Gloucestershire Hospitals NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
10.15, Thursday 13 October 2022
Lecture Hall, Redwood Education Centre, Gloucestershire Royal Hospital
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			10.15
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 8 September 2022**	Approval	Enc 1	10.20
5	**Matters arising from Board meeting held on 8 September 2022**	Assurance		
6	**Staff Story** *Katie Parker-Roberts, Head of Quality*	Information	Presentation	10.25
7	**Chief Executive's Briefing** *Deborah Lee, Chief Executive Officer*	Information	Enc 2	10.45
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	11.00
9	**Trust Risk Register** *Mark Pietroni, Medical Director*	Assurance	Enc 4	11.10
10	**Quality and Performance Committee Report** *Alison Moon, Non-Executive Director, Matt Holdaway, Chief Nurse and Director of Quality, and Qadar Zada, Chief Operating Officer*	Assurance	Enc 5	11.20
11	**Maternity Reports** *Matt Holdaway, Chief Nurse and Director of Quality*	Assurance	Enc 6	11.50
	Break (12.00-12.10)			
12	**Finance and Digital Committee Report** *Robert Graves, Non-Executive Director, Karen Johnson, Director of Finance and Mark Hutchinson, Executive Chief Digital and Information Officer*	Assurance	Enc 7	12.10
13	**Audit and Assurance Committee Report** *Claire Feehily, Non-Executive Director*	Assurance	Enc 8	12.30
14	**Estates and Facilities Committee Report** *Mike Napier, Non-Executive Director*	Assurance	Enc 9	12.40
15	**Any other business**		None	12.50
16	**Governor Observations**			
	Close by 13.00			

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 8 September 2022, 13.15, Lecture Hall Redwood Education Centre			
Chair	Deborah Evans	DE	Chair
Present	Alex D'Agapeyeff	ADA	Interim Medical Director and Director of Safety
	Robert Graves	RG	Non-Executive Director
	Steven Hardy	SH	Associate Chief Information Officer (deputising for MH)
	Balvinder Heran	BH	Non-Executive Director
	Matt Holdaway	MHo	Chief Nurse and Director of Quality
	Karen Johnson	KJ	Director of Finance
	Simon Lanceley	SL	Director of Strategy and Transformation
	Alison Moon	AM	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Interim Chief Executive Officer
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director for People and Organisational Development
Attending	Mark Aslam	MA	Clinical Lead for Organ Donation (item 11 only)
	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Anoushka Duroe-Richards	ADR	Arts Coordinator and Patient (item 6 only)
	Micky Griffiths	MG	Programme Director (item 12 only)
	Jess Gunn	JG	Guardian of Safe Working Hours (item 17 only)
	Katie Parker-Roberts	KPR	Head of Quality and Freedom to Speak Up Guardian (item 6 only)
Observers	Five governors, staff members and members of the public observed the meeting virtually. Two governors, including the Lead Governor, observed the meeting in person.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting. Colleagues from Unison attended to deliver a petition entitled *"Healthcare assistants provide vital patient care, and often undertake a wide range of duties crucial to supporting other clinical staff and their patients. We, the undersigned, call on Gloucestershire Hospitals NHS Foundation Trust to pay band 2 healthcare assistants/clinical support workers who are currently undertaking band 3 roles and duties at band 3 rate. All healthcare assistants deserve pay justice."* The Board formally received the petition and thanked Unison for attending. DE advised the Board that the Trust's Annual Members' Meeting had been postponed until 27 October due to a delay in finalising the accounts, as auditors could not conclude their work until the final CQC reports had been received. DE formally thanked ADA and MP for their work during their terms as Interim Chief Executive Officer and Interim Medical Director. DE also thanked Alan Thomas for his work during his term as Lead Governor, which would end at October's Annual Members' Meeting. The Board was advised of continued corporate governance improvements, including changes to the format of board meetings and scheduling.
2	**Apologies for absence** Claire Feehily, Non-Executive Director, Marie-Annick Gournet, Non-Executive Director, Mark Hutchinson, Executive Chief Digital and Information Officer, Qadar Zada, Chief Operating Officer.

Unconfirmed

3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 14 July 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 14 July 2022** All matters arising were noted.
6	**Staff Story** The Board heard from ADR, a patient of the Trust who was also a member of staff. ADR told the powerful story of her journey since being diagnosed with incurable ovarian cancer. ADR explained how she had dealt with incredibly difficult circumstances during the pandemic, including a stay in hospital over the Christmas period which was isolating and unnecessary. ADR had experienced some systems that had not easily allowed the best care for patients and often felt that she was not listened to. However, she stressed that every staff member she had encountered had been helpful and clearly only wanted to provide the best possible care. ADR had used her expertise to identify issues within the organisation in relation to environment and maintenance that would make significant improvements to other people using the Trust's services. The Board was moved by the story, and committed to improve the pathway for other women to ensure that people were treated as people, not just patients.
7	**Chief Executive's Briefing** MP briefed the Board as follows: • The new Prime Minister and Secretary of State for Health had announced an "ABCD" (ambulances, backlogs, care, doctors and dentists) programme for the NHS. Organisations awaited any change in policy. • Covid was now being treated as business as usual throughout the organisation. Covid and flu jabs would be available to staff in the next few weeks. • The draft CQC well-led report had been received; a factual accuracy check had been undertaken and returned, with the final report expected by 22 September. The Board had received and discussed the warning notices for Surgery and Maternity, and a reinspection of these services was anticipated. • The Trust continued to be amongst the worst-performing Trusts in the country for ambulance handover delays, although some slight improvement had been seen throughout August. The Trust was being monitored on a weekly basis, with information submitted to NHSEI. The Trust continued to review the improvements it could make as an individual organisation, along with exploring opportunities as a partner within the health system. • There continued to be significant issues within hospitals and the community to ensure an efficient pathway for Medically Optimised for Discharge patients; the local health system continued to look to ensure efficient use of resources to make pathways as effective as possible. • The Trust had implemented an emergency angiography pathway, which ADA had led. The service was available on a 24/7 basis. • MP raised the cost-of-living crisis, noting that it was important that the Trust supported staff who were struggling. Although the Trust does not set payscales, there were things that the organisation could do to help, including looking to top up salaries of lowest paid staff to the Real Living Wage. • MP wished to thank the executive team and ADA who had supported him during his time as Interim Chief Executive.

	• MP advised the Board that urgent and emergency care was now at the top of the agenda for the ICB. DE confirmed that the ICB Chair was willing to visit the Trust, and GHT and GHC were committed to joint visits to raise the profile of urgent and emergency care and encourage system ownership. RG asked about operational pressures and winter planning, and whether MP was satisfied with the realistic view that had been taken in relation to expected pressure. MP advised that whilst there was anxiety about winter, the Trust was developing a winter plan as usual, and was engaged in system wide planning.
8	**Board Assurance Framework** The Board received the Board Assurance Framework, noting that risk rationalisation continued with executive leads fully reviewing each risk. The Board was advised that once the BAF was fully embedded and mature, additional information to identify trends, significant changes and risk scoring would be included to support analysis into key areas of concern.
9	**Trust Risk Register** The Board received the report for information, noting that two new risks related to laboratory support and lack of trained haematology consultants had been added to the register. One risk related to lack of capacity within the GI Physiology service had been downgraded, and the safety risk related to radiotherapy had been closed due to the installation of a new machine which had commenced treatment in mid-August.
10	**Quality and Performance Committee Report** AM advised the Board that the Committee had highlighted a number of red areas from July's meeting, including a review of the CQC Maternity Services Report and a discussion in relation to the Trust's heatwave response which had seen a temporary move to corridor care; the Committee recognised that this was not an ideal situation and could not become business as usual, but had been the best thing to provide optimum care to patients under incredibly difficult circumstances. The Committee had also discussed concerns in relation to the Patient Safety team and the significant increase in incident reporting activity which was outweighing capacity in the team and creating a lack of resilience. Other key issues from the Quality Performance Report were highlighted as follows: • Violence and aggression incidents were discussed; there was now a focus on operational issues and involvement of GMS, with additional porters being recruited. More violence and aggression training sessions were being organised, and weekly multi-disciplinary team meetings had been established for more oversight of challenging situations. • Section 29a action plans from the CQC warning notices were regularly reviewed. • There had been no Never Events in theatres since December; the Board was advised that quality improvement work had been very successful. • The Trust was performing well in some of the cancer performance standards, but was not meeting the 62-day standard mainly due to the high volume of Urology patients. The Board was assured that there was a robust action plan in place which would improve the position. • The Board was informed that the Echocardiography diagnostic was a concern, however there was a plan in place which would contribute to a significant reduction in backlogs. RG asked about the PALS team and the improvements that had been made. MHo confirmed that an additional senior coordinator was in post which was providing support to the team and managing complex cases. The Board was advised that there had been a very high number of contracts this month and therefore the trajectory had not been met, however the team continued to monitor this closely.
11	**Organ Donation Annual Report**

	The Board received the report, noting the ongoing success of the Trust's processes for identifying potential organ donor, timely referral and provision of support for clinical teams and families by specialist nurses. During 2021-22 the Trust facilitated nine solid organ donors resulting in 19 patients receiving life saving or transforming transplants. The Trust had also made 747 referrals for consideration of tissue donation, and facilitated 64 tissue donors. The Trust aimed to achieve a 100% referral target, to expand its tissue donation services, and continue to train and educate junior doctors. The Board was assured by the processes in place, and congratulated the team for its performance during the year.
12	**Fit for the Future Programme: Engagement Report** The Board received and reviewed the Output of Engagement Report, as part of the agreed process for service change proposals. The Board was advised that the report, the Clinical Senate Panel Review and any other information deemed necessary would be used to determine recommendations and next steps. The Board was encouraged by the report and commended the team on thorough and meaningful engagement, and a clear and well-written report.
13	**Finance and Digital Committee Report** RG advised the Board that the focus of the additional meeting in August had been on the Trust's financial position, which continued to highlight a significant challenge for the Trust. A financial recovery plan was in development and would focus on a number of key actions, including a review of all income, a forensic review of the financial ledger, a review of the whole-time equivalent workforce, and divisional recovery plans. The Committee had also been apprised of the HFMA financial sustainability self-assessment, which had been submitted following the Audit and Assurance Committee in early September. In July, the Committee had focused on the Trust's financial performance and the particular issue related to an error in income assumptions for 2022-23 which had resulted in an overall net impact of £8.9m. Mitigations had been swiftly identified, however a net pressure of £1.5m remained and would reduce flexibility in the financial position. ***Financial Performance Report*** The Board noted the following key points: • The Trust was reporting a year-to-date deficit of £6.7m, which was £4.6m adverse to plan. However, the Trust maintained the planned forecast breakeven position. • The deficit was mainly driven by underperformance of out of county contracts, divisional pay pressures related to use of temporary staff, and non-pay pressures. • The financial position at month four continued to highlight a significant challenge, and a Financial Recovery Plan was in development and would be presented to Finance and Digital Committee in September. ***Digital Performance Report*** The Board received the report and noted continued positive progress on digital workstreams and projects. The Board acknowledged that additional support was required to encourage staff to complete mandatory Information Governance training in September.
14	**Audit and Assurance Committee Report** The Committee had raised concerns in relation to consistent risk reporting and the level of non-compliance of divisional achievement against Key Performance Indicators. There were a number of actions underway,

	including continued work on the Board Assurance Framework, a committee structure review, and a review of the clinical governance framework to ensure divisional compliance. The Committee had also discussed the need for a clear communication plan between the Trust and external audit to ensure any delays to audits were effectively managed.
15	**Emergency Preparedness, Resilience and Response Report** The Board received the report and formally **approved** the submission to the ICB in October.
16	**Estates and Facilities Committee Report** The Committee had received information on workforce vacancies and the actions in place to address gaps, and indicative increases in energy and fuel prices. The Committee had also received information on the requirement of an £8m investment to ensure full electrical resilience compliance, the implementation of which was in discussion. The Committee had been pleased to receive a positive sustainability report, and was assured by the green initiatives that the Trust was engaged with, or leading on.
17	**Guardian of Safe Working Hours Quarterly Report** The Board received the report for information, noting that the number of exception reports had significantly reduced during the quarter and had also fallen compared with the same quarter in 2021. There had been 61 exception reports, but no fines levied. The Board was assured that the exception reporting process was robust, and the junior doctor forum was functioning well.
18	**Any other business** None.
19	**Governor Observations** AT provided the following feedback: • The improved angiography programme was felt to be a great success. • The Fit for the Future programme was progressing well. • The Board was encouraged to ensure that the Real Living Wage was considered and addressed, as Governors had been surprised by the number of staff in the Trust who were not in receipt of this. • The Board Assurance Framework and risk management process continued to improve and were heading in the right direction. • AT felt that the Trust was a good organisation, with a great leadership team and staff. The Trust should be an Outstanding one, and AT was positive that it could get there.
Close	

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Emergency Preparedness, Resilience and Response Report	The Board formally approved the submission to the ICB in October.		

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – OCTOBER 2022

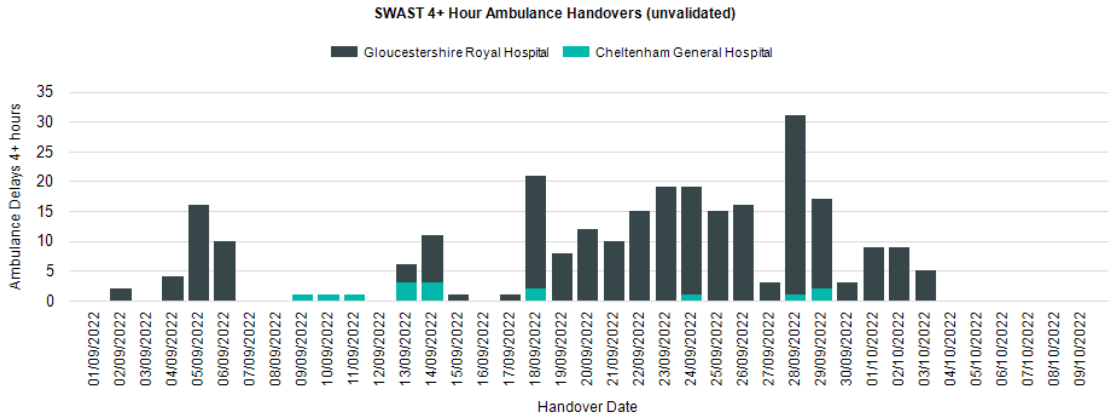
CHIEF EXECUTIVE OFFICER'S REPORT

1 Introduction

This is my first report to the Board since my return to the Chief Executive role and it has been quite a month! However, it feels very good to be back and I am hugely optimistic about the opportunities I see all around me for us to address the challenges ahead.

2 Operational Context

2.1 Whilst the Trust remains operationally very busy, recent improvements in urgent and emergency care (UEC) gives cause for optimism. The renewed focus on the things that are in the Trust's gift to control is paying dividends and these came to fruition last week during what we termed our "reset week". With the help of system partners and the Emergency Care Intensive Support Team, we changed key aspects of the operating model with significant impacts on ambulance handover delays and Category 2 ambulance response times. At the time of writing, we have not had an ambulance wait more than 4 hours to handover a patient and the mean time for handover less than two hours. Similarly, the Cat 2 response times have reduced from a peak of 160 minutes (against an 18 minute standards) to a mean in the last week of 33 minutes.



2.2 The reasons for these improvements are multifactorial but the key contributor has been the decision to share risk more evenly across the UEC pathway by pre-empting more patients to our wards. This model is being advocated nationally, particularly to those in Tier 1 for ambulance handover delays. The early evidence indicates that this has reduced the risk in the community, at our front door and in our Emergency Department. This in itself is not without consequence, particularly in respect of quality of care for patients who are pre-empted, which it is being very carefully monitored. Assurance in this regard will be presented to the Quality and Performance Committee later this month.

2.3 The key areas for focus remain the decision to admit – the Reset Week indicated there is considerable opportunity still to reduce the number of patients who are admitted from the ED; earlier in the day discharge (and weekend discharges) which is crucial to manage the potential

risks associated with pre-empting and time to ED assessment which is likely to require revision to workforce rotas for medical and nursing staff, particularly overnight.

2.4 As ever, the challenge remains how we sustain this focus and embed the improvements in to our "business as usual" model. ECIST will be integral to helping us with this approach.

2.5 External partners, Newton, continue their system work on UEC and are in the diagnostic phase. A number of workshops have been held with colleagues from across the system to undertake a series of "case reviews". From those that have attended, these have proved invaluable in identifying the key themes that will need addressing if we are to succeed in our aims. Newton plan to feedback their initial observations to system partners next week.

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

Official sensitive– not for onward circulation

NHS England

Summary Dashboard

	104ww+		78ww+		>51ww Cohort (March 78ww)		52ww+		Total Waiting List		Cancer 62 day backlog	RTT
Region	w-e 18 Sep 22 (un-published)	w-e 25 Sep 22 (un-published)	w-e 18 Sep 22 (un-published)	w-e 25 Sep 22 (un-published)	w-e 18 Sep 22 (un-published) >50ww	w-e 25 Sep 22 (un-published) >51ww	w-e 18 Sep 22 (un-published)	w-e 25 Sep 22 (un-published)	w-e 18 Sep 22 (un-published)	w-e 25 Sep 22 (un-published)	w-e 25 Sep 22 (un-published)	July 2022
SOUTH WEST	**878**	**861**	**6,439**	**6,478**	**47,574**	**45,184**	**41,474**	**42,289**	**636,449**	**639,958**	**3,744**	**61.20%**
BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE STP	0	0	265	270	4,746	4,390	3,757	3,999	96,378	97,064	557	*62.89%*
BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE STP	109	104	1,245	1,219	10,943	10,485	9,665	9,844	113,194	113,936	1,015	*65.70%*
CORNWALL AND THE ISLES OF SCILLY HEALTH & SOCIAL CARE PARTNERSHIP (STP)	6	5	364	378	3,006	2,904	2,653	2,746	44,047	44,142	119	*61.18%*
DEVON STP	636	627	3,337	3,374	18,343	17,662	16,423	16,718	173,969	175,525	1,096	*53.93%*
DORSET STP	109	105	762	776	5,792	5,402	4,969	4,990	94,030	93,998	436	*59.29%*
GLOUCESTERSHIRE STP	0	0	49	48	1,660	1,432	1,308	1,269	66,359	66,846	256	*72.33%*
SOMERSET STP	18	20	417	413	3,084	2,909	2,699	2,723	48,472	48,447	265	*63.41%*

>51WW Cohort (March 78ww): This cohort refers to the patients who will have waited over 78 weeks by the end of March if not seen prior to this point

3 | National Elective Recovery Programme Board

Source: WLMDS

2.7 This month we completed four of the five Cheltenham ward moves which are pivotal to the Trust's Winter Plan. These moves will provide the surgical division with a protected bed base and provide medicine with an additional winter ward. The aim of these moves is to protect elective operating over the winter months – especially orthopaedics which has been a casualty of winter pressures in recent years – and reduce the likelihood of needing to open poor quality escalation capacity. Significant attention has been paid to staff engagement in the planning and preparation for the moves, with positive feedback from staff in this regard. I am pleased to report that we secured national capital to enable us to make environmental improvements to the winter ward and to enable us to bring a modular build on sight at GRH to enable us to establish a much-needed Discharge Waiting Lounge with capacity to take up to 30 patients both

seated and on trolleys; this development will contribute significantly to early flow thus again reducing the need to care for patients in escalation areas.

3 Key Highlights

3.1 Care Quality Commission

On Friday the Care Quality Commission published its report into the findings following its core services inspection of Surgical Services and its Well-Led review of the Trust. Both of these inspections resulted in a downgrading of the current ratings, Surgical Services from *Requires Improvement to Inadequate* and the Trust's Well-led Rating from *Good* to *Requires Improvement.* Combined, this means the Trust's overall rating has dropped from *Good* to *Requires Improvement*.

3.2 In regard of the Well-led review, the report has raised some very important issues in respect of the culture within the Trust. There are no circumstances when it is ever acceptable for staff to feel bullied, to be subjected to discrimination or to fear reprisals when they have had the courage to speak out. These are issues that have been raised through our own staff survey and as such have received, and continue to receive, the leadership's full attention. We are determined that this report will provide further momentum and impetus to address these issues and we are working harder than ever to engage and involve our frontline colleagues in finding solutions to our challenges.

3.3 Prior to publication, Deborah Evans, Trust Chair alongside members of the Executive Team and Surgical Division hosted two face-to-face staff briefing events at Cheltenham General and Gloucestershire Royal. The events were very well attended with good engagement from staff in the room and afterwards. The Cheltenham event was recorded and again, large numbers of staff have viewed this.

3.4 For leaders and managers throughout the organisation this has been a very difficult report, with evidence of considerable reflection by very many colleagues. I personally, have reflected on my own leadership and the contribution to these findings and would like to take the opportunity to reiterate my apology to all those who have been impacted by the findings in the report.

3.5 The Trust is required to submit the required action plan within 28 days of the report being received and this is hand with lead Directors identified for each of the areas identified. Committee oversight of the action plans is under discussion but likely to fall to several committees given the broad nature of the issues raised.

3.6 In response to the CQC's recent findings with respect to maternity services, the Trust has had its first engagement event with the Maternity Safety Support Programme. Feedback from all involved has been very positive. Very many of the actions identified in response to the report have been actioned and the team is looking forward to welcoming the CQC back when they revisit the service in the next few months.

3.7 **Recruitment** The Trust, working with system partners and recruitment platform Indeed, ran a very successful event at Cheltenham Race Course aiming to recruit much needed health care support workers (HCSW). A total of 314 people were welcomed through the doors, 298 job seekers were interviewed and 270 of those were offered roles with 41% being new to care. The range of posts on offer included mental health, community, care homes, GP practice and hospital roles. We anticipate just over 120 coming to our hospitals.

3.8 This week the Royal College of Nursing instigated a ballot to seek support of their members for industrial action in response to their concerns about the national pay award which is not reflective of inflation.

3.9 **Charity.** On the 29th September, I had the pleasure of welcoming a number of Gloucestershire's entrepreneurs to a fundraising event at Berkeley Castle, in aid of our appeal to raise funds for the Gloucestershire Cancer Institute. I would like to take the opportunity to thank the Berkeley family for their generosity in agreeing to host the event and local sponsors Creed Catering, Colour Connection and the Queen's Hotel, Cheltenham at Berkeley Castle. In more good news, I was delighted to hear that our hospitals' charity has been shortlisted for Gloucestershire Charity of the Year – very well deserved.

3.10 Finally, our **apprenticeship programme** continues to go from strength with the Trust having been shortlisted in this year's Gloucestershire Live Apprenticeship Awards in the categories of Employer of the Year and Outstanding Contribution to Apprenticeships category. I am delighted that Lisa won the Outstanding Contribution to Apprenticeships award. Unfortunately, we were runners up in the Employer of the Year category but very pleased that NHS organisations were so well represented in the shortlist and congratulations to Gloucestershire Health and Care Trust for their win as Employer of the Year.

3.11 Such a lot going on….

Deborah Lee
Chief Executive Officer

10th October 2022

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	8	Enclosure Number:	3
Date	13 October 2022		
Title	Board Assurance Framework		
Author /Sponsoring Director/Presenter	Kat Cleverley, Trust Secretary		

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

Summary of Report

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

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

The Board is presented with the full Board Assurance Framework for October 2022, with a summary of key changes and developments that have occurred over the last few months.

