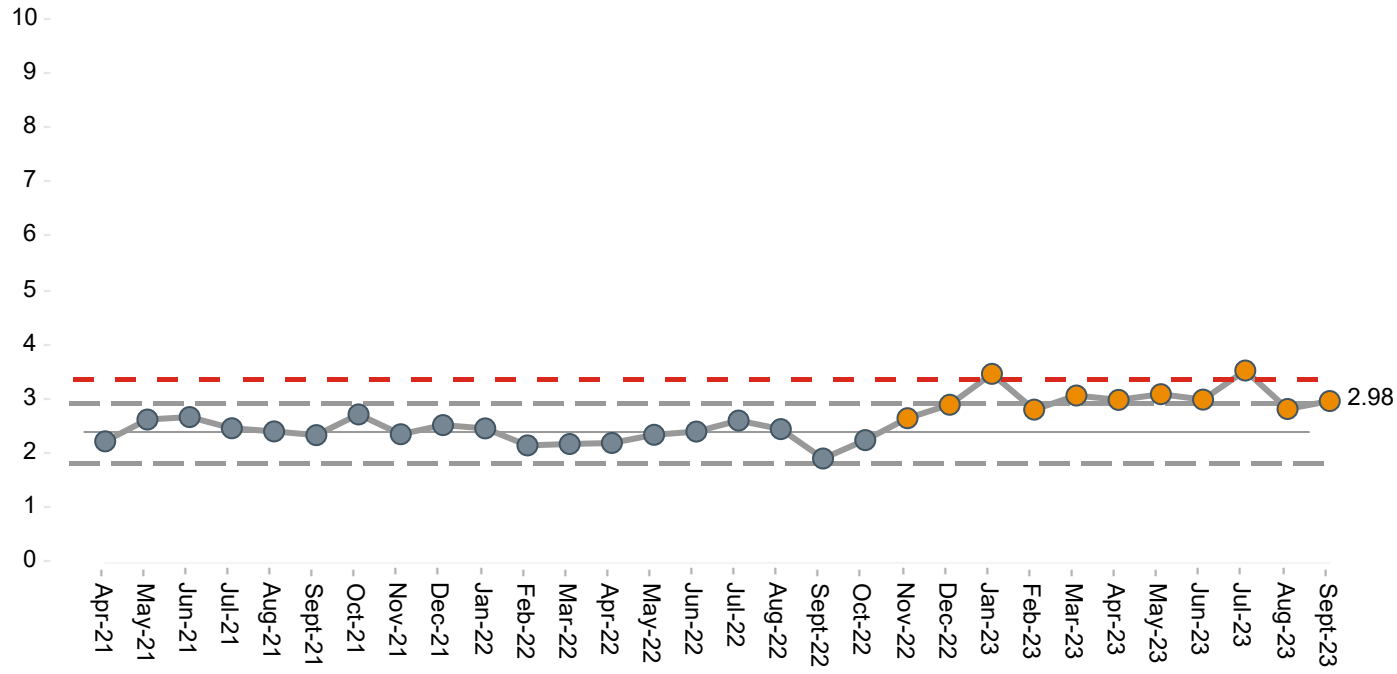
Access

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



Commentary

Minimal change within the elective pathways, with the average LOS of 2.94 still well below the target of 3.4 days.
Deputy Chief Operating Officer

Data Observations

[1] SINGLE POINT

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[2] SHIFT

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[4] 2 OF 3

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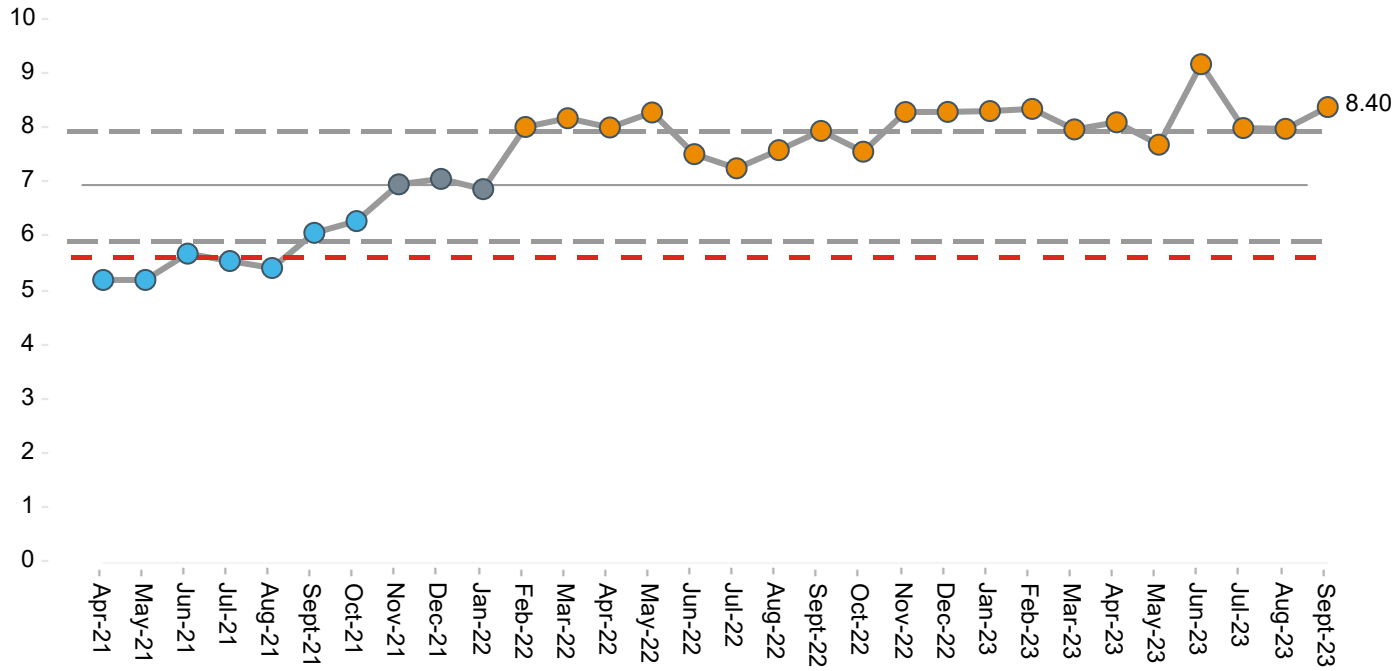
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 5.65



Data Observations

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[2] SHIFT

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Commentary

Average LOS within non-elective has risen to 8.39 days. Linked with reduced discharges and delays within longest nCTR patient group.
Deputy Chief Operating Officer

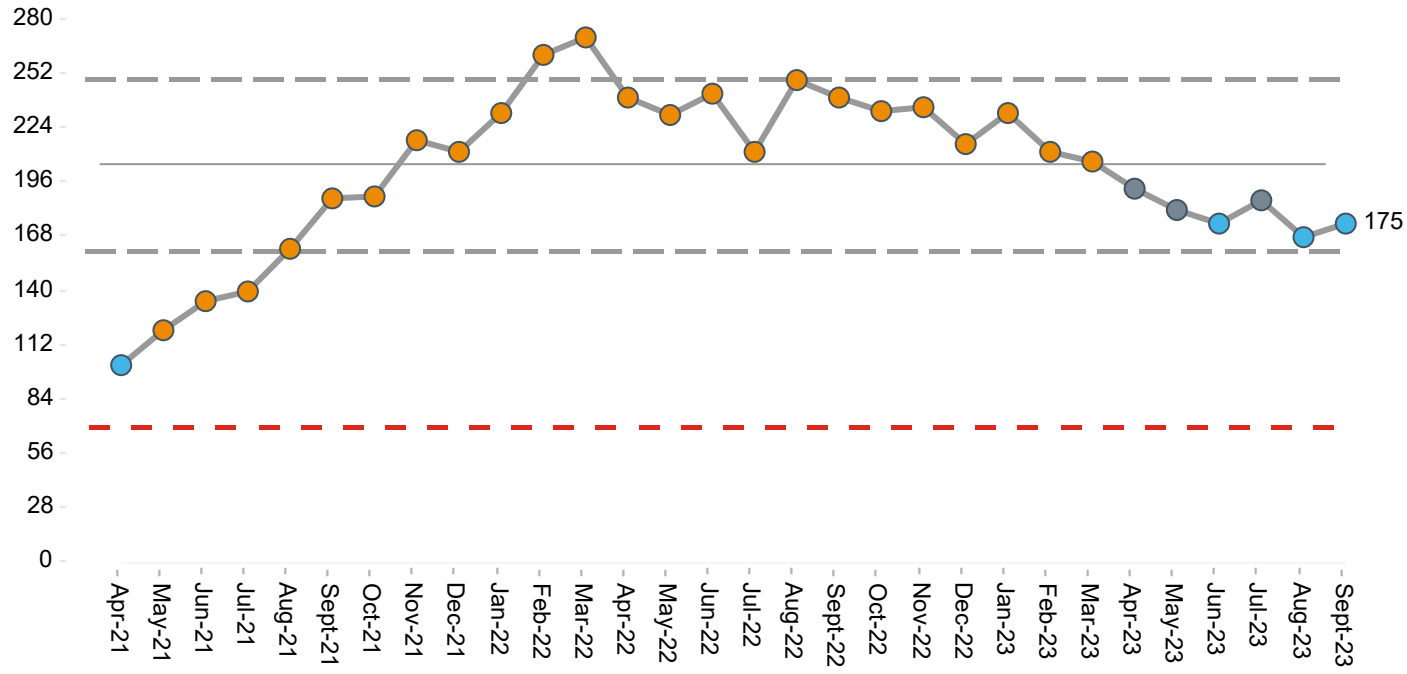
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[186] Number of patients stable for discharge

Target: ≤ 70



Commentary

Small increase in month of September, also seeing an increase in patients waiting for 30+ days. Escalation within ICB to drive performance back to where it has been.

Head of Therapy & OCT

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.

[3] RUN

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

[4] 2 OF 3

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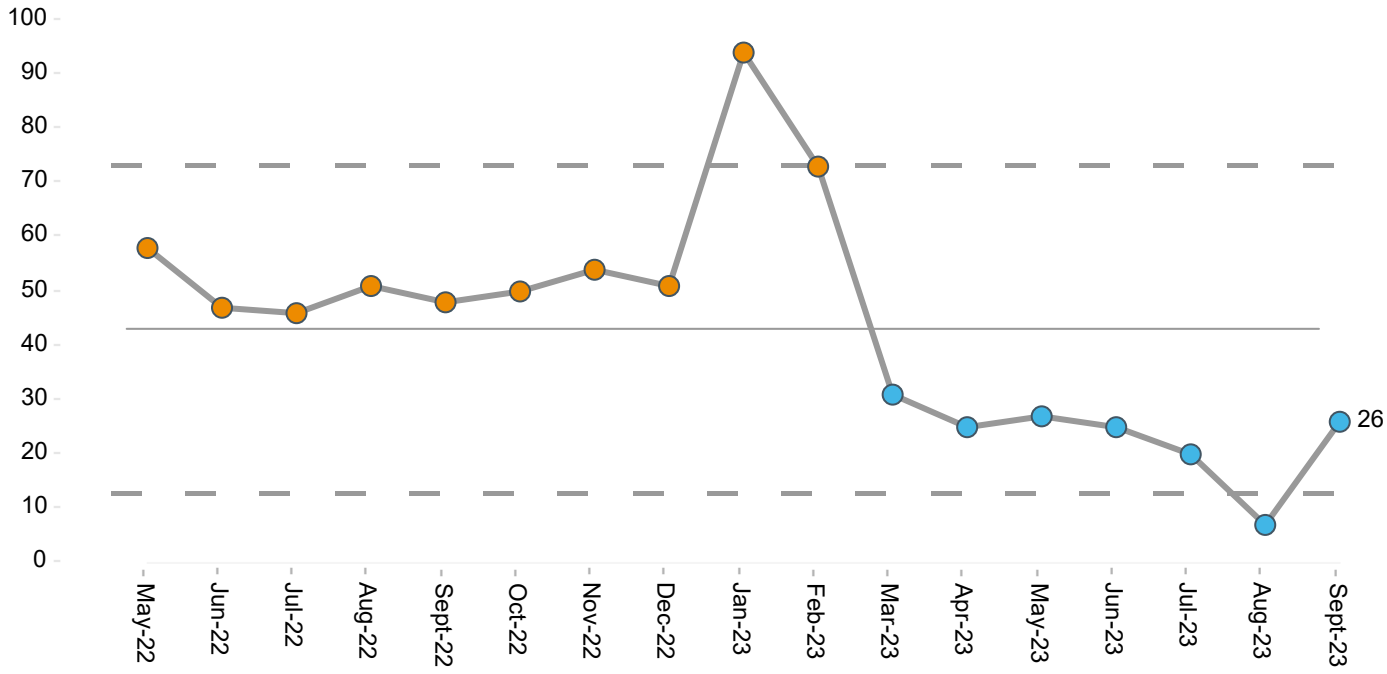
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[608] Number of patients waiting over 104 days without a TCI date

- - - Target: No Target



Data Observations

[1] SINGLE POINT

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[2] SHIFT

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Commentary

Reduction in the number of patients without at TCI date as Cancer Services continues to validate daily and work with the services on ensuring all backlog patients have agreed and proactive next steps

General Manager - Cancer

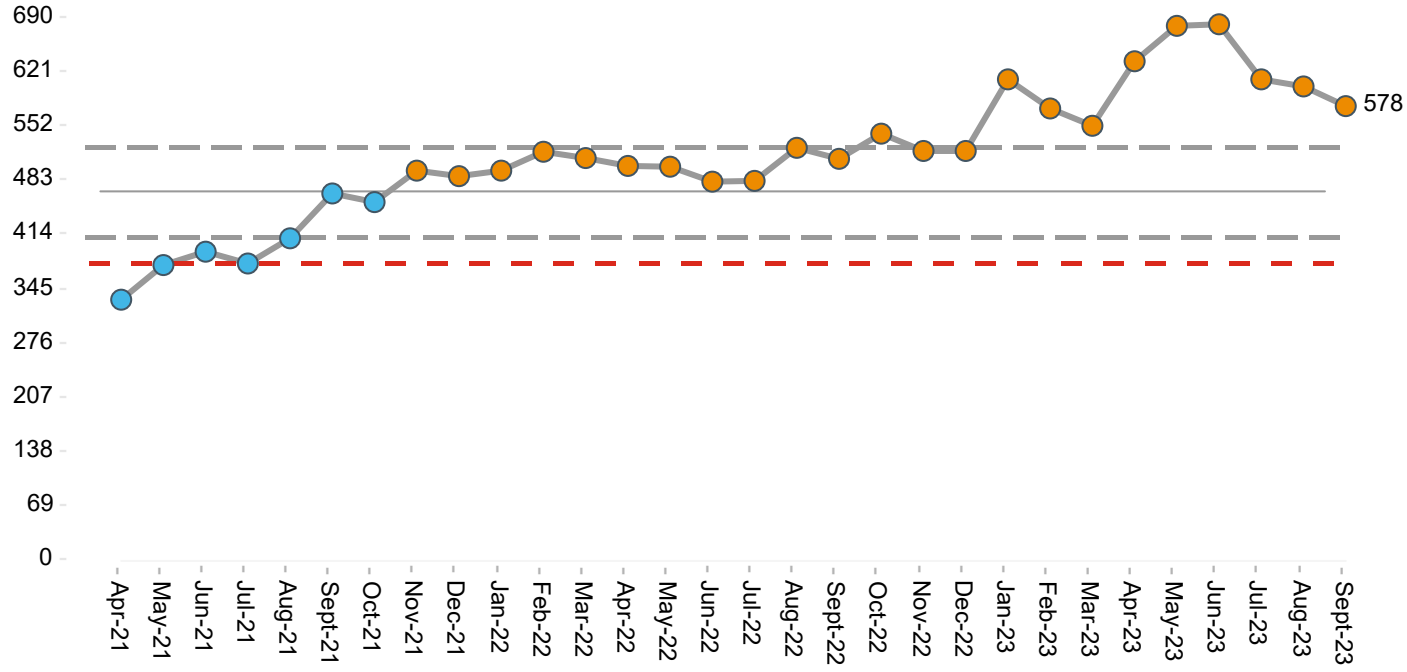
Access

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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Commentary

Ongoing work within this patient group sees an ongoing reduction in the overall number, now sitting at 559. Further work ongoing with plans to further reduce, with work both on the CTR and nCTR patient groups.

Deputy Chief Operating Officer

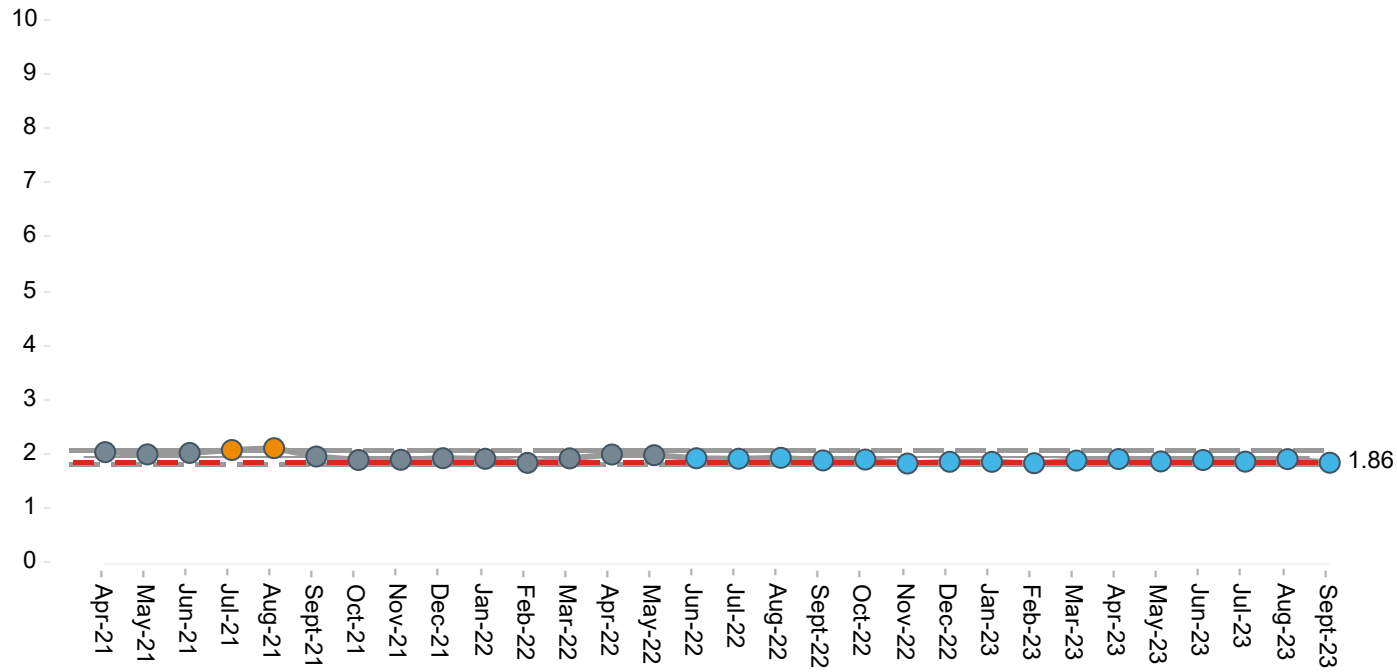
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[490] Outpatient new to follow up ratio's

- - - Target: ≤ 1.90



Commentary

A reduction has been observed in month falling to 1:1.86 which is now within the target of 1:1.9.
Associate Director of Elective Care

Data Observations

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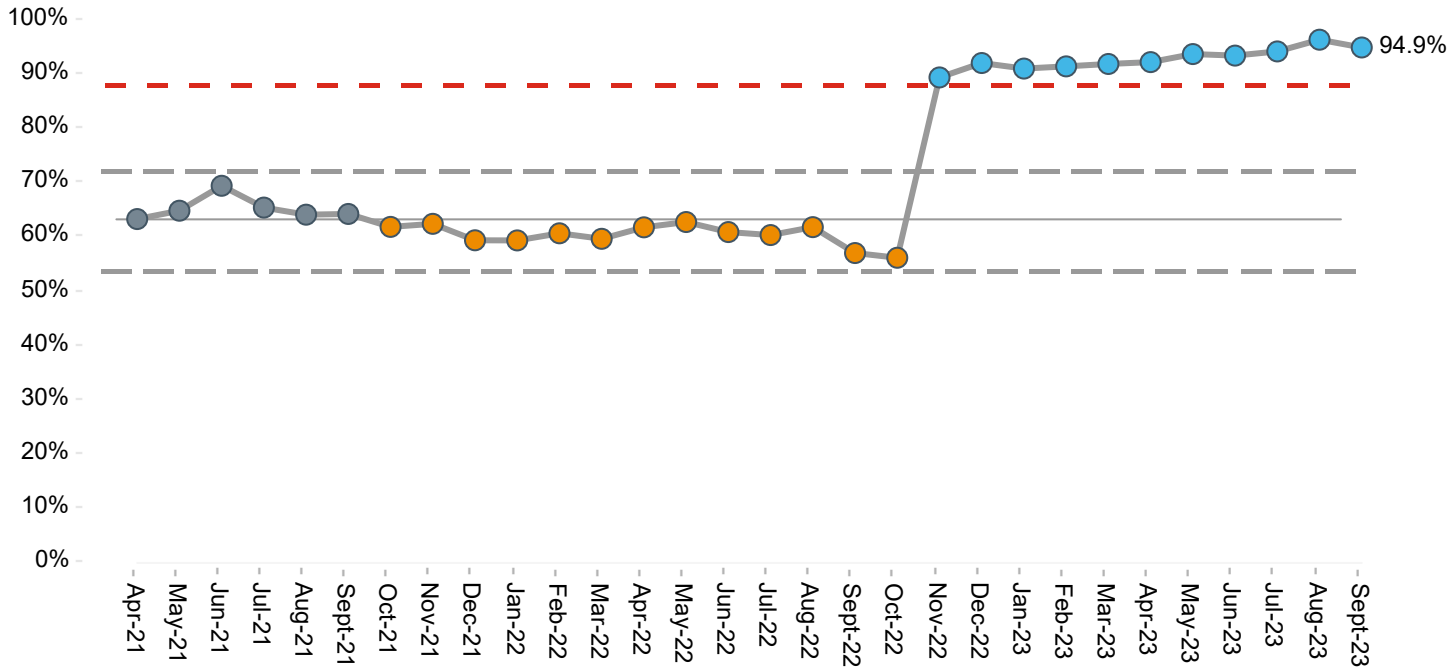
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 88.0%



Commentary

Medical Director

Data Observations

[1] SINGLE POINT

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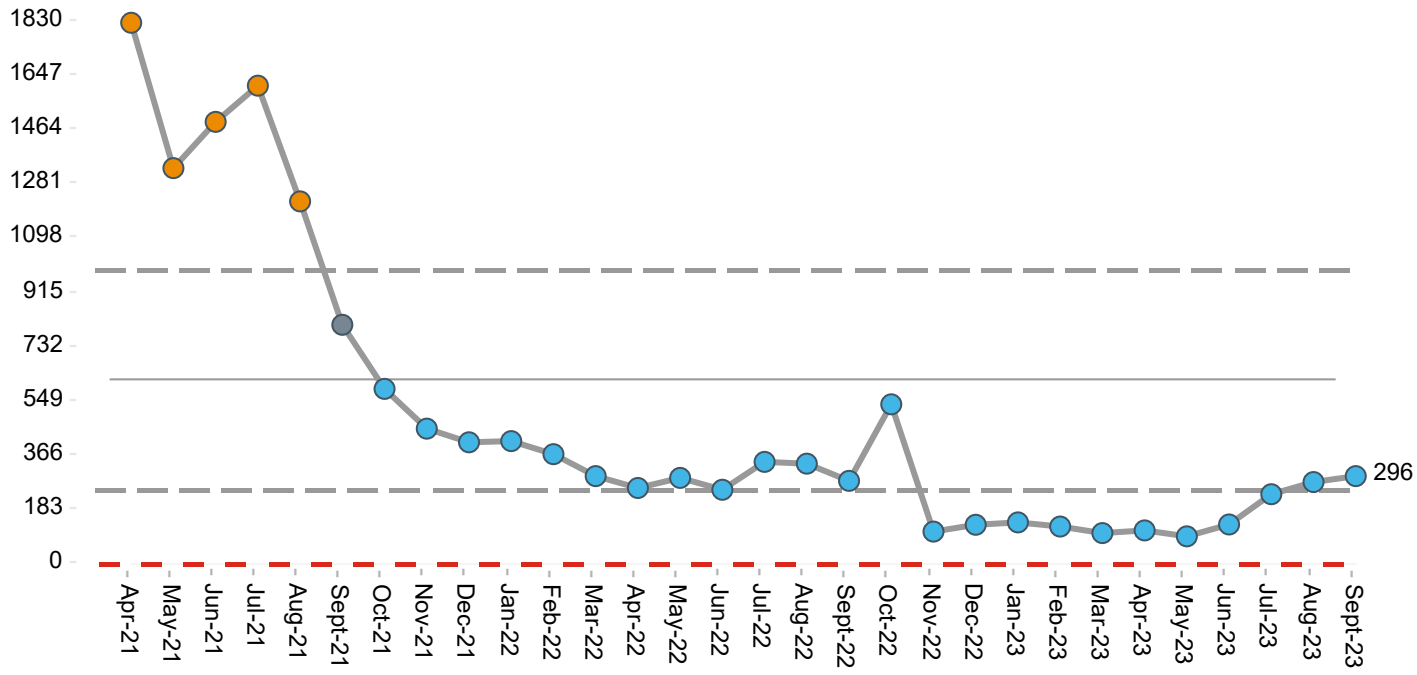
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Data Observations

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Commentary

The 70+ week category has effectively remained unchanged in month. August was finalised with 276 patients and although Septembers position is currently being validated it is anticipated to be around 280. As with over 52's, this position has stabilised due to the ENT Glanso clinics which has offset the negative impact of Industrial Action.

Associate Director of Elective Care

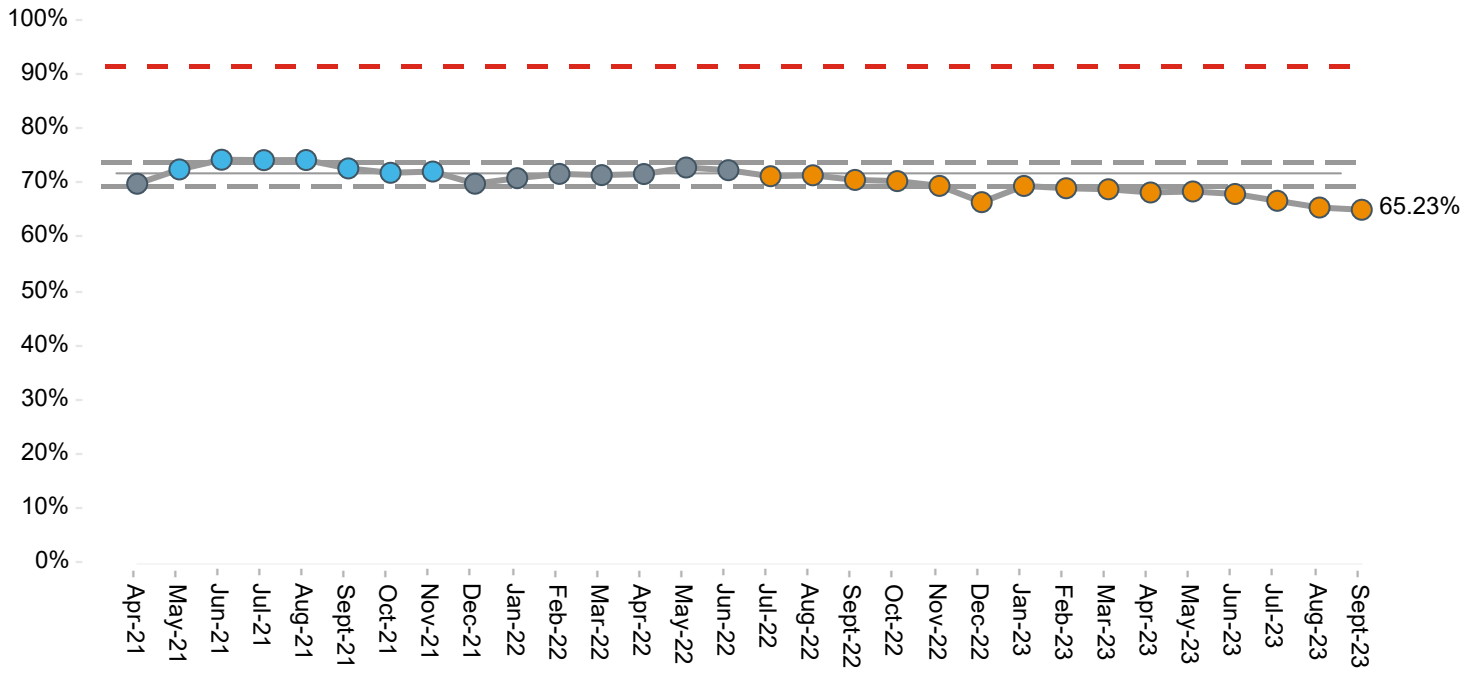
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 92.00%



Data Observations

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Commentary

See Planned Care Exception report for full details. The RTT month-end position for September is likely to remain very similar to the previous month. At present performance is referenced as just over 63%, but with in-depth validation taking place up to 17th October this will improve and is anticipated to be 64%. As referenced previously RTT performance continues to be impacted by Industrial action.
Associate Director of Elective Care

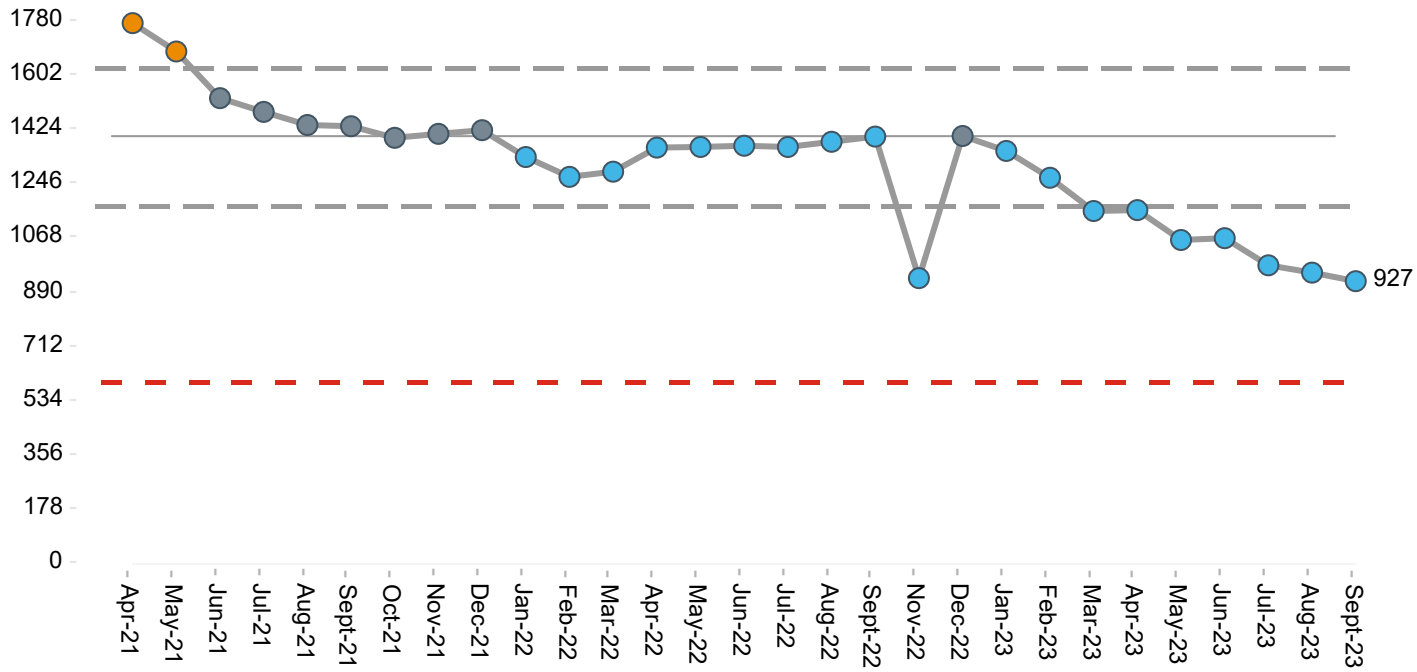
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 600