Recommendation

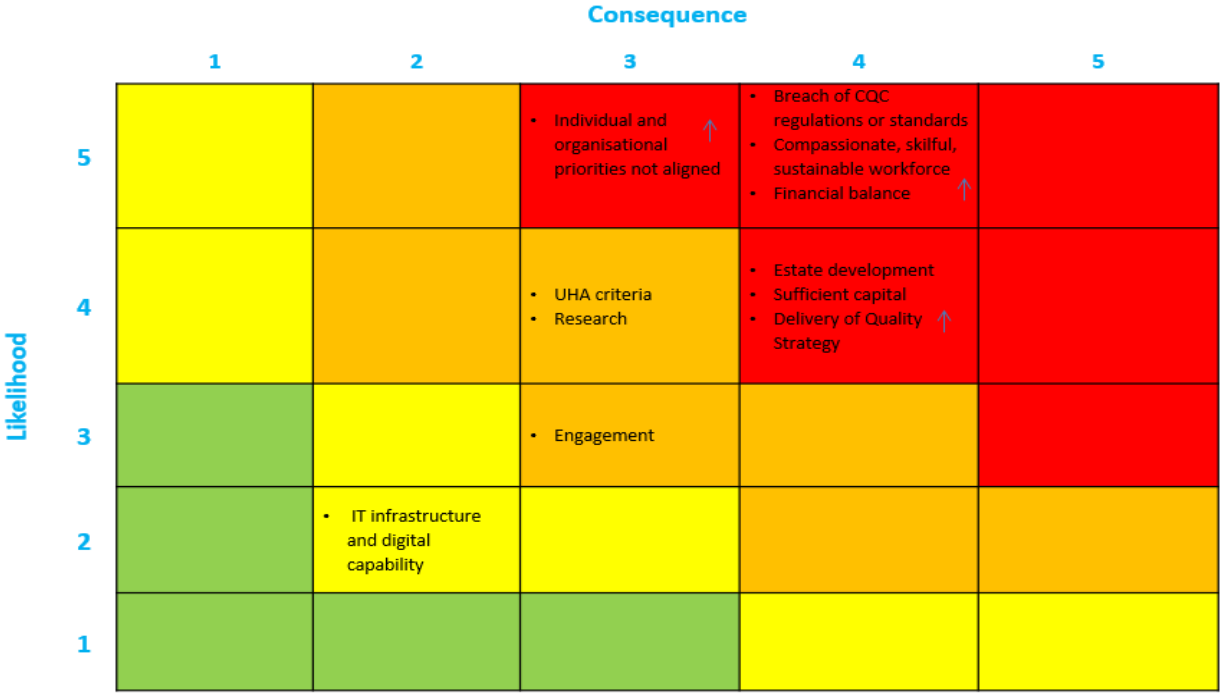
The Board is asked to note the BAF for assurance, and to continue to support its development.

Enclosures

- Board Assurance Framework October 2022

Board Assurance Framework Review

Number of risks	**11**
Number of high-rated risks	**7**
Average risk rating	**12**
Risks overdue review	**5**
• SR2 Workforce • SR5 Engagement • SR10 IT infrastructure and digital capability • SR11 UHA criteria • SR12 Research	
Risks in progress	**2**
IT and Digital External Partnerships	
Archived risks	**1**



Summary Changes		
SR1	Breach of CQC regulations or standards	Fully updated in September 2022. Risk score increased to 20.
SR2	Workforce	Fully reviewed in June 2022. Risk score increased to 20.
SR3	Delivery of Quality Strategy	Fully updated in September 2022.
SR4	Individual organisational priorities not aligned	Fully updated in September 2022.
SR5	Poor engagement	Fully reviewed in July 2022.
SR7	Failure to deliver financial balance	Fully updated in September 2022. Risk score increased to 20.
SR8	Estate development	Fully updated in September 2022. Review combination of risk with SR9.
SR9	Sufficient capital	Fully updated in September 2022. Review combination of risk with SR8.
SR10	IT infrastructure and digital capability	Full risk review in progress.
SR11	UHA criteria	Fully reviewed in April 2022. Update due.
SR12	Research	Fully reviewed in April 2022. Update due.

Board Assurance Framework Review

Committee Oversight	
Audit and Assurance Committee	Recommended risk rationalisation exercise.
Finance and Digital Committee	Fully reviewed SR7 in September 2022. Recommended increased risk score to 20.
Quality and Performance Committee	Fully reviewed SR1, SR3 and SR4 in September 2022. Target risk scores for SR1 would be reviewed.
People and Organisational Development Committee	Fully reviewed SR2 in June 2022. Recommended increased risk score to 20.
Estates and Facilities Committee	Recommended combining SR8 and SR9.

October 2022

Gloucestershire Hospitals NHS Foundation Trust

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges							
SR1	Breach of CQC regulations or other quality related regulatory standards.	July 2019	Sept 2022	CNO/DOQ	3x4=12	4x4=16	5x4=20
2. We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people							
SR2	Failure to attract, recruit and retain candidates from diverse communities resulting in the Trust workforce not being representative of the communities we serve.	April 2019	June 2022	DOP	3x4=12	3x2=6	5x4=20
3. Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other							
SR3	Failure to deliver the Trust's enabling Quality Strategy and implement the Quality Framework	July 2019	Sept 2022	MD	2x3=6	3x3=9	4x4=16
4. We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners							
SR4	Risk that individual organisational priorities and decisions are not aligned.	July 2019	Sept 2022	COO	2x3=6	4x3=12	5x3=15
5. Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services							
SR5	Poor engagement and involvement with/from patients, colleagues, stakeholders and the public.	July 2019	July 2022	DoST	1x3	3x2=6	3x3=9
7. We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources							
SR7	Failure to deliver financial balance.	July 2019	Sept 2022	DOF	4x3=12	4x4=16	5x4=20
8. We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact							
SR8	Failure to develop our estate which will affect access to services and our environmental impact.	July 2019	Sept 2022	DST	4x3=12	4x4=16	4x4=16
SR9	Inability to access sufficient capital to make required progress on maintenance, repair and refurbishment of core equipment and/or buildings.	July 2019	Sept 2022	DST	4x3=12	4x4=16	4x4=16
9. We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care							
SR10	Our IT infrastructure and digital capability are not able to deliver our ambitions for safe, reliable, responsible care.	July 2019	April 2022	CDIO	2x1=2	2x2=4	2x2=4

Board Assurance Framework Summary

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

Archived Risks (score of 4 and below)

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

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

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**CQC regulations or other quality related regulatory standards are breached** **Risks linked to the Risk Register:** S3316, C2819N, C2669N, C1945NTVN, D&S2976 Rad, WC3536O bs, M2353Diab, D&S3103 Path, C2667NIC, C1850NSafe, C3034N C3295COOCOVID, WC3257Gyn WC3536Obs, WC3685Obs M3682Emer, C2628COO C1798COO, S2715Th C2715 C3084 C1437POD C3767COO D&S2938RT	We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	A range of quality issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance	CN	SR3, SR4

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee oversees progress of improvement plans in areas of significant concern highlighted by external reviews, incidents, complaints etc. • Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board • Monitoring of performance, access and quality metrics via Quality & Performance Report • Operational Plan 2022/23	• Quality Strategy in need of refresh due to key milestones needing to be reprioritised due to challenges caused by Covid, CQC regulatory inspections and changes in personnel. • Inability to match recruitment needs due to national and local shortages and the impact on quality of care (links with People and OD Strategy) • Deteriorating staff experience leading to increased absence, vacancies, turnover, lower productivity and ultimately poor patient experience. • Quality and Performance Report in need of refresh to enable monitor of key metrics. • Divisional oversight of core service areas.

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

• Quality Strategy and delivery plan • Risk Management processes • Quality priorities for 2022/23 (as identified in Quality Account 2021/22) • QIA processes • Improvement programmes • Executive Review process • Internal audit plan adapted to respond to significant quality issues • J20 Director walkabouts • Trust investment plans prioritised according to risk • Inspection and review by external bodies (including CQC inspections) • GIRFT review programme. • External reviews of services • Patient Experience Reporting • Learning from deaths reporting • Key Issues and Assurance Report (KIAR)	

ACTIONS PLANNED

Action	Lead	Due date	Update
Workforce - Monitoring of impact of workforce challenges on quality and performance	DoQ &CN	Q2 2022/23	- Safer staffing reviews for close monitoring of workforce challenges impact on quality of care via Safer Staffing Report.
Operational Plan - Development of plan in response to NHSE/I planning guidance	COO	Q1/2 22/23 Q4 22/23	- Delivery of defined planned operational improvements - Review of new planning guidance for 2023/24
Quality Strategy and QPR - Review and refresh strategy and delivery plan - Review of metrics within QPR - Define quality priorities for 2022/23 - Development of separate Whole Person Care Strategy	DoQ &CN	End of Q3 2022/23 Q2 22/23 Q1 22/23	- This work has been delayed and will commence in Oct 2022 after Quality Governance Review - Work underway – delayed because of CQC regulatory activity - Complete and Q1 progress reported to QDG.
External reviews of services - Develop action plans in response to recent inspections	DoQ &CN	Q1 22/23 Q2 22/23 Q2 22/23 Q3 22/23	- Complete - CQC Medical Care and UEC Care report received action plan developed and being monitored by QDG. - CQC Maternity focused inspection final report received and improvement plan due with CQC 29 August 2022 – reviewed by MDG. - CQC unannounced core service inspection of surgery and Well Led awaiting report and – draft report received for factual accuracy. - CQC Well led feedback to CEO and Board raising concerns/issues with the organisation. - NHSE/I review of Maternity Service and LMNS rebooked for Nov 2022 (delayed due to extreme weather national alert and Business Continuity plans in place).

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

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
- Getting It Right First Time - there was strong agreement that the urology department has been actively progressing the national recommendations outlined within the GIRFT work streams. - End PJ Paralysis improvement programme (work programme in place and diagnostic audit to start) **Assurance Reports** <u>Cancer Delivery Group</u> - In May seven out of nine standards were met; better than the national average in eight of nine.	**CQC Update** - Section 29a warning notices for maternity and surgery **Staff Survey** - Below average NHS Staff Survey results (metrics for Quality Strategy Delivery) annual. **Assurance Reports and QPR metrics** <u>Urgent and Emergency Care Delivery Group</u> - Remains challenged service. o Ambulance handover delays o Medically fit for discharge numbers increasing o Pre-empts to ward areas (meaning corridor care for our patients) <u>Maternity Delivery Group</u> - Remains challenged service o Inadequate rating for maternity in Well Led and Safe (report published 22 July) o Midwifery staffing and maternity triage on Trust risk register o Cheltenham maternity unit to remain closed until October because of staffing. <u>Planned Care Delivery Group</u> - Challenges remain o 52-week performance was challenged, but not significantly. o diagnostic performance continued to be challenged with echo performance accounting for the majority of breaches. <u>Quality Delivery Group</u> - The incidence of violence and aggression is increasing. There is a working group reviewing this issue and taking improvement actions.	• Inspection and review by an external body - CQC Well Led Inspection June 2022 (report being reviewed for factual accuracy). • NHSE/I Insights visit for maternity September 2022 and diagnostic visit for the Maternity Safety Improvement Programme (MSIP). • Internal audit reviews 2022-25: o Outpatient Clinic Management o MCA and Consent o Discharge Processes o **Divisional Governance (Medicine)** o Cross health economy reviews o Risk Maturity o Patient Safety (Learning from Complaints/Incidents) o Clinical Programme Group o Environmental Sustainability o Data Quality o Patient Deterioration o Pressure Ulcer Management o Clinical Audit o Medical Records o Infection Prevention and Control

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

	Eating Disorders Pathway - The acute trust was not particularly well set up to treat eating disorders, with a lack of appropriate teams to facilitate; within the county no inpatient eating disorder facility, no day programme and no child or adolescent home treatment team. An ICB improvement programme has commenced to resolve issues not within the remit of the Trust).	

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Workforce June 2022

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

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

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Initial scope of e2e transactional recruitment leading to formal transformation change programme	DDfPOD	Commence 7th June 2022	Full recruitment review formally commences on 7th June 2002 reporting into the Workforce Sustainability Programme Board.

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

Development of a marketing and strategy / plan	AD of Resourcing	Commence May 2022	This will now form part of the Workforce Sustainability Programme structure and will include the procurement of an external marketing company to work in close partnership with the Trust to support the design and implementation of innovative and creative attraction solutions. Work has specifically commenced in May with plans to address the increasing challenges with admin & clerical vacancy levels.
Delivery of 2022/23 workforce plan including new roles, increased overseas recruitment and robust pipeline plans	DDfPOD	2022-23	Positive feedback was received from NHSE on the Trust's submission into the ICS workforce plan for 2022/23. Interventions and activities to deliver the workforce plan across the Trust has commenced. This will be formalised through the Workforce Sustainability Programme.
Immediate focussed planning in response to the 2021 Staff Survey outcomes	Head of L&OD/DoP	Commence April 2022	Commencement of a staff engagement and culture programme has been seen in May, with clear workstreams focussing on organisational values, staff engagement, staff survey responses, and Restorative and Just Learning.
Commencement of Workforce Sustainability Programme	DfPOD	2022-23	Presented to the Workforce Sustainability Programme Board in May 2022. Focus in the last month has seen the governance, structures and formal programme management frameworks being established to support the traction and pace critical for positive delivery outcomes.
Focussed planning of a Preceptorship Academy and commencement of a master accredited module	ADED	June 2023	Development of an accredited master module as part of the Preceptorship Programme for AHPs and RNs.

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

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

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

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR3	**Failure to deliver the Trust's enabling Quality Strategy and implement the Quality Framework**	Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other	A range of quality issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance	MD	SR2 - Quality Improvement – 268 risks linked to this BAF / 15 of these risks are Trust risks (red)

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Mar 2023	Mar 2024	-		August 22	3x3=9
4x4=16	The QS high level indicators are reflected in the staff survey results which have deteriorated	3x3=9	2x2=4		Implementation and embedding of the QS and Just, Learning and Restorative approach will take time to alter behaviours, staff perceptions and survey results.		

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of Programme team to incorporate improvement methodology	SL	March 23	Restructure of programme team completed
Review QS with new Chief Nurse on appointment	MH	Q3/Q4 22/23	Scoping begun for new milestones
Development of the Just, Learning and Restorative (JL&R) approach	CB	March 23	Planning team established
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	MH\AS \SC	Oct 22	Two engagement workshops completed

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Progress reported on QS to QPC in October 2021 and forms part of QDG update • Quality priorities agreed • Quality Account published which describes the work of the Quality Strategy priorities • Learning from deaths report	• Staff survey results	• Update to QPC on QS • Improvement Programme for JL&R approach • Improvement Programme for Staff survey • Internal audit reviews: Workforce Planning; Discharge Processes; Cultural Maturity; Divisional Governance; Cross health economy reviews; Risk Maturity

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

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR4	**Risk that individual organisational priorities and decisions are not aligned, which would result in restriction of the movement of resources (including financial and workforce) leading to an impact upon the scope of integration**	We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners	Covid-19 extraordinary response and interim arrangements	Loss of some 'historical' context. Availability of resources and investment at a time of flux/pandemic. Usual planning cycles suspended/adjusted.	Quality and Performance	COO	M3682Emer D&S3507RT WC3536Obs C1850NSafe

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

CONTROLS/MITIGATIONS

- Quality and Performance Committee oversees progress of improvement plans in areas of significant concern.
- Delivery Group exception reporting (Maternity, Quality, Planned Care and Cancer)
- Urgent and Emergency Care Board
- Monitoring of key performance metrics via Quality and Performance Report (QPR)
- Quality Strategy in place
- Risk Management processes
- Executive Review processes
- Trust investment plans
- Key issues and assurance reporting (KIAR)
- ICB attendance at Q&P Committee
- Weekly and monthly business cycles in place to monitor/deliver progress against all key KPIs
- Agreed Operational Plan (2022/23) in place
- Triumvirates in place for the Operational/Clinical Divisions
- Close working relationships between Operational Divisions and Finance/HR proven in delivery of H2 and other priorities
- Assurance meeting established twice per month to monitor and mitigate/escalate gaps in control identified (led by Finance/Operations/BI)

GAPS IN CONTROL

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

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

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

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
Continuation of Operational Plan delivery monitoring (led by BI, Finance and dCOO)	NHL	March 2023	Meeting confirmed and in diaries twice per month. Reporting being finalised
'Flow' Focussed strategy group planned. Sits with Strategy PMO.	IQ	Oct 2022	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Elective Recovery Board in place • Regular 'systemwide' planning meetings in place • KPI (Cancer performance, diagnostics etc) monitoring meetings are fully established • GIRFT Report – Urology services have made significant improvements	• Operational Plan 2022/23 not fully compliant • CQC Maternity Service report • CQC S29A Warning notice for maternity and Surgery • QPR – heat wave response stopped Ambulance Handover delays but meant corridor care for patients on our wards (pre empt policy) • Eating disorder patient issues sit with GHC and ICB (there is an ICB improvement group formed to take forward).	• Operational Plan 2022/23 to be monitored delivery on formal basis from June 2022. • 'Flow' focussed strategy and delivery group planned • Internal audit reviews 2022-25: ○ Outpatient Clinic Management ○ Discharge Processes ○ Cultural Maturity ○ Clinical Programme Group ○ Patient Safety: Learning from Complaints/Incidents ○ Patient Deterioration ○ Equalities, Diversity and Inclusion ○ Infection Prevention and Control

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

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

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

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

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

ACTIONS PLANNED

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

POSITIVE ASSURANCES

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

NEGATIVE ASSURANCES

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

PLANNED ASSURANCE

Internal audit reviews 2022-25:

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

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

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

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

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

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Dec 2022	Apr 2023	Jun 2023		Aug 21	
		5x3=15	4x3=12	4x3=12		April 21	
						Sept 20	
						July 19	
5x4=20	• Although final plan for 22/23 showed a balanced position it included £19m of savings which are not materialising. Currently £8m gap. • Increase cost of temporary staffing due to workforce challenges. • The lack of flow in the hospital causing restrictions on elective recovery impacting on the ability to earn ERF. • Pressure on operational capacity, limiting the focus on how to drive out efficiencies whilst improving patient outcomes. • Productivity information is showing a reduction in activity but not a corresponding reduction in costs to match.				• Everyone in the Trust (from Board to ward) understands and owns their element of responsibility around good stewardship of public money. • Full review of all revenue investments made during the pandemic to determine whether they are still to be supported or if financial commitment should be removed. • Continued monthly monitoring to understand the drivers of the deficit. • Drive the financial sustainability programme to start to see the recurrent benefits of financial improvement. • Targeted weekly financial oversight meetings in place for the two divisions who are experiencing adverse movement from budget. These meetings are chaired by the Chief of Service and Director of Finance is there to seek assurance. Early indications show an improved position but one that isn't at breakeven yet. • Development and acceptance of a financial recovery plan – showing clear executive leads.		

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

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

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Development of the financial sustainability team reporting within the strategy and transformation portfolio	DOF/ DOS	Feb 22	This team has now moved across, training and development ongoing. Vacancies being filled by a combination of permanent and interim staff to get the governance and reporting in place by Mar 22. Detailed plans around deliverability of the financial sustainability programme will be in first draft by end of April.
Robust benefits identification, delivery and tracking across major projects	DOF/ DOS	Jun 22	Capacity now in place to develop the process, format and framework around how we capture the benefits. This will be tested during the financial year and where necessary adapted to ensure the process is robust and effective.
Set up weekly meetings for those division that are showing financial pressure	CoS	Jun 22	This has been set up and progress is good.
Trust wide communication is being developed and sent out to inform the organisation of the financial position to get the message understood	Comms	Jul 22	Initial comms going out in term briefs in July, Financial sustainability on the agenda for 100 leaders in July. Development of Trust wide workshops to gain more traction on ideas for medium term plan during the financial year.
Financial recovery plan (FRP) developed, drivers of the pressures understood and communicated to system and regulator partners	DOF	Aug 22	The first draft of the FRP in circulation with exec colleagues, divisional reps, ICB partners. More focus needed on generating more actions with clear expectations around accountability of delivery.
HFMA self-assessment tool completed ready for internal audit review	DOF	Sept 22	HFMA self-assessment tool completed, final review taking place with final sign off by 30th Sept in preparation for internal audit review early Oct.
WTE growth from 19/20 actuals to 22/23 establishment understood and challenged	DOF	Oct 22	WTE growth will be presented to F&D in Sept with next steps clearly articulated.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Achieved key annual financial targets in 2020-21. • Achieved key annual financial targets in 2021-22.	• Temporary staff spend consistently above target.	Internal Audits planned 2022-25: • Cross health economy reviews

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Financial balance September 2022

• Continued the monitoring of financial sustainability • Move of financial sustainability to Strategy and Transformation to give focus on quality of service which should drive financial improvement • ERF monies being generated by Trust. • Improved and co-ordinated system working. • External Audit VFM report, Jun 22. • Development of productivity analysis at divisional level • Weekly reviews for those deviating from plan	• Planned Trust and System underlying deficit moving into 22/23 a significant concern. • Continuing under-delivery of recurring efficiency programme. • ERF achievement for H2 is a cause for concern • Lack of benefit realisation on schemes that should be delivering financial improvement • No real consequences of financial deviation • No review on whether to continue to stop a project if overspending	• Shared Services reviews • Risk Maturity • Data Quality • Budgetary Control • Charitable Funds • Payroll Overpayments NHSE/I scrutiny of Trust/system finances. ICS accountability and assurance on system wide transformational changes.

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

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

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

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

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

ACTIONS PLANNED

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

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

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

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

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

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

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

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

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

ACTIONS PLANNED

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

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

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

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

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

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

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

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

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

ACTIONS PLANNED

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

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

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

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

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR11	**Failure to meet University Hospitals Association (UHA), membership criteria, a pre-requisite for UHA accreditation**	We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK	The UHA has updated its membership criteria in three areas: 1. NED should be from a University with a Medical or Dental School. 2. A minimum of 20 consultants with substantive contracts of employment with the university with a medical or dental school. 3. 2-year average Research Capability Funding (RCF) of at least £200k p.a.	Unable to secure UHA membership	People and Organisational Development Committee	DoST	SR12

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

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

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Strong collaborative working and relationship with University of Gloucestershire e.g. Nursing and Radiographer programmes	• UHA is currently closed to new applications • Establishing x20 honorary contracts is a challenge	Internal audit reviews 2022-25: • Cultural Maturity • Cross health economy reviews

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

• Strong collaborative and working relationship with Bristol University e.g. Bristol Medical School • Developing relationship with University of Worcestershire e.g. Three Counties Medical School • Allocation of 51 additional F1 and F2 trainee doctors to GHFT in recognition of education programme and size of Trust • Availability of library, IT and teaching facilities for postgraduate and undergraduate education • Lead placement role in place responsible for undergraduate education	• Achieving NIHR research grant income of £725,000 per annum and the resulting RCF income of £200,000 by 2024 is a challenge given our baseline of £91k NIHR research grant income and £26k RCF	• Risk Maturity • Environmental Sustainability

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

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR12	**Inability to secure funding to support individuals and teams to dedicate time to research due to competing priorities limiting our ability to extend our research portfolio.**	We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK	Investment of funding and time into both clinical teams and R&D teams. High vacancy rates within clinical teams and inability to backfill. Non-recurrent nature of external funding. Difficulty in supporting growth of portfolio due to limited capacity of R&D teams due to non-recurrent nature of external funding (CRN). Limited capacity within support services (pharmacy, labs, radiology etc) due to lack of infrastructure and ability to guarantee long term research funding. Restrictions on use of external main funding source (CRN) impede ability to grow support to develop grant applications in house.	If we are unable to at least maintain current activity levels they will decline as will the funding, creating a vicious downward spiral. Increasingly more stringent requirements of university hospital status mean that it is less likely the Trust will achieve the status without significant funding and commitment.	People and Organisational Development	MD	SR11

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		Aug 2022	Jan 2023		2021	
4x3=12	Increase in requirements for University Hospital Status with additional focus on research specific income and joint academic posts. Growth in research delivery areas has highlighted need for growth and investment in other areas which have now become the growth limiting areas	**3x3=9**	**3x3=9**	If additional posts currently funded through non-recurrent funding can be continued (i.e., in pharmacy) along with new posts required to continue current state and standard growth of activity this will prevent a decrease in activity. If additional resource can be identified to support investment in clinical teams and grant development infrastructure (including activities such as developing CRF facilities to truly enable rapid growth of commercial research activity) this will enable growth at the rate which would enable significant change in a reasonable timescale		

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Annual business plan to key funder NIHR CRN – details plans to increase the number of commercial studies, which are a source of income. • Progress against all High Level Objectives – defined by the National Institute Health Research (NIHR) – reviewed and reported quarterly internally to Research and Innovation Forum and externally to WE Clinical Research Network. Also reviewed regularly at Trust Research Senior Management Team meetings. • Support for non-NIHR funded studies is provided by the Gloucestershire Research Support Service (GRSS) via an SLA with the NHS research active organisations in the county and including Public Health in	• Annual Business Plan that covers all research income streams rather than just NIHR funding. • Ability to produce a business case for investment that is financially neutral over the longer term • Review and refresh of strategy for final two years of strategic period (currently under development) • Progress has paused due to change in University criteria.

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

Gloucestershire County Council. Statement of intent to work more closely with the University of Gloucestershire signed. • Annual business plan submitted to West of England Clinical Research Network (CRN), who provide the main source of income to research through non-recurring, activity-based funding. • Board Approved Research Strategy (October 2019) • Capability and capacity assessments for new studies to maximise workforce utilisation • Oversight of the research portfolio by C&C, Delivery Teams and SMT • Oversight of the research portfolio by CRN West of England • Review and closure of poor performing studies to release staff with regular review of staffing at relevant meetings via monthly 1:1s and SMT • Research interests & experience incorporated into consultant interview questions. Briefing paper developed in discussion with medical staffing presented at Dec PODDG. • University Hospital Programme Group reports into relevant groups inc Strategy and Transformation, People and OD, Research governance routes.	• Model for non-medic staffing to be developed in tandem to complement the medic version to ensure a whole team approach. • Need to regroup University Hospital Implementation Group and ensure that all relevant stakeholder groups are covered.

ACTIONS PLANNED

Action	Lead	Due date	Update
Develop a business case to secure investment for the trailblazer team model to commit a number of PAs per team to support growth and development of research activity within that department. Each team taking part in this would commit to an income generation target and level of activity. In return the R&D department would also need to provide a level of activity to support that growth. The R&D department would also require investment to do this	SE/CS/ CJ	May 2022	Business case in development with relevant teams and University Hospital programme group.
Review and refresh of the research strategy for final two years of the strategic period	CS / CJ	May 2022	In progress
Develop an annual Business Plan that covers all research income streams rather than just NIHR funding.	CS	June 2022	To be started

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

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

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

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

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	9	Enclosure Number:	4
Date	13 October 2022		
Title	Trust Risk Register		
Author **Director/Sponsor**	Lee Troake, Head of Risk, Health 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 the CQC announcement that the Well-led and Surgical Report would be published on 7 October, the CEO and Board conducted a session for staff on 5 October 2022. The Risk Management Group scheduled for 5 October 2022 was cancelled to allow the CQC sessions to be prioritised by staff and leaders.

Key issues to note

NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

- None

RISK SCORE REDUCED FOR TRR RISK

- None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

- None

PROPOSED CLOSURES OF RISKS ON THE TRR

- None

Recommendation
The Board is asked to note the report.
Enclosures
Trust Risk Register

Trust Risk Register

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead title	Title of Strategic Group	Title of Operational Group	If other, please specify name of Operational Group	Title of Assurance Committee / Board	Date Risk to be reviewed by	Operational Lead for Risk	Approval status
C2803POD	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.	Divisional staff survey action plans, monitored by Executive Reviews. Divisions are offered support by PACE. Trustwide staff survey action plan. Patient and Colleague Experience Group (PACE) - leading on the triangulation of experience data and delivery of compassionate culture work streams. 2020 Hub is staffed with 3.3 WTE staff to deliver a range of health-wellbeing support. EDI team established comprised of substantive roles (EDI Lead, EDI Coordinator, EDI Administrator) and fixed-term 18 months EDI Training Specialist. Colleague Wellbeing Psychology Lead in place, with 1.6 WTE Psychology Link Workers appointed for 23 months. 1 year fixed term 0.3 Resilience Trainer appointed. Compassionate Leadership training rolled out and all leaders/managers	Create Dashboard to underpin SPEIG work priority workstreams feeding into SPEIG Review Staff Survey results EDI/Cultural Improvement plans being devised in light of DWC and staff survey results Short, medium and long-term interventions being proposed to address health-wellbeing concerns 2 x OD Specialists (fixed term) being recruited to offer additional support to a) maternity and b) junior nurse leadership development Staff Engagement and Internal Comms Manager being appointed to support internal communications effectiveness	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Workforce	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director for People & OD	People and OD Delivery Group	Staff Experience and Improvement Group		People and OD Committee	31/10/2022	Hopewell, Abigail	Trust Risk Register
D&S3743CHaem	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.	Provision of consultant for 1 day a week Increase in turn around time for film reporting Communication of reduced resource to all involved Recruitment process	Consultant to start in July 2022	Diagnostics and Specialties	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Medical Director		OHPCLI Board			30/09/2022	Johny, Asha	Trust Risk Register
F3806	The risk that the organisation is not able to manage resources within delegated budgets.	The controls that are in place to prevent the risk materialising are -sustainability programme Annual budget planning	Development of Divisional Recovery Plan Performance Management of Delivery of Recovery Plans	Corporate	Finance	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Karen Johnson	Finance and Digital Committee			Executive Management Team, Finance and Digital Committee, Trust Board, Trust Leadership Team	15/08/2022	Johnson, Karen	Trust Risk Register
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.77wte DSN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. 3)1.0wte DiSN commenced March 2021, funded by CCG for 12 month and a further one in June 2021 . 4) 0.77 Substantive diabetes nurse increased hours extended for a further	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR New Elearning module in progress to complete bimonthly audit into inpatient care for diabetes	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Chief Nurse and Director of Quality	Divisional Board - Medical, People and OD Delivery Group, Quality Delivery Group	Medical Workforce Productivity Board, Medicines Optimisation Committee, Patient Experience Group		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	30/11/2022	Mani, Vinod	Trust Risk Register
WC3257Gyn	The risk of not having a dedicated gynaecology bed base staffed by gynaecology nurses to keep women safe from avoidable harm and to provide the right care and treatment.	•Specialist gynae nurses to support in-patient care and nursing staff regardless of patient location during daytime shift •Training provided to 2b staff •Written guidance provided to 2b staff •Set up of emergency gynae assessment unit in out-patient setting- to improve flow through ED •Women attending for SMOM and genetic abnormality STOP pre-operatively seen in GOPD in order to provide emotional support and complete necessary documentation while 2b not available- staff beginning	Write a business case to ensure correct staffing write an action plan for changes to 2b to support gynaecology in-patients to find suitable location for gynaecology in-patient service Identify suitable bed base with correct capacity both short and long term Work with site team to cohort gynaecology patients to identified bed base	Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Interim Director of Quality and Chief Nurse	Divisional Board - W & C, Quality Delivery Group			Quality and Performance Committee, Trust Board, Trust Leadership Team	30/09/2022	Hutchinson, Becky	Trust Risk Register
D&S2404CHaem	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.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 - Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place.	Develop Business case to meet capacity demand succession planning for consultant retirement Raise with divison to bring recruitment incentive requirements to PODDG Develop a business case for non-medical prescriber to help with clinics Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Diagnostics and Specialties	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	Divisional Board - D & S, People and OD Delivery Group, Quality Delivery Group	OHPCLI Board		People and OD Committee, Quality and Performance Committee	13/08/2022	Johny, Asha	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Falls prevention assessments on EPR 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6. Falls prevention champions on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward trainine for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR Discuss flow sheet for bed rails on EPR at documentation group	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Other	Falls and Pressure Ulcers Group	Quality and Performance Committee, Trust Leadership Team	09/09/2022	Bradley, Craig	Trust Risk Register

		(Quality and Performance Committee) 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell Review use of slipper socks with N Jordan SIM training to use hoverjack on 7a Following presentation of W168912 N Jordan to attend ward to review completion of falls documentation and required management of patient following assessment by staff Following presenntation of W171436 to PHH N Jordan to forward information to purchase slippers for patients in ED W165353 Nadine Jordan to review with 9a x-ray identifying # and communication of #													
F2895	There is a risk the Trust is unable to generate and/or borrow sufficient capital to cover its capital programme (estates backlog value @2021 £72M of which £43M is critical infrastructure), resulting in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance, repair and refurbishment	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Corporate, Gloucestershire Managed Services	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Finance	Divisional Board - Corporate / DOG, Estates and Facilities Committee, Finance and Digital Committee	GMS Health and Safety Committee		GMS Board, Trust Leadership Team	08/08/2022	Lanceley, Simon	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Modular lab in place from Feb 2021 Maintenance was extended until April 2021 to cover repairs Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab Project manager to resolve concerns regarding other departments phasing of moves to enable works to start	Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	Capital Control Group, Centre of Excellence Delivery Group, Divisional Board - Medical	Medical Devices Group, Medical Equipment Fund		Service Review Meetings	13/08/2022	Matthews, Kelly	Trust Risk Register
D&S2517Path	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.	Air conditioning installed in some laboratory (although not adequate). Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - D & S	Pathology Management Board			31/10/2022	Lewis, Jonathan	Trust Risk Register
C1850NSafe	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's	Develop Intensive intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Divisional Board - W & C, Quality Delivery Group, Safeguarding Strategic Group	Safeguarding Adults Operational Group, Safeguarding Children Operational Group / Board		Quality and Performance Committee, Trust Board, Trust Leadership Team	27/10/2022	Freebrey, Clare	Trust Risk Register
C1437POD	The risk of being unable to recruit and retain sufficient suitably qualified clinical staff including: - Medical & Dental; Registered Nurses & Midwives and AHP professionals, thereby impacting on the delivery of the Trust's strategic objectives.	Trust Workforce Planning include as part of the Trust Business Planning Cycle template. Central workforce planning for the ICS is overseen by the ICS Workforce Steering Group Introduction of alternate/Advanced practice/new including Associate Specialists, Non- Medical Consultant, ACP, PA offering alternative solutions	Implementing Recruitment and Retention action plans ACP Business Case Multiple Recruitment and Retention Actions Workforce Planning Review 2022 Person-centred career 'plans on page' Establish Task and Finish Group for Radiographer Vacancies	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Workforce	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director for People & OD	People and OD Delivery Group	Recruitment Strategy Group		People and OD Committee	30/09/2022	Daniels, Shirley	Trust Risk Register
S2976Breast	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Maximise clinical service by current staff. Have reduced screening numbers identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are similar.	meeting with HR to progress replacement of staff in Breast screening Arrange meeting to discuss with Lead Executive Develop escalation process for when Breast Radiologist is not available to provide service Discuss the possible set up of national reporting center widen recruitment net to include head hunter agencies using Trust agreed supplier listlist	Diagnostics and Specialties, Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	Quality Delivery Group, Screening Performance Committee, Trust Health and Safety Committee	Radiation Safety Committee		People and OD Committee, Quality and Performance Committee	22/08/2022	Hunt, Richard	Trust Risk Register
WC368SOBS	The risk of delayed review, identification and treatment for pregnant women attending triage, in addition inability to adequately meet	Daily staffing review by matrons. A minimum of 2 midwives for all shift. However during a nightshift, if activity allows to reduce to 1 midwife at 02:00	Address the safe staffing element audit acuity of unit and actual staffing within triage	Women's and Children's	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Medical Director	Divisional Board - W & C, People and OD Delivery Group, Quality Delivery Group	Unscheduled Care Leaders Group		People and OD Committee, Quality and Performance Committee	30/09/2022	Harris, Rachael	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities.	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialilities to support f/u clearance of backlog To resolve outstanding areas of concern	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Out Patient Board, Quality Delivery Group			Quality and Performance Committee, Trust Leadership Team	13/08/2022	Zada, Qadar	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Digital Care Board, Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Systems Safety Group, Resuscitation and Deteriorating Patient Group		Quality and Performance Committee, Trust Leadership Team	13/08/2022	Foo, Andrew	Trust Risk Register

	recognise, plan and deliver appropriate urgent care needs	o Targeted training to specific staff groups, Band 2, Preceptorship and	Development of an Improvement Programme															
C3767COO	The risk of harm to patients and staff due to being unable to discharge patients from the Trust.	Clinical review and prioritisation Onward care team in place supporting discharge Prioritisation of end of life patients Currently GHT CHC process is reliant on ward staff to complete a number of the stages. OCT and SPC support where they are able, but there is not a constant provision of resource.	To resolve outstanding areas of concern	Ambulance Trust, Corporate, Diagnostics and Specialties, GP Services / NHS England, Gloucestershire Health and Care NHS Foundation Trust, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	COO			Executive Management Team, Quality and Performance Committee	06/09/2022	Zada, Qadar	Trust Risk Register
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	Write risk assesment Update busines case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering. meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan arrange replacement valve and acurator for air handling unit TH1 reinstate quarterly ventilation meetings	Gloucestershire Managed Services, Surgical	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - Surgery, Estates and Facilities Committee		Quality and Performance Committee, Trust Leadership Team	31/08/2022	Dobb, Michael	Trust Risk Register
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	Governance process Reporting structure Patient safety and H&S advisors monitoring the system daily Monthly performance reports on new,	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	Divisional Board - Corporate / DOG, Finance and Digital Committee, Trust Health and Safety Committee	Quality and Safety Systems Group	Finance and Digital Committee, Quality and Performance Committee, Trust Leadership Team	08/09/2022	Troake, Lee	Trust Risk Register
C2628COO	The risk of poor patient experience and poorer outcomes where there is a breach of the 18 week wait from referral to treatment due to a backlog of patients.	Monitoring by clinical urgency and prioritisation is in place Additional capacity is being sought for each specialty Weekly review of PTL by the COO Monthly oversight by Improvement Board, led by CEO	1.RTT and TrakCare plans monitored through the delivery and assurance structures Formally review the Bed modelling and scenarios proposed as part of H2 submission.	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	Divisional Board - Corporate / DOG, Planned Care Delivery Group	Out Patient Board	Quality and Performance Committee, Trust Leadership Team	13/08/2022	Zada, Qadar	Trust Risk Register
WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination. Patient flow and quality coordinator (band 7) allocated on a daily basis	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required. staff consultation on call enhancement discussion	Women's and Children's	Workforce	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Interim Chief Nurse	Divisional Board - W & C, People and OD Delivery Group		People and OD Committee	30/09/2022	Stephens, Lisa	Trust Risk Register
M2268Emer	The risk of patient deterioration, harm and poor patient experience when care is provided in the corridor during times of overcrowding in ED	Patient to staff ratio 1:4 Clinically ready to proceed patients only to be moved to the corridor and those awaiting discharge . Clear criteria in place (recorded on escalation ambulance policy)to ensure only low risk patients are placed in corridor. Patients that have been identified as at risk of fall Risk of absconding / wandering should not be placed in the corridor. Patients with that cannot access the toilet facilities by chair or walking should not be placed in corridor.	Complete CQC action plan Compliance with 90% recovery plan Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR audit form fo NIC re patients suitability Fire risk assessment Risk assessment of corridor care Review of SOP and escalation policy	Medical	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse & Director of Quality	Divisional Board - Medical, Emergency Care Delivery Group, Quality Delivery Group, Trust Health and Safety Committee	Emergency Care Operational Group, Patient Experience Group, Resuscitation and Deteriorating Patient Group	Emergency Care Board, Quality and Performance Committee, Trust Leadership Team	30/09/2022	Hayes, Sally	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel	People and OD Committee, Quality and Performance Committee, Trust Leadership Team	30/09/2022	Holdaway, Matt	Trust Risk Register

C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals.	COVID T&F Group to develop Recovery Plan to minimise harm To resolve outstanding areas of concern	Corporate	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	COO	Divisional Board - Corporate / DOG, Quality Delivery Group			Quality and Performance Committee, Trust Leadership Team	13/08/2022	Zada, Qadar	Trust Risk Register
D&S3558Pharm	The risk of breakdown of air handling unit (due to age)leading to poorer patient outcomes for oncology	Planned preventative maintenance by GMS Outsourcing for some products in place	Liaise with GMS AHU motors report of AHU status	Diagnostics and Specialties	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk		Divisional Board - D & S	Medicines Optimisation Committee		Cancer Services Management Board	30/11/2022	White, Amanda	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Infection Control Committee			Quality and Performance Committee	09/09/2022	Bradley, Craig	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months.	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - D & S, Estates and Facilities Committee, Quality Delivery Group	Pathology Management Board		Finance and Digital Committee, Quality and Performance Committee	14/09/2022	Rees, Linford	Trust Risk Register
D&S2938RT	The Workforce risk that the Radiotherapy Service will not be able to recruit and retain enough staff to maintain the cancer waiting times and extended working due to a National shortage of Therapeutic Radiographers and difficulty recruiting & retaining due to our lower pay scales and increased opportunities from promotion elsewhere.	New Band 5 radiographers are being recruited but we are seeing less than 25% of the numbers of applicants that we have seen in the past.(2019 - >40 applicants /2022 - 11 applicants) We are currently recruiting a Band 5 radiographer from overseas but there is a significant lag in time from recruitment to arrival in the Trust. We have been waiting 6 months. Attempts are being made to recruit agency staff although there is a national shortage of agency radiographers, so have only been able to recruit 3 agency radiographers in 7 months. This has changed as of 9.6.22 due to availability of staff as the Rutherford Centre has closed. There has been an agreement to increase the agency rate offered and also to look off framework for other Agencies. This has not resulted in any further agency staff being employed. As from 14th March we closed a Linac. This is to maximise use of resources by extending hours on other machines The remaining 3 machines at CGH will be working 8-6.30 shifts. This allows the maximum capacity with 3 machines	Workforce 5 year plan to include this risk Proposal to recruit apprentice for Nov 2020 Write VCP Increase access to agency staff Over recruitment of Band 5 staff Present paper requesting Retention & Recruitment uplift Banding review for Radiographer grades Work through the findings of the departmental survey VCP for additional Band 7 post Recruit to 8 x Band 5 posts Submit bid for Capital financing of Apprentice posts Recruit to additional Band 7 post Add current staff to Bank Create Action Plan for stfafing in order to support recovery of waiting list Banding Review of Radiotherapy Staffing	Diagnostics and Specialties	Workforce	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse & Director of Quality	Divisional Board - D & S	OHPCLI Board, Other	Divisional Quality Board	Other	30/11/2022	Moore, Bridget	Trust Risk Register
S2715	The risk to quality of care of patients remaining in recovery when they are either fit for discharge and require ward-based care or require care on DCC.	Use of agency staff in recovery overnight Daily sit-rep SOP for use of recovery as escalation area with breaches reported to site management DSU policy	escalate risk to divisional board escalate issues to execs and chief nurse monitoring of impact winter plan Monthly audit for overnight patients in PACU collect data on direct discharges from recovery As per request from Liz Bruce please take risk to ECDG Escalate issues to Div Tri and discuss increasing overnight PACU establishment review SOPs Discussion with specialty leads to accommodate patients within their bed base following surgery review of establishment as part of staffing risks	Surgical	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Nurse and Director of Quality (Interim)	Divisional Board - Surgery, People and OD Delivery Group, Quality Delivery Group			People and OD Committee, Quality and Performance Committee	30/08/2022	Beamish, Sally	Trust Risk Register
M3682Emer	The risk of death, serious harm or poor patient outcome due to delayed assesment and treatment as a result of poor patient flow in the Emergency Department.	Since October, the ED team has implemented several changes to processes in order to mitigate the impact on the department when there is no admitting capacity. This includes: - Revised roles and responsibilities of key roles in the ED - Reintroduced Patient Safety Huddles 5 times a day - Reconfigured ED layout, bringing cohort area closer to Pitstop and Ambulance bay - Recruited agency paramedics to staff cohort area and release SWAST crews	Please can you review Risk, discuss at Specialty Governance or Escalation to Div Board to review and sign off. Progress VCPs for Flow Coordinator and ED Assistants Submit workforce paper to Exec COO Ensure meeting to discuss ICS risks is re-established and risk M3682 is discussed with partners	Medical	Safety	Catastrophic (5)	Likely - Weekly (4)	20	15 - 25 Extreme risk	Medical Director	Divisional Board - Medical	Unscheduled Care Leaders Group		Quality and Performance Committee, Trust Leadership Team	23/07/2022	McMahon, Rory	Trust Risk Register
			1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers													

C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (CDTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Proide training to 5b in the use of cavilon advance + Provide training to ward on completion of 1st hour priorities Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed Bespoke training to DCC staff for categorisation of pressure ulcers Bespoke training to ward 4a to include 1st hour priorities produce training document on wound measurements for Rendcomb The provision of RCA support/training for TV issues to be take to pressure ulcer council Work with Knightsbridge to support staff TVN training Bespoke training in management of pressure ulcer [revention on ward 7a TVN to d/w TVN lead regarding use of share care pathway in reards to EPR. Implement training programme in management of patient pressure ulcers in ED Ward 7a W170891 training with HCA's to allow them to assist registered nurses with assessing patient skin and documenting on EPR	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group		Quality and Performance Committee, Trust Leadership Team	09/09/2022	Bradley, Craig	Trust Risk Register

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 28 September 2022		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	Urgent care remained a key challenge. There had been some modest improvement in ambulance handovers and discharges, however they were not sufficient to improve the levels of flow required to reduce length of waits in the Emergency Department. The continued impact on social care remained a key challenge at system level. High numbers of MOFD patients remained in hospitals as a result of this pressure.	The Trust continued to review its own processes, and system discussions were ongoing.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	The following key points were highlighted: • The Trust remained a high performer on elective recovery; the organisation continued to make significant progress on the number of patients on the waiting list. • A winter ward plan was in development, with 24-34 additional beds included. • The Trust's cancer performance was good. There were plans in place to improve the two-week-wait pathway, which had reported a slight reduction against target in August. The Trust had made some marginal gains against the 62-day standard, and performance against this continued to be monitored. • A slow increase in covid cases was reported.	External scrutiny had been commissioned to review theatre productivity and ensure best practice processes were utilised.
Trust Risk Register	One new risk had been added to the risk register, one had been downgraded, and one closed. New approaches were being implemented to support learning and response to Emergency Department safety concerns, including an improvement collaborative which commenced in September. The Committee discussed violence and aggression incidents, noting the clarity required around oversight and leadership.	The Committee was pleased to see the positive impact of the work around Never Events. The National Patient Safety Strategy had been released, with the Trust required to transition to the new approach within twelve months. The Board would receive a development session on this in October.
Learning from Deaths Report	The report was received for information, with the Committee particularly noting the higher than expected weekend/weekday mortality rates. The Committee noted that the statistically significant increase in mortality rates was still being investigated internally and analysed.	The Trust would utilise Dr Foster to provide additional assurance on weekend mortality rates. The Committee was assured by the governance systems in place for reviewing deaths.
Serious Incidents Report	Seven serious incidents had been reported since July. There had been no further Never Events since the last report. Two further HSIB cases had been reported. Staffing issues within the team were discussed, with vacancies, sickness levels and increase in activity impacting on the ability to progress against standards. All cases were reviewed and prioritised, however delays to complaints, moderate harm duty of candour letters, and PHSO cases were becoming significant.	The ongoing Corporate Governance review aimed to ensure appropriate reporting throughout the organisation; serious incident reporting would be part of the review.
Medicine Division Internal Audit Review	The review had been recommended for information by the Audit and Assurance Committee. Due to the significant operational pressures the Medicine Division were unable to fully engage with the audit at the time,	A follow-up review of the Medicine Division would take place in the autumn; a plan for this was being finalised.

	with auditors unable to provide an assurance opinion. Auditors had recommended to the Trust that the review was undertaken again within the next three years. Assurance was given that significant work had been undertaken on the recommendations from the audit.	
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Patient Property Update	The report detailed the progress achieved following recommendations from the Security of Patient Property report. A number of actions were in place and were regularly reviewed, including the new protocol which was due to go live on 1 November.	The Committee was assured by the progress made.
Cancer Services Annual Report	The Committee was assured by the report.	None.
Safeguarding Adults and Children Annual Report	The Committee was assured by the report.	None.
Infection Prevention and Control Annual Report	The Committee was assured by the report.	None.
Regulatory Report	The Committee was assured by the report.	None.
Items not Rated		
System feedback		
Impact on Board Assurance Framework (BAF)		
Target risk scores for SR1 would be reviewed to reflect progress against regulatory standards sooner than December 2024. An external partnerships BAF risk was in development to reflect delay related harm, urgent and emergency care, and finances across the local health system.		