Data Observations

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Commentary

Demand and capacity modelling is underway. Increased focus has been on reducing the surveillance patients outstanding from 2022 and this number is reducing. There remains the issue that we do not have enough capacity to manage current cancer activity while meeting DM01, RTT targets and waiting lists. It must be noted that we are best in the region for Upper GI Endoscopy cancer performance and 2nd best for lower GI Endoscopy cancer performance

General Manager of Endoscopy

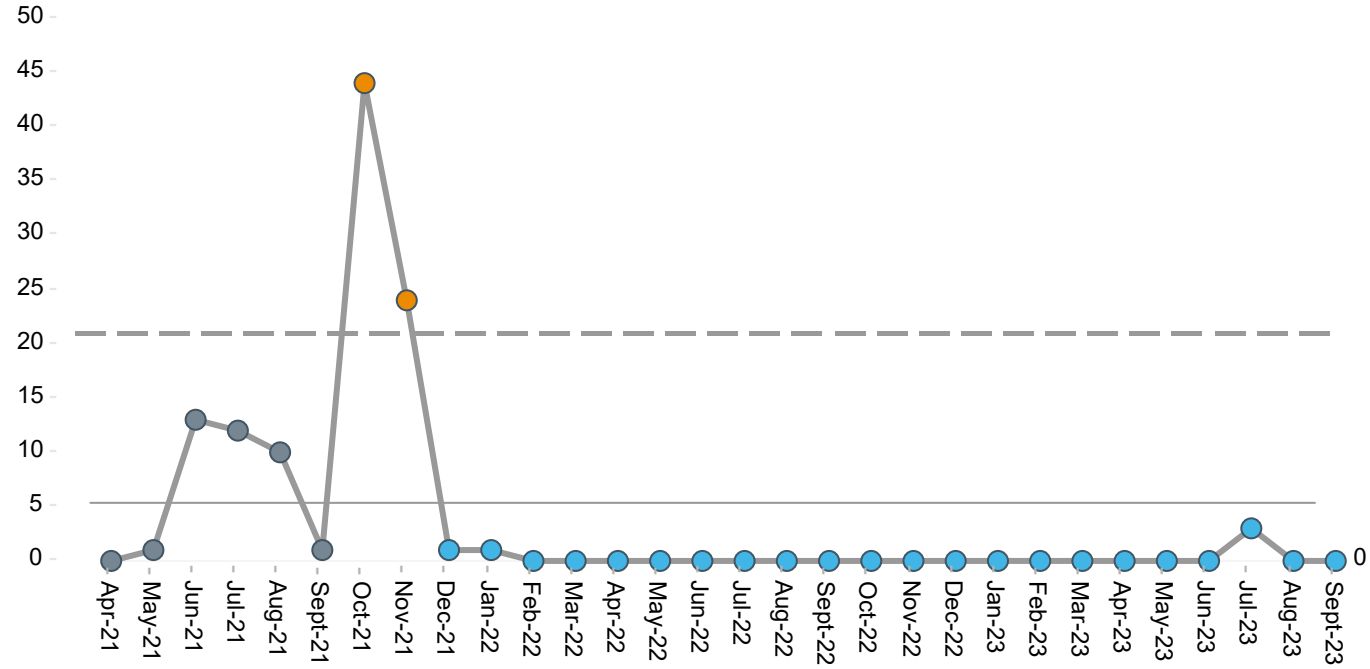
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[552] Urgent cancelled operations

- - - Target: ↓ Lower



Data Observations

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Commentary

Not given

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	Sept-23	74.6%	
	Inpatients % positive	No Target	Sept-23	89.5%	
	Maternity % positive	No Target	Sept-23	83.7%	
	Outpatients % positive	No Target	Sept-23	93.8%	
	Total % positive	No Target	Sept-23	90.7%	
Health Inequalities	Smoking Status Compliance	No Target	Sept-23	85%	
Infection Control	C. difficile - infection rate per 100,000 bed days	↓ Lower	Sept-23	31.8	
	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target	Sept-23	98	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target	Sept-23	250	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target	Sept-23	130	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target	Sept-23	228	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower	Sept-23	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7	Sept-23	8.0	
	Number of E. coli bacteraemia cases	No Target	Sept-23	4	
	Number of Klebsiella bacteraemia cases	No Target	Sept-23	3	
	Number of MSSA bacteraemia cases	≤ 8	Sept-23	2	
	Number of Pseudomonas bacteraemia cases	No Target	Sept-23	2	
	Number of bed days lost due to infection outbreaks	↓ Lower	Sept-23	22	
	Number of community-onset healthcare-associated C. difficile cases per month	≤ 5	Sept-23	5	
	Number of hospital-onset healthcare-associated C. difficile cases per month	≤ 5	Sept-23	3	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Infection Control	Number of trust apportioned C. difficile cases per month	< 10	Sept-23	8	
	Number of trust apportioned MRSA bacteraemia	= 0	Sept-23	0	
Maternity	% PPH >1.5 litres	↓ Lower	Sept-23	6.7%	
	% breastfeeding (discharge to CMW)	= 0.0%	Sept-23	59.6%	
	% breastfeeding (initiation)	No Target	Sept-23	63.8%	
	% of women smoking at delivery	≤ 14.50%	Sept-23	9.40%	
	% of women that have an induced labour	≤ 30.00%	Sept-23	25.45%	
	% stillbirths as percentage of all pregnancies	< 0.52%	Sept-23	0.44%	
	Number of births less than 27 weeks	No Target	Sept-23	1	
	Number of births less than 34 weeks	No Target	Sept-23	14	
	Number of births less than 37 weeks	No Target	Sept-23	31	
	Number of maternal deaths	No Target	Sept-23	1	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target	Sept-23	1.8%	
	Total births	No Target	Sept-23	452	
Mortality	Number of deaths of patients with a learning disability	No Target	Sept-23	2	
	Number of inpatient deaths	No Target	Sept-23	140	
	Summary hospital mortality indicator (SHMI) - national data	No Target	May-23	1.105	
MSA	Number of breaches of mixed sex accommodation	≤ 10	Sept-23	26	
Operational Efficiency	Daily Average of Boarded Patients	No Target	Sept-23	14	
Patient Advice and ..	% of PALS concerns closed in 5 days	No Target	Sept-23	81%	

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	Sept-23	330	
Patient Safety Incidents	Medication error resulting in low harm	↓ Lower	Sept-23	12	
	Medication error resulting in moderate harm	↓ Lower	Sept-23	6	
	Medication error resulting in severe harm	↓ Lower	Sept-23	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Sept-23	44	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Sept-23	0	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Sept-23	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Sept-23	9	
	Number of falls per 1,000 bed days	↓ Lower	Sept-23	6.50	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Sept-23	10	
	Number of patient safety incidents - severe harm (major/death)	No Target	Sept-23	9	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Sept-23	14	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target	Aug-23	59.24%	
	Number of DoLs applied for	No Target	Sept-23	157	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Sept-23	73	
	Total admissions aged 0-17 with DSH	↓ Lower	Sept-23	25	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Aug-23	4	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Aug-23	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	Aug-23	43	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Serious Incidents	Number of never events reported	= 0	Sept-23	0	
	Number of serious incidents reported	↓ Lower	Sept-23	3	
	Percentage of serious incident investigations completed within contract timescale	> 80%	Sept-23	10,000%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%	Sept-23	10,000.0%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Sept-23	65.3%	

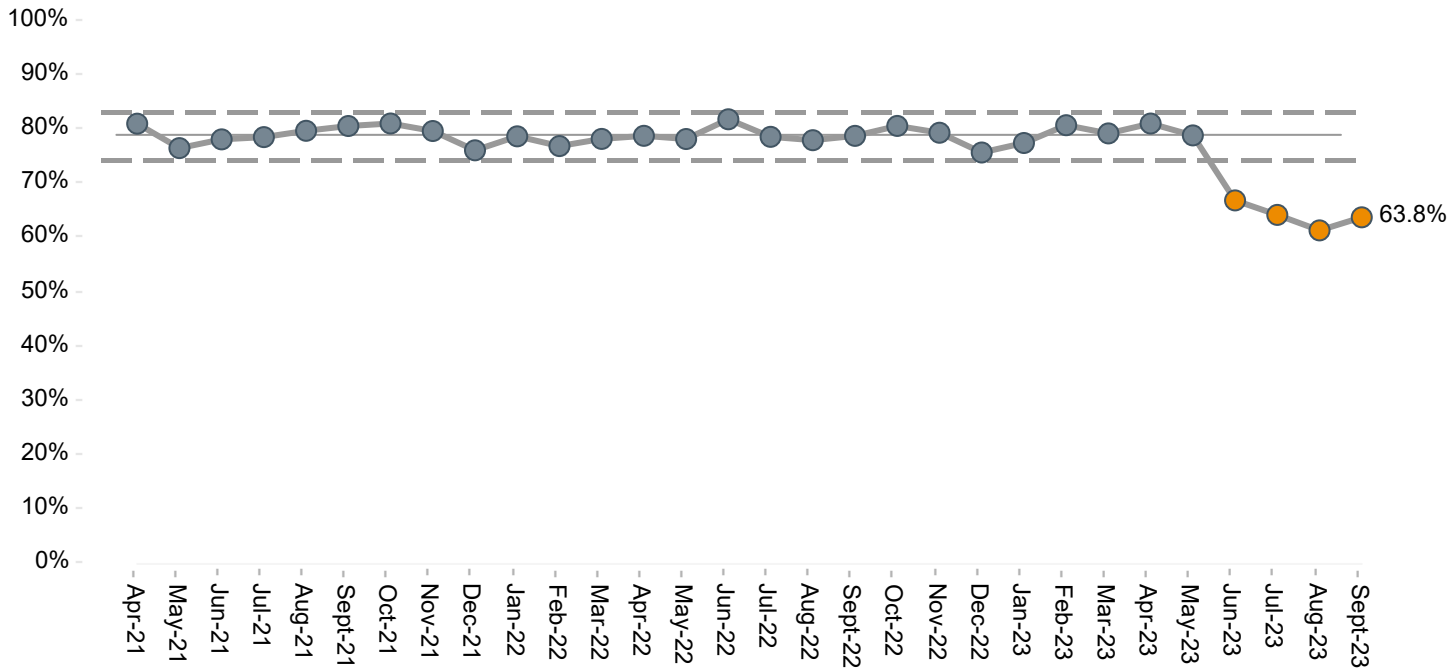
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[573] % breastfeeding (initiation)

Target: No Target



Data Observations

[1] SINGLE POINT

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

Commentary

There are some inconsistences with the breast feeding performance when comparing what is on front end of Badgernet and the what is being pulled through to the data tables. This is currently under review by the BI Team.

Divisional Director of Quality and Nursing and Chief Midwife

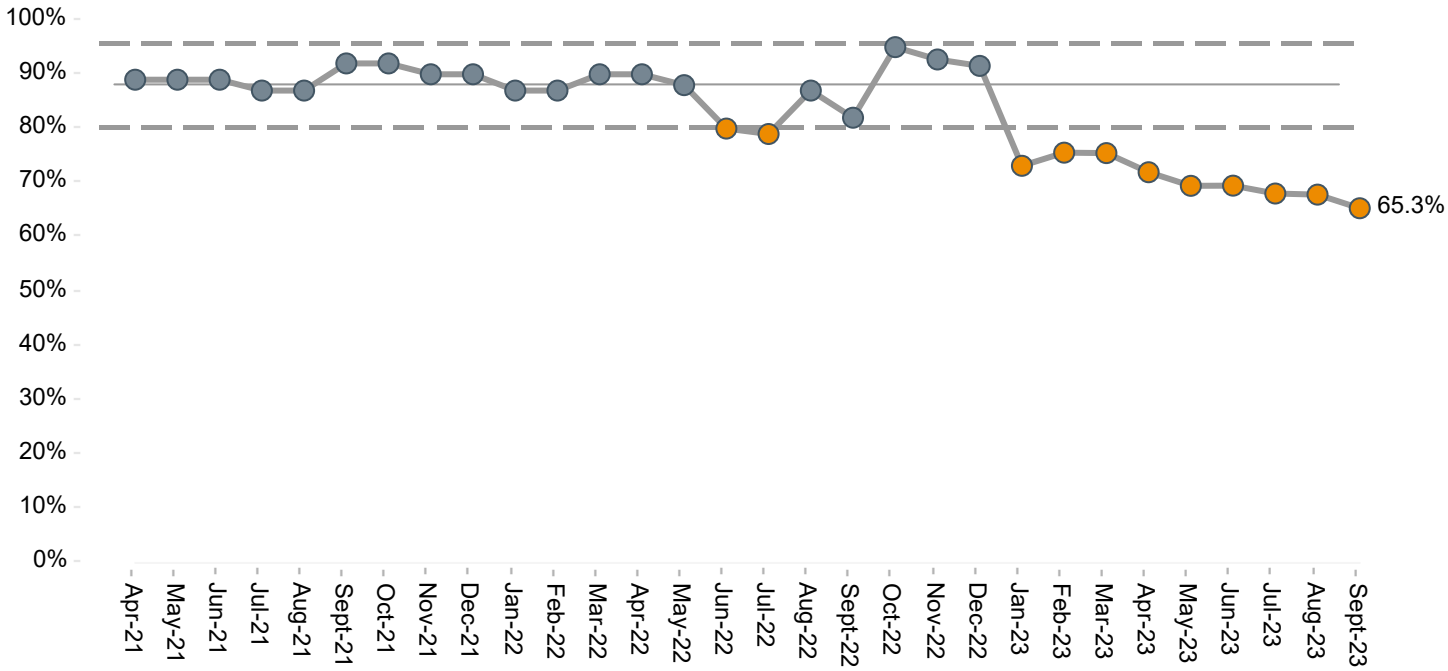
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



Data Observations

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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.

Commentary

QPR report still displaying Aug data, no expectation of improved performance. EPR changes will be deployed within a month, the solution is not complete a mandating of VTE but a further tightening of prompts to clinicians

Quality Improvement & Safety Director

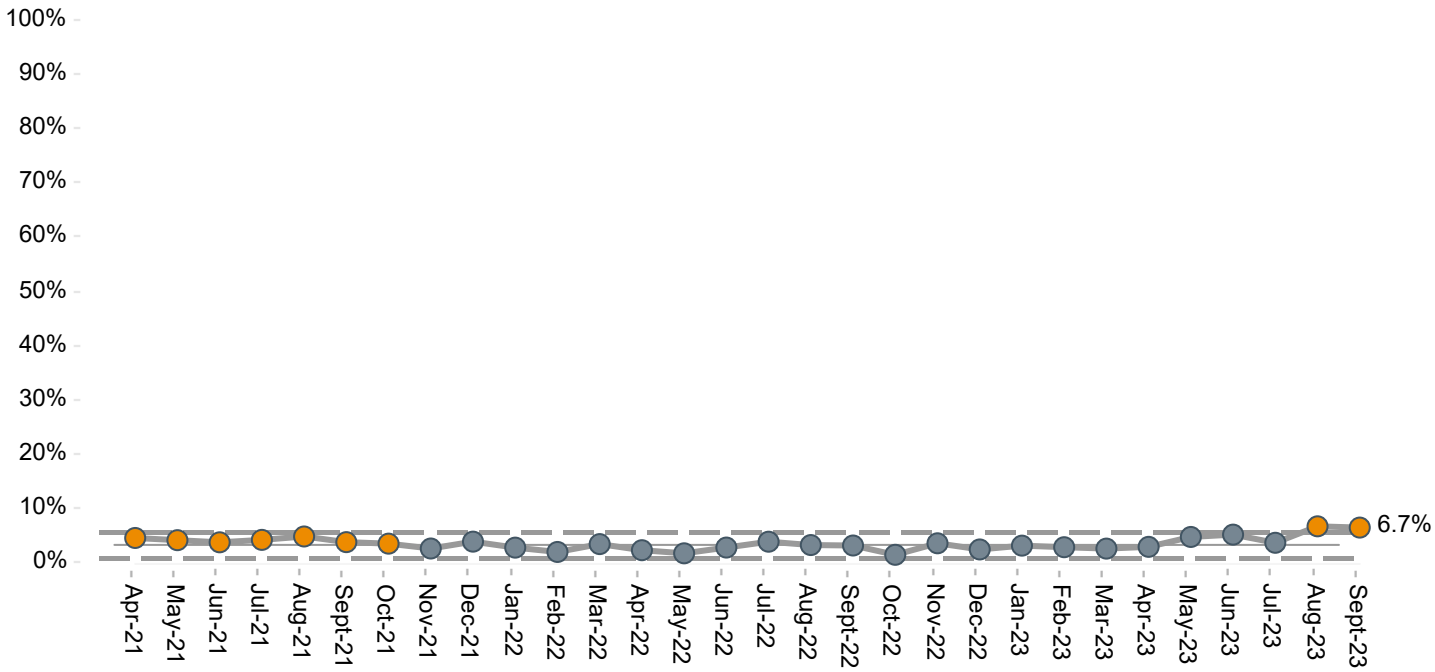
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[574] % PPH >1.5 litres

- - - Target: ↓ Lower



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[2] SHIFT

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Commentary

PPH continues to be a focus of our efforts. A recent increase has been noticed and PPH prevention updates from 2021 have been shared with all staff by our practice development team. A 2 day meeting titled 'PPH sprint' has been arranged for later this month, which will be used for a catch up review of all historic PPH cases >1.5L.

Divisional Director of Quality and Nursing and Chief Midwife

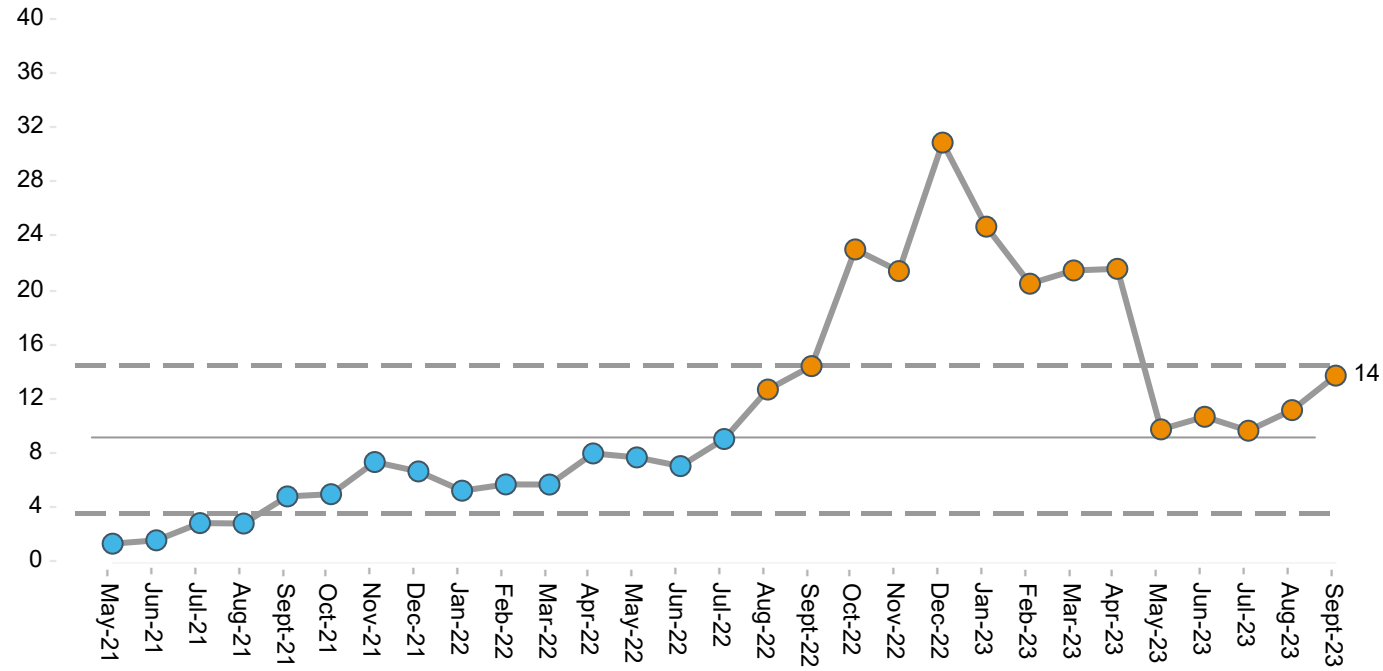
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[607] Daily Average of Boarded Patients

- - - Target: No Target



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

Director of Operations for Hospital Flow

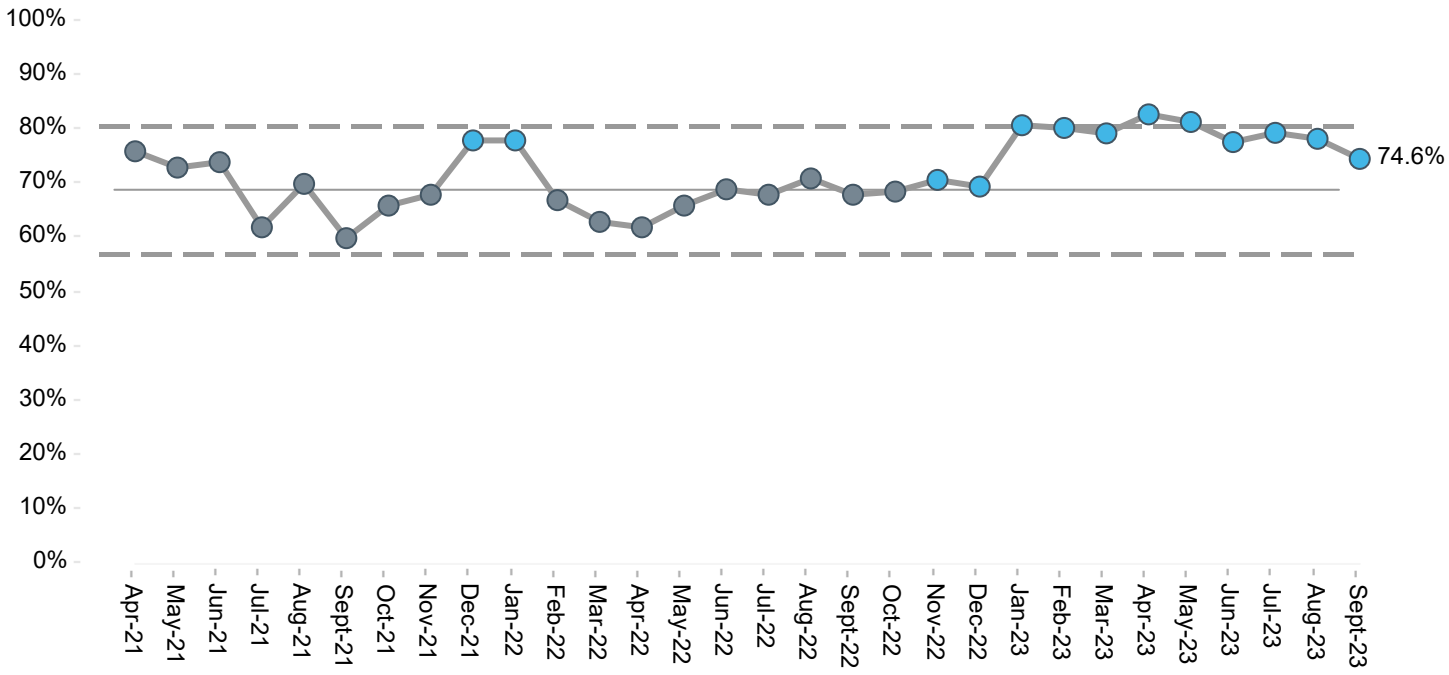
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[154] ED % positive

Target: No Target



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[4] 2 OF 3

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Commentary

The current positive FFT score for ED is at 74.6% across both sites, a decrease from 78.3% in August 2023.
This puts the score at the
lowest point in 8 months but still above average.
The higher number of attendances, industrial action has meant that the main theme
remains focused on wait times, the information provided while waiting but increasingly about basic care in the department.
Updates and
monitoring is through to QDG.
Head of Quality

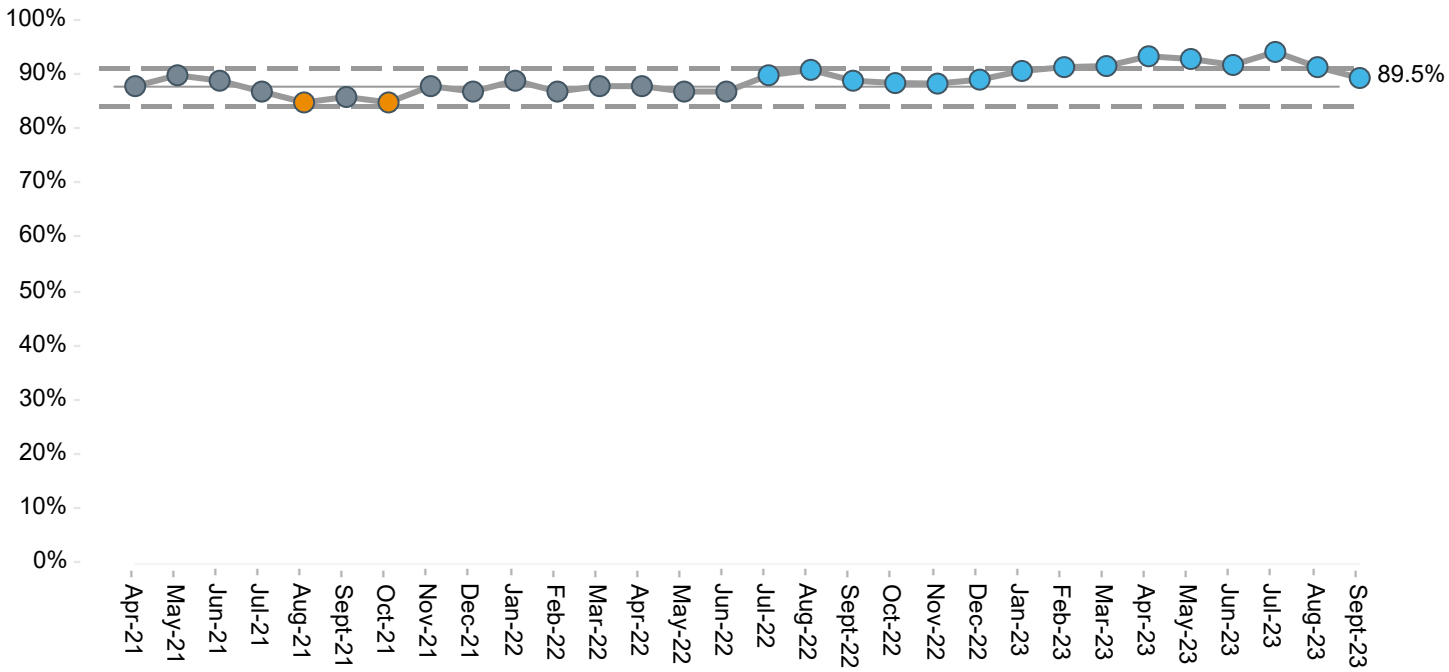
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[153] Inpatients % positive

- - - Target: No Target



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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

The current positive FFT score for Inpatient and Daycase is at 89.5%, a decrease from 91.4% in August. The first time the score has dropped below the upper control limit in 6 months. The score is still above the average.
There is not one thing driving this, however,
the challenges in flow leading to the need to reintroduce boarding alongside further industrial action are affecting patients experiences.
Patients report that staff are overall kind and caring with acknowledgement that there are significant pressures due to staffing and resources. The trend in the concerns and comments relating to the organisation and management of our services and the impact of this on communication and basic patient care continues.
Updates and monitoring will be reported through Quality Delivery Group via divisional
reports and the monthly Patient Experience Insight Report.

Head of Quality

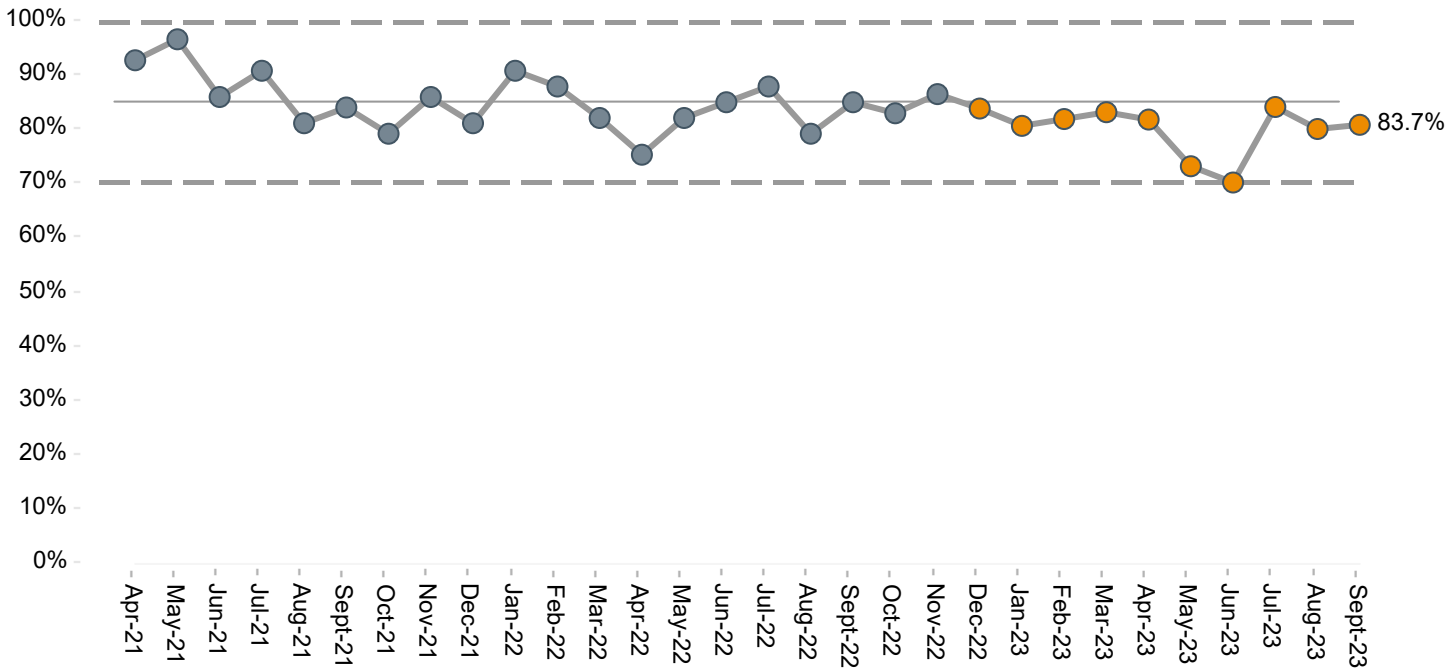
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[155] Maternity % positive

- - - Target: No Target



Data Observations

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[2] SHIFT

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Commentary

The current positive FFT score for Maternity services is 83.7%, which is a increase from August 2023 (82.9%). The positive score remains below the average (88%).

An increase, albeit slight, is really positive as the service has seen a significant improvement in score over the past couple of months compared to earlier in the year. The division have undertaken significant improvement work on the Maternity Ward as identified as part of collaborative working event. The maternity ward continues to be an area requiring improvement as per feedback. A new Patient Experience Group will have its inaugural meeting in October designed to drive further improvements.