Report to Board of Directors			
Agenda item:	**10**	**Enclosure Number:**	**5**
Date	13 October 2022		
Title	Quality and Performance Report		
Author /Sponsoring Director/Presenter	Authors: Roger Blake, Associate Director of elective care, Katie Parker-Roberts, Head of Quality, and Suzie Cro, Deputy Director of Quality and Programme Director for Nursing and Midwifery Excellence Presenting directors: Qadar Zada, Chief Operating Officer, Matt Holdaway, Director of Quality and Chief Nurse, Alex D'Agapayeff, Interim Medical Director		

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

Summary of Report

Purpose

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

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

QPR key issues to note

Quality

The exception reports for all quality metrics are at pages 16-26 and a selected number of metrics have been highlighted below.

Number of trust apportioned Clostridium

During August there were a total of 10 C. difficile cases associated with health care (3 Community onset health care associated and 7 hospital onset cases). We continue to implement the trust wide C. difficile reduction plan. The reduction plan addresses cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with C. difficile infection (CDI). The reduction plan and assurance of action completion is being monitored through the Infection Control Committee. The AMS team continue to undertake 4 AMS ward rounds weekly which involves implementing required changes to prescriptions and support training of prescribers on the ward. Outcomes of the round are reported to medical teams at the time of the round and with audit data afterwards. The IPCT and GMS are continuing to support the instigation of the national cleaning standards and agreed to explore a trial to change the cleaning products for red cleans to a more efficacious product against spores. It was also noted that a significant number of red discharge cleans are not being undertaken for C. difficile. This will be discussed at ICC

and actions have been taken to inform, educate staff on the need and on EPR a red clean is now being requested for all CDI rooms by the IPCT> The C. difficile task and finish group has now been re-launched as a ICS C.diff infection improvement group; terms of reference and ICS strategy has been developed with GHT deputy DIPC as chair. This will align to the AMS ICS and IPC ICS groups to support county wide improvements to reduce the prevalence of CDI. Furthermore, Nurse-led C. difficile ward rounds continue thrice weekly to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients.

Number of MSSA bacteraemia cases

During August we had 10 health care associated MSSA blood stream infections; 5 hospital onset health care associated (HO-HA) and 5 community onset health care associated cases. All HO-HA cases will be reviewed via rapid post infection review and findings discussed with teams for action; those with moderate or significant harm will be datixed and escalated to risk for review. A IPCT meeting has been organised to review all the cases for August to identify themes and trends for remedial action. Reducing MSSA bacteraemias continue to be a focus of the IPC strategy 2022/23 specifically related to improving the management and care of invasive devices. There are actions within the programme that will be implemented to ensure we do not breach our internally set annual limit of no more than 30 healthcare associated cases for 2022/23. A trust wide audit IV access device audit is scheduled for September 2022 as these devices have been identified as significant cause of the blood stream infections. It is also noted that there has been a regional increase in MSSA BSIs

MSSA infection rate per 100,000 bed days

During August we had 10 health care associated MSSA blood stream infections; 5 hospital onset health care associated (HO-HA) and 5 community onset health care associated cases. All HO-HA cases will be reviewed via rapid post infection review and findings discussed with teams for action; those with moderate or significant harm will be datixed and escalated to risk for review. A IPCT meeting has been organised to review all the cases for August to identify themes and trends for remedial action.

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Number of bed days lost due to infection control outbreaks

During August we had 51 closed empty beds due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways and being cohorted together in bays. There was also a ward effected by a Norovirus outbreak which resulted bed closures Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients to prevent the onward transmissions of infection. Outbreak meetings continue to ensure review of all closed areas. Patients who are red recovered (completed isolation after testing positive for COVID) are moved to closed empty beds due to COVID-9 as a means to minimise empty closed bed numbers. Bay are also no longer closed due to COVID exposure; admissions can continue despite exposures. wards affected by outbreaks are reviewed daily by the IPCT and comprehensive weekend plans are developed to support beds being re-opened out of hours

Pressure ulcers acquired as in-patient

Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. The Tissue Viability Team have worked with SWAST to provide pressure relieving equipment and training on its use to paramedics. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now taking place monthly to increase throughput. It should be noted that we have identified a data quality issue with Datix reporting and some of the pressure ulcers reported as hospital-acquired do not validate as such, this is being investigated by the external provider. Validation of the data has recently been carried out and an issue with Datix reporting has meant more pressure ulcers are reported as the report has included the unvalidated data, this has now been rectified and the data needs to be re-run.

Unstageable pressure ulcers

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Falls Update

August 2022 saw 5 falls resulting in harm, such as fractures and head injuries. Every fall resulting in moderate harm or worse is reviewed in the weekly Preventing Harm Hub where immediate safety actions and learning are rapidly assessed. The number of falls in hospital are linked to a range of factors, most acutely to safe staffing levels. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and this is now back to normal.

Number of Breaches of Mixed Sex Accommodation

The Trust is reporting mixed-sex accommodation breaches in line with national policy following a period of local agreement with the CCG that resulted in recording the MSA breaches but not reporting them due to operational pressure. All breaches, categorised in accordance with national guidelines, must be authorised by the Chief Nurse or Deputy Chief Nurse. Each month the reasons are reviewed overall, delay in transfers from critical care and recovery areas beyond 4- hours result in an MSA breach. Accurate numbers are now reported to the ICB therefore the increase we are currently observing reflects new oversight.

Friends and Family Test

The Trust had 6529 responses to FFT in August 2022, and the overall Trust FFT positive score has seen an increase in positive score this month of 89.8%. This is largely due to increases in the positive FFT score for unscheduled care

(5% increase in positive score at GRH) and a slight increase for outpatients. Comments were mostly around communication, lack of organisation, waiting and delayed appointments.. Divisions provide updates through QDG each quarter on improvement plans happening within divisions, and the patient experience team are reviewing current reporting offer to improve the way that FFT and PALS data is triangulated to support improvement plans.

Performance (exception reports at pages 27-38 of main QPR)

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients. During August, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4-hour ED standard, but continue to achieve the zero 104 weeks breaches target.

Urgent and Emergency care

August continued to be a challenging month for the Emergency Department (ED) but saw an increase in performance from 70.62% to 72.59% compared to the previous month. Ambulance handover delays increased for 30-60 minutes handovers delays however reduced slightly for those 60+ minutes. Correcting this negative trend remains a priority for the Trust, and the ED has implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.

Diagnostics

Overall diagnostic performance has improved in month and by approximately 2%. This change has been influenced by reductions in NOUS, Endoscopy and Echo breaches. Overall, the total number of patients waiting has reduced in-month by 1,076 and the total number of breaches by 397. This is the largest gain made for some time and the continued gradual improvement in Echo performance is positive.

Cancer

For cancer, performance data showed the Trust met 3 out of 9 standards with all 7 out of 9 standards above national average clearly showing a challenging month. The Trust achieved the 2ww breast symptomatic standard in July with 93.7% performance. The Trust continued strong 28 day Faster Diagnosis Standard performance with 76.2% of patients receiving their diagnosis in July. 62 day standard performance for July was 52.4% which will rise following final submission but still a very poor month. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity. At a recent NHSE/I meeting about 62 day backlogs, regional colleagues were pleased with the Trust's performance in respect of bringing long waiting patients numbers down.

Elective care

For elective care, the RTT performance did not meet the national standard, albeit a marginal improvement has been made in-month. Month end submission is anticipated to be 71.6%, up 0.2% on last month. The total incompletes continues to rise and the unconfirmed August position is expected to be around 65,000 (an increase of approx 1,250 on last month). The number of patients waiting over 52 weeks has decreased slightly, down from 1,439 last month to 1,397 in SEP August. Focus continues to be placed on patients over 70 weeks, although in month a reduction of only 3 has been made. The effect of the Haematology recovery plan should start to result in reductions soon. The over 78 week cohort however has reduced by 13 in month, and 104 breaches remains at

zero.

The Elective Care Hub are concluding the contact with patients on an RTT pathway over 18 weeks, and preliminary discussions now taking place as to how they can support a reduction in the Follow Up backlog.

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

Recommendation

The Board is asked to note the report for assurance.

Enclosures

QPR August 2022 – Dashboard

QPR August 2022 – SPC Document

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period *August* 2022

Presented at September 2022 Q&P and October 2022 Trust Board

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Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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

Indicator		Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	354	500	523	467	446	504	330	328	315	449	496	552	587
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	294	692	752	1074	952	1057	1093	1263	1357	1434	1203	1081	1169
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	77.17%	72.51%	73.80%	74.54%	73.36%	73.67%	70.92%	69.98%	68.67%	69.73%	73.02%	70.62%	72.59%
ED: % total time in department – under 4 hours (type 1)	Trajectory	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%
	Actual	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%	55.41%	59.43%	56.00%	57.39%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.81%	73.01%	72.52%	71.41%	71.57%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	1554	1598	1590	1492	1430	1273	1112	1125	1231	1248	1367	1439	1397
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.77%	18.99%	19.38%	20.76%	18.83%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	93.50%	92.00%	93.40%	92.10%	92.20%	87.00%	94.60%	94.00%	89.90%	93.40%	86.50%	87.70%	89.80%
2 week wait breast symptomatic referrals	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	93.20%	90.80%	89.80%	88.60%	84.80%	87.40%	93.90%	91.30%	89.70%	95.50%	94.10%	93.70%	88.90%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	97.10%	95.90%	97.80%	96.10%	94.70%	95.50%	97.70%	98.00%	95.10%	96.80%	94.20%	95.20%	94.10%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	100.00%	100.00%	100.00%	100.00%	99.50%	99.50%	99.60%	100.00%	100.00%	100.00%	100.00%	100.00%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	98.50%	99.40%	100.00%	98.80%	100.00%	99.50%	99.50%	100.00%	94.50%	91.10%	74.40%	77.00%	93.00%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	92.60%	88.10%	91.50%	95.20%	94.30%	88.40%	90.80%	91.00%	88.70%	95.90%	89.70%	84.90%	78.70%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	82.90%	90.80%	76.50%	85.30%	91.50%	85.90%	80.00%	90.90%	85.20%	79.20%	88.00%	90.00%	91.30%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	63.60%	72.10%	84.10%	70.60%	73.10%	75.00%	69.70%	80.60%	70.40%	76.90%	62.90%	59.50%	70.50%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	72.10%	71.00%	71.80%	72.20%	64.70%	68.40%	71.30%	78.30%	64.30%	63.60%	53.30%	52.40%	56.20%

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

														% growth from previous year	
Measure	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Monthly (Aug)	YTD
GP Referrals	7,922	8,303	8,150	8,517	7,168	7,917	8,168	9,326	8,262	9,251	9,025	8,944	9,485	19.7%	5.6%
OP Attendances	47,546	52,912	49,516	56,469	47,728	51,666	49,139	57,196	47,461	55,634	51,009	50,011	51,990	9.3%	-0.1%
New OP Attendances	14,662	16,658	15,956	18,297	15,355	16,423	16,109	18,619	14,881	17,665	16,419	16,327	16,889	15.2%	2.2%
FUP OP Attendances	32,884	36,254	33,560	38,172	32,373	35,243	33,030	38,577	32,580	37,969	34,590	33,684	35,101	6.7%	-1.1%
Day cases	4,525	4,310	4,187	4,536	3,940	4,121	4,202	4,958	4,103	4,721	4,618	4,678	5,180	14.5%	2.1%
All electives	5,468	5,237	5,217	5,492	4,940	4,798	5,049	5,981	4,978	5,792	5,608	5,627	6,124	12.0%	2.4%
ED Attendances	12,006	13,186	13,044	11,988	10,943	11,433	10,545	12,306	11,616	12,551	12,092	12,596	11,915	-0.8%	2.5%
Non Electives	4,333	4,244	3,998	3,867	3,445	3,461	2,948	3,311	3,032	3,369	3,349	3,316	3,080	-28.9%	-26.3%

Trust Scorecard - Safe (1)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Infection Control																
COVID-19 community-onset - First positive specimen <=2 days after admission	140	118	192	126	131	183	156	219	146	64	92	127	59	302	No target	
COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	12	12	18	28	52	64	86	118	126	58	32	92	29	216	No target	
COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	2	0	1	1	23	21	37	47	37	30	25	53	14	92	No target	
COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	9	1	9	5	23	29	72	79	67	41	30	90	29	138	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	0	1	0	0	0	0	0	1	0	0	Zero	
MRSA bacteraemia - infection rate per 100,000 bed days						3.4						3.5			Zero	
Number of trust apportioned Clostridium difficile cases per month	15	7	4	12	8	3	7	8	15	8	12	4	10	35	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	9	4	1	8	5	2	5	6	10	6	7	2	7	23	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	6	3	3	4	3	1	2	2	5	2	5	2	3	12	<=5	
Clostridium difficile - infection rate per 100,000 bed days	51.1	23.5	13	40.6	27.3	10.2	25.9	27	53.9	27.6	42.9	13.9		41.3	<30.2	
Number of MSSA bacteraemia cases	5	5	0	2	5	3	3	2	2	1	5	5	10	8	<=8	
MSSA - infection rate per 100,000 bed days	17	16.8		6.8	17	10.2	11.1	6.8	7.2	3.5	17.9	17.4		9.4	<=12.7	
Number of ecoli cases	0	3	5	7	5	5	5	2	9	4	4	7	6	17	No target	
Number of pseudomona cases	1	1	0	1	0	0	0	0	0	1	0	1	2	1	No target	
Number of klebsiella cases	3	4	2	2	2	0	0	1	1	3	0	1	3	4	No target	
Number of bed days lost due to infection control outbreaks	60	1	93	176	453	444	637	335	74	2	12	52	51	88	<10	>30

Trust Scorecard - Safe (2)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Patient Safety Incidents																
Number of patient safety alerts outstanding	0	0	0	1	1										Zero	
Number of falls per 1,000 bed days	7.5	7	6.7	7	6.7	7.3	7.6	8.2	7.5	6.9	7.6	7.5	6	7.3	<=6	
Number of falls resulting in harm (moderate/severe)	5	5	5	3	9	5	10	9	4	4	4	5	5	12	<=3	
Number of patient safety incidents - severe harm (major/death)	3	6	7	10	7	7	10	28	6	8	10	14	13	24	No target	
Number of category 2 pressure ulcers acquired as in-patient	27	19	22	41	43	37	40	50	46	39	34	24	32	119	<=30	
Number of category 3 pressure ulcers acquired as in-patient	3	0	1	2	4	2	1	2	2	3	1	1	0	6	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient	5	1	4	9	9	12	14	10	12	18	14	10	7	44	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	4	6	1	7	12	13	7	8	12	21	10	2	5	43	<=5	
RIDDOR																
Number of RIDDOR	2			3	5	10	10	8	5	10		10	2		SPC	
Safeguarding																
Number of DoLs applied for	59	69	53	48	68	64	53	69	47	67	69	55	72	183	TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	7	4	6	1	5	2	3	4	3	7	6	3	4	16	TBC	
Total attendances for infants aged < 6 months, other serious injury	0	0	0	0	0	0	1	0	0	0	0	1	2	0	TBC	
Total admissions aged 0-17 with DSH	11	18	35	39	18	46	24	35	32	29	34	29	17	95	TBC	
Total ED attendances aged 0-17 with DSH	52	73	102	115	54	125	69	113	90	75	93	87	61	258	TBC	
Total number of maternity social concerns forms completed	46	72	58	65	52	67	70	71	72	72	80	78	101	222	TBC	
Total admissions aged 0-17 with an eating disorder	6	9	11	5	8	5	7	10	7	10	11	12	10	28	TBC	

Trust Scorecard - Safe (3)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Serious Incidents																
Number of never events reported	1	0	1	1	2	1	2	0	0	0	1	0	0	1	Zero	
Number of serious incidents reported	4	6	4	4	4	4	3	4	6	5	4	6	3	15	No target	
Serious incidents - 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																
% of adult inpatients who have received a VTE risk assessment	87.1%	92.0%	92.3%	90.7%	90.9%	87.5%	87.1%	90.7%	90.8%	88.5%	80.8%	79.9%	87.2%	86.8%	>95%	

Trust Scorecard - Effective (1)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Maternity																
% of women on a Continuity of Carer pathway	10.80%	10.90%	11.80%	10.30%	9.60%	10.20%	14.70%	12.60%	10.10%	9.10%	9.30%	8.70%	8.60%	9.10%	No target	
% C-section rate (planned and emergency)	32.02%	30.42%	31.59%	31.63%	32.44%	33.19%	31.45%	33.48%	34.48%	35.65%	37.93%	35.34%	34.57%	36.06%	No target	
% emergency C-section rate	17.98%	16.76%	17.76%	17.05%	15.61%	17.77%	15.72%	18.03%	19.08%	19.57%	21.55%	19.40%	17.61%	20.09%	No target	
% of women booked by 12 weeks gestation	91.4%	88.8%	91.0%	91.7%	92.6%	91.1%	90.5%	92.1%	90.1%	92.3%	90.1%	89.4%	92.7%	90.9%	>90%	
% of women that have an induced labour	28.49%	25.41%	25.00%	25.66%	24.95%	29.42%	33.09%	31.21%	30.52%	35.14%	29.49%	31.21%	30.02%	31.73%	<=33%	>30%
% stillbirths as percentage of all pregnancies	0.00%	0.00%	0.19%	0.00%	0.00%	0.43%	0.00%	0.64%	0.00%	0.00%	0.00%	0.22%	0.22%	100.00%	<0.52%	
% of women smoking at delivery	8.19%	10.16%	10.07%	8.80%	11.86%	12.58%	10.78%	11.46%	8.88%	9.11%	8.76%	9.13%	12.53%	8.92%	<=8.0%	
% breastfeeding (discharge to CMW)	48.4%	53.9%	48.0%	50.3%	48.1%	47.1%	46.0%	46.3%	45.5%	48.8%	59.8%	59.9%		60.4%		
% breastfeeding (initiation)	79.8%	80.8%	81.1%	79.5%	76.3%	78.8%	76.8%	78.2%	78.7%	77.6%	81.5%	78.6%	61.8%	79.3%	>=81%	
% PPH >1.5 litres	6.7%	4.9%	4.5%	3.4%	4.9%	3.6%	2.2%	3.9%	3.5%	2.4%	4.0%	4.5%	4.3%	3.2%	<=4%	
Number of births less than 27 weeks	0	1	2	2	0	1	0	1	3	0	4	0	1	7		
Number of births less than 34 weeks	11	18	13	9	10	7	4	9	13	8	15	4	8	36		
Number of births less than 37 weeks	33	47	49	32	44	33	19	43	49	35	50	38	38	134		
Number of maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total births	544	558	546	537	497	471	413	473	442	465	475	471	466	1,384		
Percentage of babies <3rd centile born > 37+6 weeks	0.9%	1.4%	1.1%	1.9%	2.4%	3.2%	1.7%	4.2%	1.4%	2.4%	0.6%	2.1%	2.1%	1.4%		
Mortality																
Summary hospital mortality indicator (SHMI) - national data	1	1	1	1	1.1	1.1	1.1	1.1	1.1						NHS Digital	
Hospital standardised mortality ratio (HSMR)	108.6	108.3	108.8	106.9	102.6	100.9	104	106.7	107.9	113.4					Dr Foster	
Hospital standardised mortality ratio (HSMR) - weekend	113.8	113.8	115.6	113.8	109.4	108	111.7	114.6	115.9	105.6					Dr Foster	
Number of inpatient deaths	156	163	183	191	189	218	183	179	185	174	172	170	168	531	No target	
Number of deaths of patients with a learning disability	2	2	2	4	1	3	1	1	3	2	2	1	0	7	No target	

Trust Scorecard - Effective (2)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Readmissions																
Emergency re-admissions within 30 days following an elective or emergency spell	9.54%	9.04%	8.18%	8.10%	8.10%	8.05%	7.32%	7.06%	7.52%	7.49%	7.78%	7.48%		7.60%	<8.25%	>8.75%
Research																
Research accruals	192	456	426	236	172	185	173	142	191	193	186	140	234		No target	
Stroke Care																
Stroke care: percentage of patients receiving brain imaging within 1 hour		47.5%	51.9%	50.0%	45.8%	72.7%	70.0%	73.4%	69.2%	67.6%	73.2%	71.4%	80.8%	69.3%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	91.8%	84.9%	66.7%	72.7%	75.4%	46.3%	91.0%	96.3%	97.7%	97.3%	96.3%	98.3%		97.1%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours		12.70%	15.10%	16.70%	8.70%	9.10%	75.00%	56.40%	69.20%	71.00%	61.00%	63.50%	80.00%	57.00%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival		44.60%	48.80%	40.50%	39.60%	54.50%	75.00%	59.50%	72.40%	70.40%	67.60%	61.90%	65.40%	72.00%	>=75%	<65%
Trauma & Orthopaedics																
% of fracture neck of femur patients treated within 36 hours	60.7%	56.1%	43.5%	50.8%	47.9%	59.4%	43.4%	50.7%	24.3%	26.7%	27.3%	37.7%	43.3%	25.9%	>=90%	<80%