Head of Quality

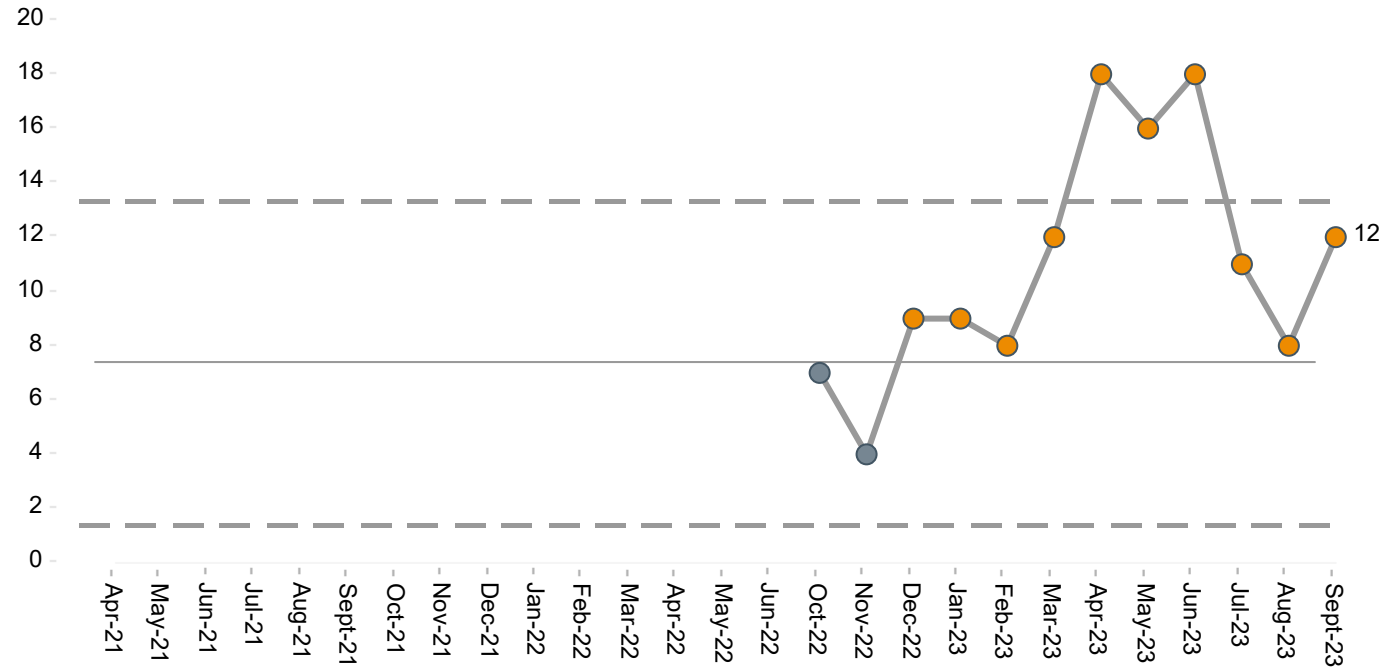
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[460] Medication error resulting in low harm

- - - Target: ↓ Lower



Data Observations

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[2] SHIFT

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Commentary

This will be reviewed at the medication safety group
Quality Improvement & Safety Director

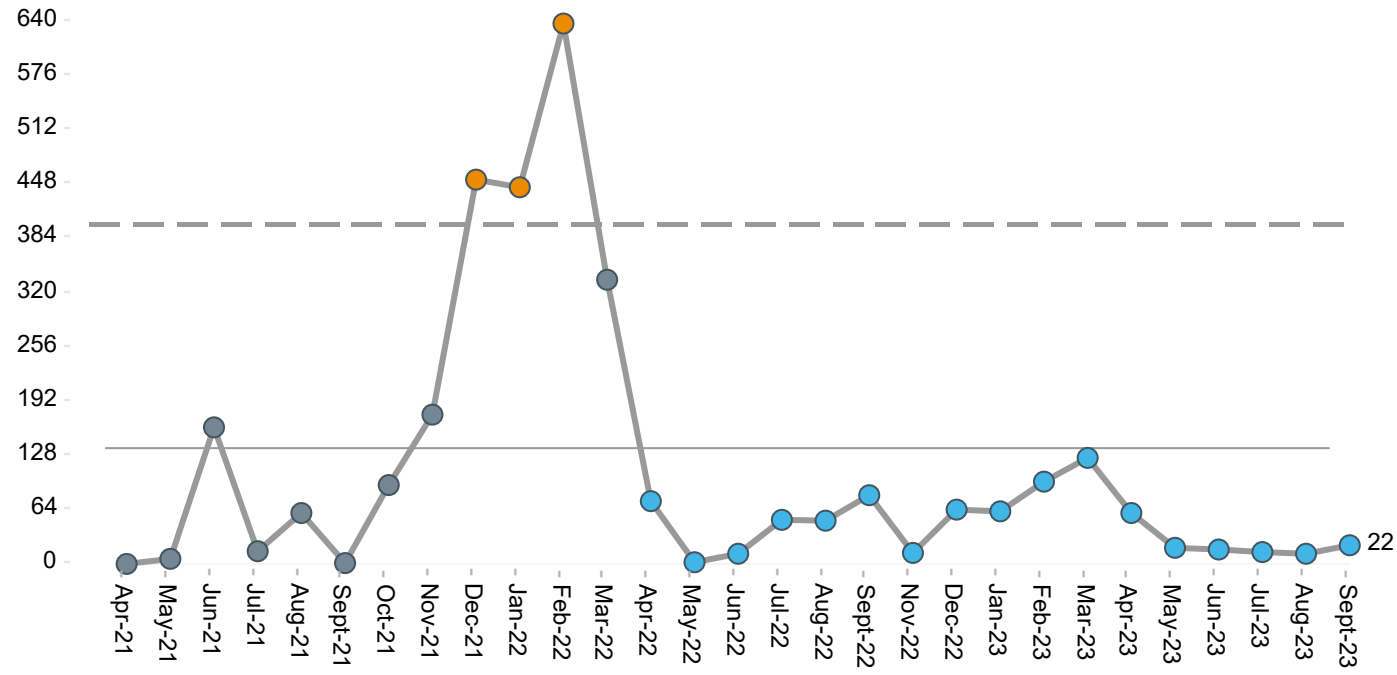
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



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Commentary

During Sept 2023, 22 bed days were lost due to outbreaks associated with transmission of COVID-19. The IPCT reviewed all outbreak affected areas and supported use of empty beds where possible for patients who were deemed safe to use them this significantly reduced the number of empty beds in closed areas. The IPCT continued to also support with ensuring implementation of effective IPC practices to minimise risk of transmission including use of single room isolation, testing and cleaning. Global staff communications on COVID-19 practices has been sent in response to the increased prevalence of COVID. The IPC ICS group have instigated bi-weekly review of COVID procedures and will instigate any actions across the system in response to changing COVID prevalence.

Director of Infection Prevention & Control

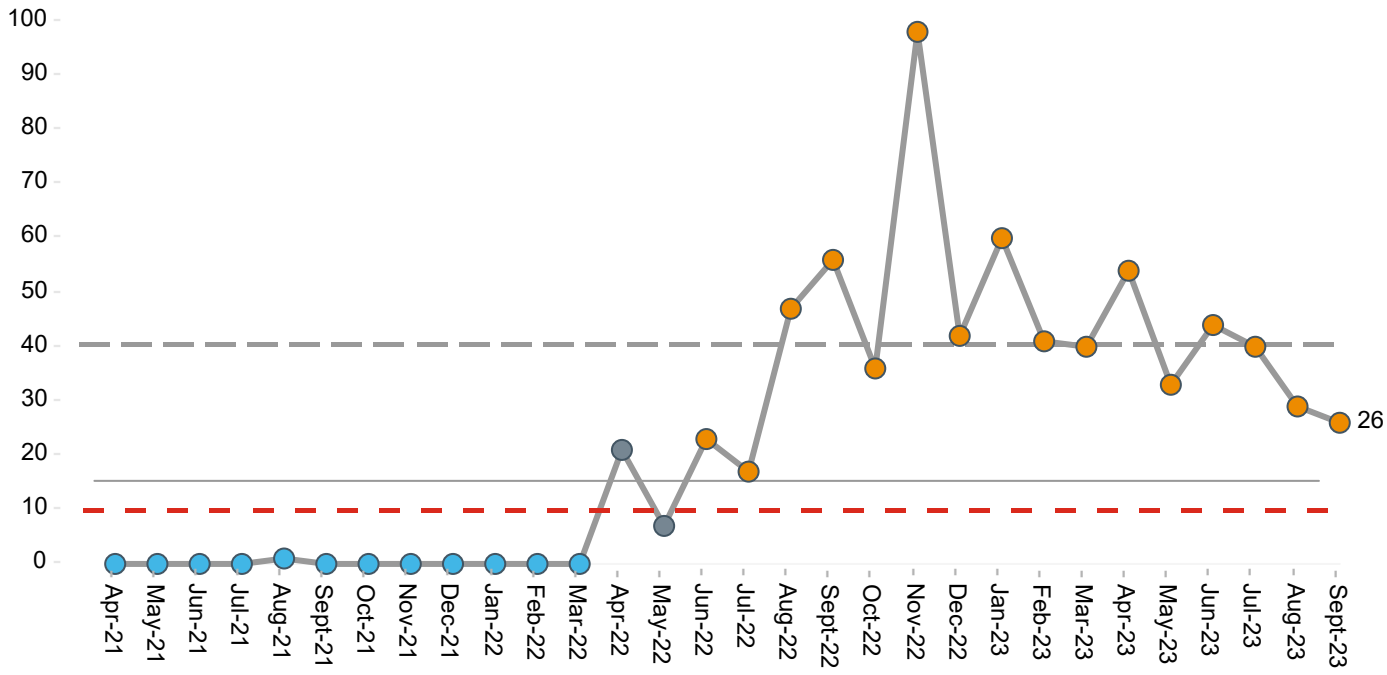
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[148] Number of breaches of mixed sex accommodation

Target: ≤ 10



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[4] 2 OF 3

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

Commentary

Deputy Chief Nurse

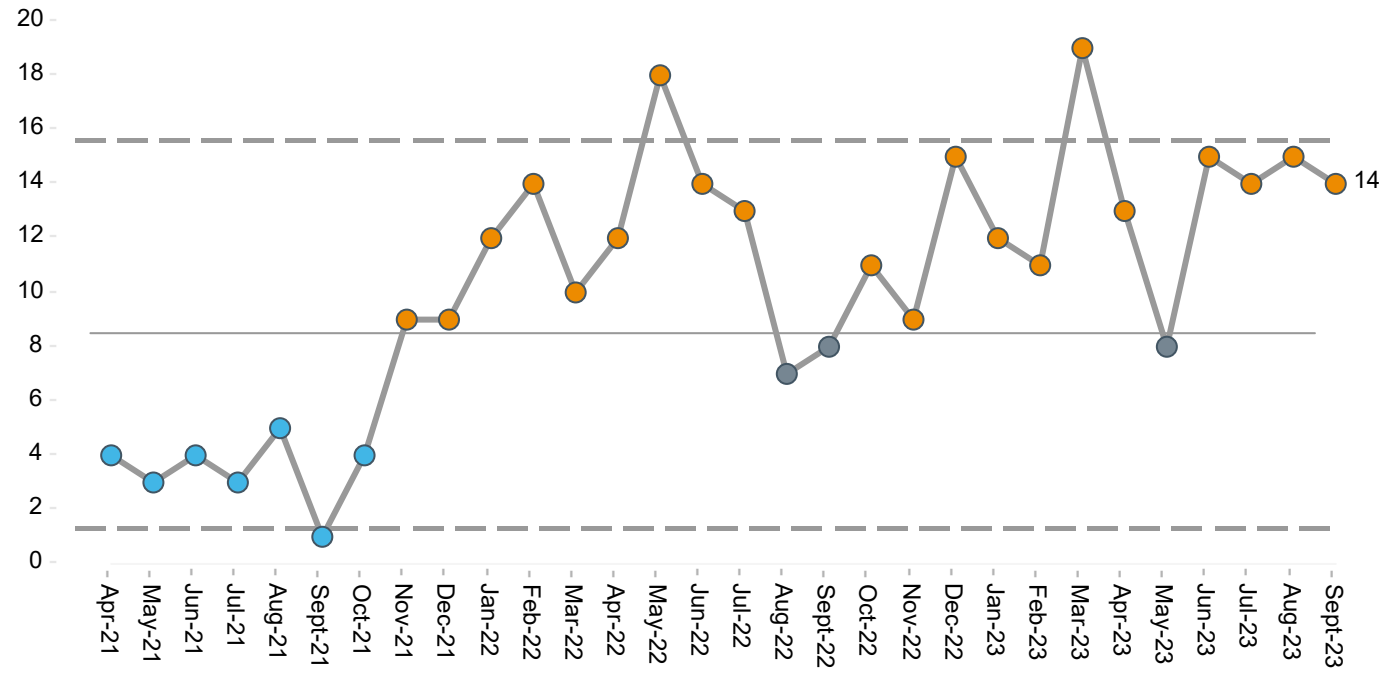
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[461] Number of unstagable pressure ulcers acquired as in-patient

- - - Target: ↓ Lower



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Commentary

Similar to the previous month there were 14 unstageable pressure ulcers acquired in hospital during September 2023. Each of these are reviewed with the ward team as part of the Preventing Harm Hub. Risk factors include not enough care hours available per patient, prolonged immobility in the ED and periods spent in hospital corridors. Three of these cases were on FAS that have had additional patients for the whoile month.

Deputy Chief Nurse

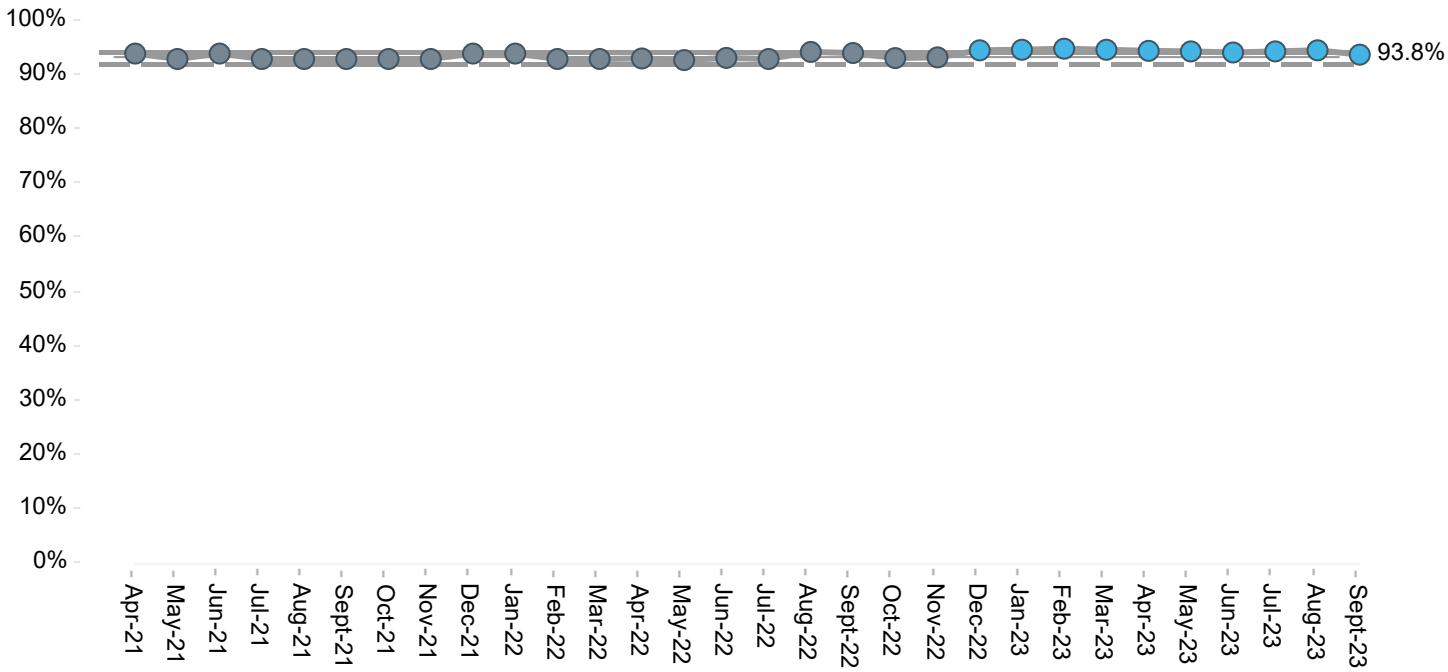
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[291] Outpatients % positive

- - - Target: No Target



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[4] 2 OF 3

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Commentary

The current positive FFT score for Outpatients is 93.8%, a decrease from 94.6% in August. This is the lowest score in 9 months but the positive score remains above average.

Industrial action has impacted on clinic availability. Comments do remain positive overall with many saying 'thank you', however, the main themes for improvement continue to be waits for appointments, waits in the outpatient departments and patients not feeling they have enough time when in their appointment.

Head of Quality

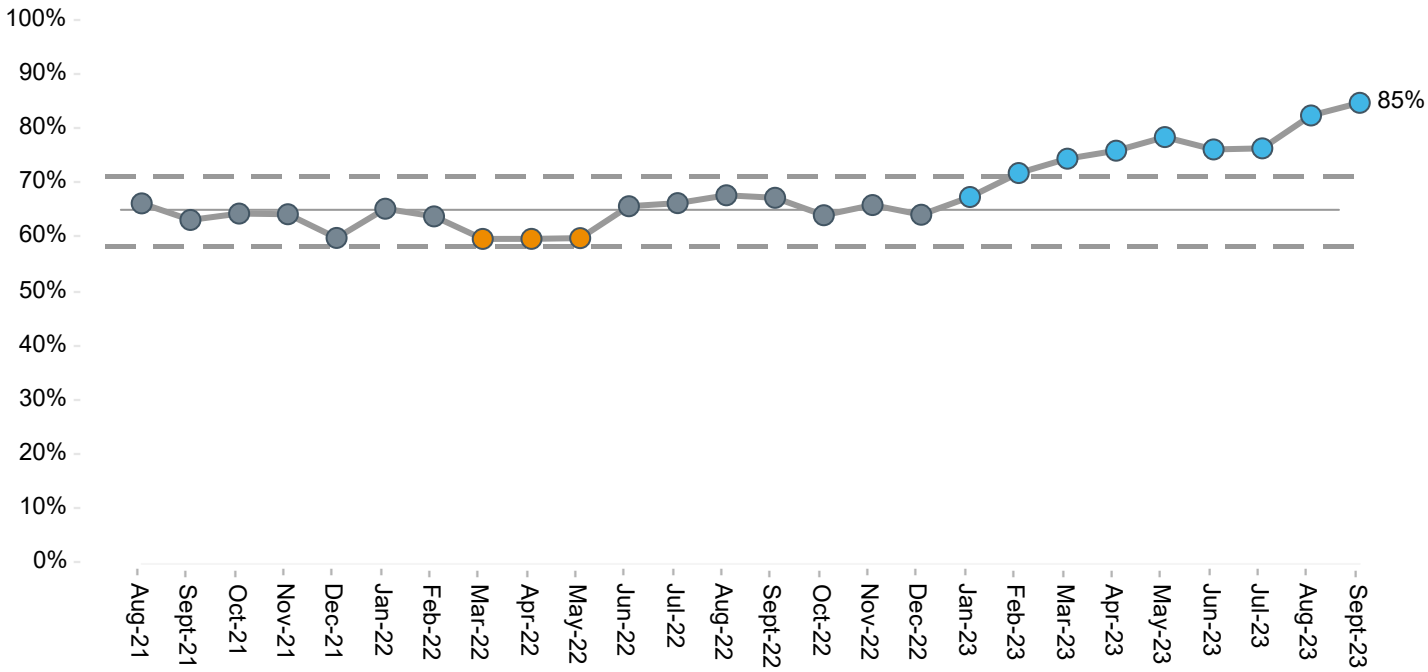
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[610] Smoking Status Compliance

- - - Target: No Target



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Commentary

Every patient admitted to GHT who smoke will be offered NHS funded tobacco treatment. All inpatients should have their smoking status recorded. General compliance of recording on this field has been variable and improvements can be seen on the wards where the team have rolled out and currently doing interventions. Trustwide compliance is at 84% for September and this varies by ward. There are 2 wards remaining in CGH that have been booked in for Oct.

Head of Inequalities, Health Improvement

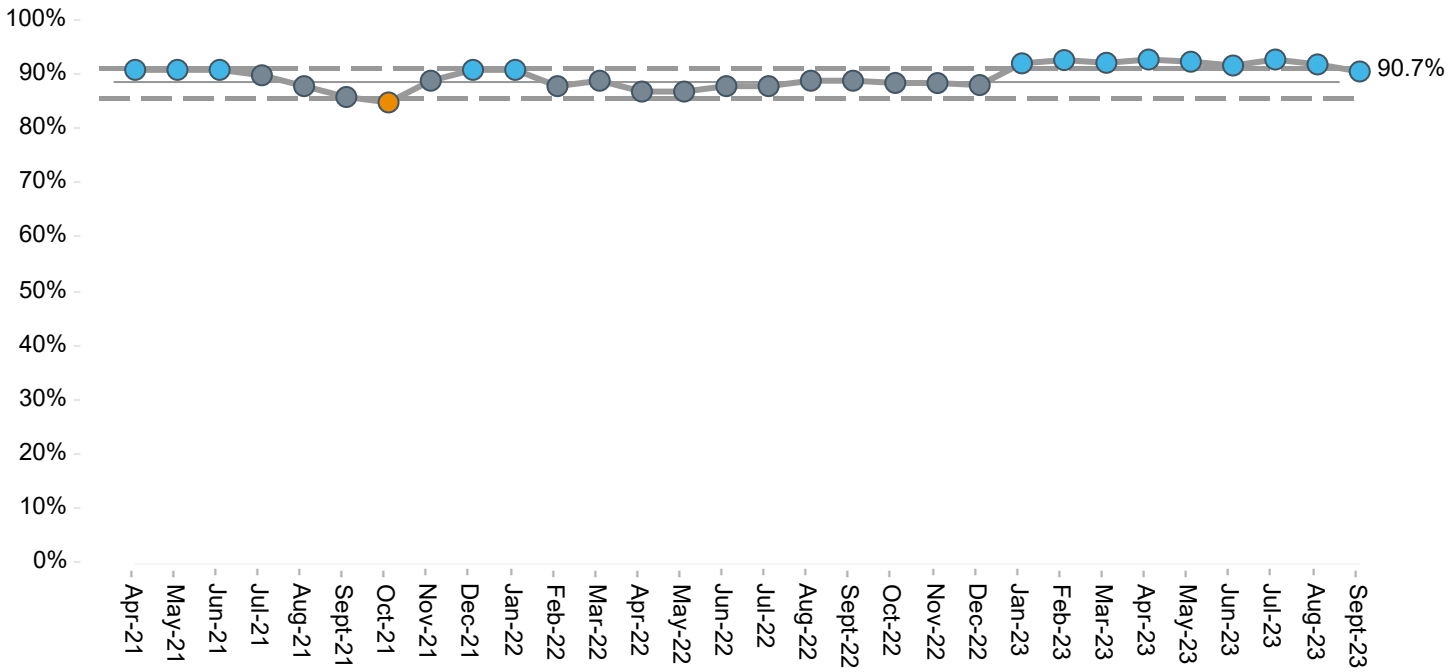
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[156] Total % positive

Target: No Target



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Commentary

The overall Trust FFT positive score has seen a decrease this month to 90.7% compared to 92.0% in August.

Our overall score sees us
move to our lowest score in 8 months but we are still above average. The decrease is as a result of decreases in positive score across three of the four care types. There are many contributing factors to this decrease including the impact of industrial action and challenges with flow through our hospitals.
Head of Quality

Report to Board of Directors				
Date	9 November 2023			
Title	Learning from Deaths report Q4, January to March 2023			
Author /Sponsoring Director/Presenter	Sponsor: Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO Author: Carolyne Claydon, Governance & Business Lead, Medical Directorate and Pam Adams, Trust Mortality Co-ordinator			
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

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

Key issues to note

1. All deaths are reviewed within the Trust via the independent Medical Examiner Service.
2. There is good local learning from problems in care and ensuring these are being reflected within specialties.
3. Learning from serious incidents is monitored through SERG, summaries are found in Appendix 2 (for QPC only).
4. Timeliness and completion rate has been impacted by high clinical workload with the added pressures from continued industrial action.
5. Family feedback shows good satisfaction, analysis is reported under the national end of life clinical audit themes and will be interpreted by the End of Life group to identify areas for improvement. There is special cause variation showing a decline in positive feedback (predominantly in Medicine) which coincides with increased pressure on the unscheduled care pathway, boarding and multiple transfers between wards.
6. Mortality indicators across most parameters for SHMI have normalised with the exception of for Weekend Admissions. The data analysis shows that a decrease in diagnosis of dementia in the population affects the risk profile (expected deaths calculation) and adversely affects overall SHIMI.

Recommendation

The Committee is asked to NOTE the Learning from Deaths Quarterly Report.

Enclosures

Appendix 1 - Mortality Quarterly Dashboard & Divisional Performance – Q4 2022/23
Appendix 2 – Bereavement Feedback Report
Appendix 3
a) Quality & Performance Committee #NOF Report – July 2023
b) Hip Fracture Analysis at GRH at GRH, January 2023 to August 2023

Gloucestershire Hospitals
NHS Foundation Trust

BOARD OF TRUSTEES – November 2023

LEARNING FROM DEATHS REPORT

1. **Aim**

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

1.2 This report covers the period January to March 2023 and is an update from the previous report.

2. Learning From Deaths

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

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

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

c. Serious incident review and implementation of action plans. (Appendix 2 for Q&PC only).

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

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

2.3 All families are given the opportunity to provide feedback to the bereavement team on the quality of care. The feedback is overwhelmingly positive and is routinely shared with the relevant ward area via datix. (Appendix 4)

2.4 The family feedback analysis from Bereavement is analysed through to the End of Life meeting and triangulated with the national end of life survey data. Highlights and recommendations from the End of Life Group will be noted in this report.

2.4 The main learning from structure reviews is through the feedback, reflection and discussion in local clinical meetings. Completion of structure reviews sits around 66% within 3 months. Performance and feedback of learning is presented to HMG on a rolling basis from Divisions and two examples of this can be seen in Appendix 3 (Q&PC only). Themed issues are being tracked in nine areas over time through datix reporting.

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

groups. Summary reports on closed action plans are presented to Quality and Performance Committee.

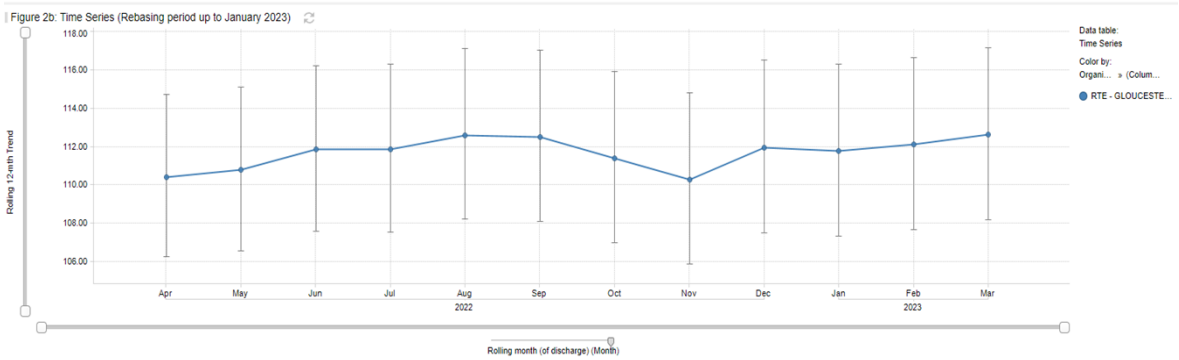
3. **Mortality Data** - SHMI

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

3.2 SHMI Review

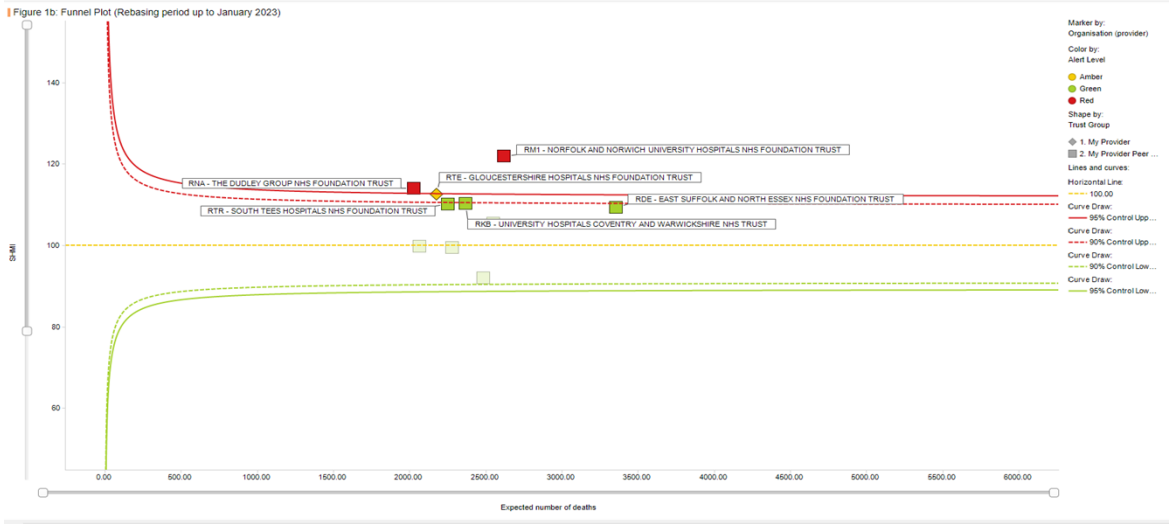
The picture shows a gradual rising trend from Nov 22 but due to rise in expected deaths calculation, SHMI is now within expected range. At March 2023, SHMI is 112.6. The initial analysis approach is described below.

SHMI Rolling 12 Month Trend



Comparison with Model Hospital peers shows that 2 peer Trusts remain above expected limits for SHMI with GHFT on the 95% upper control limit and 3 others on the 90% upper control limit

Rolling 12month SHMI-Model Hospital Peers



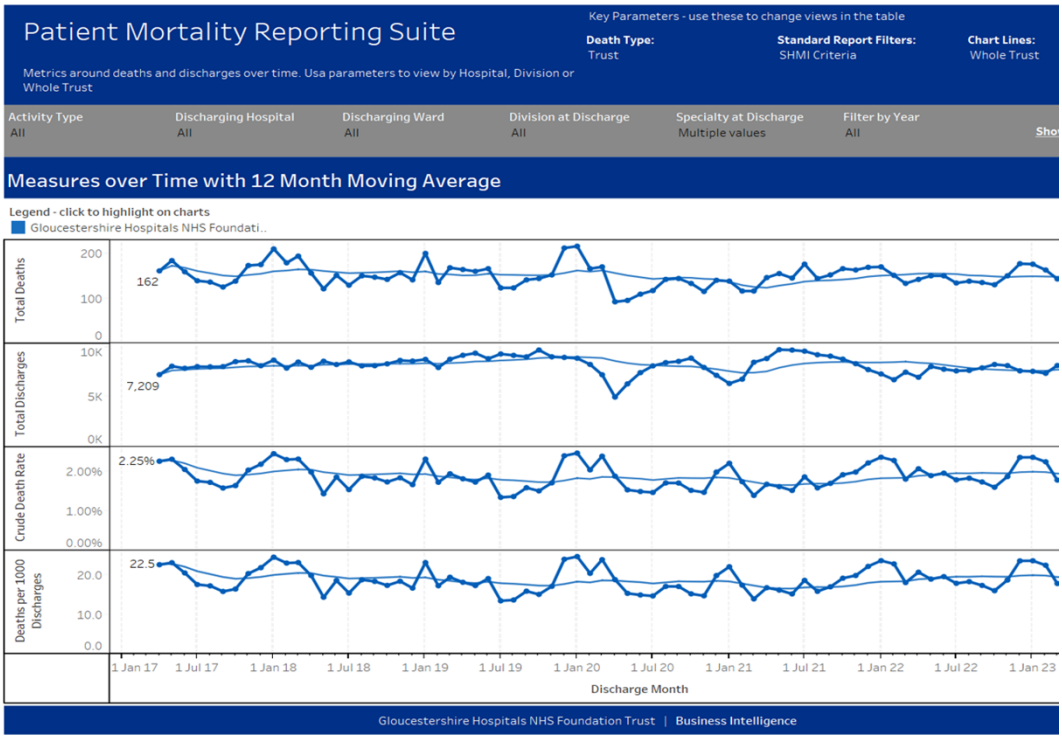
Methodology:

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

Current SHMI position:

- The trust had significantly higher than expected deaths for the past 4 publications, and the trend over the past 2 years has shown a consistent increase. This has fallen back over Q4 2023 and now falls just within the “as expected” range.

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



Conclusion:

- SHMI for the Trust has fallen back to “As Expected” following a rise in the Expected Deaths calculation.

3.4 A detailed review by Business Intelligence looked at the role of changes in patient numbers admitted with a diagnosis of dementia and its impact on expected deaths and therefore SHMI.

Dementia coding has a major influence on expected deaths via its Charlson Coding weighting. If fewer patients are known to have dementia on admission to hospital, the rate of expected deaths overall will decrease leading to a bigger gap between observed and expected deaths. SHMI will therefore rise accordingly.

Over the last 3 financial years, dementia rates as measured by coding on admission have shown a decrease:

	Financial Year			
	2019/20	2020/21	2021/22	2022/23
Average of admissions coded with Dementia%	9.02%	9.04%	7.49%	5.83%

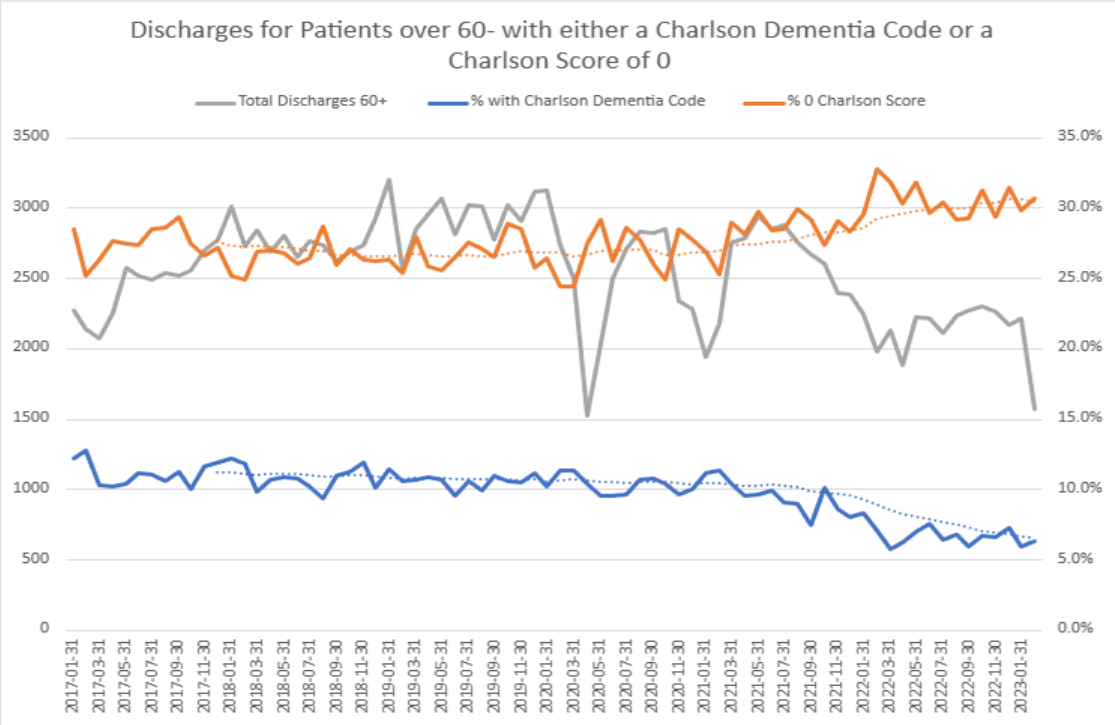


Chart 1
This is looking at SHMI applicable episodes only (no daycases, still births or COVID admissions) since 2017, and is limited to patients that were age 60 and over at admission.

In the latest financial year 2022-23, this is a year-on-year relative decrease of 3.19% which would have had a significant impact on Expected Deaths. Coding numbers for other chronic health conditions have not showed a similar pattern. This data trend has several possible reasons behind it:

- Fewer patients have dementia
  - Very unlikely in an aging population
- Fewer patients are receiving a diagnosis of dementia
  - Diagnosis is often made by GPs in collaboration with GHC Memory Clinics
- Fewer patients with dementia are being admitted to hospital
  - Unlikely given a significant factor in co-morbid conditions
- Number of patients living with dementia has fallen due to impact of pandemic leading to increased deaths in this group
  - Known to be a factor as strong link with frailty and data in chart 1 shows a decrease in total discharges in over 60s

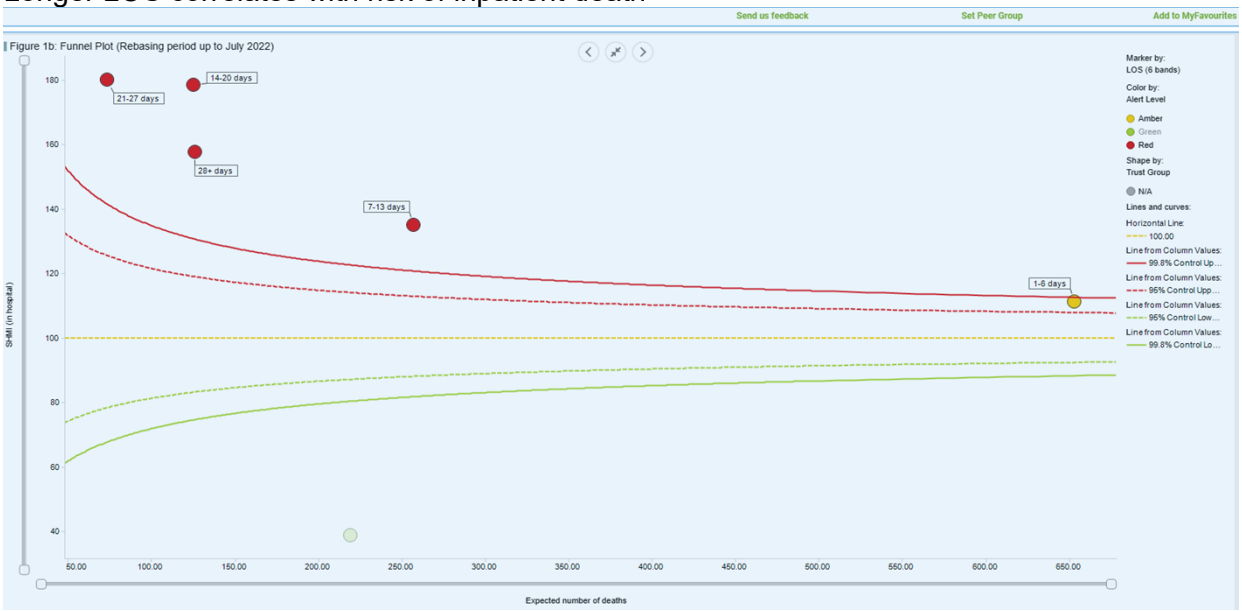
The ICB Mortality Group has discussed these issues and are investigating if diagnosis rates within primary care have fallen in last 2 years.

3.5 Sepsis

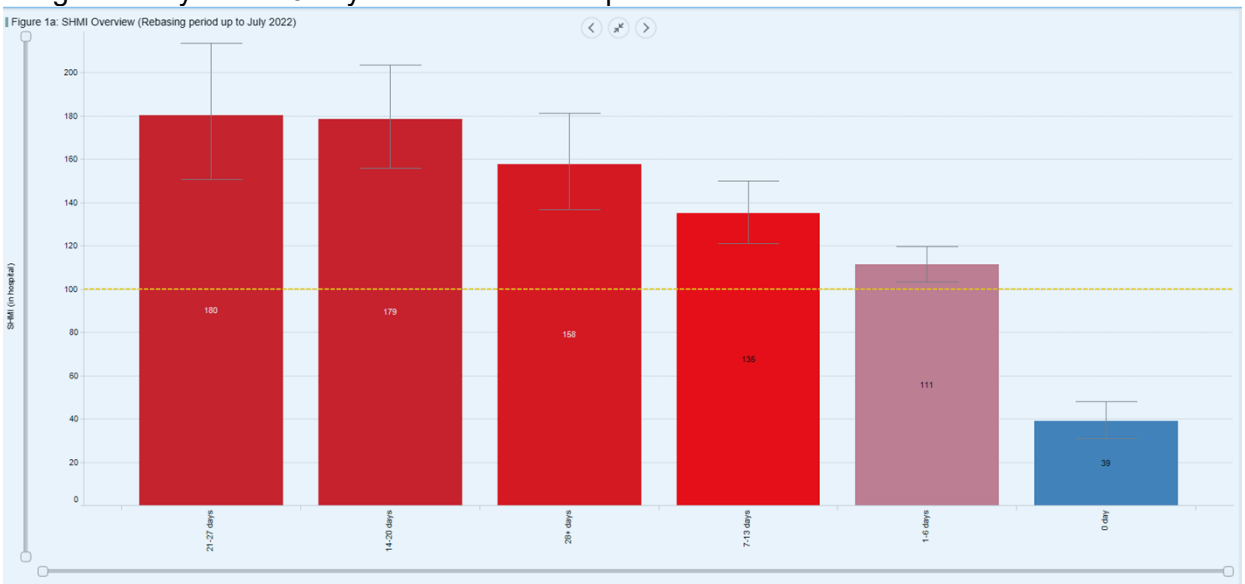
A review of sepsis following shows the Trust remains within normal distribution and therefore not outlying. HMG will contine to track this indicator periodically.

3.6 Impact of Length of Stay on SHMI

Longer LOS correlates with risk of inpatient death



Length of Stay above 6 days correlates with Inpatient SHMI rises as shown below



3.7 Fractured Neck of Femur mortality

a) In July 2023, a report was presented to Quality & Performance Committee which summarised the key performance issues that are contributing to performance of the Trauma Service against the key Fractured Neck of Femur (#NOF) targets set nationally, and recommended required steps to improvement. (Appendix 3a)

b) In addition, in September 2023, additional analysis was provided to the Hospital Mortality Group (Appendix 3b).

c) **Background** - In 2014, GHFT had the worst #NOF mortality rate in the country at 12.5%, as a result the RCS were invited to review. In 2016 GHFT had both a BOA review and joined the Scaling Up Programme for Hip Fracture Improvement, this led to 6 key improvement actions which drove key improvements on two key metrics: time to theatre and thirty-day mortality. Throughout much of 2018 GHFT remained above the national average for these metrics.

d) In 2019, there was a breakdown in pathways, tied with a reduction in the overall trauma bed-base at Gloucester Royal Hospital which has consistently led to a non-delivery of meeting time to theatre requirements (43.8 hours at 31st May 2023), and 30-day mortality rate above the national average (11% at 31st May 2023).

e) The key enabler to improved performance is improved access to theatres, which will be supported by dedicated bed base. A further enabler is greater availability of dedicated MDT teams to support post-op recovery. The steps to recovery will take time to deliver, particularly the elements relating to recruitment and greater trauma theatre lists in GRH due to the reliance on Chedworth and 5th Orthopaedic theatres opening.

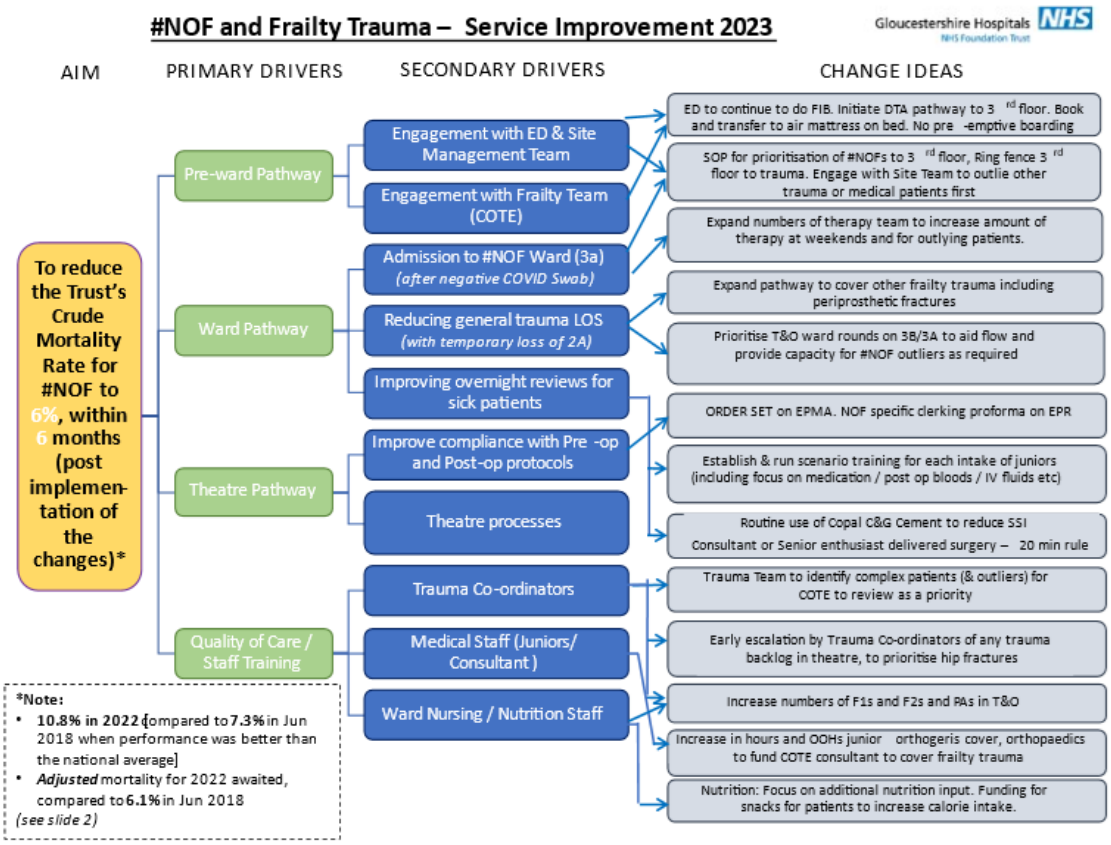
f) At September's Hospital Mortality Group (HMG), discussion took place on whether the mortality data was being driven by capacity issues or theatre space issues, and further analysis on this is due at October's HMG.

g) It was clarified that #NOF data goes to the HIP Fracture Working Group and Equality and Improvement Group each month and then to T&O Theatres and then to Divisional Quality Governance meeting. If there is anything problematic, this is raised through the Trust Quality Delivery Group. Any concerns are also to be raised with the Medical Director and the Chief Operating Officer if necessary, and this will continue to be monitored on a monthly basis until the mortality statistics are within the normal range.

Table taken from report presented at HMG in September 2023 (Full report – Appendix 5b)

Hip fracture analysis at GRH. Data period 01/01/2023 – 31/08/2023	01/01/2023-31/08/2023
Admissions	550
Failed surgery <36 hrs - total	62.7%
(No operation)	*2.5%*
(No theatre time)	*48.9%*
(Medical)	*11.3%*
Average time to surgery	43.8 (46.4) hrs
Assessed by therapists day of/after surgery	99.3%
Mobilised day of /after surgery	89%
Pressure ulcer incidence	2.3%
BPT attainment	36.2%
Average acute ward length of stay	14.9 days
Average Trust length of stay	16.3 days
Admitted from and discharged directly to own home from Trust:	68%
Crude 30-day mortality (01/01/2023 – 31/07/2023)	8.2%

Table take from report presented to Quality & Performance Committee, July 2023 (full report – Appendix 5a).



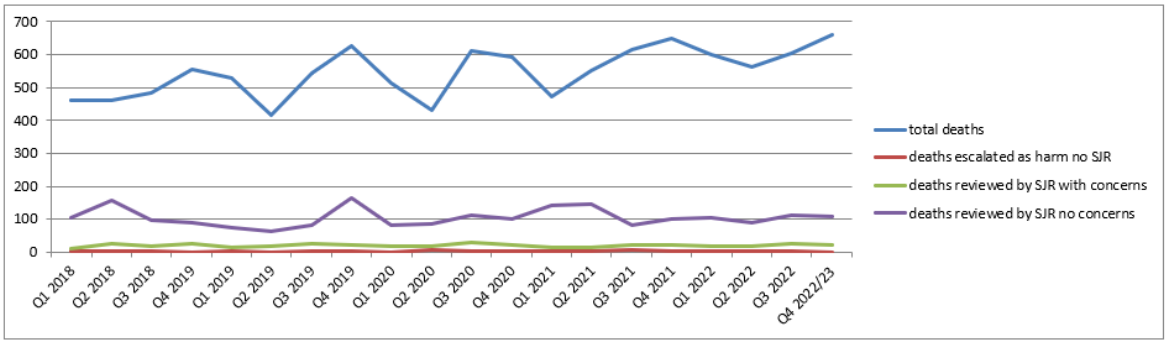
4. Structured Judgement Review Process

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

4.2 Deaths identified for review (next page)

Mortality Quarterly Dashboard: Quarter 4 (January to March 2023) – Appendix 1)

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
644	605	**6**	5	**24**	26	**102**	114	127 (20%)	140 (23%)	**1**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
2409	2287	**19**	18	**77**	72	**408**	472	489 (20%)	532 (23%)	**4**	2



Assessment Scores

Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		Score 2 – Poor Care		Score 3 – Adequate Care		Score 4 – Good Care		Score 5 – Excellent Care		Deaths escalated to harm review panel following SJR	
This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)
0	0	13	32	29	95	43	210	9	76	2	4

Problems identified in care and care record									
Problem in assessment, investigation or diagnosis		Problem with medication /IV fluids /electrolytes /oxygen		Problem related to treatment/management plan		Problem with infection control		Problem related to operation/ invasive procedure	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
3	3	0	3	3	6	0	0	1	3
Problems identified in care and care record									
Problem in clinical monitoring		Problem in resuscitation following a cardiac or respiratory arrest		Other Problem		Quality of Patient Record Poor or very poor			
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)		
0	3	0	1	5	6	1	4		

System Indicators

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)		Completion of Key Learning Message (% of total requiring review)		Deaths selected for review but not reviewed to date (% of total requiring review)	
This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter	This Quarter	Last Quarter
83 (66%)	89 (64%)	5 (71%)	5 (100%)	92 (73%)	75 (54%)	29 (23%)	27 (19%)
This Year	Last Year	This Year	Last Year	This Year	Last Year	This Year	Last Year
327 (66%)	Measurement amended	14 (66%)	14 (66%)	286 (87%)	194 (36%)	84 (26%)	29 (5%)

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

4.4 The Performance against standard tables above illustrates the general performance of 66% which maintains an improvement from last year which averaged around 56%.

5. Family Feedback from Bereavement team

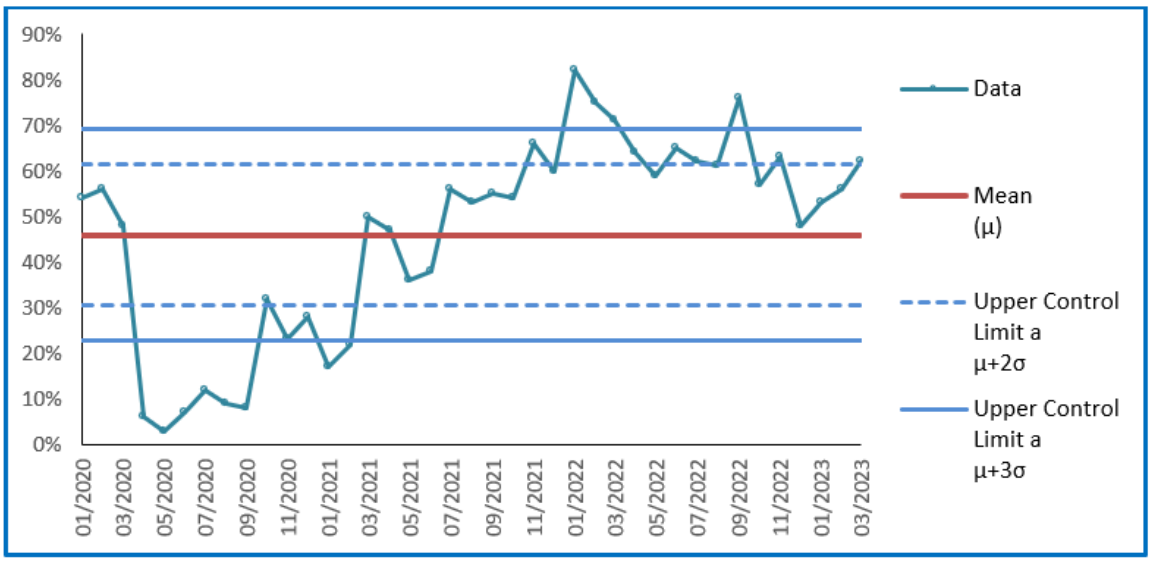
5.1 Following a review of family feedback mechanism with the End of Life lead, a new set of indicators and themed reporting has been developed. The themed reporting is based on the national End of Life audit categories which allowed triangulation of feedback with the findings of the annual audit. This data is presented at the End of meeting Life (as the expert group) as part of their meetings and informs discussion on assurance and improvement work with highlights can be seen in Appendix 2.

Trustwide

Percentage of feedback received of all deaths

1.0 Trustwide

1.1. The percentage of deaths where feedback received.



6 Consecutive points near to or outside of lower control limit during period where feedback not requested by bereavement team.

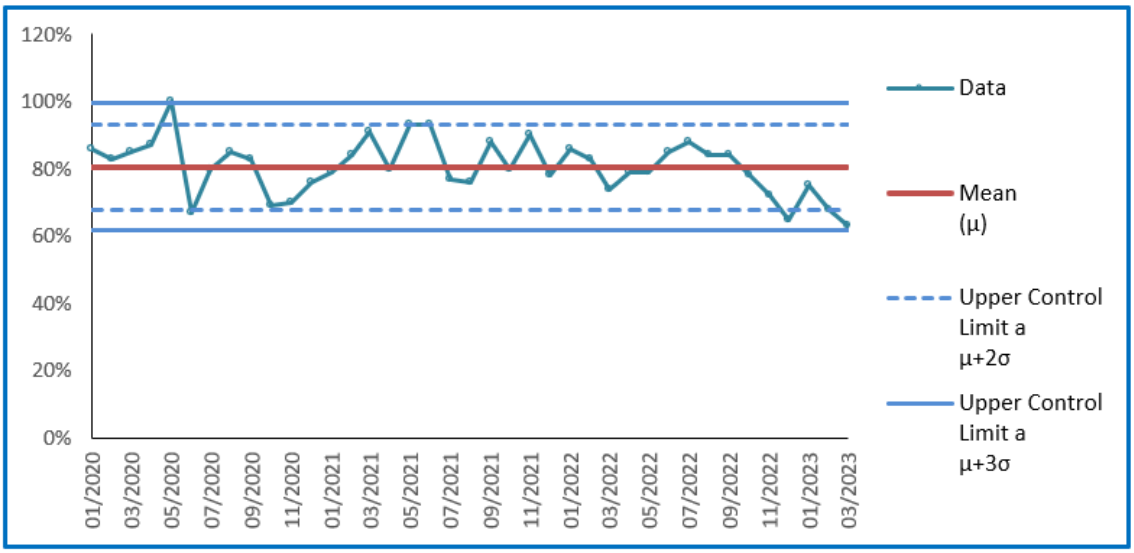
18 consecutive points above the mean between July 2021 and December 2022

3 consecutive points outside of upper control limit Jan to March 2022

Single point above upper control limit in September 2022

Note new staff in bereavement between October and December 22 learning processes

1.2 The percentage of positive feedback received (all deaths where feedback received)



Increasing trend in % of positive feedback between Oct 2020 and March 2021 and Mar 2022 and July 2022

6 points consecutive points below the mean from 09/22 to 03/23

5.3 Conclusion

Family feedback has increased in the Q4 (Jan to March 2023) and hit the upper control limit of 60%. This will progress to an adjustment in mean by the next report. The positive feedback remains a concern although has improved slightly in the last quarter.

6. Learning from Deaths

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

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

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

6.3 Serious incidents that result in death all have action plans. A summary of the individual closed actions plans and learning in the past 3 months is attached for information (Appendix 2).

6.4 Feedback from bereaved families has come up with several themes both positive and negative which are included in Appendix 4. Recurrent themes include negative communication regarding being unprepared for the death, lack of clarity on diagnosis, communication re admission, ward moves, mixed messages, getting

through to hospital and being informed re death.

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

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

7. LeDeR report

7.1 There were 27 confirmed deaths of inpatients with learning disabilities in 2022/2023. This is within normal variation. Of these deaths in 2022 – 2023 reviewed by LeDeR, only one was graded 2 and that person died in GRH. In contrast, 4 deaths in 2022 – 2023 were graded 'excellent'

7.2 Each LD review produces a 'learning on a page' these are fed back to the ward areas to share learning. Almost all of these provide evidence of good hospital care. Occasionally these are also classified as a serious incident, these incidents also have a Trust action plan and would be included in the SI action plan section.

The implementation of previously planned improvements was showcased at the LeDeR 'Dying to make a difference' conference held at the end of March 2023. Of particular note, our recognition of the usual 'triangle of care' (patient, family, HCPs) pulling out into a 'square of care' (patient, family, carers, HCPs) for people with LD was something many professionals working with people with LD had not recognised previously. The opportunity was taken to explain that patients do not always respond positively to sepsis treatment, and our observation that most people with LD in Gloucestershire are now following a frailty pathway for the final 3 years of their life.
The new Chief AHP has taken on the piloting of the blue wristband for modified eating and drinking guidelines as a Trustwide project. The Best Interests meeting suite of leaflets has been launched. The Learning Disability introductory training to groups of new staff has been comprehensively revised to weave in the learning from the 2022 – 2023 LeDeR reviews.

8. Conclusions –

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

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

8.3 Learning from serious incidents is monitored through SERG, summaries are found in Appendix 2 alongside LeDeR feedback summaries.

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

8.5 Family feedback shows good satisfaction, analysis is reported under the national end of life clinical audit themes and will be interpreted by the End of life group to identify areas for improvement. There is special cause variation showing a decline in positive feedback (predominantly in Medicine) which coincides with increased pressure on the unscheduled care pathway, boarding and multiple transfers between wards.

8.6 Mortality indicators across most parameters for SHIMI have normalised with the exception of for Weekend Admissions. The data analysis shows that a decrease in diagnosis of dementia in the population affects the risk profile (expected deaths calculation) and adversely affects overall SHIMI.

9. Recommendations

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

Authors: Carolyne Claydon, Governance & Business Lead, Medical Directorate
Pam Adams, Trust Mortality Co-ordinator

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

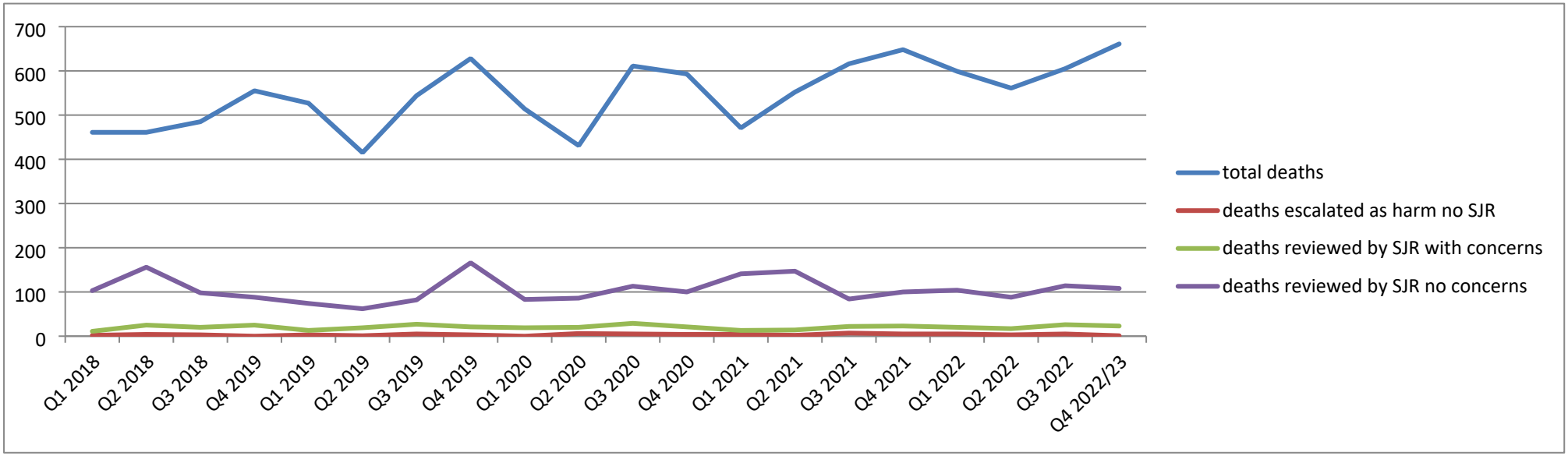
October 2023

Appendix I - Mortality Quarterly Dashboard: Quarter 4 (Jan – Mar 2023)

Mortality Data Quality Assured till Mar 2023

Trust wide

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of adult deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
644	605	**6**	5	**24**	26	**102**	114	127 (20%)	140 (23%)	**1**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
2409	2287	**19**	18	**77**	72	**408**	472	489 (20%)	532 (23%)	**4**	2



Overall rating of deaths reviewed under SJR methodology											
Score 1 – Very Poor Care		Score 2 – Poor Care		Score 3 – Adequate Care		Score 4 – Good Care		Score 5 – Excellent Care		Deaths escalated to harm review panel following SJR	
This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)	This Quarter	This year (YTD)
0	0	**13**	32	**29**	95	**43**	210	**9**	76	**2**	4

Problems identified in care and care record									
Problem in assessment, investigation or diagnosis		Problem with medication /IV fluids /electrolytes /oxygen		Problem related to treatment/management plan		Problem with infection control		Problem related to operation/ invasive procedure	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
3	**3**	**0**	**3**	**3**	**6**	**0**	**0**	**1**	**3**

Problems identified in care and care record							
Problem in clinical monitoring		Problem in resuscitation following a cardiac or respiratory arrest		Other Problem		Quality of Patient Record Poor or very poor	
This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)	This Quarter	This Year (YTD)
0	**3**	**0**	**1**	**5**	**6**	**1**	**4**

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)		Completion of Key Learning Message (% of total requiring review)		Deaths selected for review but not reviewed to date (% of total requiring review)	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
83 (66%)	**89 (64%)**	**5 (71%)**	**5 (100%)**	**92 (73%)**	**75 (54%)**	**29 (23%)**	**27 (19%)**
This Year	Last Year	**This Year**	Last Year	**This Year**	Last Year	**This Year**	Last Year
327 (66%)	Measurement amended	**14 (66%)**	14 (66%)	**286 (87%)**	194 (36%)	**84 (26%)**	29 (5%)

Surgical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
99	117	**3**	0	**4**	11	**8**	7	**13 (11%)**	**18 (15%)**	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
312	349	**2**	5	**19**	10	**37**	53	**61 (20%)**	61 (17%)	**0**	0

	Total number of deaths	**Deaths presented to harm review panel (No SJR undertaken)**	**Total number of deaths selected for review under SJR methodology (% of total death)**	**Deaths investigated as serious or moderate harm incidents. Following SJR**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Critical care	30	1	1 (9%)	0	0	1
T&O	34	1	8 (44%)	0	1	0
Upper GI	6	0	0 (2%)	0	0	0
Lower GI	26	0	63(50%)	0	0	0
Vascular	1	0	0 (0%)	0	0	0
Urology	2	1	1 (1%)	N/A	N/A	N/A
Breast	0	N/A	N/A	N.A	N/A	N/A
ENT	2	0	0 (0%)	N/A	N/A	N/A
OMF	0	N/A	N/A	N/A	N/A	N/A
Ophthalmology	0	N/A	N/A	N/A	N/A	N/A

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of intial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
10 (45%)	12 (48%)	**0**	2 (100%)	**18 (82%)**	14 (56%)	**1 (4.6%)**	4 (16%)
This Year (YTD)	Last Year	**This Year(YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
38 (46%)	Measurement amended	**5 (83%)**	2 (100%)	**64 (88%)**	19 (31%)	**7 (10%)**	2 (3%)

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

Medical Division

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
514	443	**3**	0	**18**	14	**92**	100	**110 (%)**	**114 (26%)**	**2**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
1246	1808	**11**	5	**40**	57	**261**	408	**318**	465 (26%)	**3**	2

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Acute medicine	**111**	0	10 (12%)	**0**	**0**	**0**