Trust Scorecard - Caring (1)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Friends & Family Test																
Inpatients % positive	85.4%	86.4%	85.0%	88.0%	87.8%	89.1%	87.1%	88.3%	88.0%	87.2%	87.2%	90.0%	91.2%	87.5%	>=90%	<86%
ED % positive	70.5%	60.9%	66.7%	68.0%	78.8%	78.6%	67.6%	63.5%	62.7%	66.9%	69.8%	68.1%	71.5%	66.5%	>=84%	<81%
Maternity % positive	84.8%	87.7%	82.4%	89.7%	84.3%	94.1%	91.9%	85.7%	78.2%	85.2%	88.9%	91.8%	82.1%	83.6%	>=97%	<94%
Outpatients % positive	93.7%	93.2%	93.3%	93.9%	94.7%	94.3%	93.4%	93.2%	93.1%	92.8%	93.2%	93.0%	94.2%	93.0%	>=94.5%	<93%
Total % positive	88.5%	86.2%	85.4%	89.4%	91.2%	91.0%	88.6%	88.0%	87.2%	87.4%	88.3%	88.5%	89.8%	87.6%	>=93%	<91%
Number of PALS concerns logged	238	264	274	248	230	266	248	254	229	253	231	285	329	713	No Target	
% of PALS concerns closed in 5 days	82%	76%	65%	78%	71%	65%	73%	78%	67%	75%	77%	70%	77%	73%	>=95%	<90%
MSA																
Number of breaches of mixed sex accommodation	1	0	0	0	0	0	0	0	21	7	23	17	47	51	<=10	>=20

Trust Scorecard - Responsive (1)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Cancer																
Cancer - 28 day FDS (all routes)	78.9%	78.3%	81.0%	78.4%	78.8%	73.7%	82.9%	81.7%	78.4%	79.8%	73.5%	76.7%	78.7%	77.1%	>=75%	
Cancer - urgent referrals seen in under 2 weeks from GP	93.5%	92.0%	93.4%	92.1%	92.2%	87.0%	94.6%	94.0%	89.9%	93.4%	86.5%	87.7%	89.8%	90.1%	>=93%	<90%
Cancer - 2 week wait breast symptomatic referrals	93.2%	90.8%	89.8%	88.6%	84.8%	87.4%	93.9%	91.3%	89.7%	95.5%	94.1%	93.7%	88.9%	93.2%	>=93%	<90%
Cancer - 31 day diagnosis to treatment (first treatments)	97.1%	95.9%	97.8%	96.1%	94.7%	95.5%	97.7%	98.0%	95.1%	96.8%	94.2%	95.2%	94.1%	95.4%	>=96%	<94%
Cancer - 31 day diagnosis to treatment (subsequent – drug)	100.0%	100.0%	100.0%	100.0%	100.0%	99.5%	99.5%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>=98%	<96%
Cancer - 31 day diagnosis to treatment (subsequent – surgery)	92.6%	88.1%	91.5%	95.2%	94.3%	88.4%	90.8%	91.0%	88.7%	95.9%	89.7%	84.9%	78.7%	91.1%	>=94%	<92%
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	98.5%	99.4%	100.0%	98.8%	100.0%	99.5%	99.5%	100.0%	94.5%	91.1%	74.4%	77.0%	93.0%	88.5%	>=94%	<92%
Cancer - 62 day referral to treatment (urgent GP referral)	72.1%	71.0%	71.8%	72.2%	64.7%	68.4%	71.3%	78.3%	64.3%	63.6%	53.3%	52.4%	56.2%	61.2%	>=85%	<80%
Cancer - 62 day referral to treatment (screenings)	82.9%	90.8%	76.5%	85.3%	91.5%	85.9%	80.0%	90.9%	85.2%	79.2%	88.0%	90.0%	91.3%	82.1%	>=90%	<85%
Cancer - 62 day referral to treatment (upgrades)	63.6%	72.1%	84.1%	70.6%	73.1%	75.0%	69.7%	80.6%	70.4%	76.9%	62.9%	59.5%	70.5%	70.4%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	4	9	10	4	3	2	2	5	2	2	15	12	12	19	Zero	
Number of patients waiting over 104 days without a TCI date	12	18	21	23	25	14	22	50	73	58	47	46	51	178	<=24	
Diagnostics																
% waiting for diagnostics 6 week wait and over (15 key tests)	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.77%	18.99%	19.38%	20.76%	18.83%	19.38%	<=1%	>2%
The number of planned/surveillance endoscopy patients waiting at month end	1,439	1,435	1,397	1,410	1,422	1,334	1,269	1,286	1,365	1,367	1,371	1,367	1,384	1,368	<=600	
Discharge																
Patient discharge summaries sent to GP within 24 hours	61.1%	61.7%	60.5%	61.4%	58.4%	58.7%	62.0%	59.8%	60.1%	60.7%	59.5%	62.8%		60.1%	>=88%	<75%

Trust Scorecard - Responsive (2)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Emergency Department																
ED: % total time in department - under 4 hours (type 1)	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%	55.41%	59.43%	56.00%	57.39%	56.46%	>=95%	<90%
ED: % total time in department - under 4 hours (types 1 & 3)	77.17%	72.51%	73.80%	74.54%	73.36%	73.67%	70.92%	69.98%	68.67%	69.73%	73.02%	70.62%	72.59%	70.52%	>=95%	<90%
ED: % total time in department - under 4 hours CGH	88.74%	77.05%	83.00%	79.80%	79.03%	79.17%	73.72%	65.48%	65.44%	65.10%	69.81%	66.22%	63.29%	66.78%	>=95%	<90%
ED: % total time in department - under 4 hours GRH	57.55%	51.82%	52.48%	54.91%	53.96%	55.55%	52.12%	52.88%	49.00%	50.54%	54.23%	50.84%	54.51%	51.28%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	1	15	53	448	631	653	394	606	690	616	634	629	674	1,940	Zero	
ED: % of time to initial assessment - under 15 minutes	43.5%	28.0%	30.3%	30.2%	37.4%	35.4%	30.0%	22.9%	20.7%	36.9%	39.1%	41.1%	45.8%	39.1%	>=95%	<92%
ED: % of time to start of treatment - under 60 minutes	30.7%	22.8%	27.8%	27.1%	32.6%	31.8%	26.1%	23.1%	22.2%	22.3%	25.8%	23.0%	28.7%	25.8%	>=90%	<87%
Number of ambulance handovers over 60 minutes	294	692	752	1,074	952	1,057	1,093	1,263	1,357	1,434	1,203	1,081	1,169	3,994	Zero	
% of ambulance handovers < 15 minutes				23.11%	23.53%	24.72%	18.20%	15.73%	9.81%	11.80%	14.97%	13.85%	14.30%	12.28%	>=65%	
% of ambulance handovers < 30 minutes				42.28%	45.54%	44.45%	34.48%	29.58%	21.14%	24.68%	30.96%	32.57%	33.40%	25.76%	>=95%	
% of ambulance handovers 30-60 minutes	9.48%	13.85%	14.55%	14.21%	13.90%	15.56%	13.25%	13.17%	13.32%	16.72%	18.66%	19.80%	20.90%	16.34%	<=2.96%	
Operational Efficiency																
Cancelled operations re-admitted within 28 days	89.06%	80.60%	73.75%	74.03%	80.23%	71.60%	93.48%	95.59%	76.90%	81.48%	78.05%	87.18%	61.20%	78.50%	>=95%	
Urgent cancelled operations	10	1	44	24	1	1	0	0	0	0	0	0	0	0	No target	
Number of patients stable for discharge	158	179	178	213	162	239	252	257	233	238	211	229	253	227	<=70	
Number of stranded patients with a length of stay of greater than 7 days	421	472	468	503	499	491	537	538	513	493	498	491	534	501	<=380	
Average length of stay (spell)	4.84	5.32	5.47	6.03	6.02	6.13	6.67	6.68	6.62	6.68	6.32	6.16	6.38	6.54	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.39	5.99	6.22	6.97	7	6.78	7.93	8.06	7.91	8.03	7.46	7.16	7.55	7.79	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.31	2.25	2.48	2.28	2.46	2.42	2.07	2.13	2.13	2.27	2.32	2.53	2.33	2.24	<=3.4	>4.5
% day cases of all electives	82.74%	82.28%	80.24%	82.57%	79.74%	85.87%	83.20%	82.88%	82.40%	81.49%	82.33%	83.12%	84.57%	82.06%	>80%	<70%
Intra-session theatre utilisation rate	89.32%	84.80%	87.91%	85.46%	83.33%	86.64%	84.99%	87.39%	87.55%	87.94%	84.94%	85.50%	88.34%	86.79%	>85%	<70%

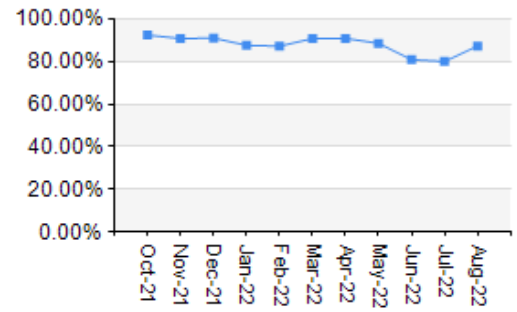
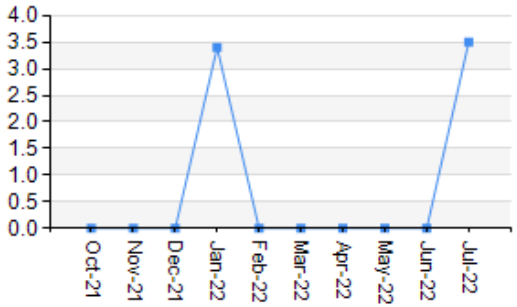
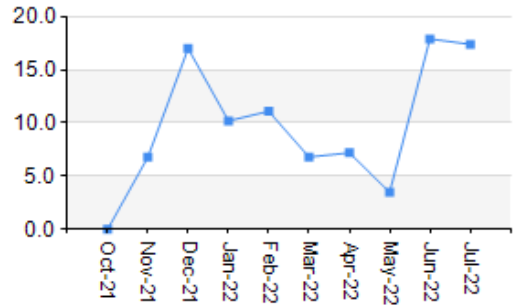
Trust Scorecard - Responsive (3)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Outpatient																
Outpatient new to follow up ratio's	2.13	2	1.94	1.93	1.96	1.95	1.88	1.96	2.04	2.02	1.97	1.96	1.97	2.01	<=1.9	
Did not attend (DNA) rates	7.24%	7.15%	7.17%	7.03%	7.23%	7.62%	7.01%	7.30%	7.44%	6.86%	6.63%	6.73%	6.34%	6.96%	<=7.6%	>10%
RTT																
Referral to treatment ongoing pathways under 18 weeks (%)	74.39%	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.81%	73.01%	72.52%	71.41%	71.57%	72.45%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	5,582	5,642	5,593	5,642	5,847	5,272	5,087	5,135	5,419	5,386	5,806	6,312	6,384	5,537	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,906	2,946	2,935	2,641	2,605	2,292	2,165	2,182	2,421	2,490	2,579	2,678	2,841	2,497	No target	
Referral to treatment ongoing pathway over 70 Weeks (number)	611	403	295	228	205	207	185	148	128	145	125	172	169	133	0	

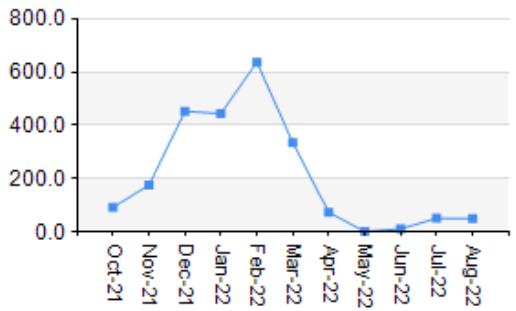
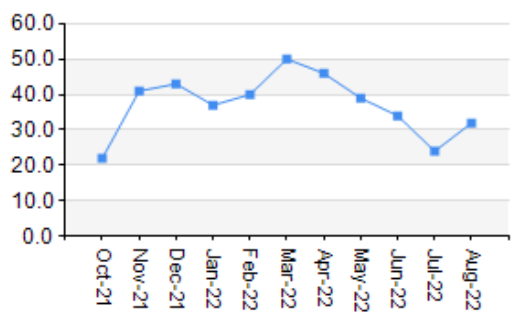
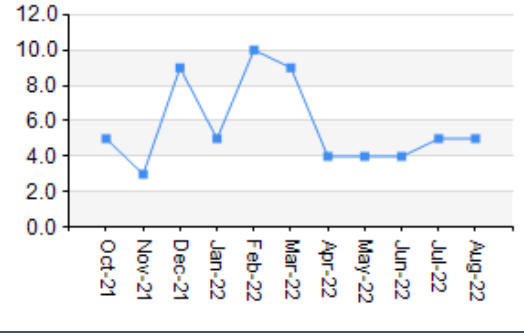
Trust Scorecard - Well Led (1)

	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	22/23 Q1	Standard	Threshold
Appraisal and Mandatory Training																
Trust total % overall appraisal completion	79.0%	78.0%	78.0%	79.0%	80.0%	80.0%	78.0%	77.0%	78.0%	80.0%	80.0%	79.0%	79.0%	80.0%	>=90%	<70%
Trust total % mandatory training compliance	90%	88%	87%	87%	87%	87%	87%	86%	86%	86%	86%	86%	87%	86%	>=90%	<70%
Safe Nurse Staffing																
Overall % of nursing shifts filled with substantive staff	97.22%	99.61%	97.11%	95.93%	89.16%	85.93%	87.53%	85.28%	92.70%	90.90%	83.97%	80.60%	86.63%	89.09%	>=75%	<70%
% registered nurse day	95.11%	98.11%	95.49%	94.07%	87.59%	84.20%	85.30%	82.60%	89.11%	89.31%	81.76%	78.48%	83.63%	86.63%	>=90%	<80%
% unregistered care staff day	98.32%	96.58%	95.82%	95.07%	84.77%	83.85%	83.66%	74.95%	89.59%	88.03%	81.86%	77.73%	86.10%	86.39%	>=90%	<80%
% registered nurse night	101.09%	102.46%	100.10%	99.31%	91.99%	89.02%	91.54%	90.13%	99.35%	93.78%	88.03%	84.51%	92.23%	93.59%	>=90%	<80%
% unregistered care staff night	111.39%	111.67%	105.90%	103.45%	94.98%	95.26%	97.78%	91.50%	103.36%	101.17%	100.46%	92.96%	105.05%	101.63%	>=90%	<80%
Care hours per patient day RN	4.7	4.6	5	5.1	5	4.9	4.8	4.8	5.2	5.1	5.6	4.9	6.1	5.2	>=5	
Care hours per patient day HCA	3.3	3.5	3.2	3.1	3.1	3	2.9	2.8	3.2	3.1	2.7	3	3.8	3.1	>=3	
Care hours per patient day total	8	8.1	8.1	8.3	8.1	7.9	7.7	7.6	8.4	8.2	8.3	7.9	10	8.3	>=8	
Vacancy and WTE																
% total vacancy rate	7.50%	6.82%	6.39%	7.37%	8.09%	11.16%	10.68%	10.45%	10.79%	10.61%	10.97%	10.66%	10.12%		<=11.5%	>13%
% vacancy rate for doctors	7.80%	7.41%	6.74%	7.45%	7.05%	8.88%	8.35%	7.99%	7.91%	7.79%	7.75%	7.98%	-652.05%		<=5%	>5.5%
% vacancy rate for registered nurses	9.40%	7.89%	7.87%	8.17%	8.64%	14.46%	14.29%	14.09%	14.34%	14.60%	15.05%	14.54%	15.02%		<=5%	>5.5%
Staff in post FTE	6685.55	6730.66	6718.8	6686.83	6627.94	6648.33	6678.52	6707.09	6683.74	6683.28	6659.49	6688.51	6963		No target	
Vacancy FTE	537.29	491.56	457.02	530.17	582.02	834.81	799.75	782.28	807.64	794.16	821.21	906.67	122.39		No target	
Starters FTE	36.53	79.76	42.43	59.94	70.65	77.03	69.31	51.46	91.38	85.03	60.58	94.35	86		No target	
Leavers FTE	78.84	68.51	89.94	66.53	81.1	88.76	47.74	84.88	67.55	83.93	67.04	75.62	69.27		No target	
Workforce Expenditure and Efficiency																
% turnover	10.7%	11.1%	11.7%	11.7%	12.3%	12.9%	11.8%	13.8%	14.2%	14.4%	14.5%	14.5%	14.7%		<=12.6%	>15%
% turnover rate for nursing	9.77%	9.72%	9.70%	10.52%	10.83%	10.99%	10.69%	12.15%	12.80%	13.03%	13.05%	13.80%	14.58%		<=12.6%	>15%
% sickness rate	3.8%	3.9%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%	4.1%	4.2%	4.2%	4.2%	4.2%		<=4.05%	>4.5%

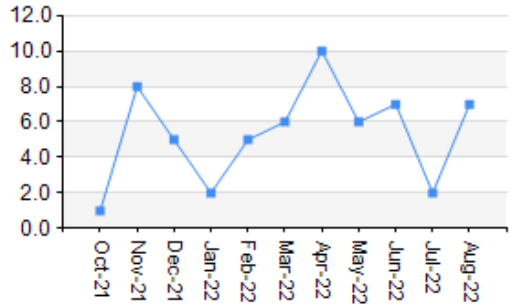
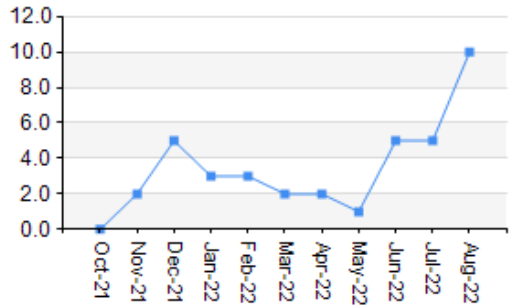
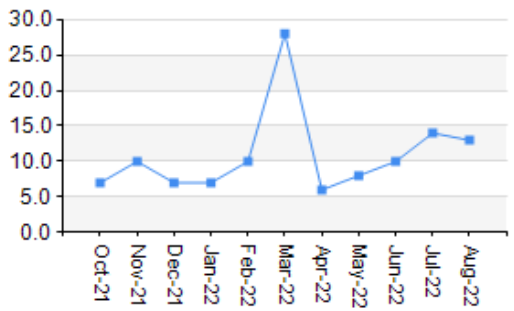
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		The electronic capture of the assessments is now in the final stages of planning as part of the new electronic prescribing system. This will allow a more accurate picture of performance and better drive any improvement required.	**Quality Improvement & Safety Director**
MRSA bacteraemia - infection rate per 100,000 bed days **Standard: Zero**		In August we did not identify an MRSA bacteraemia; we had a case reported in July 2022 and this represents 1 case for 2022-23 so far. A root cause analysis was undertaken doe this case and as a result of the issues identified related to PVC documentation the IPCT have met with the EPR team to make improvements to the record. We also started to undertake an ongoing audit of MRSA screening and decolonisation to support actions for change in light of the missed opportunity to provide daily decolonisation/ Octenisan through the patient's admission.	**Associate Chief Nurse, Director of Infection Prevention & Control**
MSSA - infection rate per 100,000 bed days **Standard: <=12.7**		During August we had 10 health care associated MSSA blood stream infections; 5 hospital onset health care associated (HO-HA) and 5 community onset health care associated cases. All HO-HA cases will be reviewed via rapid post infection review and findings discussed with teams for action; those with moderate or significant harm will be datixed and escalated to risk for review. A IPCT meeting has been organised to review all the cases for August to identify themes and trends for remedial action. Reducing MSSA bacteraemias continue to be a focus of the IPC strategy 2022/23 specifically related to improving the management and care of invasive devices. There are actions within the programme that will be implemented to ensure we do not breach our internally set annual limit of no more than 30 healthcare associated cases for 2022/23. A trust wide audit IV access device audit is scheduled for September 2022 as these devices have been identified as significant cause of the blood stream infections. It is also noted that there has been a regional increase in MSSA BSIs	**Associate Chief Nurse, Director of Infection Prevention & Control**

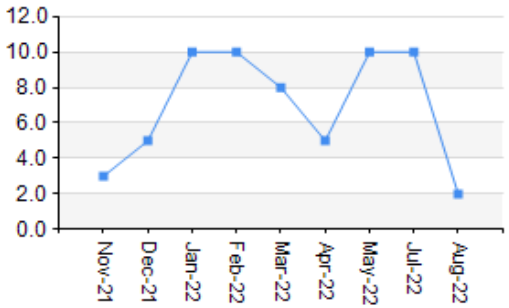
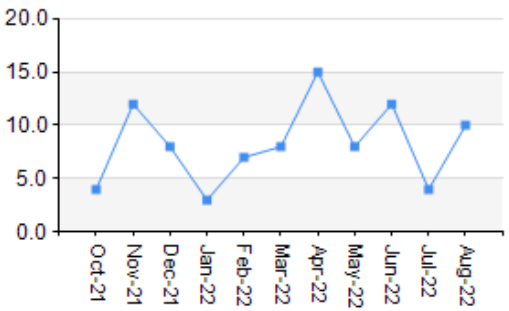
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of bed days lost due to infection control outbreaks **Standard: <10**		During August we had 51 closed empty beds due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways and being cohorted together in bays. There was also a ward effected by a Norovirus outbreak which resulted bed closures Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients to prevent the onward transmissions of infection. Outbreak meetings continue to ensure review of all closed areas. Patients who are red recovered (completed isolation after testing positive for COVID) are moved to closed empty beds due to COVID-9 as a means to minimise empty closed bed numbers. Bay are also no longer closed due to COVID exposure; admissions can continue despite exposures. wards affected by outbreaks are reviewed daily by the IPCT and comprehensive weekend plans are developed to support beds being re-opened out of hours	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of category 2 pressure ulcers acquired as in-patient **Standard: <=30**		Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. The Tissue Viability Team have worked with SWAST to provide pressure relieving equipment and training on its use to paramedics. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now taking place monthly to increase throughput. It should be noted that we have identified a data quality issue with Datix reporting and some of the pressure ulcers reported as hospital-acquired do not validate as such, this is being investigated by the external provider. Validation of the data has recently been carried out and an issue with Datix reporting has meant more pressure ulcers are reported as the report has included the unvalidated data, this has now been rectified and the data needs to be re-run	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		August 2022 saw 5 falls resulting in harm, such as fractures and head injuries. Every fall resulting in moderate harm or worse is reviewed in the weekly Preventing Harm Hub where immediate safety actions and learning are rapidly assessed. The number of falls in hospital are linked to a range of factors, most acutely to safe staffing levels. Current improvement work is focussed on increased compliance with falls assessments on admission, when completed there is evidence they prevent falls. We know that increased visiting hours reduces falls and this is now back to normal.	**Associate Chief Nurse, Director of Infection Prevention & Control**