Cardiology	**22**	0	17 (86%)	**0**	**0**	**0**
Emergency Department	**77**	0	59 (97%)	**2**	**7**	**2**
Gastroenterology	**19**	0	0 (0%)	**N/A**	**N/A**	**N/A**
Neurology	**7**	0	1 (1%)	**N/A**	**N/A**	**N/A**
Renal	**39**	0	2 (1%)	**0**	**1**	**0**
Respiratory	**85**	1	4 (4.6%)	**0**	**0**	**0**
Rheumatology	**0**	N/A	N/A	**N/A**	**N/A**	**N/A**
Stroke	**22**	0	3 (0.12%)	**N/A**	**N/A**	**N/A**
COTE	**112**	2	13 (17%)	**0**	**3**	**5**
Diabetology	**18**	0	1 (6.6%)	**0**	**0**	**0**
Endoscopy	**0**	0	N/A	**N/A**	**N/A**	**N/A**

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
72 (66%)	55 (72%)	**3 (37.5%)**	3 (60%)	**73 (66%)**	38 (50%)	**17 (15%)**	14 (18%)
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
265 (70%)	Measurement amended	**12 (66%)**	11 (65%)	**220 (62%)**	202 (50%)	**55 (13%)**	25 (5%)

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

Diagnostic and Specialties

Total number of deaths, deaths selected for review and deaths escalated due to problems in care identified											
Total number of deaths		Deaths investigated as harm incidents/complaints (No SJR undertaken)		Deaths selected for review under SJR methodology with concerns		Deaths selected for review under SJR methodology with no concerns		Total number of Deaths selected for review under SJR methodology (% of total deaths)		Deaths investigated as serious or moderate harm incidents. Following SJR	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
29	29	**0**	0	**1**	1	**2**	7	**3**	8	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
104	72	**0**	1	**5**	1	**10**	7	**16**	9 (10%)	**0**	0

	Total number of deaths	**Deaths presented to harm review panel (Prior to SJR/SJR not undertaken)**	**Total number of deaths selected for review under SJR methodology**	**Deaths investigated as serious or moderate harm incidents. Following SJR (total)**	**Number of SJRs with very poor or poor care**	**Number of SJRs with excellent care**
Lead Specialty						
Oncology	**25**	**0**	**2 (9%)**	**0**	**0**	**0**
Clinical haematology	**4**	**0**	**1 (%)**	**0**	**0**	**0**

Performance against standards for review							
Deaths reviewed within 3 months of request (% of total requiring review)		**2nd reviews (where indicated) within 1 month of initial review (% of total requiring review)**		**Completion of Key Learning Message (% of total requiring review)**		**Deaths selected for review but not reviewed to date (% of total requiring review)**	
This Quarter	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter	**This Quarter**	Last Quarter
1 (50%)	2 (66%)	**N/A**	N/A	**1 (50%)**	3 (100%)	**0**	0
This Year (YTD)	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year	**This Year (YTD)**	Last Year
8 (50%)	Measurement amended	**1 (100%)**	1 (100%)	**11 (69%)**	7 (78%)	**2 (12%)**	2 (22%)

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

Maternity and Gynaecology

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

	Total number of deaths	Deaths presented to harm review panel (Prior	Total number of deaths selected for review	Deaths investigated as serious or moderate	Number of SJRs with very poor or poor care	Number of SJRs with excellent care

		to SJR/SJR not undertaken)	under SJR methodology	harm incidents. Following SJR (total)		
Lead Specialty						
Gynaecology	**1**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Maternity	**0**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

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

Date report compiled: 02/05/2023

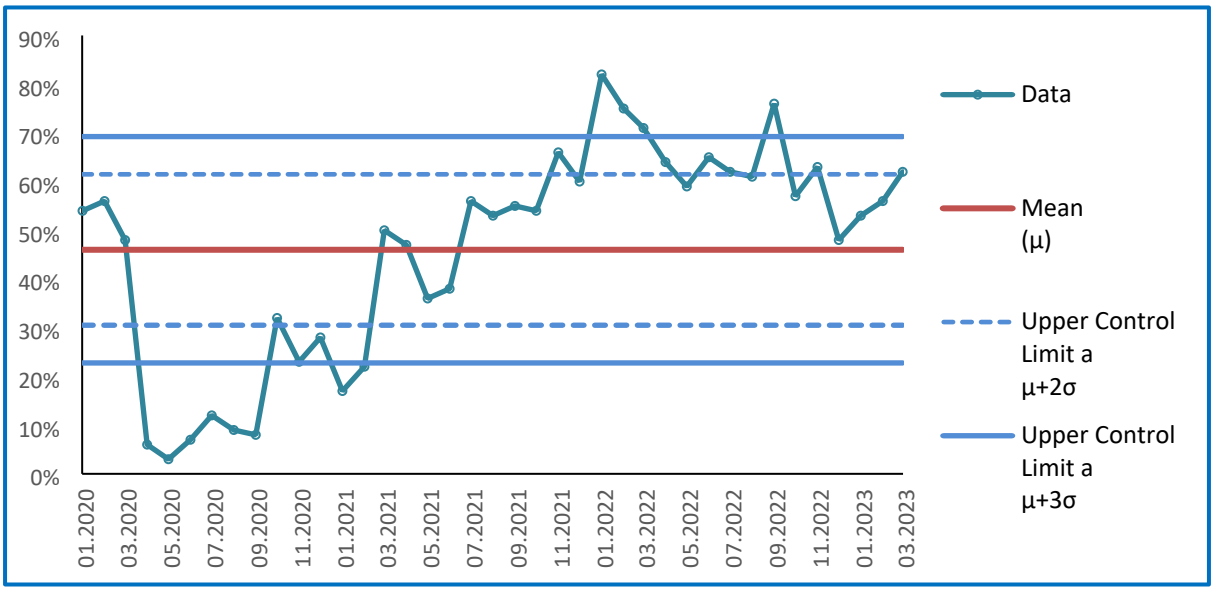
Author: Nicky Holton

Feedback from families and others to bereavement team

Jan-Mar 2023

1.0 Trustwide

1.1. The percentage of deaths where feedback received.



6 Consecutive points near to or outside of lower control limit during period where feedback not requested by bereavement team.

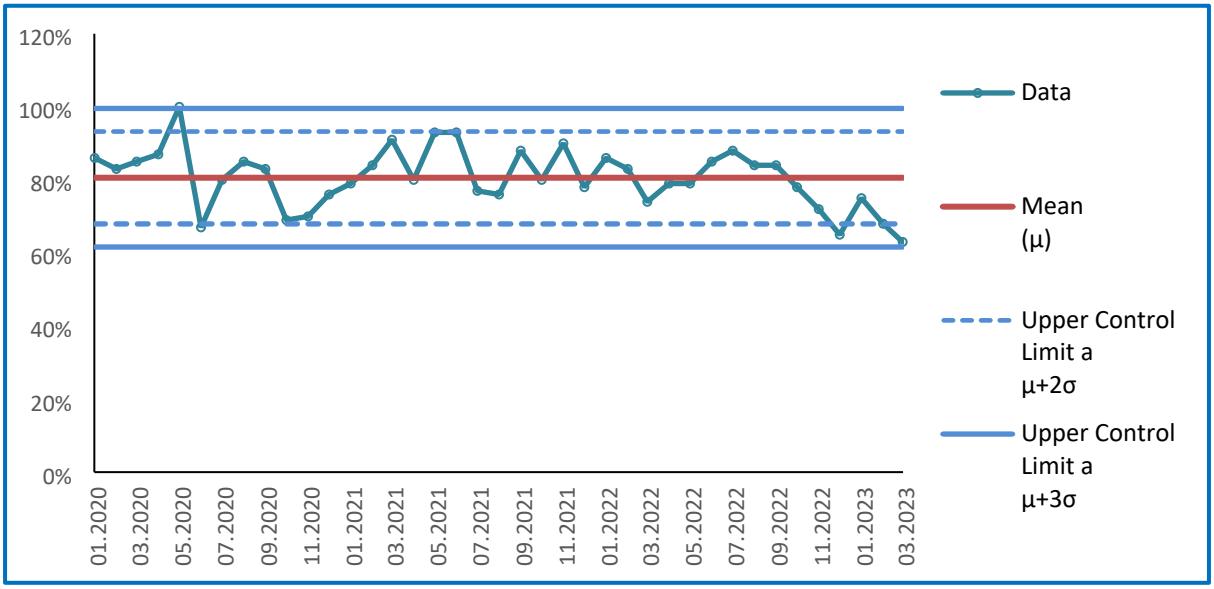
18 consecutive points above the mean between July 2021 and December 2022

3 consecutive points outside of upper control limit Jan to March 2022

Single point above upper control limit in September 2022

Note new staff in bereavement between October and December 22 learning processes

1.2 The percentage of positive feedback received (all deaths where feedback received)

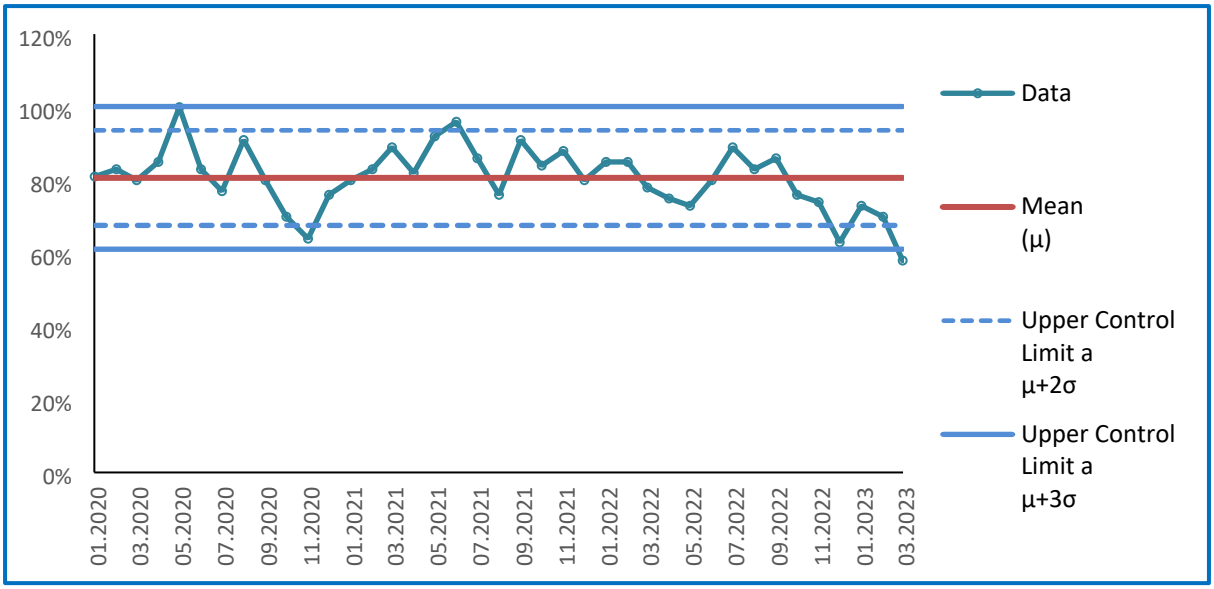


Increasing trend in % of positive feedback between Oct 2020 and March 2021 and Mar 2022 and July 2022

6 points consecutive points below the mean from 09/22 to 03/23

2.0 Medical Division

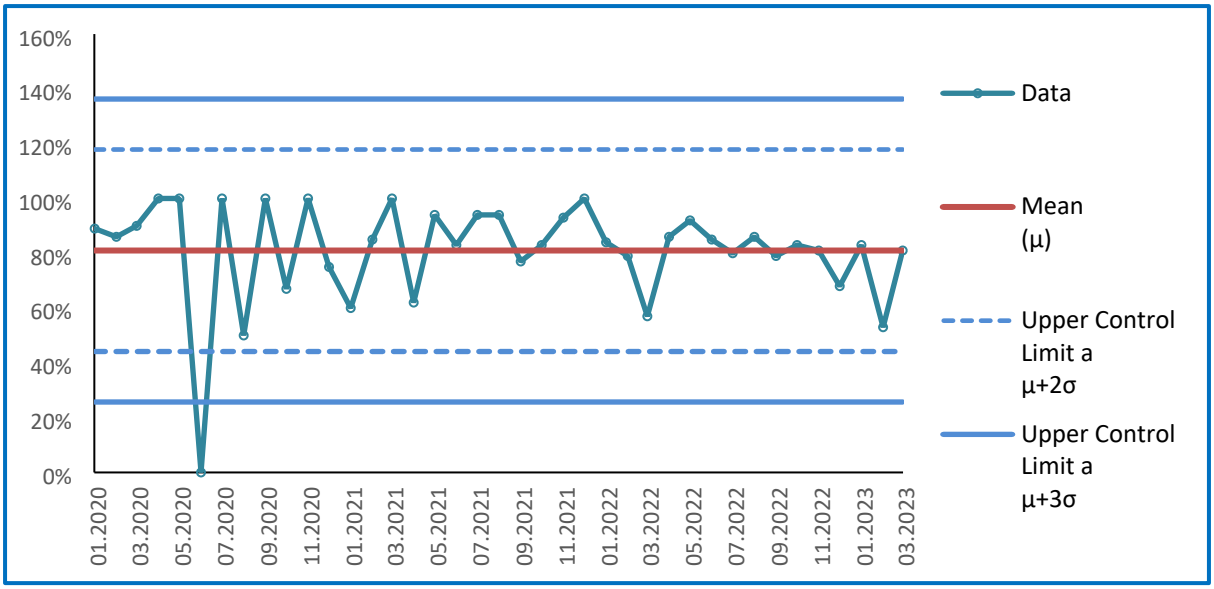
2.1 The percentage of positive feedback received (all deaths where feedback received)



6 consecutive points below the mean between sept 22 and mar 23

3.0 Surgical Division

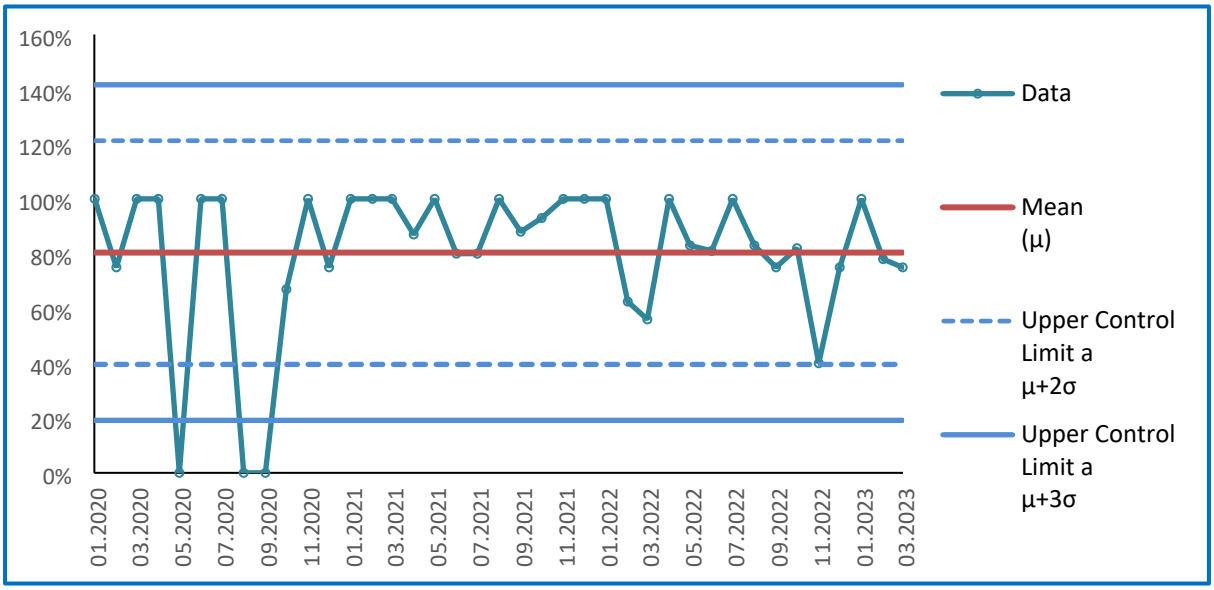
3.1 The percentage of positive feedback received



Special cause variation in June 2020 where only 3 feedback responses received.

4.0 Diagnostics and Specialties Division

4.1 The percentage of positive feedback received



Special cause variations resulting where no feedback received

12 consecutive points on or above the mean between jan 21 and Jan 22

Single point on lower control limit in November 2022

5.0 Themes of Feedback (jan-mar 2023)

5.1 Communication with the dying person

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

5.2 Communication with families and others

There were 19 negative and 6 positive comments about communication. The positive comments were mostly generic re family feeling they were kept informed, one referred to the kindness shown by the nurse informing them of the death

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

"The morning he died they were told 3 different causes of death,(bleeding Ulcer, Covid, Kidney failure) Communication was poor."

"Dreadful communication. Family was told the patient was on Ward 4 - they rang ward all night with no answer, but found out in the morning she was actually still in ED. On 5/1/23, family were with the patient when she died in the early evening, then received a phone call around midnight to inform them that she had died."

"The only issue was when nurse rang to tell them he had died - they couldn't understand a word. This is not a complaint, but just a language barrier."

"Arrived on ward at appointed time to speak to Dr as she had questions, but was told to come back another day as they were too busy. Not told that father had a stroke."

"Nobody had communicated to the family that mum went into hospital Saturday night. We were unaware until the following day, which caused a lot of stress."

"medical communication was vague and done with medical terminology the family didn't understand. Family didn't understand that death was imminent."

"Unfortunately the family felt that the doctor who notified daughter of the death was lacking in empathy."

The most common theme was lack of or delayed communication re the death and in more than one case relatives discovering their relative dead in bed.

"Family entered the room but nobody had told them that "their relative" had died."

"nobody called to say patient had passed away"

"Family reported that nobody let them know patient had died. Found this very upsetting"

"son was disappointed to have not been contacted sooner when mum was reaching end of life care."

"Family very unhappy that they were called to come back as he was deteriorating and were told to go into the bay where he was, only to find he was dead in bed. Should have been informed ahead of seeing him."

5.3 Needs of families and others

Most comments were generic regarding support given to families and others.

"we were grateful that the family were allowed to stay with her"

2 comments related to a lack of privacy and 2 comments re side room availability, one positive and one negative.

5.4 Individualised plan of care

Where there was specific mention of plans of care comments tended to be negative. There were 3 negative comments about pain control, 2 in hospital falls, 1 pressure ulcer, 2 failures to recognise and act on complications, 2 relating to diabetic management, 2 related to blood tests and 1 delay to theatre. Several comments related to generic delays.

"discussions were held around feeding through a tube but the actions weren't always followed through until the following day"

"Last 4 days of life were dreadful (pain, discomfort, agitation)and was very distressing"

"Family felt pain issues were not controlled and lack of blood tests on 2nd day among other issues

“Complications that were not noticed, family want investigations into perforation and tear that wasn't noticed which caused pancreatitis.”

“Several cases of negligence regarding blood sugars, cannulas”

5.5. Families and others experience of care

The majority of comments were generic and positive

“Resus department was the 'Rolls Royce' of service and care – fantastic”

“everyone has been absolutely amazing - cant put into words how kind everyone was and so caring. Absolutely brilliant care”

“Hospital is an example to others, everyone was so helpful. everything was lovely”

“The care was outstanding and words can't do justice”

“Kind and wonderful staff who kept him cosy and cared for”

“Care was wonderful by wonderful people (nurses and consultants). Such bad reports of the hospital, but they were lovely.”

Families and others commented on staffing and the pressures they observed the services being under

“The staff did everything that they could but were rushed off their feet”

“Well looked after despite pressures on ward”

“They did a grand job under the circumstances that the NHS is going through”

“everyone was so busy and attitude of staff wasn’t good”

“The family got the sense of how under pressure the hospital is. Despite this, the support was really great to both the patient and the whole family.”

“incredibly grateful to all medical staff, just arent enough of them”

“Not enough drs - constantly changing.“

2 comments related to multiple moves, 2 related to being in a corridor, 1 being on a trolley and 2 regarding lost property. 3 related to previous discharges or discharge attempts.

Quality and Performance Committee
26th July 2023
Via MS Teams

Report Title
Fractured Neck of Femur Performance Diagnostic Report & Recovery Plan
Sponsor and Author(s)
Author: Sydney Walsh (General Manager, T&O) and Peter Kempshall (Hip Fracture Lead, T&O Consultant) Executive Sponsor: Alexandra Matthews (Divisional Director or Operations, Surgery)
Executive Summary
Purpose This report summarises the key performance issues that are contributing to performance of the Trauma Service against the key Fractured Neck of Femur targets set nationally, and recommended required steps to improvement. **Background** In 2014, GHFT had the worst #NOF mortality rate in the country at 12.5%, as a result the RCS were invited to review. In 2016 GHFT had both a BOA review and joined the Scaling Up Programme for Hip Fracture Improvement, this led to 6 key improvement actions which drove key improvements on two key metrics: time to theatre and thirty-day mortality. Throughout much of 2018 GHFT remained above the national average for these metrics. In 2019, there was a breakdown in pathways, tied with a reduction in the overall trauma bed-base at Gloucester Royal Hospital which has consistently led to a non-delivery of meeting time to theatre requirements (43.8 hours at 31st May 2023), and 30-day mortality rate above the national average (11% at 31st May 2023). **Key Points to Note** The key enabler to improved performance is improved access to theatres, which will be supported by dedicated bed base. A further enabler is greater availability of dedicated MDT teams to support post-op recovery The steps to recovery will take time to deliver, particularly the elements relating to recruitment and greater trauma theatre lists in GRH due to the reliance on Chedworth and 5th Orthopaedic theatres opening.
Recommendations
Quality and Performance Committee is requested to review the recommendations set out within this paper to understand current limitations on the service and areas for improvement.
Impact Upon Strategic Objectives
Current performance jeopardises delivery of the Trust's strategic objective to improve the quality of care for our patients.
Impact Upon Corporate Risks
Current performance against best practice tariff will cause a loss of income. The last 18month performance represents a loss of £900,000:

2022 – BPT = 41.8% of 799 cases (£604,000 lost) 2023 (thus far) – BPT = 38.8% of 352 cases (£280,500 lost)
Regulatory and/or Legal Implications
None identified.

Resource Implications			
Finance		Information Management & Technology	
Human Resources		Buildings	

Action/Decision Required							
For Decision		For Assurance		For Approval		For Information	✓

Date the paper was presented to previous Committees						
Quality & Performance Committee	**Finance Committee**	**Audit & Assurance Committee**	**People and OD Committee**	**Remuneration Committee**	**Trust Leadership Team**	**Other**
N/A	N/A	N/A	N/A	N/A	N/A	UEC Improvement Board (07/07/2023)
Outcome of discussion when presented to previous Committees						

SBAR: Fractured Neck of Femur Performance

1.0 Situation

The trauma service is under increasing pressure to deliver high quality care, and meet time to theatre and 30-day mortality requirements for the treatment of fractured neck-of-femurs (#NOF).

The impact of the reduction in trauma bed-base, increasing demand on the service and a reduction in Care of the elderly (COTE) input to patients has contributed to the poorer outcomes for patients since 2019.

2.0 Background

The Royal College of Physicians data (Appendix 1) demonstrates the local performance against the metrics from February 2016 to April 2023. It is evident that performance against the following metrics has been declining since 2019, whilst the annual number of patients being seen has increased:

- Patients (number per month)
- Hours to operation (annual)
- 30-day mortality (annual)

In 2014, GHFT had the worst #NOF mortality rate in the country at 12.5%, as a result the RCS were invited to review. In 2016 GHFT had both a BOA review and joined the Scaling Up Programme for Hip Fracture Improvement, this led to 6 key improvement actions which drove key improvements on two key metrics: time to theatre and thirty-day mortality. Throughout much of 2018 GHFT remained above the national average for these metrics.

In 2019, there was a breakdown in pathways, tied with a reduction in the overall trauma bed-base at Gloucester Royal Hospital which has consistently led to a non-delivery of meeting time to theatre requirements (43.8 hours at 31st May 2023), and 30-day mortality rate above the national average (11% at 31st May 2023).

3.0 Assessment

The trauma service has two monitored metrics, which demonstrate the performance of our #NOF service. The below outlines the limitations to achieving these.

3.1 Time to Theatres (Target within 36 hours).

The trauma service has seen a decrease in this performance metric annually since 2020, whilst in 2018 77% of patients made it to theatre within 36 hours (10% of those who did not were on medical grounds), in 2022, only 41.8% of patients made it to theatre within 36 hours (15% of those who did not were on medical grounds).

The root cause analysis of the majority of breaches demonstrates three themes:

a.) **Insufficient ring-fenced Trauma/NOF beds**

During the Covid-19 move of Vascular surgery to GRH, 2A (21 beds) was lost from the trauma bed base, this has displaced a number of Trauma patients to other surgical wards. This means that they are not receiving care from trained orthopaedic nurses, or the same level of therapy care. This means that patients have poorer experience with a number of wards moves (Appendix 2), from March – May 2023, 17 patients experienced 3 or more ward moves during their admission (8.5% of all admissions). Thus far, in 2023, 43% of all #NOFs were admitted to an alternative ward other than 3A (Appendix 6). Whilst a portion of these patients were admitted within the trauma bed base, over the time period 22% of all #NOFs were admitted to wards other than 3A and 3B.

b.) **Theatre capacity and utilisation**
During the centralisation of trauma work to GRH as part of the fit for the future programme of work, there was a loss of 10 trauma sessions. The service also has historically had poor utilisation of its given theatre sessions. However, due to a strong focus on this since January 2023, the service line has demonstrated a sustained improvement with the service achieving 84% utilisation in May 2023 (Appendix 5). From October 2023 there will be an increase of 26 theatre sessions over a 5-week period when elective services are repatriated to CGH. There is further potential for additional gains as a full spinal repatriation is being reviewed to also begin from October 2023. From May 2023, CGH will host all elective orthopaedic work other than paediatrics (10 sessions over a 5-week period).

c.) **#NOF Length of Stay**
#NOF Acute ward LoS has increased from 12.6 days in 2021 to 17.2 days in 2022. The increased LoS represents further bed pressures, which can increase the length of time patients spend in ED, further increasing the length of time to theatre. There have been improvements in 2023 and average acute LoS has reduced to 14.2 days, however, further improvements could be made to provide all outlying patients the same level of therapy support as our 3A patients receive. Internal service plans will look at creating a ring-fenced NOF receiving bay through a repatriation of the TATU service. This would allow patients to receive earlier multi-disciplinary management as outlined in NICE guidelines 1.8[1].

3.2 30-day Mortality %.
30-day mortality for #NOF patients have deteriorated, whilst there were improvements made in 2021 when crude mortality was 6.6%, 2022 saw this rise again to 10.8%, and currently in 2023 it sits at 11%.

The root cause analysis of the majority of breaches demonstrates that there are staffing gaps in the following areas:

a.) **Therapies Staffing**

Current therapy staffing represents the below:

Grade	Total Requirement (wte)	Total in post (wte)	Total vacancy (wte)
B7	2.4	2.4	0
B6	2	1	1
B5	3	2	1
B4	2.6	2.6	0
B3	3.6	3.6	0
B2	1	1	1

Current therapy provision does not provide enough cover to outlying #NOF patients, and an increase would need to be delivered in order to provide this.

Furthermore, current vacancies mean that the weekend provision is limited, as the rota is not adequately covered.

b.) **Orthogeriatric Staffing**

The British Geriatric Society[2] provide a clear recommendation for amount of Orthogeriatric support required by number of #NOFs, this is 2PA's of Consultant Orthogeriatric per 100 patients. In 2022, GHFT admitted 799 #NOF patients (Appendix 3), this would be 16 PAs of Consultant time. This does however, not include the additional ~180 patients per year with femoral shafts (~80) and peri-prosthetic fractures (~100). When these additional cases are factored, the recommendation for Orthogeriatrician support would be 20 PAs. At present at GHFT we have 7.8 PAs of consultant time, and a further 6PAs of Associate Specialist time, this leaves us

[1] Recommendations | Hip fracture: management | Guidance | NICE
[2] Wilson. H, (2010), Falls and Bone Health, British Geriatric Society – Published in June 2010 issue of BGS Newsletter

over 6PAs under-staffed in this area. In addition, in September 2023 there will be a loss of one of the Orthogeriatric consultants due to an internal move and this will reduce this further leaving only 4.4 PAs of consultant time.

Junior Orthogeriatric input has also decreased since 2018, despite #NOF admissions increasing. Following the centralisation of Trauma to GRH as part of fit for the future, the orthogeriatric junior cover on the CGH site was eradicated, therefore, despite the cohort and numbers of patients being centralised the junior team was not repatriated across. Over the next 13 years there is a predicted increase of #NOF admissions by 20% in line with a population increase within the over 65's (Appendix 4).

c.) **Nursing staffing**
The safer care nursing tool has been employed to review adequate nursing staffing for safe care of our patients across 3A, this demonstrates where there is a deficit in the nursing numbers on this ward (please note this does also include the 2A Annex as the wards are currently linked) (Appendix 7). Further consideration on the nursing workforce must be given that when 2A returns to trauma, this is going to impact the nursing staffing across the whole trauma bed base. Potentially members of 3A who are trained in #NOF care, will be staffing 2A, in order to open the bed base. This risk is being mitigated with Trust approval to begin overrecruiting to 3A in order to enhance the number of staff which will be moved to 2A.

d.) **Time to theatre**

Time to theatre is a direct contributing factor to 30-day mortality of patients, the factors to which are outlined above.

3.3 Workforce gap
There is clear evidence to show that there is sustained growth in the demand for #NOF admissions and surgery over the past 10 years, as well as evidence that demonstrates an increasing demand in the future, there is both a current staffing gap against existing guidelines and this is likely to be exacerbated in the future through increased service demand. The reduction in the orthogeriatric junior workforce since the 2018 centralisation of trauma, as well as the failure to meet the PA consultant requirements per patient put significant pressure on existing staffing. Therapy cover is inconsistent for those on outlying wards causing patient inequalities, the cost to replicate this staffing is outlined below,

In order to deliver the correct levels of equitable care there is a need to deliver the below staffing:

<u>Orthogeriatrics:</u>
In order to fulfil the deficit in Orthogeriatric consultant cover (currently 6 PA of DCC activity), we will need to recruit one additional consultant, as well as considering the loss of a further consultant in September 2023 due to an internal move.

- Consultant salary range - £145,000 (built in assumption for 5% pay award)

Recruitment to the additional post will therefore, represent a £145,000 investment into the service.

Further review into the junior medical staffing requirement will need further work-up, and will likely represent the need for further investment.

<u>Therapies:</u>
Current staffing is listed above, there is however a 3wte vacancy rate (1x B6, 1x B5, 1x B2). This would represent a cost of £112,751;

- B2 – £27,565
- B5 – £38,061
- B6 - £47,126

In order to provide therapy support to outlying patients there would be a need to recruit an additional 1wte B6, and 1wte B3, this would represent a cost increase of £75,901;

- B3 - £28,774
- B6 - £47,126

Total cost of the phases to introduce the above additional staffing would be £220,900. Increases to performance would promote improved performance against BTP.