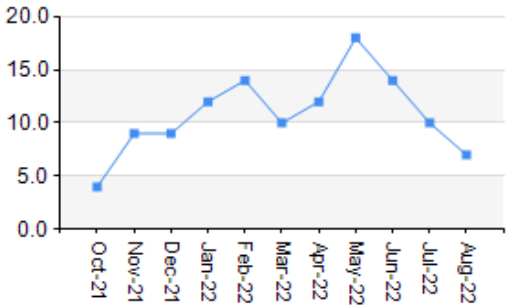
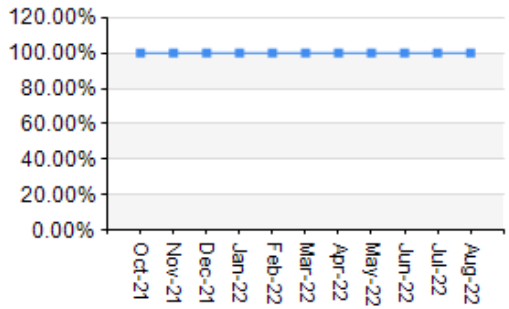
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		During August there were a total of 10 C. difficile cases associated with health care; which includes 7 hospital onset cases. We continue to implement the trust wide C. difficile reduction plan. The reduction plan addresses cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with C. difficile infection (CDI). The reduction plan and assurance of action completion is being monitored through the Infection Control Committee.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of MSSA bacteraemia cases **Standard: <=8**		During August we had 10 health care associated MSSA blood stream infections; 5 hospital onset health care associated (HO-HA) and 5 community onset health care associated cases. All HO-HA cases will be reviewed via rapid post infection review and findings discussed with teams for action; those with moderate or significant harm will be datixed and escalated to risk for review. A IPCT meeting has been organised to review all the cases for August to identify themes and trends for remedial action. Reducing MSSA bacteraemias continue to be a focus of the IPC strategy 2022/23 specifically related to improving the management and care of invasive devices. There are actions within the programme that will be implemented to ensure we do not breach our internally set annual limit of no more than 30 healthcare associated cases for 2022/23. A trust wide audit IV access device audit is scheduled for September 2022 as these devices have been identified as significant cause of the blood stream infections. It is also noted that there has been a regional increase in MSSA BSIs	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of patient safety incidents - severe harm (major/death) **Standard: No target**		Under Review	**Quality Improvement & Safety Director**

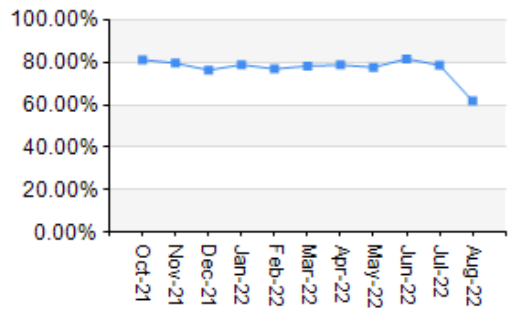
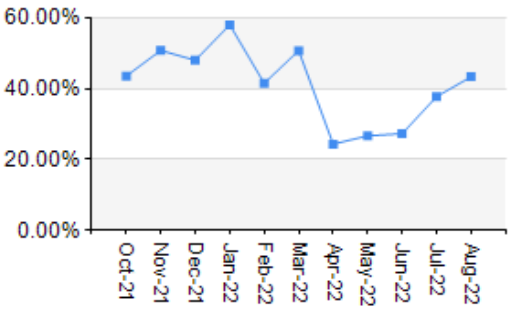
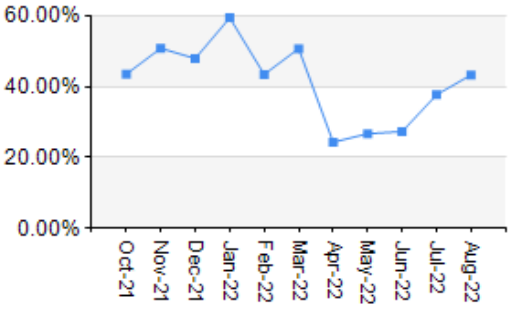
Exception Reports - Safe (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of RIDDOR **Standard: SPC**		Under Review	**Quality Improvement & Safety Director**
Number of trust apportioned Clostridium difficile cases per month **Standard: 2020/21: 75**		During August there were a total of 10 C. difficile cases associated with health care (3 Community onset health care associated and 7 hospital onset cases). We continue to implement the trust wide C. difficile reduction plan. The reduction plan addresses cleaning, antimicrobial stewardship, IPC practices such as hand hygiene and glove use, timely identification and isolation of patients with diarrhoea and optimising management of patient with C. difficile infection (CDI). The reduction plan and assurance of action completion is being monitored through the Infection Control Committee. The AMS team continue to undertake 4 AMS ward rounds weekly which involves implementing required changes to prescriptions and support training of prescribers on the ward. Outcomes of the round are reported to medical teams at the time of the round and with audit data afterwards.The IPCT and GMS are continuing to support the instigation of the national cleaning standards and agreed to explore a trial to change the cleaning products for red cleans to a more efficacious product against spores. It was also noted that a significant number of red discharge cleans are not being undertaken for C. difficile. This will be discussed at ICC and actions have been taken to inform, educate staff on the need and on EPR a red clean is now being requested for all CDI rooms by the IPCT> The C. difficile task and finish group has now been re-launched as a ICS C.diff infection improvement group; terms of reference and ICS strategy has been developed with GHT deputy DIPC as chair. This will align to the AMS ICS and IPC ICS groups to support county wide improvements to reduce the prevalence of CDI. Furthermore, Nurse-led C. difficile ward rounds continue thrice weekly to ensure the both treatment and management optimisation for CDI recovery. Also, all patients with a history of C. difficile who have been admitted to the trust are reviewed daily proactively. On these ward rounds the IPCN's aim to either support prevention of a relapse or recurrent CDI or ensure their recurrence, if suspected, is managed effectively. Optimising management of CDI patients should reduce time to recovery and length of staff and therefore reduce ongoing risk of C. difficile transmission to other patients.	**Associate Chief Nurse, Director of Infection Prevention & Control**

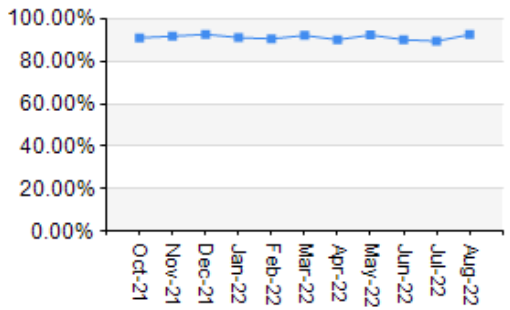
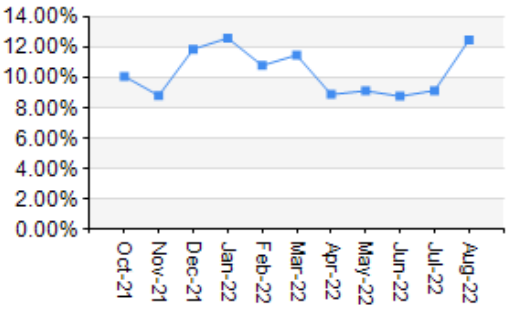
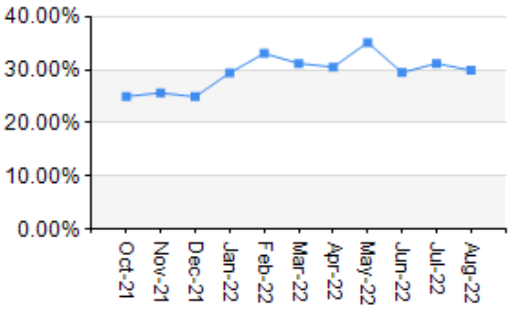
Exception Reports - Safe (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. The Tissue Viability Team have worked with SWAST to provide pressure relieving equipment and training on its use to paramedics. Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now taking place monthly to increase throughput. It should be noted that we have identified a data quality issue with Datix reporting and some of the pressure ulcers reported as hospital-acquired do not validate as such, this is being investigated by the external provider. Validation of the data has recently been carried out and an issue with Datix reporting has meant more pressure ulcers are reported as the report has included the unvalidated data, this has now been rectified and the data needs to be re-run.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Serious incidents - 72 hour report completed within contract timescale **Standard: >90%**		Under Review	**Quality Improvement & Safety Director**

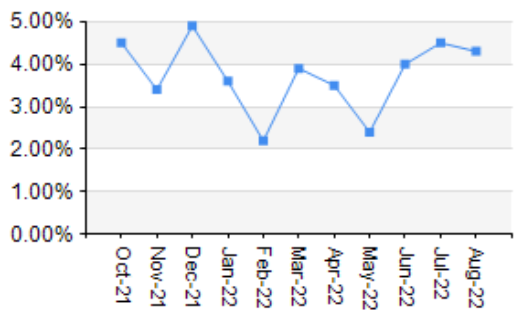
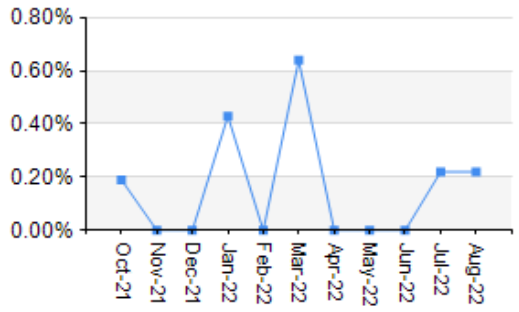
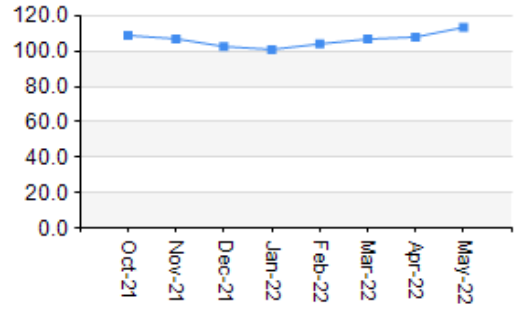
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		The service have been auditing practice for our yearly Baby friendly Initiative audit which we need to provide to UNICEF to maintain our accreditation .This was sent at the end of last month and we are waiting for feed back and will develop an action plan as required ,Infant feeding pages on maternity website have been reviewed and updated ,sat morning feeding drop in's run by the Breast feeding network in ante natal clinic are due to be re-instated in October. Joint midwife and Health visitor training to start again in their localities. Both the last 2 items were stopped for the pandemic	**Divisional Director of Quality and Nursing and Chief Midwife**
% fractured neck of femur patients meeting best practice criteria **Standard: >=65%**		The #NOF pathway is a key performance indicator within T&O and Orthogeriatric services, with performance monitored through specialty governance meetings and the Service Line Review report, and data and specific commentary on improvement/deteriorating in month is provided at Exec Review. #NOFs are now cohorted onto the 3rd floor as standard practice, and work is ongoing on a number of actions to support improving performance, including prioritising NOF on triage in ED, NOF admission proforma on EPR and looking to increase therapist funding and radiographer support.	**General Manager – Trauma & Orthopaedics**
% of fracture neck of femur patients treated within 36 hours **Standard: >=90%**		The #NOF pathway is a key performance indicator within T&O and Orthogeriatric services, with performance monitored through specialty governance meetings and the Service Line Review report, and data and specific commentary on improvement/deteriorating in month is provided at Exec Review. #NOFs are now cohorted onto the 3rd floor as standard practice, and work is ongoing on a number of actions to support improving performance, including prioritising NOF on triage in ED, NOF admission proforma on EPR and looking to increase therapist funding and radiographer support.	**General Manager – Trauma & Orthopaedics**

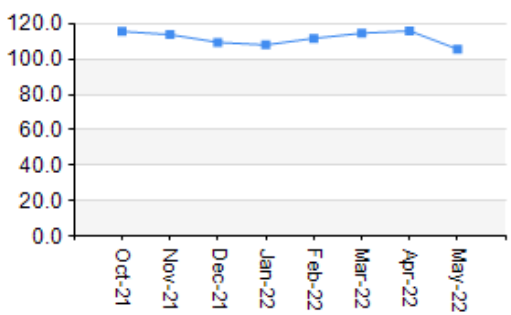
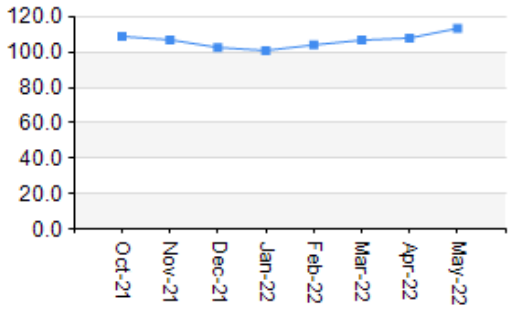
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of women booked by 12 weeks gestation **Standard: >90%**		Staff shortages are potentially having an impact. It is also possible that there is an element of late data entry impacting on this metric. The service are going to look into specific areas to identify if any one area has a worse rate than another, enabling them to target support where it is needed. The Trust is moving across to a new data warehouse which requires re-writing of all reports and may result in slight delays in updating of reports as have to be subject to validation and reconciliation. Some figures may also change as the new data warehouse takes data directly from Trak with no processing in the background eg it may be that data will be based on more appropriate fields, differences in rounding up or down, so this too could be having an impact. It has also been noted that the number of bookings have been increasing.	**Divisional Director of Quality and Nursing and Chief Midwife**
% of women smoking at delivery **Standard: <=8.0%**		There has been an issue within the service with a lack of working CO monitors between June and August which would have had an impact	**Divisional Director of Quality and Nursing and Chief Midwife**
% of women that have an induced labour **Standard: <=33%**		Under Review	**Divisional Director of Quality and Nursing and Chief Midwife**

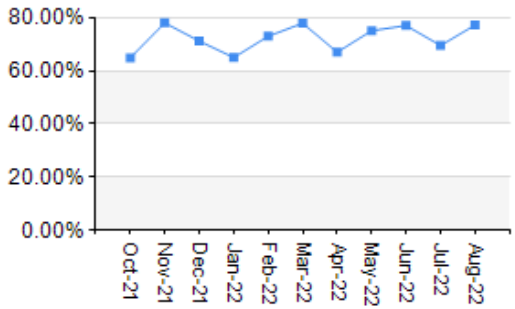
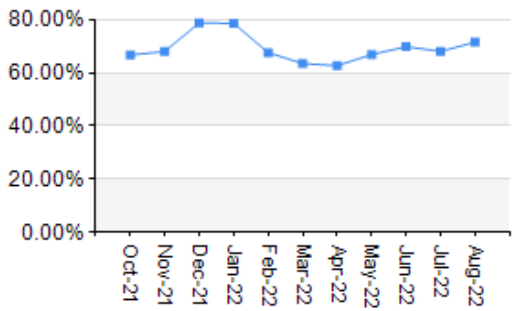
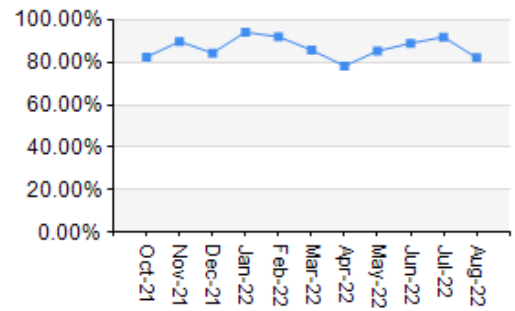
Exception Reports - Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% PPH >1.5 litres **Standard: <=4%**		An audit has been undertaken of July of PPH 1500ml and above, as highlighted last month this was the first time PPH>4% in 2022 (n=21). The PPH rate at LSCS was the highest it has been in 2022 (43%) and 7/9 were EMLSCS. 2 cases were placental abruptions. Review of notes highlight some learning, including management of uterotonics (in particular 2 hour 'prophylactic' syntocinon infusion rather than 'treatment' 4 hour regime) A potential reluctance to have a 4 hour infusion has been muted by the new Obstetric registrars (perhaps due to the extra resources this uses when staffing is suboptimal – the patient will obviously need to stay on LW for longer). There is also evidence that escalation to obstetricians regarding second stage management has not always occurred when required due to unit activity. A repeat survey to newly rotated Obstetric junior doctors again highlights that a second 'pair of hands' to assist with OVDs in the room is rarely achievable. I have asked PDM to help with renewed effort to re-iterate the fundamentals of the PPH prevention work previously undertaken, for example displays on LW	**Divisional Director of Quality and Nursing and Chief Midwife**
% stillbirths as percentage of all pregnancies **Standard: <0.52%**		Under Review	**Divisional Director of Quality and Nursing and Chief Midwife**
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**		These metrics have flagged as red for the last three months, these are being investigated in Hospital Mortality Group, there is no clear cut answer to the increase. The biggest concern is it relates to congestion as that will be the hardest to overcome. There will be further investigation in to diagnostic groups that are flagging as increased mortality observed compared to expected. There is also work looking at the comorbidity scoring which has a significant impact into expected mortality rates.	**Deputy Medical Director**

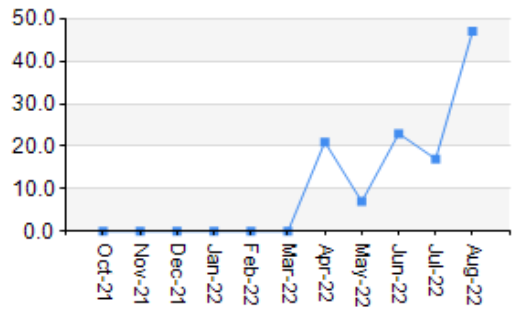
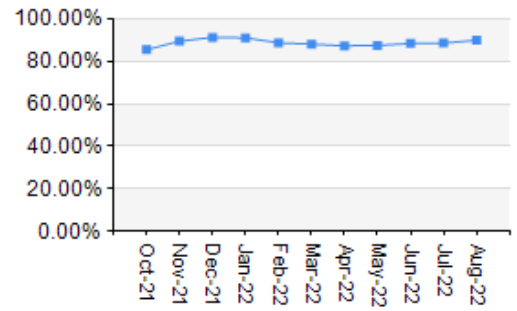
Exception Reports - Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Hospital standardised mortality ratio (HSMR) - weekend **Standard: Dr Foster**		These metrics have flagged as red for the last three months, these are being investigated in Hospital Mortality Group, there is no clear cut answer to the increase. The biggest concern is it relates to congestion as that will be the hardest to overcome. There will be further investigation in to diagnostic groups that are flagging as increased mortality observed compared to expected. There is also work looking at the comorbidity scoring which has a significant impact into expected mortality rates.	**Deputy Medical Director**
Summary hospital mortality indicator (SHMI) - national data **Standard: NHS Digital**		These metrics have flagged as red for the last three months, these are being investigated in Hospital Mortality Group, there is no clear cut answer to the increase. The biggest concern is it relates to congestion as that will be the hardest to overcome. There will be further investigation in to diagnostic groups that are flagging as increased mortality observed compared to expected. There is also work looking at the comorbidity scoring which has a significant impact into expected mortality rates.	**Deputy Medical Director**

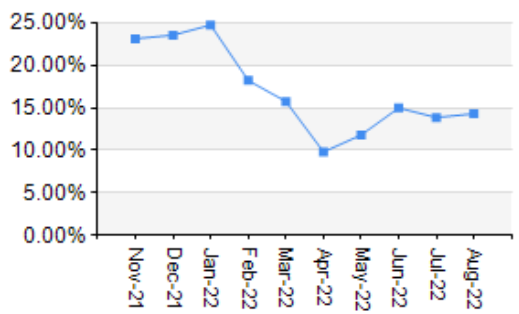
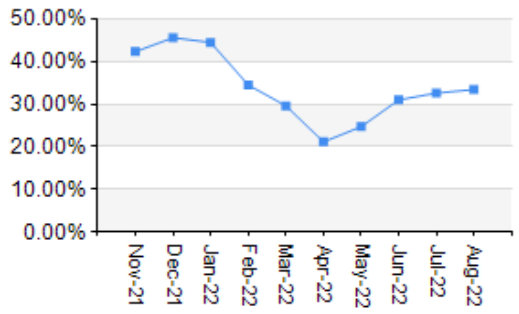
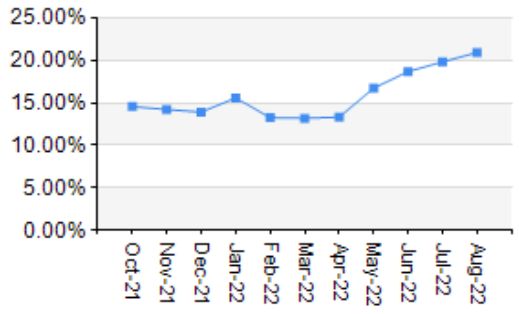
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		The % of PALS Concerns closed within 5 days is 77.2%, an increase from 69.5% in July. This is a great achievement as the team actually saw a large increase in the number of concerns received (329 up from 285 in July which is the highest number this year).	**Head of Quality**
ED % positive **Standard: >=84%**		The current positive FFT score for ED is at 71.5% across both sites, an improvement from 68% in July, with the main theme emerging focussed on wait times, which is reflective of the operational pressures in the department. GRH ED has seen a 5% improvement in the score this month which has contributed significantly to this improvement. The team are receiving reports on the feedback weekly, to support local real time improvement in response to emerging themes, and provide updates through to QDG.	**Head of Quality**
Maternity % positive **Standard: >=97%**		The current positive FFT score for Maternity services is 82.1%. The division are working with the Maternity Voices Partnership to review feedback themes emerging from FFT and other sources, to put an improvement plan in place which is monitored in the division, and updates provided through to QDG and MDG. A workshop is being planned for October/November to review priority areas for this improvement work, supported by a QI collaborative. This work is being supported by the Patient Experience team.	**Head of Quality**

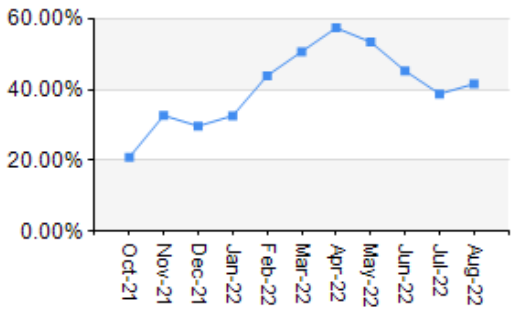
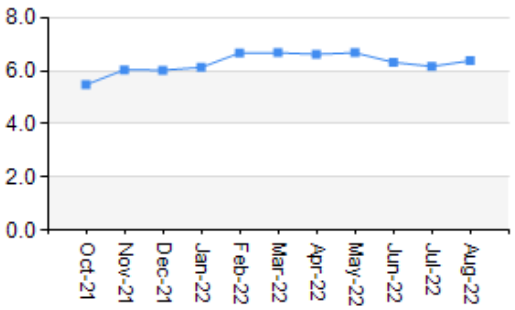
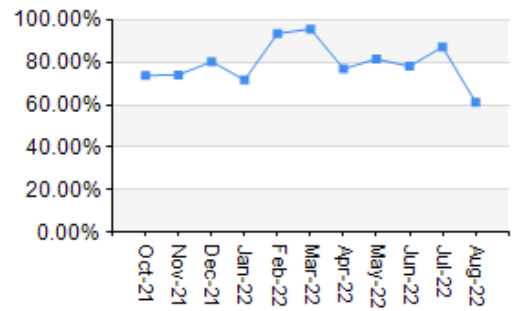
Exception Reports - Caring (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of breaches of mixed sex accommodation **Standard: <=10**		The Trust is reporting mixed-sex accommodation breaches in line with national policy following a period of local agreement with the CCG that resulted in recording the MSA breaches but not reporting them due to operational pressure. All breaches, categorised in accordance with national guidelines, must be authorised by the Chief Nurse or Deputy Chief Nurse. Each month the reasons are reviewed overall, delay in transfers from critical care and recovery areas beyond 4-hours result in an MSA breach. Accurate numbers are now reported to the ICB therefore the increase we are currently observing reflects new oversight.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Total % positive **Standard: >=93%**		The Trust had 6529 responses to FFT in August 2022, and the overall Trust FFT positive score has seen an increase in positive score this month of 89.8%. This is largely due to increases in the positive FFT score for unscheduled care (5% increase in positive score at GRH) and a slight increase for outpatients. Comments were mostly around communication, lack of organisation, waiting and delayed appointments.. Divisions provide updates through QDG each quarter on improvement plans happening within divisions, and the patient experience team are reviewing current reporting offer to improve the way that FFT and PALS data is triangulated to support improvement plans.	**Head of Quality**