This has been raised as an intolerable risk for 2021/22 consideration of trust wide funding in December 2020. *Separate business cases will be submitted for each of the individual staffing groups.*

Nursing:

The safer care nursing tool represents the deficit in nursing on 3A (please note this also includes 2A Annex staffing as the ward budgets are combined). From the tool there are currently the below deficits which represent the below:

SNCT Element	This Ward
Level 0 patients (daily average)?	0.00
Level 1a patients (daily average)?	6.6
Level 1b patients (daily average)?	24.9
Level 1c/2 patients (daily average)?	4.8
Level 3 patients (daily average)?	0.0
Patients	36.2
Preferred time-out?	22.0%
Preferred RforA time?	9.7%
Preferred RN proportion?	60%
Level 0 multiplier	0.99
Level 1a multiplier	1.38
Level 1b multiplier	1.72
Level 1c/2 multiplier*	1.72
Level 3 multiplier	5.96
RNs required	**36.0**
HCAs required	**24.0**
Total FTEs required	**60.1**

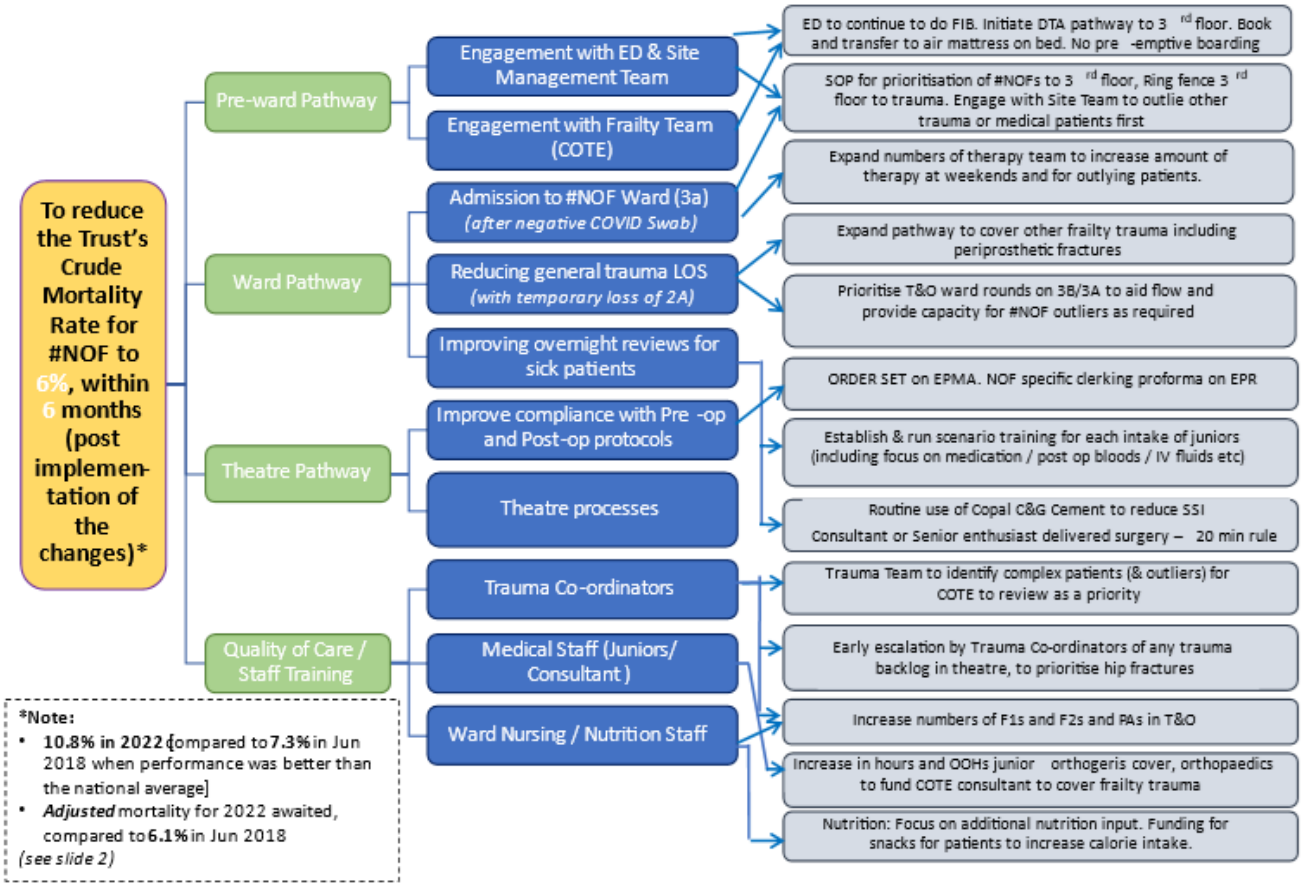
RNs funded	**22.2**
HCAs funded	**23.8**
Total FTEs funded	**46.0**

RN variance	**-13.8**
HCA variance	**-0.2**
Total variance	**-14.0**

4.0 Action Plan and Driver Diagram

#	Action	Owner	Status	Update
1	Increase Orthogeriatric Consultant staffing, with one additional funded consultant	Divisional	Open	Discussed at Hip# MDT – paper to be written for submission by T&O Leads
2	Increase the establishment of the therapies workforce to support the outliers to be seen promptly	Divisional	Open	Outcome of UEC Improvement Board, for Simon Lovett to be linked in for development of a business case
3	Return full trauma bed-base to Trauma	Trust	Open	Pending completion date for handover, nursing recruitment ongoing for the area
4	Ring-fence a #NOF receiving bay on the third floor	Trust	Open	Specialty identifying areas that could be a potential for use, potential location for 3A if TATU is rehoused
5	Run dedicated #NOF theatre lists in GRH	Specialty	Open	On-hold until Chedworth Day Surgery unit is fully operational when there will be additional trauma capacity at GRH
6	Introduce Copal High Concentration Antibiotic Cement	Specialty	Open	SBAR to go to Quality Committee in August 2023
7	Review T&O Junior Doctor Rota's to see where shared cover of 3A can be given	Specialty	Open	Specialty reviewing at present for new August rotation and new expanded junior doctor workforce
8	Review a flagging system to patients who have experienced multiple wards moves	Trust	Open	Discussed at UECIB, to form part of the action plan held here

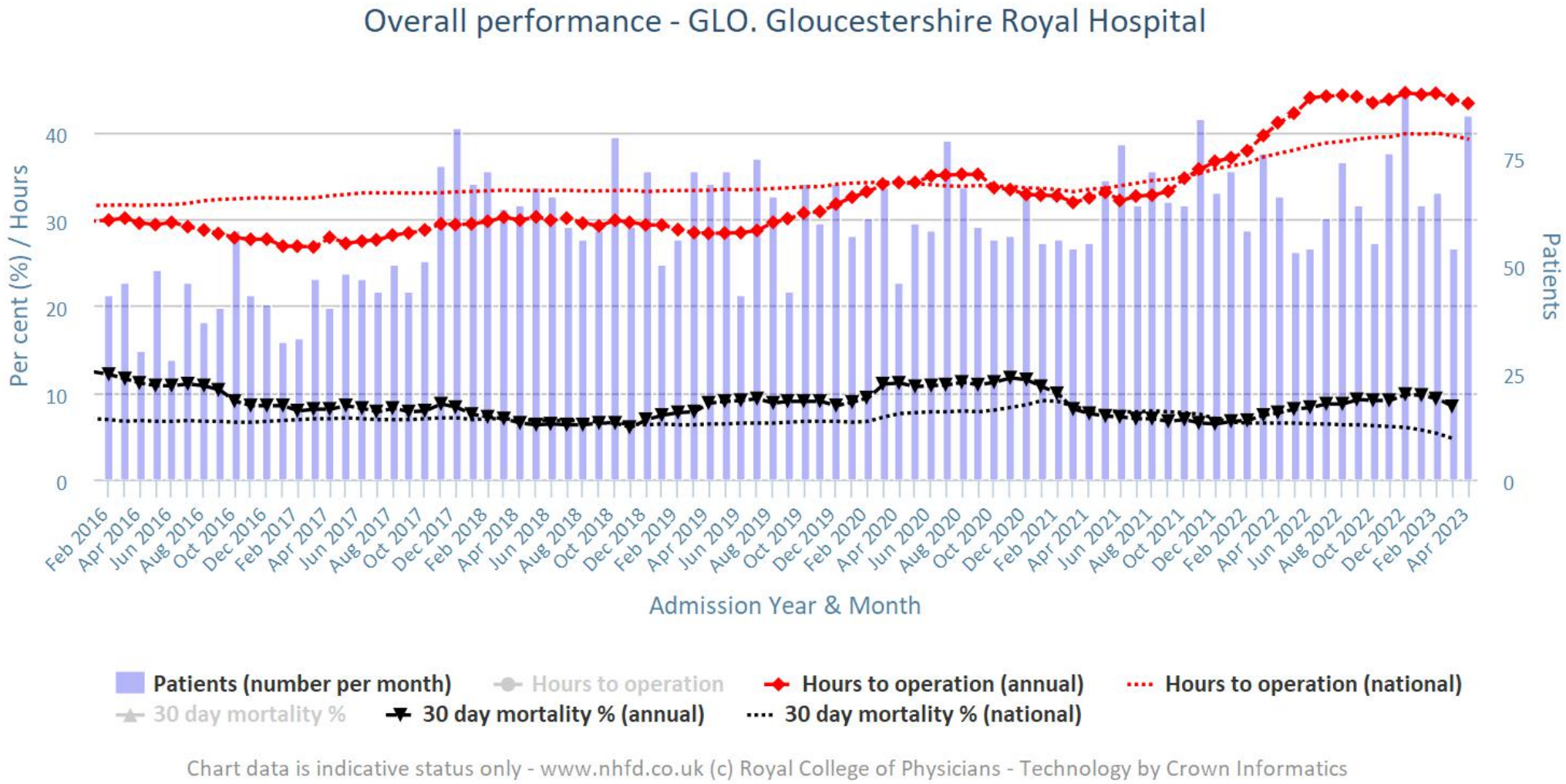
#NOF and Frailty Trauma – Service Improvement 2023



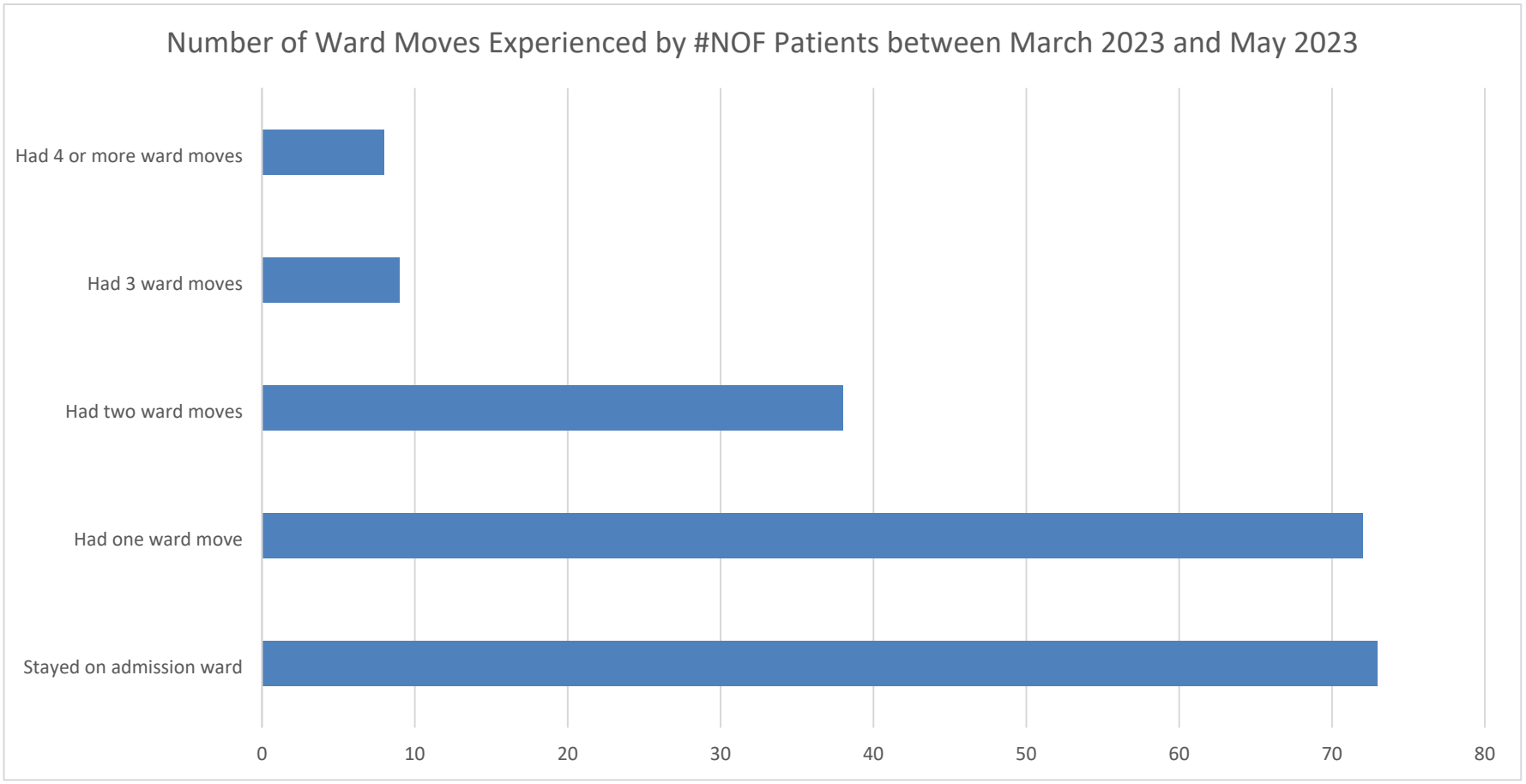
*Note:
- **10.8% in 2022** (compared to **7.3%** in Jun 2018 when performance was better than the national average]
- ***Adjusted*** mortality for 2022 awaited, compared to **6.1%** in Jun 2018

(see slide 2)

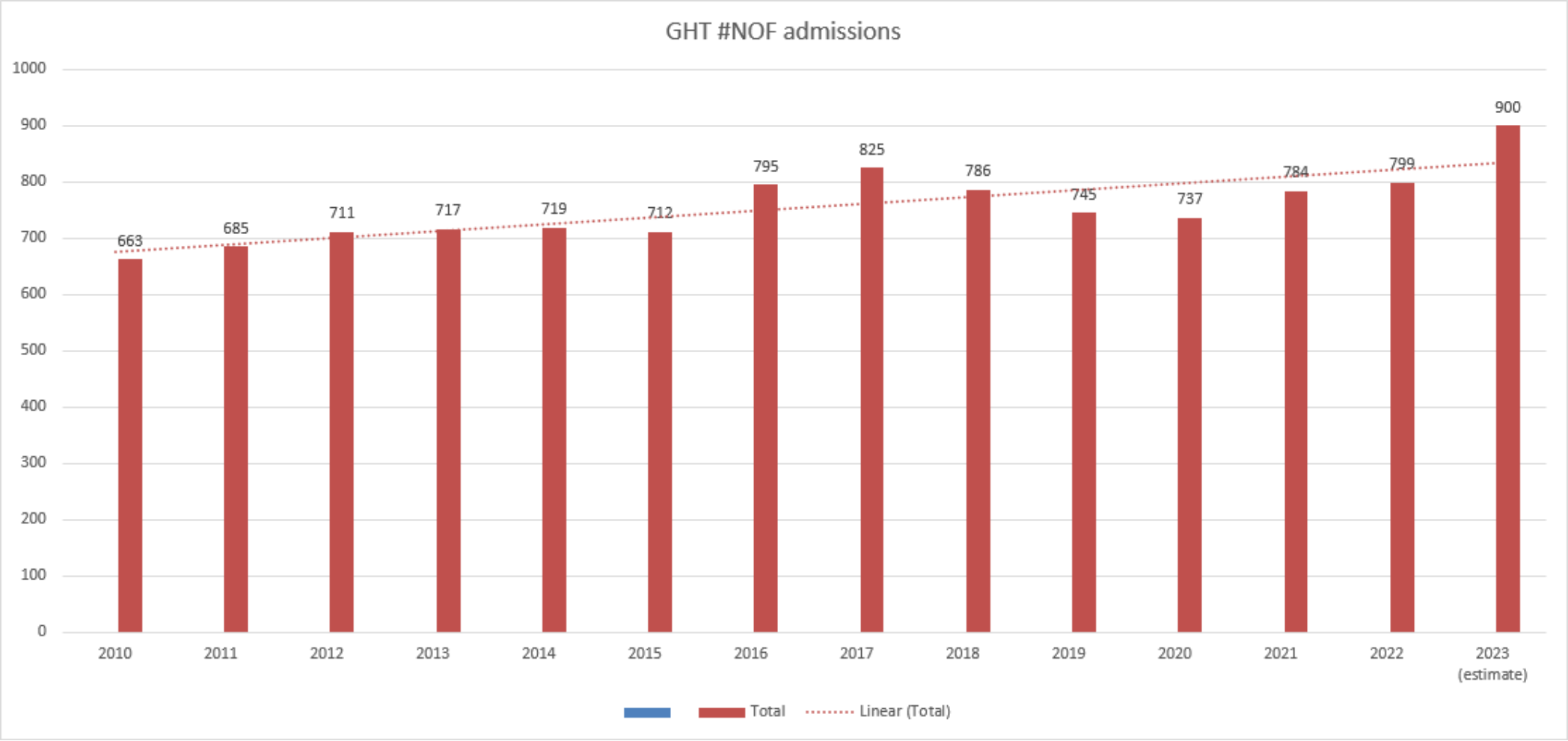
Appendix 1: SSNAP performance 2019



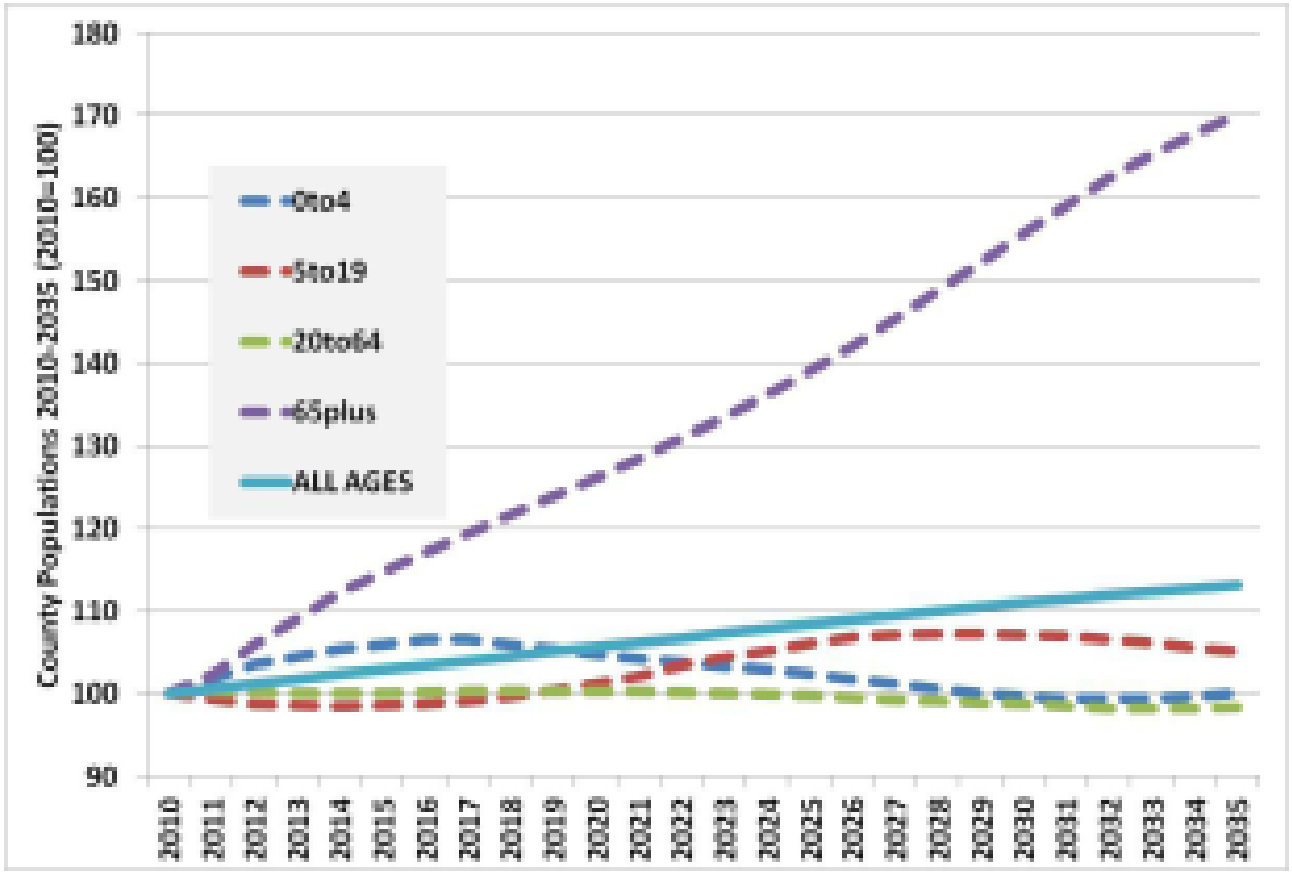
Appendix 2: Audit of the number of ward moves experienced by #NOF patients (live snapshot taken, does not account for any further movement of patients who remained inpatients at this time)



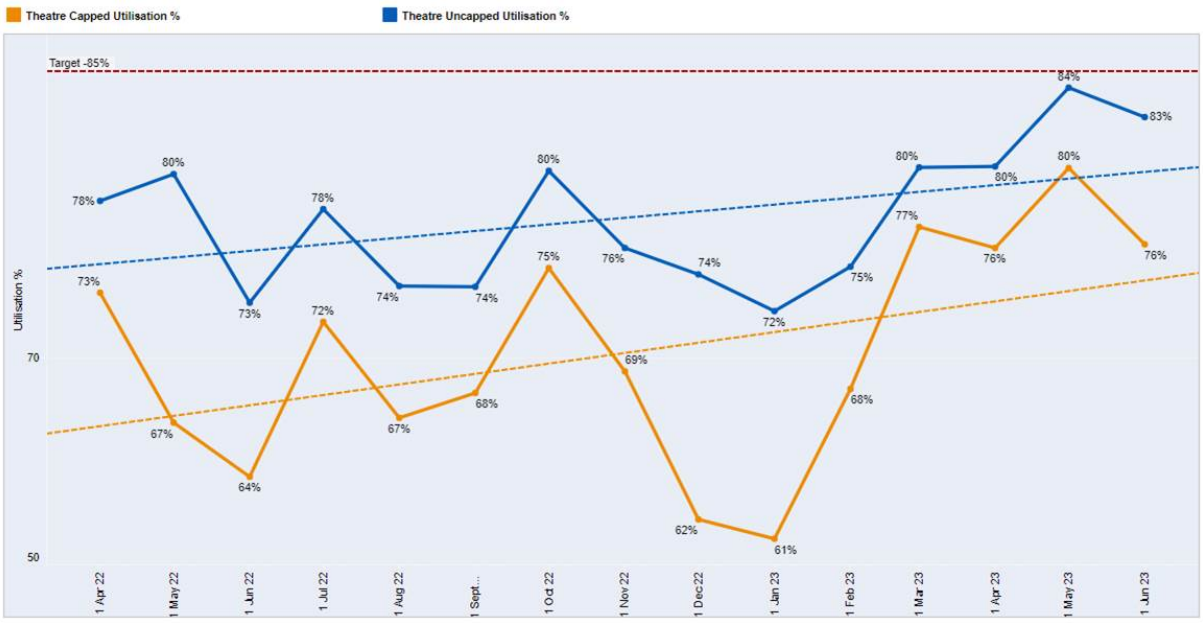
Appendix 3: NOF's Admitted Since 2010



Appendix 4: Population projections for Gloucestershire



Appendix 5 – Trauma Theatre Utilisation



Appendix 6 – Admission destination of all #NOF patients from January 2023-May 2023

	3A	Other	Total	% Outlier admissions
Jan	38	26	64	40%
Feb	31	36	67	54%
Mar	29	25	54	46%
Apr	42	43	85	51%
May	36	46	82	56%

Appendix 7 – SCNT 3A and 2A Annex

SNCT Level

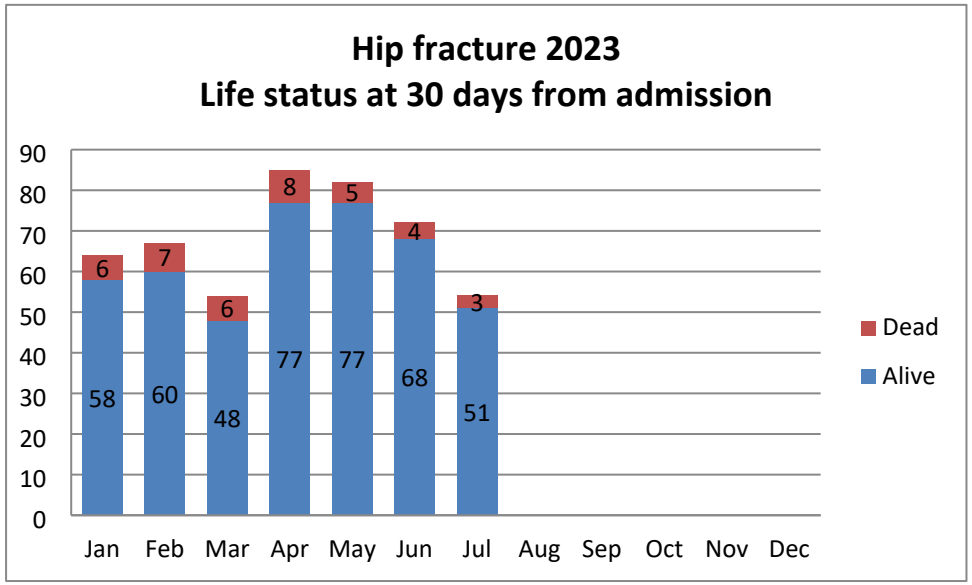
Census Day	0	1a	1b	1c*	2	3
1	0	7	24	5	0	0
2	0	7	24	5	0	0
3	0	7	25	4	0	0
4	0	7	25	5	0	0
5	0	6	25	5	0	0
6	0	4	25	5	0	0
7	0	8	26	4	0	0
8	0	3	22	5	0	0
9	0	7	25	5	0	0
10	0	4	20	5	0	0
11	0	3	25	4	0	0
12	0	7	24	5	0	0
13	0	7	25	5	0	0
14	0	7	25	5	0	0
15	0	7	25	6	0	0
16	0	7	25	5	0	0
17	0	7	25	5	0	0
18	0	7	25	5	0	0
19	0	8	26	5	0	0
20	0	10	28	4	0	0
21	0	8	28	4	0	0
Average	**0.00**	**6.57**	**24.86**	**4.81**	**0.00**	**0.00**
%	0.00	18.13	68.59	13.27	0.00	0.00

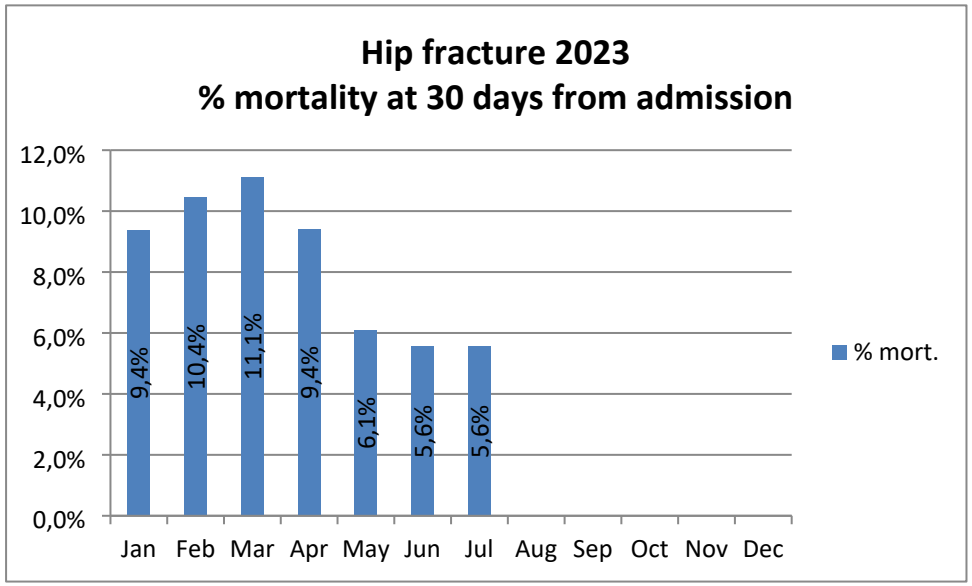
SNCT Element	This Ward
Level 0 patients (daily average)?	0.00
Level 1a patients (daily average)?	6.6
Level 1b patients (daily average)?	24.9
Level 1c/2 patients (daily average)?	4.8
Level 3 patients (daily average)?	0.0
Patients	36.2
Preferred time-out?	22.0%
Preferred RforA time?	9.7%
Preferred RN proportion?	60%
Level 0 multiplier	0.99
Level 1a multiplier	1.38
Level 1b multiplier	1.72
Level 1c/2 multiplier*	1.72
Level 3 multiplier	5.96
RNs required	**36.0**
HCAs required	**24.0**
Total FTEs required	**60.1**
RNs funded	**22.2**
HCAs funded	**23.8**
Total FTEs funded	**46.0**
RN variance	**-13.8**
HCA variance	**-0.2**
Total variance	**-14.0**

Hip fracture analysis at GRH. Data period 01/01/2023 – 31/08/2023

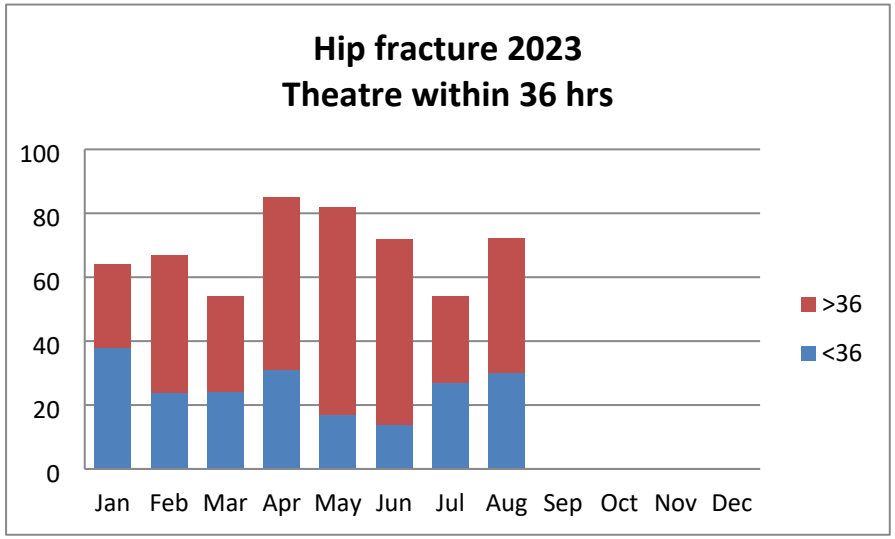
	01/01/2023-31/08/2023
Admissions	550
Failed surgery <36 hrs - total	62.7%
(No operation)	*2.5%*
(No theatre time)	*48.9%*
(Medical)	*11.3%*
Average time to surgery	43.8 (46.4) hrs
Assessed by therapists day of/after surgery	99.3%
Mobilised day of /after surgery	89%
Pressure ulcer incidence	2.3%
BPT attainment	36.2%
Average acute ward length of stay	14.9 days
Average Trust length of stay	16.3 days
Admitted from and discharged directly to own home from Trust:	68%
Crude 30-day mortality (01/01/2023 – 31/07/2023)	8.2%

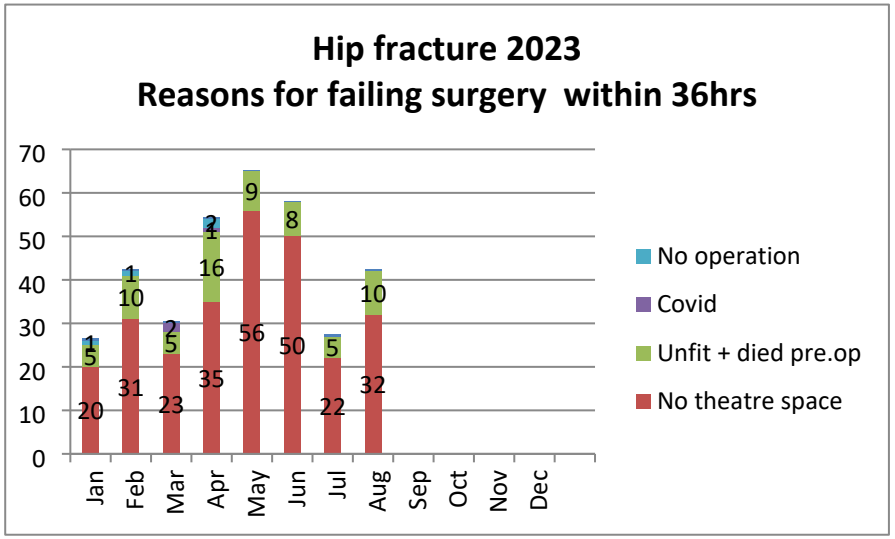
AWSept2023

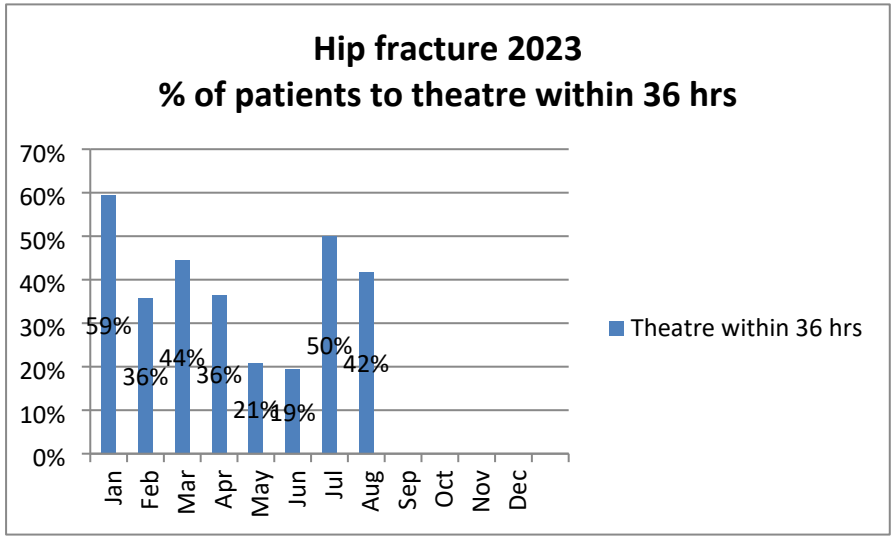

Hip fracture 2023
Life status at 30 days from admission
90
80
70
60
50
40
30
20
10
0
6
7
6
8
5
4
3
58
60
48
77
77
68
51
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Dead
Alive


Hip fracture 2023
% mortality at 30 days from admission
12,0%
10,0%
8,0%
6,0%
4,0%
2,0%
0,0%
9,4%
10,4%
11,1%
9,4%
6,1%
5,6%
5,6%
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
% mort.

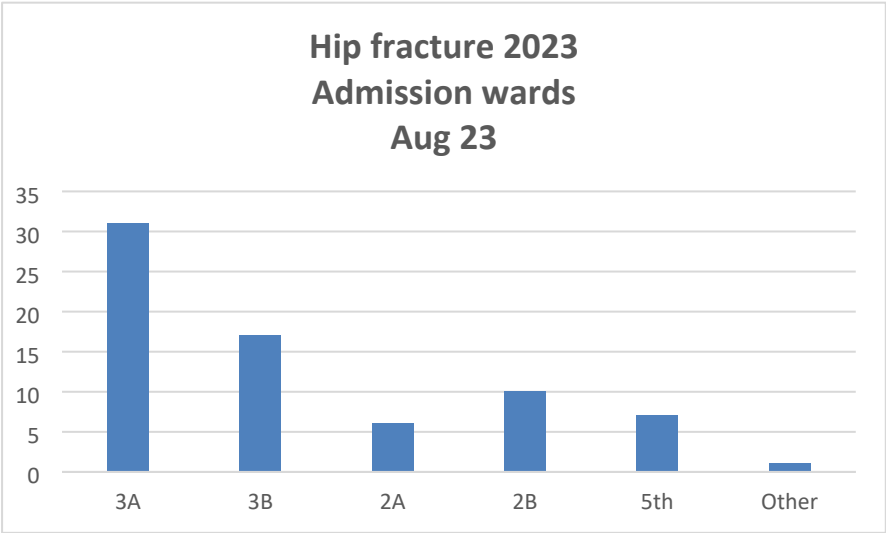
AWSept2023


Hip fracture 2023
Theatre within 36 hrs
100
80
60
40
20
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
>36
<36


Hip fracture 2023
Reasons for failing surgery within 36hrs
70
60
50
40
30
20
10
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
No operation
Covid
Unfit + died pre.op
No theatre space


Hip fracture 2023
% of patients to theatre within 36 hrs
70%
60%
50%
40%
30%
20%
10%
0%
59%
36%
44%
36%
21%
19%
50%
42%
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
Theatre within 36 hrs

AWSept2023



	3A	Other	Total	% outlier admissions
Jan	38	26	64	40%
Feb	31	36	67	54%
Mar	29	25	54	46%
Apr	42	43	85	51%
May	36	46	82	56%
June	23	49	72	68%
July	32	22	54	41%
August	31	41	72	57%

KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 9 October 2023

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
Retention Update	Reporting focused on Admin and Clerical staff group as known retention issues, large number of vacancies and increase in lever over past five years; • NHS pay rates uncompetitive compared to Amazon and hospitality. • Evidence that leavers going to GHC for promotion; • Top reasons for leaving included retirement, work life balance and promotion, with no surprises when considering ethnicity and age data. • No national pathway for career or progression support for admin and clerical staff. • Encourage staff to return after retirement. Work life balance also needed review.	Need to understand areas/services most impacted by Admin vacancies. Deep dive to be undertaken. Review exit data capture 'Retire and return' policy myth busting needed alongside work/life balance review.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Agency Controls	Workforce sustainability programme launched to review various workstreams including grip and control of agency reduction in medical and nursing teams. Significant effort going into the reduction of costs along with pressure from the system to reduce costs. The programme was structured and comprehensive	Process commended but feedback sought on impact within Medicine. Requested assurance that the plan was mapped out and key milestones were understood
EDI Attrition Data Update	Further review of data in relation to EDI, showed that there was no evidence to prove that a high number of ethnic minorities were adversely impacted in the recruitment process in comparison to white applicants. Data showed clustering between Bands 3 and 6.	Line managers do not have access ethnicity information until interview. Workforce feel this is not the case and further detail sought on percentages/bandings.
Staff Survey and NQPS update	Staff survey commenced 2 September 2023 with interesting feedback to date and not all staff aware of £5 reward voucher. Uptake, as at PODC, was 14% (>double 2022)	National Quarterly Pulse Survey also undertaken and results appeared to be improving (overall response and per division).

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.

	Team working with GMS to run a survey in parallel. Survey was in a positive place, but a lot more work was needed. Place to work and standard of care scores improving, but less favourable if "neutral" responses removed!".	
WRES/WDES	Race Equality Standard findings showed some improvement on last year, but overall continued to show that the experience for minority staff experiences' worse that white colleagues. Key metrics improved in all areas, but not to level that Trust wanted. Disability Equality Standard data challenging, due to staff not declaring their disability status.	"So what' action via EDI workforce group.
Health & Safety:	Report for information: • Water safety risk action plan has 116 actions of which (28 signed off, 35 awaiting sign off and 53 outstanding). • Planned HSE (Health & Safety Executive) inspection to look at two themes relating to violence and aggression. • GMS had competent persons in fire safety and was expected to ensure compliance with the First Safety Order and relevant HTM for fire safety in next 12 months. • No responsible person to advise within GMS on asbestos. • Entonox sampling continued with issues still within the birthing unit • 33 obsolete hoists being removed from the Trust. Risk H&S team working with divisions to ensure compliance with the health surveillance legal requirements and Trust policy.	Reviewed at Risk Management Group meeting. CQC position not known at present. Civil claim being managed by DAC Beachcroft LLP. New workstream for asbestos being developed. Work in progress Audit programme to mitigate the impact was underway. .
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Equality annual report	Provided for information and comment and also going to QPC. Need for consistent language and terminology flagged.	Communications team to monitor and enforce correct terms and language.
Items not Rated		
Risk Register, FTSU update and People Performance Dashboard – DEFFERED to next meeting ICS update		
Impact on Board Assurance Framework (BAF)		
SR3: Discussion on scoring in relation to ongoing confirmed that the score needed to be high due to ongoing pressures, but agreed to maintain score at 20. SR4: Staff Experience Taskforce work commended.		

Report to Public Board				
Date	09 November 2023			
Title	Quarterly Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training (April – June 2023)			
Author **Director/Presenter**	Dr Shyam Bhakthavalsala, Guardian of Safe Working Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO			
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

1. A total of 80 exception reports have been raised from the beginning of April 2023 to the end of June 2023.
2. No fines have been levied during that period.
3. The overall rate of exception reports has risen compared to the same reporting period the previous year. This will continue to be monitored to identify any trends, possibly in relation to industrial action.
4. Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £517.85 (32.75 additional hours worked.)
5. Total number of hours given as TOIL as result of exception reporting of additional hours worked: 1.5 hours.
6. The post of the Guardian of Safe Working remained vacant between April 2023 and September 2023. The administration associated with exception reporting was being overseen by the Medical Director's office during this period.
7. A new Guardian has been appointed from September 2023.

Recommendation

That the Board accepts the report for assurance and information.

Enclosures

Quarterly Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training.

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

For Presentation to Public Board
Thursday 9 November 2023

1. Executive Summary

1.1 This report covers the period of 1 April 2023 to 30 June 2023

1.2 During this period, there were 80 exception reports logged. Although this is significantly fewer than those in the previous quarter, still amounts to a 32.5% increase compared to the same reporting period last year.

1.3 Zero (0) fines were levied.

2. Introduction

2.1 Under the 2016 Terms and Conditions of Service (TCS) for Junior Doctors, the Trust provides an exception reporting process for working hours or educational opportunities that vary from those set out in work schedules. The Guardian oversees exception reports and assures the Board of compliance with safe working hour's limits. The Terms and Conditions have been updated in 2019, with further requirements being monitored.

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

High level data

Number of doctors / dentists in training (total):	496	
No. of trust doctors	225	
Total Junior doctors	496	
Amount of time available in job plan for guardian:	1PA	
Administrative support:	4Hrs	
Amount of job-planned time for educational supervisors: (first/additional trainees to maximum 0.5 SPA)		0.25/0.125 PAs

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department	
Department	**Additional training and trust grade vacancies**
ED	**2x ST1/2** **8X Trust Registrar**
Oncology	**1x Clinical Fellow Palliative care**
T&O	**4x Trust Dr (ST1)**
Surgery	**1x Ophthalmology Clinical Fellow** **1x Trust Registrar Anaesthetic** **2x Anaesthetic St3**
General Medicine	**1x Renal IMT2** **1x Cardiology St1/2** **1x Cardiology Clinical Fellow** **1x Respiratory IMT2** **4x Clinical Medical Education Fellow** **2x General Medicine St1** **2X Registrar COTE/Stroke** **13x Trust Registrar Acute Medicine**
Women's & Children's	**2x Trust Registrar St3 O&G** **1x Trust Registrar St5 O&G**

(Based on data available at time of writing)

4. Medical Agency and Bank for Junior Doctors

4.1 Data supplied by Finance.

4.2 The total expenditure on agency and bank locum cover, across all divisions, over the reporting period was £6,011,357.

4.3 The breakdown of medical agency and bank spend by quarter and division can be seen in the table below:

Locum agency spend

Division Summary	April	May	June
Diagnostics & Specialist	49,966	63,942	33,423
Medicine	330,036	302,465	412,511
Surgery	69,376	67,410	85,504
Women and Children	-	-	-

NHS Locum Bank Spend

Division Summary	April	May	June
Diagnostics & Specialist	71,698	75,634	61,694
Medicine	1,004,270	985,180	824,713
Surgery	365,772	430,273	315,783
Women and Children	199,243	155,072	107,392

5. Additional Costs

5.1 Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £517.85 (32.75 additional hours worked.)
Total number of hours given as TOIL as result of exception reporting of additional hours worked: 1.45 h

6. Exception Reports

6.1 The following exception reports were raised across the following specialties:

Exceptions Raised				
Specialty	***Working Hours***	***Educational Opportunities***	***Service Support Available***	***Of which, no. of ISCs***
A&E	3		1	
General Medicine	53	3	7	1
General Surgery	2			
Medical Oncology	2			
Obstetrics & Gynaecology	2			1
Paediatrics	2			
Geriatric Medicine	1			
Respiratory Medicine	1			
Surgical Specialties	2			
SUB-TOTALS	**68**	**3**	**9**	**2**
TOTAL EXCEPTION REPORTS inc. ISCs = 80				

7. Fines Levied

7.1 For the period 1 April 2023 to 30 June 2023, no fines have been levied.

8. Issues Arising

8.1 There were 2 ERs with immediate safety concerns, both of which related to the service support, i.e., FY1 doctors having to work or expected to work at a more senior level, or without additional support. Both these ERs have been closed with remedial actions in place with the trainee's consent.

9. Actions Taken to Resolve Issues

9.1 A new Guardian of Safe Working has been appointed from 01/09/2023 with 1 PA time allocation. The post remained unoccupied between April '23 to September '23, with most of the duties being carried out by the Medical director's office. Moving forward, the Medical Director's office would continue to undertake necessary data collection and support for preparing board reports, allowing the Guardian to focus on issues being raised through Exception Reports and follow up liaison with Junior Doctors.

9.2 The former Guardian of Safe Working followed up where necessary on any exception reports which were stalling at local level. This would often involve meeting with the junior doctor who raised the exception report and / or their supervising consultant. This will be continued by the new GOSW.

9.3 Any exception reports relating to education matters are referred to the Director of Medical Education, Dr Preetham Boddana, for oversight or follow up when necessary and any exceptions reports raising an immediate safety concern are being followed up by Guardian of Safe working and escalated to the Medical Director's office where necessary.

9.4 The administration for the Guardian of Safety Work Hours has not been as robust as it could have been, in particular that around monitoring, chasing and closing exception reports, due to capacity issues in the Medical Staffing team. The Medical Director's office is working with the department concerned so that exception reports are followed up and actioned within the agreed timeframes.

10. Junior Doctors Forum

10.1 The Junior Doctor's forum is expected to meet every other month and is a useful forum for juniors to raise any issue of concern and keep informed of current business issues within the Trust. This has not been occurring on a regular basis more recently, however with the election of the new forum and JDF chair, these meetings are expected to resume shortly.

11. Summary

11.1 A total of 80 exception reports have been raised from the beginning of April 2023 to the end of June 2023.

11.2 No fines have been levied during that period.

11.3 The overall rate of exception reports has risen compared to the same reporting period the previous year.

11.4 Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £517.85 (32.75 additional hours worked.)

11.5 Total number of hours given as TOIL as result of exception reporting of additional hours worked: 1.45 h

11.6 A new Guardian of Safe Working has been appointed from September 2023.

Author:	**Dr Shyam Bhakthavalsala, Guardian of Safe Working**
Presenting Director: and	**Prof Mark Pietroni, Director for Safety, Medical Director Deputy CEO**
Date:	**09.11.2023**

Recommendation

X For assurance

To approve

Appendices:

Link to rota rules factsheet:

Rota rules at a glance | NHS Employers

Link to exception reporting flow chart (safe working hours):

Safe-working-flow-chart-orange (nhsemployers.org)

Report to Board of Directors

Date	09/11/2023
Title	WRES/WDES Report and Action Plans
Author / Sponsoring Director/ Presenter	Author: Maria Smith, Associate Director of Education, Learning and Culture Sponsor: Dr Claire Radley, Director for People and OD

Purpose of Report (Tick all that apply ✓)

To provide assurance	✓	To obtain approval	
Regulatory requirement		To highlight an emerging risk or issue	
To canvas opinion		For information	✓
To provide advice		To highlight patient or staff experience	

Summary of Report

The Workforce Race Equality Standard (WRES) report for the year 2022/2023 and the Workforce Disability Equality Standard (WDES) report 2022/2023, provides a comprehensive overview of our Trusts commitment to Equality, Diversity and Inclusion with regards to Racial and Disability Equality, by following a framework to collect and analyse data on workforce racial and disability inclusion and colleague experiences, identifying actions to address any disparities identified.

For the WRES report, nine key metrics are assessed.

Metrics 1 to 4 and 9, are derived from our Electronic Staff Records (ESR) data as of 31st March 2023. This data offers insights into our Trusts racial diversity and inclusion efforts and covers the representation of ethnicity in various organisational roles, as well as promotion rates.

Metrics 5 to 8 is taken from the 2022 Staff Survey Results and focuses on the qualitative aspects of workplace inclusivity, including staff perceptions and experiences of racial discrimination, harassment, bullying and workplace culture. These survey results provide critical information to assess the lived experiences of our colleagues.

We have 3 High Priority Areas identified for improvement at GHFT:

- Indicator 6: Harassment, Bullying or abuse from staff in the last 12 months against BME staff **(22.25% BME vs 16.5% White)**
- Indicator 7: Belief that the Trust provides equal opportunities for career progression or promotion against BME staff **(41.1% BME vs 51% White)**
- Indicator 8: Discrimination from a manager/team leader of other colleagues in the last 12 months against BME Staff **(24% BME vs 8% White)**

Our WRES Action plan contains actions for all metrics, however, specific actions have been identified to address the High Priority Areas which include:

- Staff Experience Improvement Programme:
  - Addressing Discrimination Workstream
    - Allyship programme

        - Improve the experience of our Internationally Educated Colleagues
    - Teamwork and Leadership
    - Speaking up and Raising Concerns
    - Restorative and Just Culture
- The launching of a new leadership development pathway – for both incoming leaders, new to leadership and current leaders
- Cultural Competence Train the Trainer sessions for cascade training throughout the Trust
- Re-Launching of the Reciprocal Mentoring Programme

The WDES report contains the assessment of 10 key metrics.

Metrics 1 to 3, 9b and 10 captures information from our ESR data, providing insights into the representation of our disabled colleagues and their experiences.

Metrics 4 to 9a are based on the 2022 Staff Survey results, offering a deeper understanding of the challenges and opportunities faced by our disabled colleagues. These metrics encompass a wide range of aspects, from workplace accommodations to career development opportunities for disabled colleagues.

The recommended Metrics that require specific focus within our WDES Action Plan are:

- Metric 1: Disabled representation in the workforce (clinical) **(Trust representation is 2.8% since 2022, National average for 2023 is 5%, making GHT ranked 193/212)**

- Metric 2: Likelihood of appointment from shortlisting **(Likelihood ratio Non-disabled / Disabled 1.39 vs National 0.99, ranked 189/212 Trusts)**

- Metric 5: Career Progression **(Non-disabled 50.4% vs Disabled 43.9%, National average for Disabled colleagues is 52.1%)**

- Metric 6: Presenteeism **(Non-disabled 24.7% vs Disabled 36%, National average for Disabled colleagues is 27.7%)**

- Metric 7: Feeling Valued **(Non-disabled 34.8% vs Disabled 27.1%, National average for Disabled colleagues is 35.2%)**

- Metric 9a: Staff Engagement **(Non-disabled 6.4 vs Disabled 5.9, National average for Disabled colleagues is 6.42)**

- Metric 10: Disabled representation on the Board **(bottom ranked Trust 212 out of 212)**

All recommended metrics that require specific focus are more than 5.0% worse than national average (proportion, not percentage points).

Our WDES action plan not only identifies actions for the above highlighted areas of concerns but also to continue to build on changes made to improve the experience of our disabled colleagues.

Recent appointment for our Lead for Colleague Health and Wellbeing will be prioritising how our

disabled colleagues are supported within the organisation. The Disability Staff Network, which is part of our Inclusion Network, is being reviewed and relaunched to ensure that there is clear co-design of support, policies, procedures and guidance with insight and experience from our disabled colleagues. Focus will be on our Reasonable Adjustments and the co-creation of a Reasonable Adjustments policy, guidance and education for line managers to ensure an understanding of the process to follow and the support available.

Both the WRES and WDES reports serve as vital tools in evaluating our Trusts progress in promoting racial and disability equality, while also guiding future actions and initiatives with clear benchmarking against other organisations.

Risks or Concerns

C4009POD
C4010POD

Financial Implications

Whilst funding has been identified for the overarching cultural programme, specific activity and investment is required for progression of the EDI agenda. Some funds have been ring-fenced for the remainder of 23/24, but further funding will be required in the future.

Approved by: Director for People and OD	**Date: 06/11/23**

Recommendation

Board to note the Trust's WRES and WDES data and plans.

Enclosures

WRES 2023 Report
WRES 2023 Action Plan
WDES 2023 Report
WDES 2023 Action Plan

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Workforce Race Equality Standard 2022–2023

the **Best Care for Everyone**
care / listen / excel

Introduction

Welcome to the 2023 Workforce Race Equality Standard (WRES) Report. The WRES report enables the Trust to publish data on the employment experiences of our Black, and Minority Ethnic (BME) staff compared to those of our white staff.

The WRES was introduced in 2015, designed to demonstrate progress in ensuring colleagues from BME backgrounds have equal access to opportunities and receive fair treatment in the workplace.

Nine measures (metrics) enable NHS organisations to compare the experience of BME and white staff. The information provided within this report includes the data for the nine key WRES metrics and describes the actions taken during 2022 and those planned for 2023/24. These actions are based on areas for further development, identified and informed through the WRES metrics and action plan, and staff survey. Metrics 5 to 8 are based on the staff survey results for 2022.

At Gloucestershire Hospital NHS Foundation Trust (GHNHSFT), as at 31st March 2023, our Electronic Staff Records (ESR) data shows the following:

Workforce Data	2022/23 Headcount	2023	2021/22 Headcount	2022 %	% Difference
Total Workforce	8097		7740		
BME staff	1466	18.1%	1273	16.5	1.6% Increase compared to the previous year's data
White staff	5730	70.8%	5870	75.8%	5% Lower than the previous year's data
Ethnicity Unknown	901	11.1%	597	7.7%	Increase of 3.4% have unknown ethnicities on our ESR system

Aims

The aims of this report are to:

- Compare the workplace and career experiences of the Trusts EM and white staff, using data drawn from WRES reporting in 2023.
- Present high-level findings and analysis of the WRES metrics data.
- Highlight trends in NHS staff survey data published, covering the periods of 2022.
- Suggest actions that will improve the experiences of Ethnic Minority staff against each metric.
- Raise awareness of race equality within the Trusts workforce and outline some of the challenges that EM staff collectively experience at work.

WRES Metrics

WRES Metric	White, BME & Ethnicity unknown or Null
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2	Relative likelihood of staff being appointed from shortlisting across all posts
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4	Relative likelihood of staff accessing non-mandatory training and CPD
9	Percentage difference between the organisations' Board voting membership and its overall workforce

WRES Data
Non-Clinical Workforce

Indicator 1	Data Item	White 2022	BME 2022	White 2023	BME 2023	Ethnicity Unknown /Null
1a) Non-Clinical Workforce Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Under Band 1	5	4	10	2	2
	Band 1	4	1	4	0	0
	Band 2	391	35	177	22	20
	Band 3	497	40	469	43	32
	Band 4	228	12	231	19	25
	Band 5	140	17	143	14	10
	Band 6	146	13	135	22	15
	Band 7	75	3	72	3	4
	Band 8a	43	4	46	5	4
	Band 8b	29	3	35	2	1
	Band 8c	21	1	19	1	1
	Band 8d	11	1	10	1	1
	Band 9	3	0	2	0	0
	VSM	5	1	5	1	0

Clinical Workforce

Indicator 1	Data Item	White 2022	BME 2022	White 2023	BME 2023	Ethnicity Unknown/Null
1a) Clinical Workforce Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Under Band 1	31	2	23	5	20
	Band 1	0	0	0	0	0
	Band 2	669	164	811	223	128
	Band 3	205	39	262	50	17
	Band 4	188	8	217	22	138
	Band 5	868	488	781	494	261
	Band 6	952	149	987	193	63
	Band 7	488	42	509	62	30
	Band 8a	135	14	138	18	7
	Band 8b	42	2	44	1	1
	Band 8c	11	3	9	4	1
	Band 8d	4	1	5	1	0
	Band 9	3	0	4	0	1
	VSM	1	0	3	0	0
Of which Medical & Dental						
	Consultants	317	91	325	95	23
	Non-consultant career grade	80	70	64	81	39
	Trainee grades	278	65	280	82	57

Non-Clinical
BME representation has remained the same as the previous year but white representation has decreased slightly from 1,598 to 1,358.

Clinical
BME representation has increased from 912 to 1,073, white representation from 3,597 to 3,703.
.
The number of BME senior leaders (8a+) has increased from 30 to 34, with the highest representation in bands 8a and 8c.

There has been a decrease in bands 8b and no change to bands 8d and above.

Total BME representation in Band 8a+

Band	Total BME representation in Band 8a+	
B8a	23	increase of 4 since 2022.
B8b	3	decrease of 2 since 2022
B8c	5	increase of 1 since 2022
8d	2	No change to the previous year's data
B9	0	No change to the previous year's data
VSM	1	No change to the previous year's data

Indicator 2	Data Item	White	BME	Ethnicity Unknown/Null
2) Relative likelihood of staff being appointed from shortlisting across all posts	Number of shortlisted applicants	3709	1698	68
	Number appointed from shortlisting	1001	313	11
	Relative likelihood of appointment from shortlisting	26.99%	18.43%	16.18%
	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	1.46		

A figure above 1 indicates that BME staff are more likely to be appointed from shortlisting compared to white staff

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)

Likelihood of White staff being appointed from shortlisting compared to BME staff has increased by 0.17 from the previous year.

Indicator 3	Data Item	White	BME	Ethnicity Unknown/Null
3) Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on year end data.	Number of staff entering the formal disciplinary process	7	1	0
	Likelihood of staff entering the formal disciplinary process	0.12%	0.07%	0.00%
	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		0.58	

A figure equal to 1 indicates that BME staff are no more likely to enter the formal disciplinary process over white staff.

The data above indicates that white staff are more likely to enter a formal disciplinary process (0.12%) than BME staff (0.07%). The figure has decreased by 0.1 and shows that white staff are marginally more likely to enter a formal disciplinary process.

Indicator 4	Data Item	White	BME	Ethnicity Unknown/Null
4) Relative likelihood of staff accessing non-mandatory training and CPD	Number of staff accessing non-mandatory training and CPD	3150	1036	527
	Likelihood of staff accessing non-mandatory training and CPD	54.97%	70.67%	58.49%
	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	0.78		

BME staff are more likely to access non – mandatory training and Continued Professional Development compared to white staff, with 70.67% BME and 54.97% white staff.

The gap has decreased since 2022 by 0.5 decimal points, with white staff becoming less likely to access mandatory training/CPD. However, 58.49% of staff whose ethnicity is unknown are likely to complete their mandatory training too.

Indicator 5		2021	2022
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	White	29.9%	28.3%
	BME	37.6%	31.8%

31.8% of BME staff have experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, compared to 28.3% of white staff. Since the previous year, the figures have decreased for both ethnic categories, white (1.6%) and BME (5.8%).

Indicator 6		2021	2022
Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	White	26.5%	16.5%
	BME	34.6%	22.25%

22.25% of BME staff have experienced harassment and bullying abuse from staff in the last 12 months, compared to 16.5% of white staff. The figures have decreased for both ethnic categories White (10%) and BME (12.35%)

Indicator 7		2021	2022
Percentage believing that trust provides equal opportunities for career progression or promotion	White	56.4%	51%
	BME	35.7%	41.1%

41.1% of BME staff believe that the trust provides equal opportunities for career progression or promotion, compared with 51% of white staff. The figure for white staff has decreased by 7.7% however has increased by 5.4% for BME.

Indicator 8		2021	2022
In the last 12 months have you personally experienced discrimination at work from any of the following? Manager/team leader or other colleagues	White	7.7%	8%
	BME	24.9%	24%

BME staff are much more likely to experience higher levels of discrimination from managers, team leader or other colleagues, than their white colleagues. With 24% and 8% respectively. Since the previous year, there has been a marginal increase of 0.3% for white staff and a decrease of 0.9% for BME.

Indicator 9	Data Item	White	BME	Ethnicity Unknown/Null
9) Percentage difference between the organisations' Board voting membership and its overall workforce Note: Only voting members of the Board should be included when considering this indicator	Total Board Members	11	3	4
	Of which: voting board members	4	2	4

	Board
61.1%	Board members are white
16.7%	Board members are BME. (vs. 18.1% of the overall workforce)
40%	Board voting membership are White, a decrease of 30% compared to the previous year
20%	Board voting membership is BME, which a 10% decrease compared to the previous year.
40%	Overall Board have not declared their ethnicity on ESR
	Of the Trust Non-voting Board Members 87.5% of its members are white, 12.5% of the board IS BME. 11.5% last year

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Workforce Disability Equality Standard Report 2022–2023

the Best Care for Everyone
care / listen / excel

Introduction

Launched in 2019, the Workforce Disability Equality Standard (WDES) requires that all NHS organisations publish data and action plans against ten indicators of workforce disability equality, the aim being to improve the work experience of disabled staff. Each year, comparisons are made to enable the Trust to demonstrate progress against the indicators of disability equality. It also allows the Trust better understand the experiences of its disabled employees and support positive change for all by creating a more inclusive environment.

The data presented in this report will help the Trust create a more inclusive culture, by using a data driven approach to inform organisational change.

Workforce Data	Disabled	Non-Disabled	Unknown
	2.94%	51.24%	45.82%
Headcount			
8095	238	4148	3709

WDES Metrics

WDES Metric	Disabled, Non-disabled & Disability Unknown or Null
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2	Relative likelihood of non-Disabled staff compared to Disabled staff being appointed from shortlisting across all posts
3	Relative likelihood of non-Disabled staff compared to Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure (Metric based on data from a two-year rolling average)
4-9a	NHS Staff Survey data
9b	Has your organisation taken action to facilitate the voices of your Disabled staff to be heard?
10	Percentage difference between the organisations' Board voting membership and its overall workforce

Non-Clinical - Data Submission

Indicator 1	Data Item	Disabled	Non-Disabled	Unknown/Null
1a) Non-Clinical Workforce Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Under Band 1	0	1	13
	Band 1	0	1	3
	Band 2	12	84	123
	Band 3	24	285	235
	Band 4	16	132	127
	Band 5	6	88	73
	Band 6	3	99	70
	Band 7	5	39	35
	Band 8a	2	24	29
	Band 8b	4	18	16
	Band 8c	0	11	10
	Band 8d	0	6	6
	Band 9	0	1	1
	VSM	0	5	1

Clinical WDES - Data Submission

Indicator 1	Data Item	Disabled	Non-Disabled	Unknown/Null
1a) Non-Clinical Workforce Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce	Under Band 1	1	1	13
	Band 1	0	1	3
	Band 2	33	84	123
	Band 3	14	285	235
	Band 4	14	132	127
	Band 5	35	88	73
	Band 6	33	99	70

	Band 7	13	39	35
	Band 8a	7	24	29
	Band 8b	2	18	16
	Band 8c	0	11	10
	Band 8d	0	6	6
	Band 9	0	1	1
	VSM	0	5	1

Indicator 2	Data Item	Disabled	Non-Disabled	Unknown/Null
2) Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.	Number of shortlisted applicants	631	7719	426
	Number appointed from shortlisting	100	1703	204
	Relative likelihood of non-disabled being appointed from shortlisting compared to disabled staff	1.39		

The relative likelihood of non-disabled staff being appointed from shortlisted compared to disabled staff ratio is 1.39. Disabled applicants are less likely to be appointed from shortlisting than non-disabled candidates.

Indicator 3	Data Item	Disabled	Non disabled	Unknown/Null
3. **Relative likelihood of non-Disabled staff compared to Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure (Metric based on data from a two-year rolling average).**	Average number of staff entering formal capability process over the last 2 years for any reason (Total divided by 2)	4.5	25	21.5
	Of these, how many were on the grounds of ill health	4.5	24.5	14
	Likelihood of staff entering the formal capability process	0	0.000121	0.002022

Those with an unknown disability are much more likely to enter the formal capability process.

Indicator 4	Data Item	Disabled	Non disabled
Percentage of Disabled Staff compared to non-disabled staff experiencing harassment bullying or abuse from:	**(1) Patients/Service users, their relatives or other members of the public**	36.2%	27%
	Managers	20.7%	11.8%
	Other colleagues	28.2%	20.2%
Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment bullying or abuse at work they or a colleague reported it.		49.3%	44.3%

Staff with a disability are more likely to have experienced harassment, bullying or abuse at work from there managers and other colleagues.

Disabled staff are more likely to report incidents of harassment, bullying or abuse compared to non-disabled.

Indicator 5	Disabled	Non disabled
Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	44.5%	51.9%

Equal opportunities for career progression or promotion – 44.5% of disabled staff (4% decrease 2021/22) believed they had equal opportunities for career progression or promotion. This compares to 51.9% of non-disabled staff.

Indicator 6	Disabled	Non disabled

Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	35.9%	24.7%

35.9% of disabled staff say that they have felt pressured to come to work, despite not feeling well enough to perform their duties. This number has decreased compared to the previous year. Whereas the number has increased for non-disabled staff.

Indicator 7	Disabled	Non disabled
Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.	27.2%	34.8%

27.2% of colleagues with a disability feel that their work is valued compared with 34.8% of non-disabled colleagues. This is lower than the previous reporting period, where colleagues with disability were 29.4%.