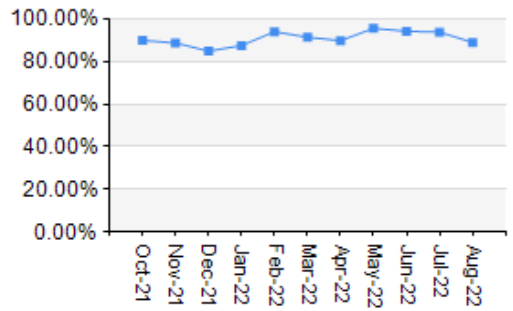
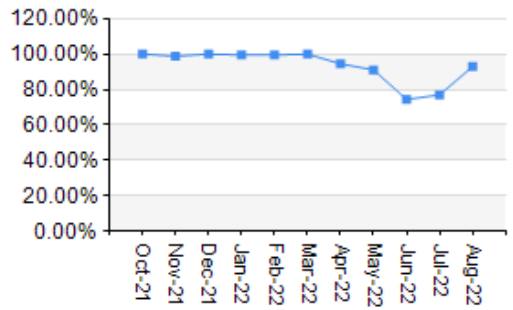
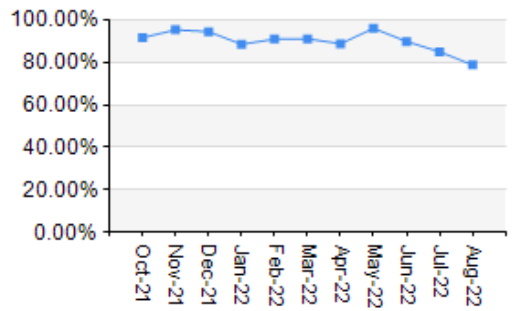
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers < 15 minutes **Standard: >=65%**		There has been an increased focus on the 'Green to Go' stance, whereby staff receiving handovers from Ambulance crew are more proactive in pressing the green button on the electronic patient information screens held by SWAST to denote and timestamp a completed handover. This is evidenced in a raise in this months data in comparrison to July.	**General Manager of Unscheduled Care**
% of ambulance handovers < 30 minutes **Standard: >=95%**		There has been an increased focus on the 'Green to Go' stance, whereby staff receiving handovers from Ambulance crew are more proactive in pressing the green button on the electronic patient information screens held by SWAST to denote and timestamp a completed handover. This is evidenced in a raise in this months data in comparrison to July.	**General Manager of Unscheduled Care**
% of ambulance handovers 30-60 minutes **Standard: <=2.96%**		There has been an increased focus on the 'Green to Go' stance, whereby staff receiving handovers from Ambulance crew are more proactive in pressing the green button on the electronic patient information screens held by SWAST to denote and timestamp a completed handover. This is evidenced in a raise in this months data in comparrison to July.	**General Manager of Unscheduled Care**

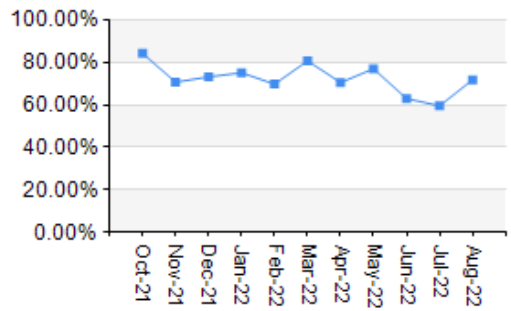
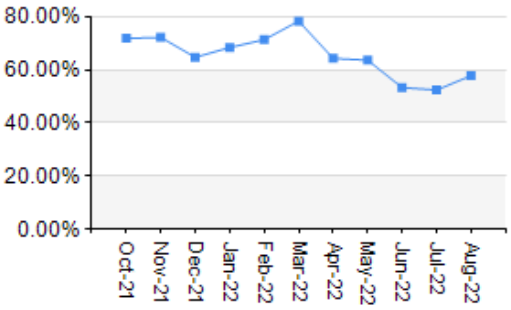
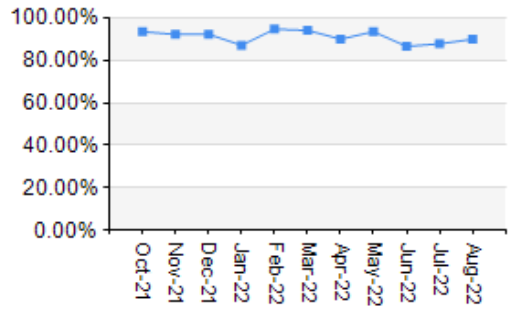
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers over 60 minutes **Standard: <=1%**		The Trust saw an average increase of ambulance handovers over 60 mins by 2.6% comapared to July. There was a minimal increase in total ambulance arrivals	**General Manager of Unscheduled Care**
Average length of stay (spell) **Standard: <=5.06**		ALOS has fallen back in-month, increasing to 6.38 days. This deterioration is likely to be due to the 'Bank Holiday Effect' which may have delayed some progress of some patients. Work is planned to ensure we better mitigate 'seasonal events' which are planned and known; to reduce the negative impact on performance	**Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In July there were a total of 19 patients cancelled on the day that could not be rescheduled within 28 days, which is a significant increase on previous months. These included 8 Ophthalmology; 4 T&O; 2 Gynae; 2 Cardiology; 2 Urology and 1 Vascular patient. The reasons were varied but primarily due to consultant with covid; consultant sickness; bed capacity or trauma demand.	**Associate Director of Elective Care**

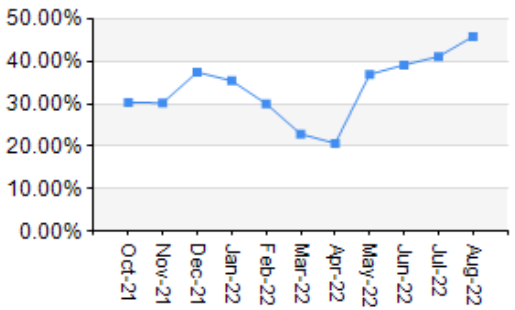
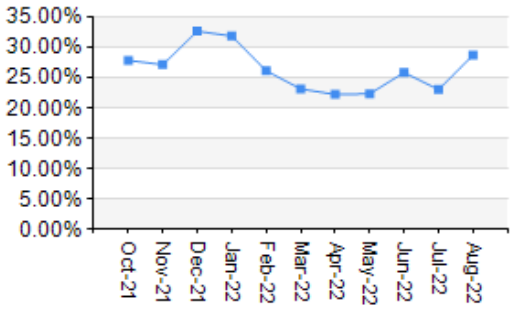
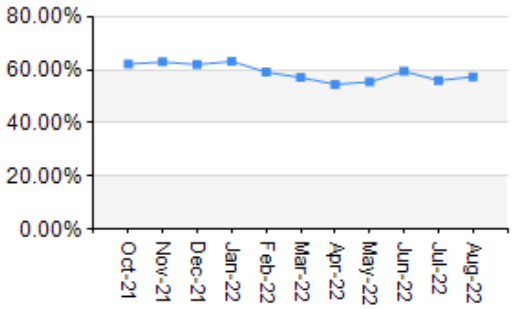
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer - 2 week wait breast symptomatic referrals **Standard: >=93%**		2ww breast symptoms performance (unvalidated) Standard = 93% National = 68% GHFT = 88.9% DFS = 144 Breaches = 16	**General Manager - Cancer**
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy) **Standard: >=94%**		31 day subs radiotherapy performance (unvalidated) Standard = 94% National = 92% GHFT = 74.4% Treated = 158 Breaches = 11 Backlog of patients now significantly reduced with performance improving (2 breaches off meeting target). Sept projected to meet standard.	**General Manager - Cancer**
Cancer - 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		31 day subs surgery performance (unvalidated) Standard = 94% National = 82% GHFT = 78.7% Treated = 75 Breaches = 16 Breast 3, Gynae 2, LGI 1, Uro 10 All breaches related to theatre capacity	**General Manager - Cancer**

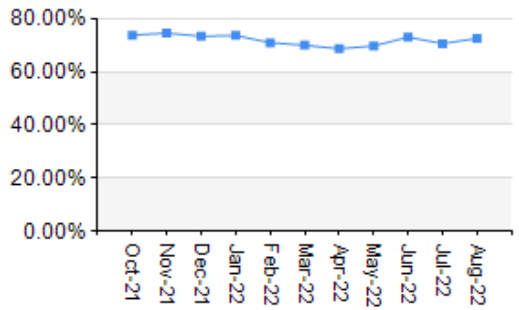
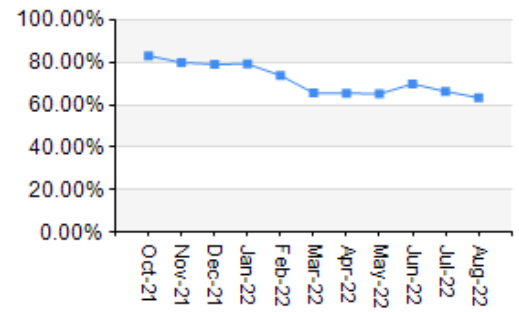
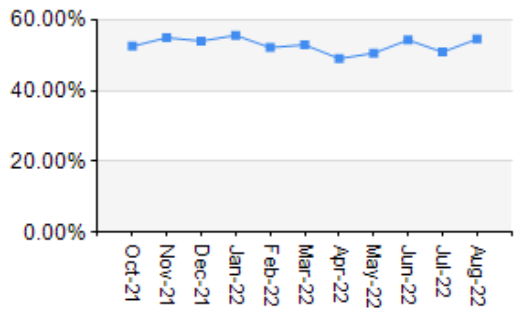
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer - 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated) Standard = N/A National = 74% GHFT = 76.6% Treated= 22, Breaches=6.5 Uro - 3 Skin - 2 Gynae - 1 lung - 0.5 4.5 breaches related to complex diagnostic pathways, 1 patient initiated breach and one due to OPA capacity.	**General Manager - Cancer**
Cancer - 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) Standard = 85% National = 61% GHFT = 55.1% Treatments = 213.5, Breaches 93.5 Urology=49, LGI = 20 Skin = 7 Treatment numbers very high indicating the high demand currently on cancer services. Performance continues to be impacted by prostate	**General Manager - Cancer**
Cancer - urgent referrals seen in under 2 weeks from GP **Standard: >=93%**		2ww Performance (unvalidated) Standard = 93% National = 77.8% GHFT = 89.8% DFS = 2579 Breaches 263 Skin=54, Lower GI=121, Gynae=35 High demand and capacity issues impacting Dermatology and Lower GI (Surgical)	**General Manager - Cancer**

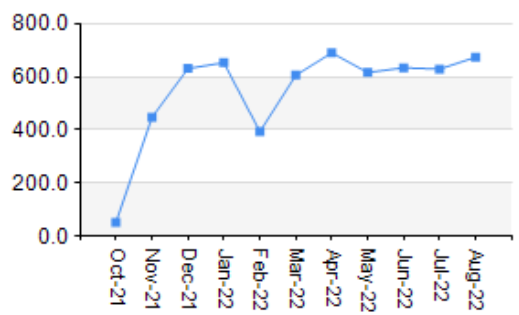
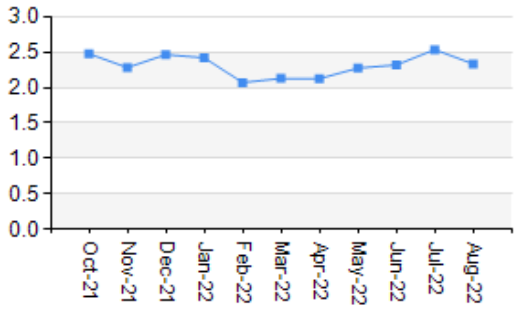
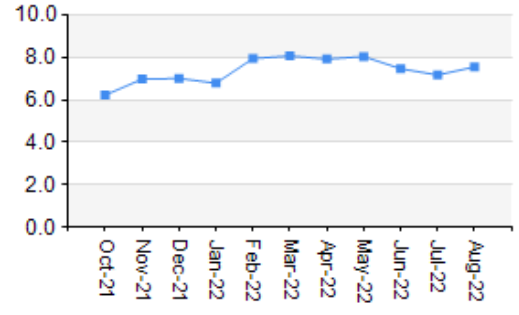
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to initial assessment - under 15 minutes **Standard: >=95%**		The data captured evidenses continued significant improvement in the percentage of patients receiving an initial assessment in under 15 mins. This has been maintained through rolling triage training of staff.	**General Manager of Unscheduled Care**
ED: % of time to start of treatment - under 60 minutes **Standard: >=90%**		As the department continue to improves the time to initial assessment, our data reflects the improivement also in the commencement of treatment. In August our time to clinician saw an 11% decrease from the previous month, meaning patients were seen on average 16 minutes quicker than in July.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (type 1) **Standard: >=95%**		Our average 4 hour standard of care data saw an improvement in August by 1.4%. This has been support by identifying appropriate escalations and pre-empts to support and faciliatate capacity.	**General Manager of Unscheduled Care**

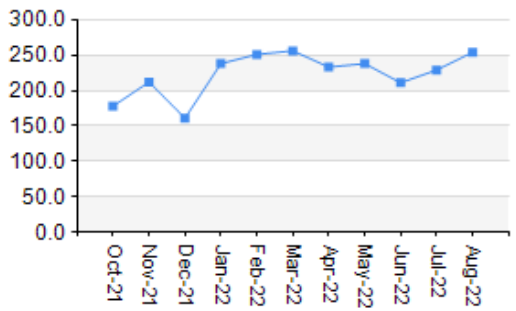
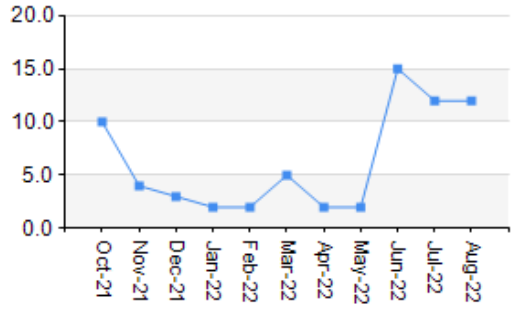
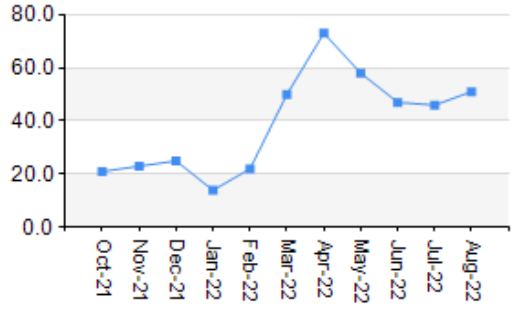
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department - under 4 hours (types 1 & 3) **Standard: >=95%**		Our average 4 hour standard of care data saw an improvement in August by 1.4%. This has been support by identifying appropriate escalations and pre-empts to support and faciliatate capacity.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours CGH **Standard: >=95%**		CGH continues to experience a number of challenges in terms of flow and capacity resulting in an increase of 9% in time to be seen by clinician since July. We also saw an increase in CGH time to triage with an average total time in ED increasing by 21% in camparisson to July.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours GRH **Standard: >=95%**		As the Trust continues to respond to the challenges of IPC 'pop-ups' and the resulting closures of inpatient beds, we have continued to focus on approate other pathways for patients attending the department. In August we saw a contined raise in our referals to SDEC.	**General Manager of Unscheduled Care**

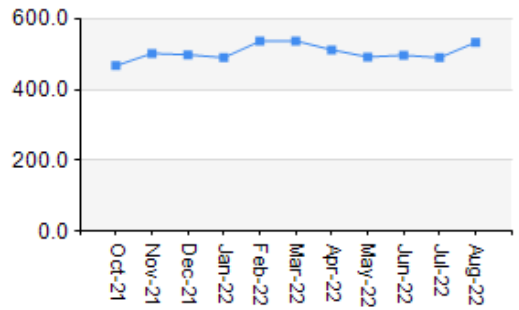
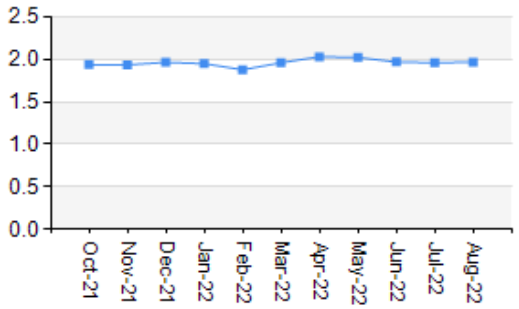
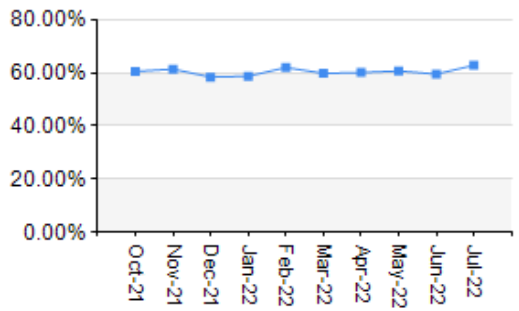
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		Despite flexing into corridor care and downstream ward pre-empts we have seen a raise across the oprganisation of patients waiting in the Emergency Department for over 12 hours. Coupled with the data we know in regards to the improvement of our 'Time to clinician' and the 1.3% increase in our SDEC pathway zero, the 12 hour wait data has largly been impacted by inpatient capacity.	**General Manager of Unscheduled Care**
Length of stay for general and acute elective spells (occupied bed days) **Standard: <=3.4**		An improvement of 0.2 days has occurred in month and continues to remain well within target.	**Deputy Chief Operating Officer**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		Similar to Length of Spell an increase has been experienced in month, moving by +0.4 days. This correlates with an increase in the number of stranded patients.	**Deputy Chief Operating Officer**

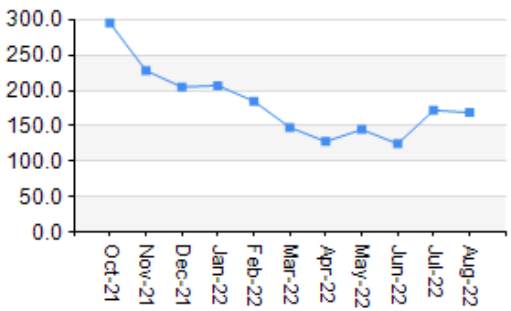
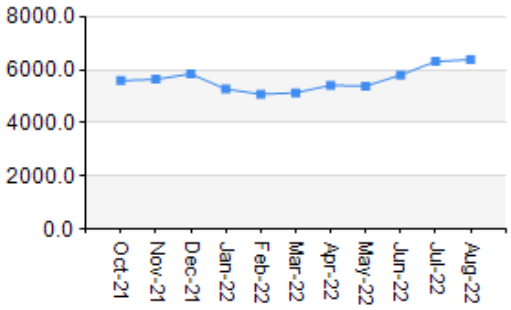
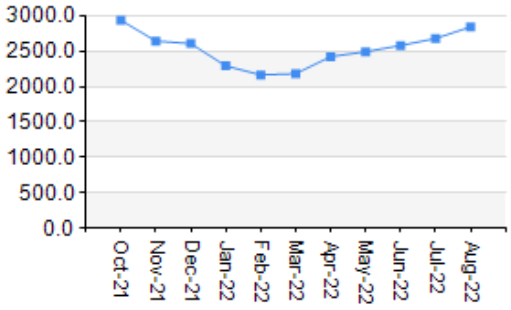
Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients stable for discharge **Standard: <=70**		Numbers have increased back up to April levels due to a lack of flow within the 3 main discharge pathways, community hospitals, home first and assessment beds. This relates to these three pathways now having their own significant numbers of 'medically stable' patients awaiting onward progression. This issue is well recognised at ICS level and forms a significant part of the Sloman and Winter challenge work.	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Total number of 104 day patients - 51 (down from 70's in July/August) Total number of patients with a TCI = 15 Total number of patients without a TCI = 36 4 awaiting TCI, 4 awaiting pathology, 15 needing further investigation (no diagnosis), 3 diagnosed - awaiting further investigation, 7 referred late into GHFT, 3 referred out to tertiary centre	**General Manager - Cancer**
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		Total number of 104 day patients - 51 (down from 70's in July/August) Total number of patients with a TCI = 15 Total number of patients without a TCI = 36 4 awaiting TCI, 4 awaiting pathology, 15 needing further investigation (no diagnosis), 3 diagnosed - awaiting further investigation, 7 referred late into GHFT, 3 referred out to tertiary centre	**General Manager - Cancer**

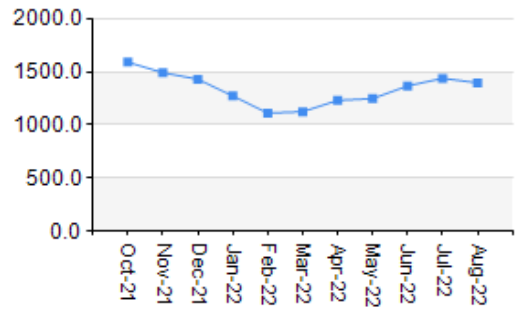
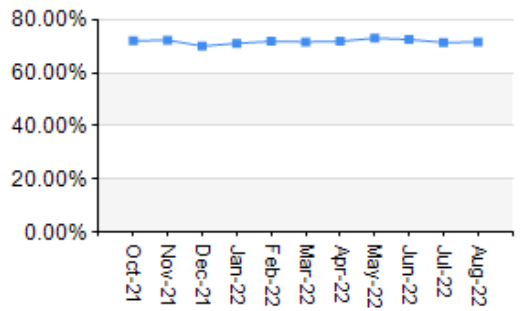
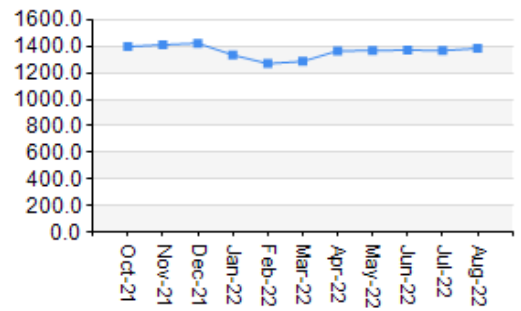
Exception Reports - Responsive (9)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		This has jumped in month to one its highest positions all year with an extra 43 patients. This is just 4 patients short of the peak experienced in March 2022.	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		Largely unchanged and remains marginally above target at 1.97	**Associate Director of Elective Care**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		This metric continues to be low, limited improvement over the course of the last year. As explained previously – EPMA implementation should make a significant impact on this metric this has been delayed till November. The EPMA role out will lead to discharge summaries being produced on sunrise and should be far more efficient process	**Medical Director**