Indicator 8	Disabled
Percentage of Disabled staff saying that their employer has made adequate adjustment(s)	72.3%

72.3% of colleagues with disability reported that they feel the Trust provides adequate adjustment(s). This has increased by 0.8% in the previous reporting period.

Indicator 9a	Org Overall	Disabled	Non-Disabled
The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation	6.3	5.9	6.4

Indicator 9b	Disabled
Has the organisation taken action to facilitate the voices of the disabled staff to be heard	Yes

The Trust's inclusion network is made up of Ethnic minority, LGTBQ+ and Disabled staff where colleagues can raise concerns and discuss planned actions for its' disabled colleagues.

The Trust has an established EDI steering group, providing the more senior leadership with time to focus on each strand of inclusion, including disability.

The Disability Network has made significant improvements moving the EDI agenda forward ensuring we continue to engage and evolve colleagues with disabilities and long-term conditions in our key decision making.

Indicator 10	Data Item	Disabled	Non disabled	Unknown/Null
Board vs Organisational Workforce	**Percentage difference between the organisation's Board voting membership and its organisation's overall workforce disaggregated.**	-2.94%	-31.24%	34.18%
	Total Board members percentage by disability	0%	38.89%	61.11%

The total Board members by percentage without disability is 38.89%, however, those who have not recorded their disability status is 61.11%.

KEY ISSUES AND ASSURANCE REPORT
Finance and Resources Committee, 26 October 2023

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
None		

Items rated Amber

Item	Rationale for rating	Actions/Outcome
GMS Key Issues and Assurance Report	A verbal update from the last GMS Board was provided. A red risk around recruitment was noted, difficulties in providing HR resource to GMS were noted and colleagues were looking at what more could be done to improve processes. Benchmarking of hard to fill roles was taking place and the Committee noted that some salaries were considerably behind those paid by agencies or the private sector. Another red risk around the year end position was also noted.	The KIAR was noted.
Financial Performance Report	At M6, the Trust was reporting a deficit of £13,043k; £3,839k adverse to plan; the drivers were noted. The Financial Sustainability Plan (FSP) target for the Trust was £34.7m. and year-to-date (YTD) the programme had delivered £13.3m of savings (£9.9m recurrent; £3.5m non-recurrent). The programme was slightly ahead of plan by £0.5m.	The Committee noted the seriousness of the position and received the contents of the report as a source of assurance that the financial position was understood. Reducing the £9.7m red-rated schemes would be the focus of work over the coming months
Financial Sustainability Report	At M6, year to date performance was better than plan by £0.6m driven primarily by timing of delivery. £13.3m of efficiencies had been delivered at M6, of which £3.5m was non-recurrent. The Committee noted that Patient Portal was on track but there was more work to do on cash release.	Divisions were working on mitigations to assure delivery against plan. It was agreed that the Business Case would be provided at the next meeting of this Committee. A productivity dashboard was being developed and this would come bi-monthly to FRC. In intervening months, a deep dive would take place into individual areas.
Capital Programme Report	At M6, additional NHSE funding of £2.2m had been approved and additional System contingency of £0.3m had been allocated to the Trust. This brought the forecast programme funding (including IFRS16) to £59.8m. Year to date, excluding IFRS 16 capital, the Trust had goods delivered,	CM and SP agreed to discuss the renal contract and consider if additional expertise could be utilised to review options. The student accommodation lease contract would be brought back to the

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.

	works done or services received to the value of £24.3m, against a planned spend of £28.1m; a variance of £3.8m. In month, the Trust delivered a £7.6m gross capital spend against a forecast of £6.0m. The £4.2m Renal Dialysis MES contract was being reviewed; it was believed that some equipment did not qualify as IFR16 and would move to system capital. It was reported that the current student accommodation lease being considered was not affordable.	next meeting.
Procurement Bi-Annual Reports	The Committee received the Procurement Bi-annual forward look report and Procurement Bi-Annual Performance and Assurance Report. Key risks including challenging market conditions and the mitigations in place were noted. The Committee discussed recruitment and retention issues affecting the service and the number of people moving around the ICS system to higher grade positions.	ET agreed to discuss the key risks with colleagues in the region and update the Committee. The Committee agreed to look at how evidence of the movement of staff across the ICS could be captured. This would be used to demonstrate how a system shared service approach might reduce service disruption.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Premises Assurance Model (PAM)	The 2023 PAM document was submitted in September and reflected the current status of the estate and associated services.	Going forward an action plan would be taken to GMS Board quarterly. It was agreed that the document must come to FRC before submission next time.
GMS Workforce Action Plan	The workforce action plan commenced in August 2022; progress against the actions was noted. Retention had improved, and enhanced rates for weekend and overtime work had made some positive impact. The biggest concern was now the time it took for onboarding of new starters.	The Committee welcomed the improved position and agreed that a more --- responsive and appropriate recruitment process was needed for GMS staff.
Move to Electrical Vehicles and Charging	The Committee received an update on the requirements and provisions for EV Charging on Trust estates, and looked at next steps to deliver this requirement if deemed appropriate. The NHS had committed to a 90% use of electric vehicles by 2028; the Trust and GMS currently had no fully electric vehicles and only a small number of hybrid vehicles	IQ agreed to look at working across the system to share vehicles and charging points. The Committee noted the report and agreed to provide feedback to IQ.

	within its fleet. There was no provision for EV charging within the Trust estate.		
Items not Rated			
	Project Completion Report Process	Contract Management Group Overview Report	
Business Cases and Investments			
Case	**Comments**	**Approval**	**Actions**
Gloucestershire Cancer Institute, OBC	The OBC sought approval for a charity funded £15 million development at CGH. This followed approval of the Strategic Outline Business Case by the Trust Board in November 2019. The scheme had been developed to reduce unwarranted variation in clinical quality and efficiency, and to improve cancer care.	APPROVED	Additional information on risks would be included when the report went forward to Board. The Committee APPROVED the development of a full business case (subject to the further information requested). DL and IQ to discuss a way forward to the FBC
Linac Business Case	The business case was approved by the capital equipment group and the capital delivery group on 17th October. FRC approval was needed due to the value of the funds required. The total request for funding was £2,131k from the 24/25 capital programme and the Committee noted that sufficient funds were included in the latest capital plan for 24/25.	APPROVED	The Committee APPROVED the case for a replacement linear accelerator. The Committee APPROVED the award of the contract to Varian Medical Systems UK Limited.
Impact on Board Assurance Framework (BAF)			
The Finance BAF was noted. The Estates BAF had been reviewed and updated.			

KEY ISSUES AND ASSURANCE REPORT
Finance and Resources Committee, 29 September 2023

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
Financial Recovery Overview	An accountability framework had been developed. Areas showing a reduction in run rate were noted, recovery plans for each division were available. All investments and corporate vacancies had been reviewed. Medicine had been put into enhanced oversight but there had been limited outputs so far. Actions in place were noted.	

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Medium Term Financial Plan	NHSE had set out a requirement for systems to produce a MTFP covering three years (with the first year being 2023/24). The updated plan was required to show how recurrent balance would be delivered. It was agreed that the Trust's run rate in 23/24 would improve by £1.5m recurrently. In addition, the FSP target would increase to 3% which would give a c£4m improvement. A target around productivity of £3m was included as the implied opportunity was suggesting £114m. These improvements would bring the Trust's external saving target to £27.9m which was £900k higher than the internal target.	The Committee received the report as a source of assurance that the financial position was understood and SUPPORTED the inclusion of the position presented in the ICS submission on the 29 September.
Financial Performance Report	The Committee noted that at M5 and reported that the system continued to predict break even. The Trust was reporting a deficit of £10,869k which was £2,437k adverse to plan. The drivers of this position were noted, including industrial action. These were being offset by underspends within corporate areas and the release of reserves. Agency spend for this year was lower than the previous year.	The agency spend for this year and the previous year would be shared with the Committee. The Committee received the contents of the report as a source of assurance that the financial position was understood.
Financial Sustainability Report	The committee noted the position at M4. HB reported that year to date performance was better than planned by £0.1m, driven primarily by timing of delivery. There continued to be pressure on the overall programme to the value of £10.8m. Actions were in place to mitigate this risk, including seeking specialist external support for a short-term piece of programme scoping which would include identification of potential	KJ agreed to share the improvement actions agreed at a recent ICB meeting.

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

	savings. Divisions had started identifying areas for improvement including 600 agency shifts being replaced by bank. The overall position had improved by £0.5M on the previous month. The Committee noted that the Efficiency Board continued to push the £14.2M programme and new governance process were being put into place for the £12.4m programme.	
Capital Programme Report	At the end of August (M5), additional NHSE funding of £2.2m had been approved to support ERCP and CT Scanner projects. Expected in-year donations of £0.5m included in the Plan were yet to be secured, resulting in a current funded programme of £58m. Year to date, excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £15.5m, against a planned spend of £23m; a variance of £7.5m. This left £42.5m of non-IFRS 16 capital to deliver in the remainder of 23-24. Costs were awaited from the contractors for the statutory fire works required in Kemerton.	The Committee noted the M5 capital position detailed within the report. Costs for the statutory fire works in Kemerton would be included in the programme when available.
Digital Transformation Report	The overview of the digital programme for the current financial year, delivered as part of the five-year digital strategy 2019-24 was noted. Updates were provided on projects, reported under the five programmes: • Sunrise EPR • Clinical Systems Optimisation • Business Intelligence • Infrastructure • Cyber Security and Information Governance:	The Committee noted the update.
Digital Strategy and progress against predicted targets	The Trust had been awarded HIMMS Level 5. Level 6 was not quite reached due to complex issues around prescribing. There were some gaps, which were being worked through and funding was in place for next year. The new Strategy would focus on benefits of work undertaken so far, and embed and ensure stability.	The Committee noted the report and agreed that it was a significant achievement to be awarded Level 5.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None		
Items not Rated		
Digital Risk Register		

Business Cases and Investments			
Case	**Comments**	**Approval**	**Actions**
Award of M&E Measured Terms Contract and uplift of the Building MTC limit	The Committee APPROVED the three-year limit for the MTC Building works, which were awarded in March 2023 be uplifted from £1,000,000 to £3,000,000 over the three-year period.	APPROVED	
Procurement of 2Nr. IR Lab Equipment	The Committee gave APPROVAL for an order to be placed with Siemens Healthineers for the purchase of the medical equipment required to install into 2Nr. Interventional Radiology rooms as part of the IGIS project**.**	APPROVED	
Impact on Board Assurance Framework (BAF)			

Report to Board				
Date	9 November 2023			
Title	M6 Financial Performance Report Month Ended 30 September 2023			
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

This purpose of this report is to present the financial position of the Trust at Month 4.

Revenue
The Trust is reporting a year to date (YTD) deficit of £13.043m which is £3.8m adverse to plan. This is the position after adjusting for donated assets impact and Salix grant.
The ICS YTD deficit position of £14.9m which is £6m adverse to plan. This is the result of a £3.8m adverse to plan position from GHFT, a £0.8m YTD deficit position at GHC and a £3m deficit position at GICB.

Capital
The Trust is reporting a YTD position of £24.3m against a planned spend of £28.1m which is a variance of £3.8m. This excludes IFRS 16 capital.

The Trust is reporting a breakeven forecast outturn in line with the plan.

Recommendation

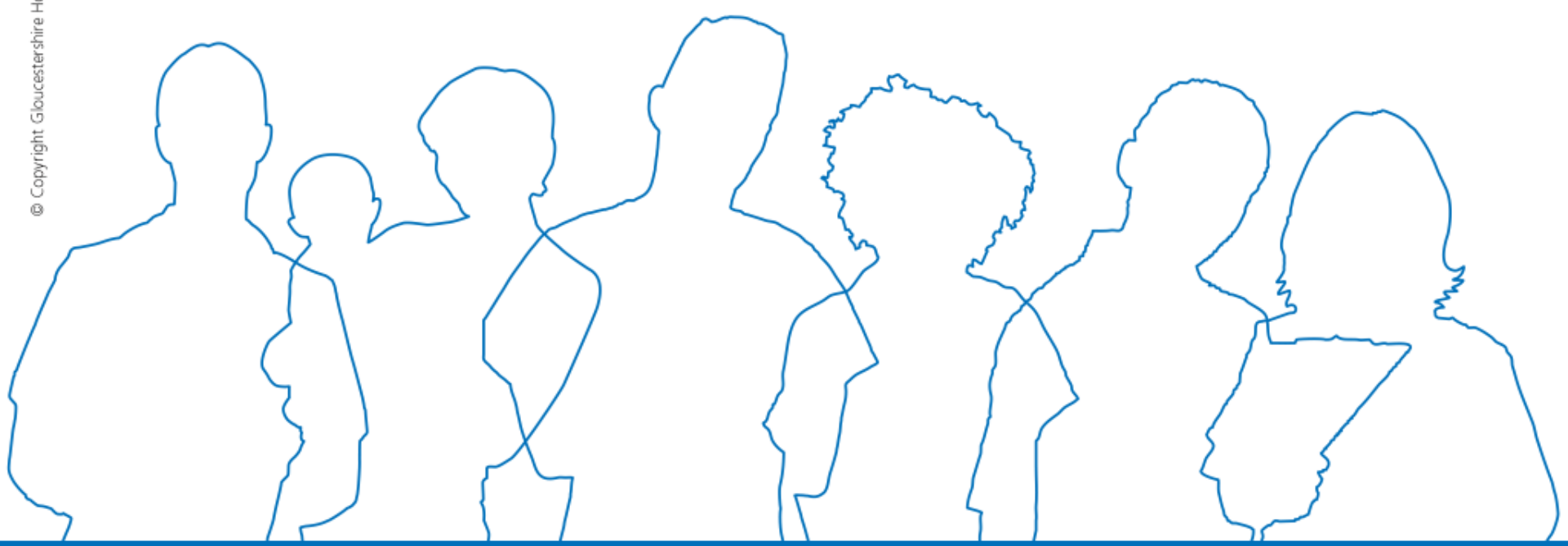
The Board is asked to **RECEIVE** the contents of the report as a source of assurance that the financial position is understood.

Enclosures

Gloucestershire Hospitals
NHS Foundation Trust

Report to the Finance & Resources Committee

Financial Performance Report
Month Ended 30th September 2023



Gloucestershire Hospitals
NHS Foundation Trust

Revenue & Balance Sheet

Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

System Overview

The ICS is required to breakeven for the year. At month 6, all organisations within the system are forecasting to deliver to a breakeven financial position at year-end in line with the plan.

The ICS year-to-date (YTD) deficit position of £14.9m which is £6m adverse to plan. This is the result of a £3.8m adverse to plan position from GHFT, £0.8m favourable position at GHC and a £3m adverse variance at GICB due to prescribing cost pressures. Actions are underway across the system to identify mitigations to offset these pressures.

Month 6

M6 YTD Financial position is reporting a deficit of £13,043k which is £3,839k adverse to plan. The position includes :

- Industrial Action costs £2,014k
- AfC Pay Award pressure £402k and PFI indexation above planned inflation £372k
- Net impact of elective activity underperformance £4,140k, including £2,550k due to IA and £1,590k due to productivity
- GICB support to fix elective element of contract to offset underperformance £1,800k benefit
- Unfunded nursing for Courtyard (10-18 patients) and AMU at GRH (26 unfunded beds open) £1,271k
- SDEC open after 23:00 £130k
- FAS - up to 8 additional patients £154k
- Guiting - 3 additional patients £204k
- Ward 4b - swing bay is open without funding (6 patients) £446k
- Ward 7b - 2 RNs providing care for one patient each day £338k
- DTAs in ED - can be up to 50 (budget can cover 20) £1,722k
- Overseas Nursing Supernumerary costs £1,485k
- Interest receivable and payable lower than plan £2,449k benefit
- Reserves £10,254k benefit
- Release of prior year accruals (corporate) £1,215k

The Financial Sustainability Plan (FSP) target for the Trust is £34.7m in 23/24 and year-to-date the programme has delivered £13.3m of savings (£9.9m recurrent; £3.5m non-recurrent). The programme overall is slightly ahead of plan by £0.5m. However, the FSP programme target increases over the latter part of year and there remains significant risk of delivery due to £9.7m red-rated schemes. Reducing this will be the focus of work over the coming months.

Month 6 headlines

Gloucestershire Hospitals NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £13m deficit which is £3.9m adverse to plan		I&E Position YTD is £13m deficit which is £3.9m adverse against the plan of £9.2m deficit.
Income is £372m YTD which is £11.6m favourable to plan		M6 income position is £372m YTD which is £11.2m favourable to plan. This is driven by GMS reporting additional income due to pay award funding and capital margin. It is also driven by overperformance of pass through drugs and HEE income which is netting off underperformance on elective contracts. Further information is on the Activity slide.
Pay costs are £238m YTD which is £14m adverse to plan		Pay costs are £238m YTD which is £14m adverse to plan. Pressures include Industrial Action costs and covering escalation & vacancies within ED, Acute Medicine, theatres and trauma.
Non Pay costs are £142.6m YTD which is £0.8m adverse to plan.		Non Pay costs (included non-operating costs) are £142.6m YTD which is £0.8m adverse to plan. This position includes overspends on clinical supplies within the Surgery Division, increased PFI costs due to indexation and pressures due to high energy costs.
Delivery against Financial Sustainability Schemes		The Financial Sustainability Plan (FSP) target for the Trust is £34.7M. In Month 6, the Trust had planned efficiencies of £12.9M and achieved £13.4M.
The cash balance is £47.9m		Cash has reduced by £14.7m in month due to capital expenditure. Delivery of financial sustainability schemes is essential to ensure that cash is available in order to meet expenditure commitments.

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 ICBs:

- 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 6 YTD position is below.
The System is also required to monitor against these metrics plus achievement of Mental Health Standard.

Group Position	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Financial efficiency – variance from efficiency plan	12,864	13,397	533
Financial stability – variance from breakeven*	(9,204)	(13,043)	(3,839)
Agency spending against ledger budget	(4,199)	(10,457)	(6,259)
**adjusted position*			

The Trust is adverse to plan for Financial Stability and Agency Spending.

It is favourable to plan for Financial Efficiency. It is expected that this will deteriorate in future months because many FSP plans are phased to deliver in the latter part of the year and there remain high risk schemes totalling £9.7m.

M6 Group Position versus Plan

Gloucestershire Hospitals NHS Foundation Trust

The financial position as at the end of September 2023 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 September the Group's consolidated position shows a deficit of £13m deficit which is £3.8m adverse to plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 6 Financial Position	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**	**Plan £000s**	**Actuals £000s**	**Variance £000s**
SLA & Commissioning Income	332,830	333,703	874			0	332,830	333,703	874
PP, Overseas and RTA Income	2,077	2,654	577			0	2,077	2,654	577
Other Income from Patient Activities	5,994	7,204	1,210			0	5,994	7,204	1,210
Operating Income	23,844	25,892	2,048	35,676	44,964	9,288	20,044	28,628	8,584
Total Income	**364,744**	**369,453**	**4,709**	**35,676**	**44,964**	**9,288**	**360,944**	**372,189**	**11,245**
Pay	(216,849)	(224,553)	(7,704)	(12,123)	(14,113)	(1,990)	(224,197)	(238,457)	(14,260)
Non-Pay	(147,877)	(151,306)	(3,428)	(22,280)	(30,271)	(7,991)	(136,390)	(139,558)	(3,169)
Total Expenditure	**(364,727)**	**(375,859)**	**(11,132)**	**(34,403)**	**(44,384)**	**(9,981)**	**(360,586)**	**(378,015)**	**(17,429)**
EBITDA	**17**	**(6,406)**	**(6,423)**	**1,273**	**580**	**(693)**	**358**	**(5,826)**	**(6,184)**
EBITDA %age	**0.0%**	**(1.7%)**	**(1.7%)**	**3.6%**	**1.3%**	**(2.3%)**	**0.1%**	**(1.6%)**	**(1.7%)**
Non-Operating Costs	(5,006)	(2,422)	2,584	(1,273)	(580)	693	(5,346)	(3,002)	2,345
Surplus / (Deficit)	**(4,988)**	**(8,827)**	**(3,839)**	**0**	**0**	**(0)**	**(4,988)**	**(8,827)**	**(3,839)**
Dontated Asset, Impairment & Salix Grant Adjustment	(4,216)	(4,216)	0	0	0	0	(4,216)	(4,216)	0
Adjusted Surplus / (Deficit)	**(9,204)**	**(13,043)**	**(3,839)**	**0**	**0**	**(0)**	**(9,204)**	**(13,043)**	**(3,839)**

* Trust position excludes £20m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £42m of inter-company transactions, including dividends

Balance Sheet

	Group Closing Balance 31st March 2023 £000	GROUP Balance as at M6 £000	B/S movements from 31st March 2023 £000
Non-Current Assests			
Intangible Assets	16,483	14,431	(2,052)
Property, Plant and Equipment	357,717	368,592	10,875
Trade and Other Receivables	3,901	3,838	(63)
Investment in GMS	0	0	0
Total Non-Current Assets	**378,101**	**386,861**	**8,760**
Current Assets			
Inventories	12,312	13,603	1,291
Trade and Other Receivables	46,622	34,620	(12,002)
Cash and Cash Equivalents	49,193	47,868	(1,325)
Total Current Assets	**108,127**	**96,091**	**(12,036)**
Current Liabilities			
Trade and Other Payables	(104,686)	(94,874)	9,812
Other Liabilities	(11,160)	(22,729)	(11,569)
Borrowings	(5,904)	(6,049)	(145)
Provisions	(7,929)	(8,766)	(837)
Total Current Liabilities	**(129,679)**	**(132,418)**	**(2,739)**
Net Current Assets	**(21,552)**	**(36,327)**	**(14,775)**
Non-Current Liabilities			
Other Liabilities	(7,603)	(5,291)	2,312
Borrowings	(41,793)	(43,358)	(1,565)
Provisions	(2,824)	(2,824)	0
Total Non-Current Liabilities	**(52,220)**	**(51,473)**	**747**
Total Assets Employed	**304,329**	**299,061**	**(5,268)**
Financed by Taxpayers Equity			
Public Dividend Capital	397,288	400,848	3,560
Equity	0	0	0
Reserves	28,113	28,113	(0)
Retained Earnings	(121,073)	(129,900)	(8,827)
Total Taxpayers' Equity	**304,329**	**299,061**	**(5,268)**

Gloucestershire Hospitals
NHS Foundation Trust

The table shows the M6 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, of which £1.5m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £55.8m.

As at the end of September (M6), additional NHSE funding of £2.2m had been approved and additional System contingency of £0.3m has been allocated to the Trust. This brings the forecast programme funding (including IFRS 16) to £59.8m.

YTD Position

As of the end of September (M6), the Trust had goods delivered, works done or services received to the value of £24.3m, against a planned spend of £28.1m, equating to a variance of £3.8m behind plan.

In month, the Trust delivered a £7.6m gross capital spend against a forecast of £6.0m.

The current internal forecast outturn position is showing a gross capital spend of £66.2m versus a gross forecast funded position of £59.8m, a £6.4m overspend. This position comprises a £5.0m overspend within System capital projects, a £5.5m overspend on IFRS 16, and a £4.1m underspend in National Programme funded projects.

The £5.5m increase in relation to IFRS16 capital has been reported to NHSI in the M6 Provider Financial Return (PFR) as a result of the revised IFRS 16 assessments. The system capital and national programme forecast variances have yet to be reported within the PFR but conversations have begun, alerting the region of our position since the M6 close.

The Trust are looking at various mitigations to the forecast variances internally as well as involving our system partners and the region should the variances require some additional support to resolve. This paper outlines the current working assumption around the proposed mitigations that have been identified.

23/24 Programme Funding Overview

Gloucestershire Hospitals NHS Foundation Trust

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m, of which £1.5m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £55.8m. As at the end of September (M6), additional NHSE funding of £2.2m had been approved and additional System contingency of £0.3m has been allocated to the Trust. This brings the forecast programme funding (including IFRS 16) to £59.8m.

The current forecast funding can be divided into the following components; Operational System Capital (£26.2m), National Programme (£22.6m), STP Capital – GSSD (£0.6m), IFRIC 12 (£1.1m), Government Grant (£6.7m), Donations (£1.1m) and IFRS16 capital (£1.5m).

The breakdown of secured funding is shown in the below.

in £000's

		Plan	Forecast	Variance	Secured
DIGITAL	Digital	5,700	5,700	0	5,700
MEDICAL EQUIPMENT	Medical Equipment	5,996	5,981	15	5,981
ESTATES	Estates	14,192	14,207	(15)	14,207
CENTRAL CONTINGENCY	Central Contingency	0	286	(286)	286
Total Charge against Capital Allocation (excluding impact of IFRS 16)		**25,888**	**26,174**	**(286)**	**26,174**
RIGHT OF USE ASSET	Right Of Use Asset	1,478	1,478	0	1,478
Total Charge against Capital Allocation (including impact of IFRS 16)		**27,366**	**27,652**	**(286)**	**27,652**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Image Sharing	326	174	152	174
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	iRefer	0	152	(152)	152
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Digital Pathology	115	115	0	115
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Equipment 22/23	451	451	0	451
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Enabling works	4,185	4,185	0	4,185
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Digital	2,540	2,540	0	2,540
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	5th Orthopaedic Theatre	8,703	8,703	0	8,703
NAT PROG: RIGHT OF USE ASSET: NEW	Leases: Community Diagnostic Centre	4,098	4,098	0	4,098
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	CT Scanner	0	954	(954)	954
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	Endoscopic Retrograde Cholangiopancreatography (ERCP)	0	1,251	(1,251)	1,251
STP PROGRAMME: GSSD	Gloucestershire Hospitals Strategic Site Development	561	561	0	561
IFRIC 12	PFI Lifecycle	1,126	1,126	0	1,126
DONATIONS VIA CHARITABLE FUNDS	Gamma Camera	514	514	0	514
DONATIONS VIA CHARITABLE FUNDS	Jet Ventilator	61	61	0	61
DONATIONS VIA CHARITABLE FUNDS	2 incubators for SCBU GRH	0	31	(31)	31
DONATIONS VIA CHARITABLE FUNDS	Other potential charitable donations	500	469	31	0
GRANT	PSDS 3a Salix (Grant Funded)	6,724	6,724	0	6,724
Total Additional Capital		**29,904**	**32,109**	**(2,205)**	**31,640**
Gross Capital Funding Total (including IFRS 16)		**57,270**	**59,761**	**(2,491)**	**59,292**
Excluding IFRS16		(1,478)	(1,478)	0	(1,478)
Gross Capital Funding Total (excluding IFRS 16)		**55,792**	**58,283**	**(2,491)**	**57,814**

23/24 Programme Spend Overview

Gloucestershire Hospitals NHS Foundation Trust

As of the end of September (M6), the Trust had goods delivered, works done or services received to the value of £24.3m, against a planned spend of £28.1m, equating to a variance of £3.8m behind plan.

In month, the Trust delivered a £7.6m gross capital spend against a forecast of £6.0m.

Capital Programme Year-to-Date expenditure by programme area is shown in the below.

in £000's	In Month			Year to Date		
	Last Forecast for this Month £000's	In Month Actual £000's	Variance to Last Month Forecast £000's	Plan £000's	Actual £000's	Variance to Plan £000's
DIGITAL	588	502	86	1,880	1,851	29
MEDICAL EQUIPMENT	137	23	114	2,963	318	2,644
ESTATES	1,614	2,572	(957)	8,373	9,914	(1,541)
22/23 VAT RECLAIMS	0	0	0	0	(593)	593
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**2,340**	**3,097**	**(757)**	**13,216**	**11,490**	**1,726**
RIGHT OF USE ASSET	1,918	3,090	(1,172)	549	4,307	(3,758)
Total Charge against Capital Allocation (including impact of IFRS 16)	**4,258**	**6,187**	**(1,930)**	**13,765**	**15,797**	**(2,032)**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	35	3	32	441	38	403
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	543	613	(69)	4,324	1,827	2,497
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	111	(211)	322	3,733	547	3,186
NAT PROG: RIGHT OF USE ASSET: NEW	375	375	(0)	0	375	(375)
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	0	0	0	0	0	0
STP PROGRAMME: GSSD	0	0	0	561	561	0
IFRIC 12	94	94	0	563	563	0
DONATIONS VIA CHARITABLE FUNDS	0	31	(31)	575	31	544
GRANT	585	509	75	4,154	4,567	(413)
Gross Capital Spend Total	**6,000**	**7,602**	**(1,601)**	**28,116**	**24,305**	**3,811**
Exluding IFRS16	(1,918)	(3,090)	1,172	(549)	(4,307)	3,758
Gross Capital Spend Total (excluding IFRS 16)	**4,082**	**4,511**	**(429)**	**27,567**	**19,998**	**7,569**

Recommendations

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a deficit of £13,043k which is £3,838k adverse to plan.
- Note the Trust capital position as of the end of September 2023.

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**
Board Date:	**November 2023**

KEY ISSUES AND ASSURANCE REPORT Audit and Assurance Committee, 26 September 2023		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
There were NO items rated as RED.		
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Matters arising	Three important actions remain open from previous meeting which will hopefully be closed by next meeting: • External audit lessons learned review on 6 October 2023 • More Committee time to be spent on audit plan in future • Audit improvement plan being progressed.	Noted progress and plan to close in November 2023.
Internal Audit	***Progress report*** Received and noted. Key findings from two audits were noted: ***Workforce Planning audit report*** • Workforce planning had previously been financially driven and scope exists to further improve the collaboration across finance, operations and workforce • Opportunities for Divisions and business partners to have greater involvement d in workforce planning to improve efficacy of plans., • Ineffective engagement and ownership of workforce planning from managers • No formal check and challenge process in place to monitor performance against workforce plans across the year. ***Appraisals and Revalidation audit report*** • Draft policy not finalised, requiring update and approval. • Complaints reports not always available for the appraisal due to Complaints team capacity, even with three weeks' notice. ***Follow Up Report*** Update on progress made since the last meeting with a number of actions being closed, although disappointment at amount of effort required to do this. Long overdue risks from older audits would be reviewed to determine their value and relevance to ensure appropriate effort on follow up.	Updates on action plans to progress recommendations from both audits will be reported to future meetings. New process to be implemented to progress follow-up actions with Trust Secretary supporting BDO on this.

Risk Assurance Report	Key issues were noted: • No new risks; one downgrade and one closure. • 30 risks on Trust Risk Register (TRR) and moved to a single score approach as part of new Risk Management Strategy • Datix Cloud "go live" on 3 October 2023 will show risk patterns; incident reporting to follow at end of October 2023. • Over 100 risks to be reviewed with 30-40% expected to close and 30% specialty risks.	Twice weekly training sessions were happening in readiness for Datix Cloud launch, but some technical system difficulties alongside the absence of a "sandbox" training environment had impacted on these. "Go/No Go" decision would sit with Risk Management Group.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
External audit progress report	Verbal update from Deloitte the audit manager confirmed the Trust's audit certificate for FY23 had been issued and that both the charity and GMS certificate and accounts would be approved and finalised by the end of September, concluding the Group audit as fully complete.	Noted lessons learned review meeting scheduled to discuss and identify improvements for future audits.
Counter Fraud Report	Key points were noted: • Revised Counter Fraud, Bribery and Corruption Policy reviewed • Report on two new cases since last meeting alongside five closed cases with details of sanctions imposed. • Work underway to show "savings" from cases being addressed.	AAC RATIFIED the revised Counter Fraud, Bribery and Corruption Policy subject to minor update to differentiate between types of cautions.
GMS report	Key points were noted: • Accounts to be finalised 29 September 2023 • Staff engagement audit report sent to BDO • No counter fraud issues • Insurance claims reduction (15 to 12 over year) • Workforce and recruitment inflation identified as a risk. • Increase in retention and training compliance. • Interim leadership arrangement continued but two new NEDs appointed.	Discussed impact of new GMS committees on follow-up actions and how the Trust could best support. Staff engagement audit to be reviewed at next meeting
Losses and Compensations Report	The Committee noted three ex-gratia payments totalling £1,072.00 and approved the write off of 56 invoices.	None.
Single Tender Actions Report	Two waivers were processed during the reporting period, with a value of £262,955. No retrospective waivers.	None.
HFMA self-assessment	Key points were noted: • Ownership of and progress on actions identified from initial self-assessment and BDO internal audit • Eight of 17 actions completed to date with nine in progress.	Five of these would close post-launch of budget holder e-learning launches at the

	• System wide approach to financial controls to share learning and practice.	end of month (subject to resolution of technical issues).
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
No significant changes noted.		