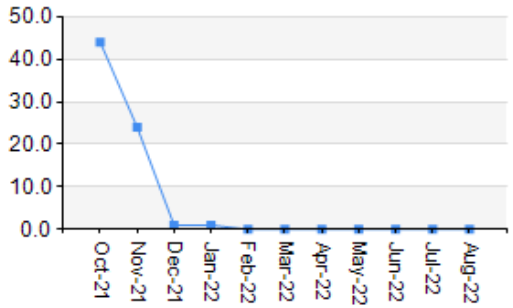
Exception Reports - Responsive (10)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathway over 70 Weeks (number) **Standard: 0**		This cohort has reduced very slightly in month with just 3 less patients. The services impacted the most remain Clinical Haematology and Oral Surgery both of which have recovery plans in place which should result in reductions over the coming months.	**Associate Director of Elective Care**
Referral to treatment ongoing pathways 35+ Weeks (number) **Standard: No target**		The number of patients over 35 weeks has increased in month, by 72 patients. This is now the highest level this financial year.	**Associate Director of Elective Care**
Referral to treatment ongoing pathways 45+ Weeks (number) **Standard: No target**		This cohort has increased 163 over the past month which continues to the gradual trend that has been observed since February 2022.	**Associate Director of Elective Care**

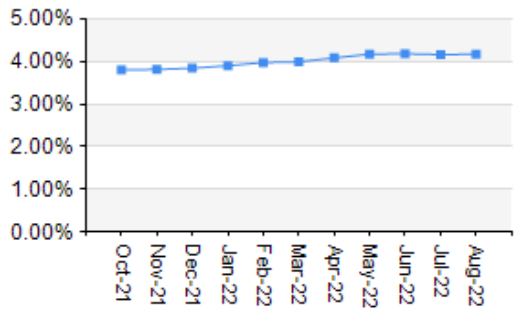
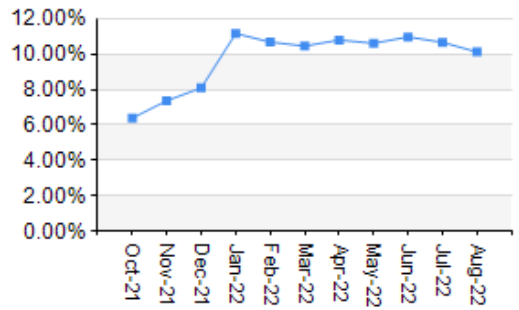
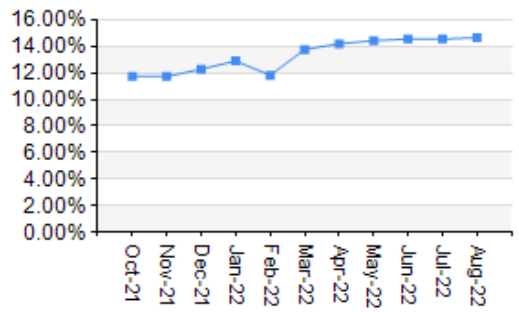
Exception Reports - Responsive (10)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathways over 52 weeks (number) **Standard: Zero**		See Planned Care Exception report for a full breakdown. Performance in August has seen a slight improvement in 52 week breaches, with a reduction of approximately 40 on last month. The three specialties that have made most gains are Oral Surgery (-91), Ophthalmology (-21) and T&O (-14).	**Associate Director of Elective Care**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. RTT performance is currently reported as 71.57% and is not anticipated to change significantly prior to submission. Performance has marginally improved in month by just 0.2%. However performance remains stable GHT remains significantly above the national average.	**Associate Director of Elective Care**
The number of planned/surveillance endoscopy patients waiting at month end **Standard: <=600**		Breach numbers are high due to baseline demand and capacity gap, and the lower priority level to book cohort in comparison to risk stratified 2WW, BCSP and requirement to meet DM01 target. Planned surveillance endoscopy breaches have increased due to reduction in administrative validation support, but it is suspected to reduce in the coming months one a Surveillance administrator is recruited. In addition with the support of Insourcing activity as part of the elective recovery plan. This will provide sufficient capacity to fill our current gap in demand, enabling reduction of surveillance backlog.	**Deputy General Manager of Endoscopy**

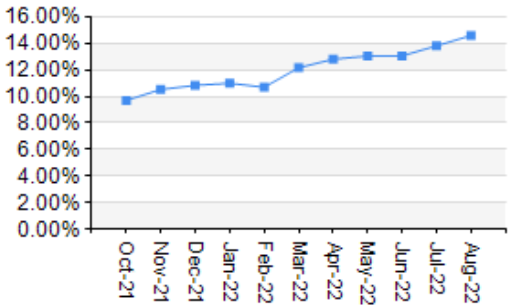
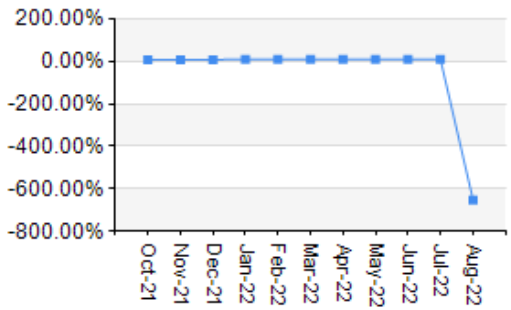
Exception Reports - Responsive (10)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Urgent cancelled operations **Standard: No target**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days,	**Director of Operations - Surgery**

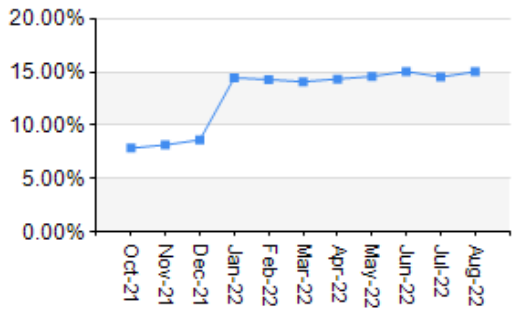
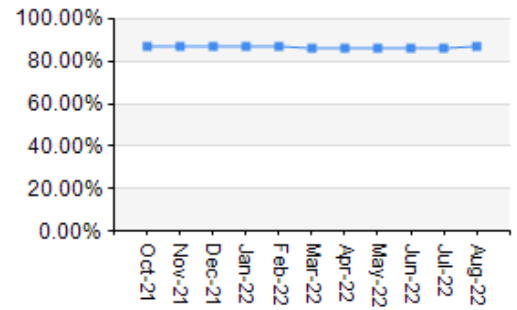
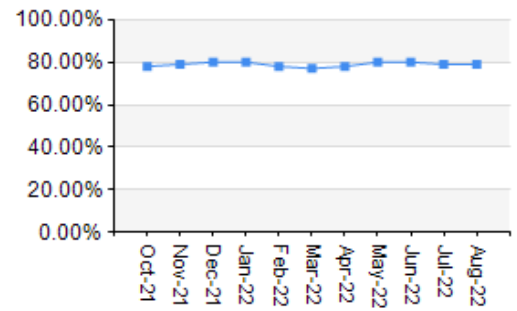
Exception Reports - Well Led (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% sickness rate **Standard: <=4.05%**		A short term post within the P&OD function is being recruited to, supported by NHSE/I funding, with the aim of achieving improved sickness absence levels and developing enhanced support for managers.	**Director of Human Resources and Operational Development**
% total vacancy rate **Standard: <=11.5%**		Workforce plans and sustained recruitment pipelines remain a focus Trust wide and across Divisions, with challenges across specific chard to fill posts and specialities, plus support roles such and admin and clerical. Recruitment to the new role of Marketing and Attraction Lead will imminently commence in order to develop and design a clear recruitment marketing strategy, underpinned by proactive and innovative solutions for the Trust, in order to increase the attraction presence both locally and nationally.	**Director of Human Resources and Operational Development**
% turnover **Standard: <=12.6%**		Turnover continues to be of key focus across all staff groups. Understanding reasons for staff leaving remains a priority in order to support the development of informed retention initiatives.	**Director of Human Resources and Operational Development**

Exception Reports - Well Led (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% turnover rate for nursing **Standard: <=12.6%**		Pastoral care and preceptorship for both newly appointed overseas and newly qualified nurses are key in ensuring the Trust invests sufficiently in a structured, quality transition in order to guide and support all new nurses.	**Director of Human Resources and Operational Development**
% vacancy rate for doctors **Standard: <=5%**		Focus remains on the cohort of internationally recruited Doctors from Mumbai being deployed within Medicine and Surgery. This will positively affect the current vacancy position, however, ongoing recruitment remains a focus.	**Director of Human Resources and Operational Development**

Exception Reports - Well Led (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		The International Nurse recruitment plan remains on track with successful approval now received from the recent NHSE/I bid for an additional 64 overseas nurses to be recruited by 31st December 2022.	**Director of Human Resources and Operational Development**
Trust total % mandatory training compliance **Standard: >=90%**		Mandatory training compliance remains below the 90% target and has remained at 86% for the last couple of months. It has raised slightly to 87%. Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process. Subject leads are communicated with as to ideas to improve compliance. Safeguarding Adults Level 2 remains the lowest compliance rate. Work with the subject lead as to potential reasons for this.	**Deputy Director of People and Organisational Development**
Trust total % overall appraisal completion **Standard: >=90%**		The Trust appraisal rate continues at 79% for a second month. Medicine slight improvement (88%), Surgery (80%) and D&S (78%) Divisions have the highest compliance rates. The lowest Divisional Appraisal rates are Corporate (74%) and Women & Children (69%) and the non-division staffing group at (56%). Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process. Communication is happening with L&OD as to how best support staff to receive a yearly appraisal and for managers to have the ability to undertake them.	**Deputy Director of People and Organisational Development**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period August 2022

Presented at September 2022 Q&P and October 2022 Trust Board

Contents

Gloucestershire Hospitals
NHS Foundation Trust

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 inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals
NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients. During August, the Trust did not meet the national standards for 52 week waits, diagnostics or the 4-hour ED standard, but continue to achieve the zero 104 weeks breaches target.

August continued to be a challenging month for the Emergency Department (ED) but saw an increase in performance from 70.62% to 72.59% compared to the previous month. Ambulance handover delays increased for 30-60 minutes handovers delays however reduced slightly for those 60+ minutes. Correcting this negative trend remains a priority for the Trust, and the ED has implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.

Overall diagnostic performance has improved in month and by approximately 2%. This change has been influenced by reductions in NOUS, Endoscopy and Echo breaches. Overall, the total number of patients waiting has reduced in-month by 1,076 and the total number of breaches by 397. This is the largest gain made for some time and the continued gradual improvement in Echo performance is positive.

For cancer, performance data showed the Trust met 3 out of 9 standards with all 7 out of 9 standards above national average clearly showing a challenging month. The Trust achieved the 2ww breast symptomatic standard in July with 93.7% performance. The Trust continued strong 28 day Faster Diagnosis Standard performance with 76.2% of patients receiving their diagnosis in July. 62 day standard performance for July was 52.4% which will rise following final submission but still a very poor month. Current 62 day performance impacted by an increase in complex patients requiring multiple investigations, waits for prostate biopsy, diagnostic and elective capacity. At a recent NHSE/I meeting about 62 day backlogs, regional colleagues were pleased with the Trust's performance in respect of bringing long waiting patients numbers down.

For elective care, the RTT performance did not meet the national standard, albeit a marginal improvement has been made in-month. Month end submission is anticipated to be 71.6%, up 0.2% on last month. The total incompletes continues to rise and the unconfirmed August position is expected to be around 65,000 (an increase of approx 1,250 on last month). The number of patients waiting over 52 weeks has decreased slightly, down from 1,439 last month to 1,397 in August. Focus continues to be placed on patients over 70 weeks, although in month a reduction of only 3 has been made. The effect of the Haematology recovery plan should start to result in reductions soon. The over 78 week cohort however has reduced by 13 in month, and 104 breaches remains at zero.

The Elective Care Hub are concluding the contact with patients on an RTT pathway over 18 weeks, and preliminary discussions now taking place as to how they can support a reduction in the Follow Up backlog.

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

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

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

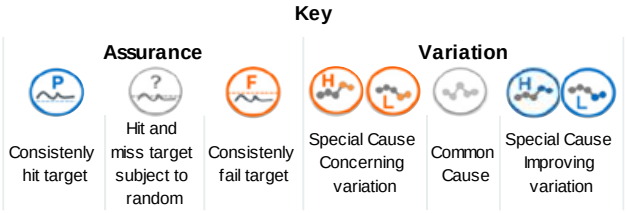
MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Cancer	Cancer - 28 day FDS (all routes)	>=75%	Aug-22	78.7%	Common Cause	
Cancer	Cancer - urgent referrals seen in under 2 weeks from GP	>=93%	Aug-22	89.8%	Common Cause	
Cancer	Cancer - 2 week wait breast symptomatic referrals	>=93%	Aug-22	88.9%	Common Cause	
Cancer	Cancer - 31 day diagnosis to treatment (first treatments)	>=96%	Aug-22	94.1%	Common Cause	
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – drug)	>=98%	Aug-22	100.0%	Common Cause	
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Aug-22	78.7%	Concern (Low)	
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Aug-22	93.0%	Concern (Low)	
Cancer	Cancer - 62 day referral to treatment (urgent GP referral)	>=85%	Aug-22	56.2%	Concern (Low)	
Cancer	Cancer - 62 day referral to treatment (screenings)	>=90%	Aug-22	91.3%	Common Cause	
Cancer	Cancer - 62 day referral to treatment (upgrades)	>=90%	Aug-22	70.5%	Common Cause	
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Aug-22	12	Common Cause	
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Aug-22	51	Concern (High)	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Aug-22	18.83%	Concern (High)	
Diagnostics	The number of planned/surveillance endoscopy patients waiting at month end	<=600	Aug-22	1,384	Concern (High)	
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Jul-22	62.80%	Improvement (High)	
Emergency Department	ED: % total time in department - under 4 hours (type 1)	>=95%	Aug-22	57.39%	Concern (Low)	
Emergency Department	ED: % total time in department - under 4 hours (types 1 & 3)	>=95%	Aug-22	72.59%	Concern (Low)	
Emergency Department	ED: % total time in department - under 4 hours CGH	>=95%	Aug-22	63.29%	Concern (Low)	
Emergency Department	ED: % total time in department - under 4 hours GRH	>=95%	Aug-22	54.51%	Concern (Low)	

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Aug-22	674	RunChart	
Emergency Department	ED: % of time to initial assessment - under 15 minutes	>=95%	Aug-22	45.8%	Concern (Low)	
Emergency Department	ED: % of time to start of treatment - under 60 minutes	>=90%	Aug-22	28.7%	Concern (Low)	
Emergency Department	Number of ambulance handovers over 60 minutes	Zero	Aug-22	1,169	Concern (High)	
Emergency Department	% of ambulance handovers < 15 minutes	>=65%	Aug-22	14.3%	RunChart	
Emergency Department	% of ambulance handovers < 30 minutes	>=95%	Aug-22	33.4%	RunChart	
Emergency Department	% of ambulance handovers 30-60 minutes	<=2.96%	Aug-22	20.9%	Concern (High)	
Emergency Department	% of ambulance handovers over 60 minutes	<=1%	Aug-22	41.6%	Concern (High)	
Maternity	% of women booked by 12 weeks gestation	>90%	Aug-22	92.7%	Common Cause	
Operational Efficiency	Number of patients stable for discharge	<=70	Aug-22	253	Concern (High)	
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Aug-22	534	Concern (High)	
Operational Efficiency	Average length of stay (spell)	<=5.06	Aug-22	6.4	Concern (High)	
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Aug-22	7.5	Concern (High)	
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Aug-22	2.3	Improvement (Low)	
Operational Efficiency	% day cases of all electives	>80%	Aug-22	84.6%	Common Cause	
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Aug-22	88.3%	Common Cause	
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Aug-22	61.2%	Common Cause	
Operational Efficiency	Urgent cancelled operations	No target	Aug-22	0	Improvement (Low)	

Access Dashboard

Gloucestershire Hospitals
NHS Foundation Trust

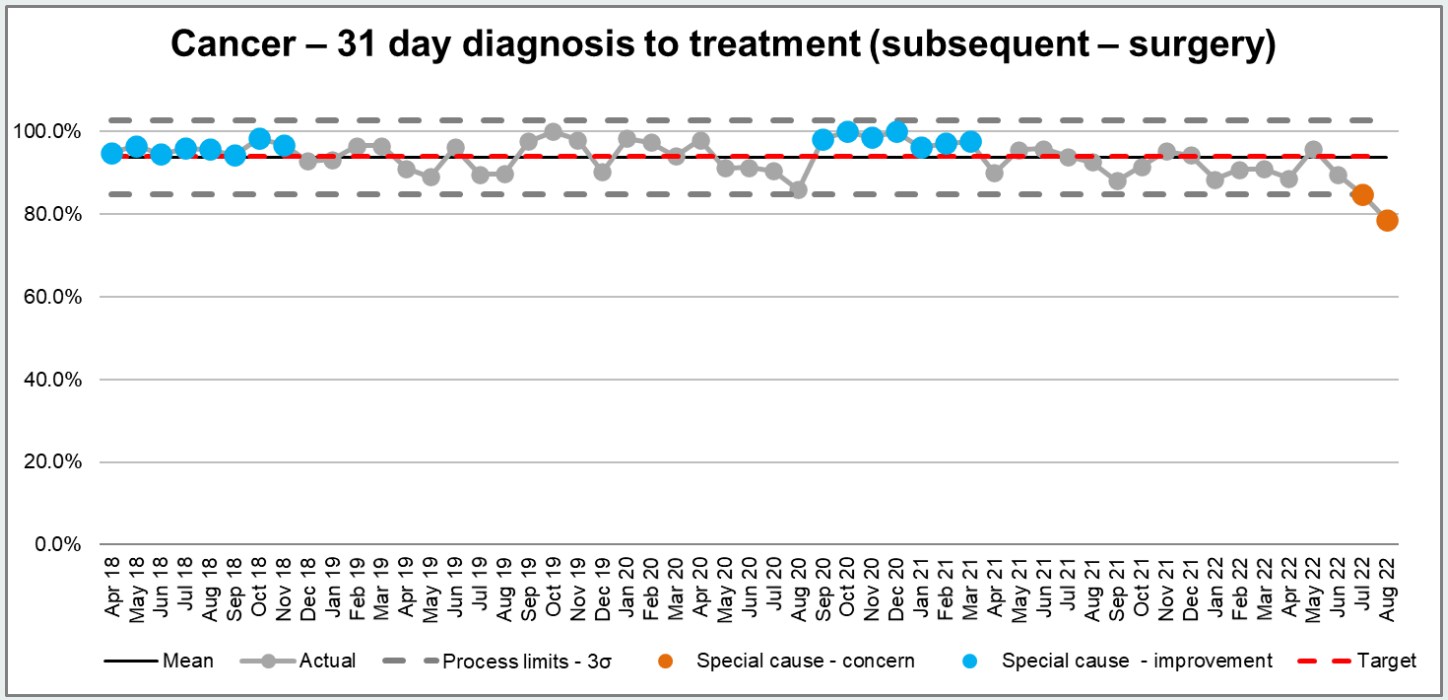
This dashboard shows the most recent performance of metrics in the Access category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance			
Outpatient	Outpatient new to follow up ratio's	<=1.9		Aug-22	1.97	Common Cause	
Outpatient	Did not attend (DNA) rates	<=7.6%		Aug-22	6.3%	Common Cause	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%		Jul-22	7.5%	Common Cause	
Research	Research accruals	No target		Aug-22	234	RunChart	
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Aug-22	71.57%	Concern (Low)	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Aug-22	6,384	Concern (High)	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Aug-22	2,841	Concern (High)	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Aug-22	1,397	Concern (High)	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	0		Aug-22	169	Common Cause	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		Aug-22	80.8%	RunChart	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Jul-22	98.3%	Common Cause	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		Aug-22	80.0%	RunChart	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		Aug-22	65.4%	RunChart	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Aug-22	43.30%	Concern (Low)	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Aug-22	43.3%	Concern (Low)	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

31 day subs surgery performance (unvalidated)
Standard = 94%
National = 82%
GHFT = 78.7%
Treated = 75 Breaches = 16

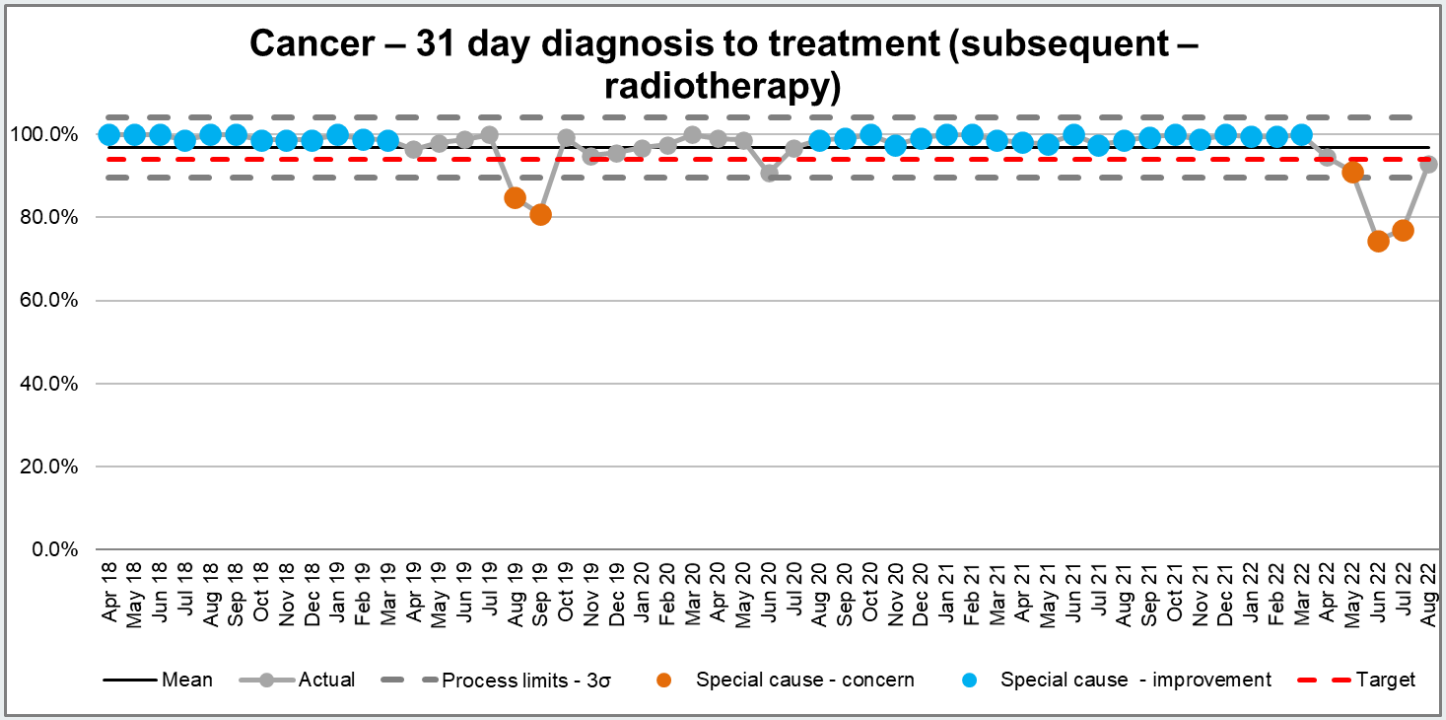
Breast 3, Gynae 2, LGI 1, Uro 10 All breaches related to theatre capacity
- General Manager - Cancer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day subs radiotherapy performance (unvalidated)
Standard = 94% /National = 92%
GHFT = 74.4%
Treated = 158 Breaches = 11

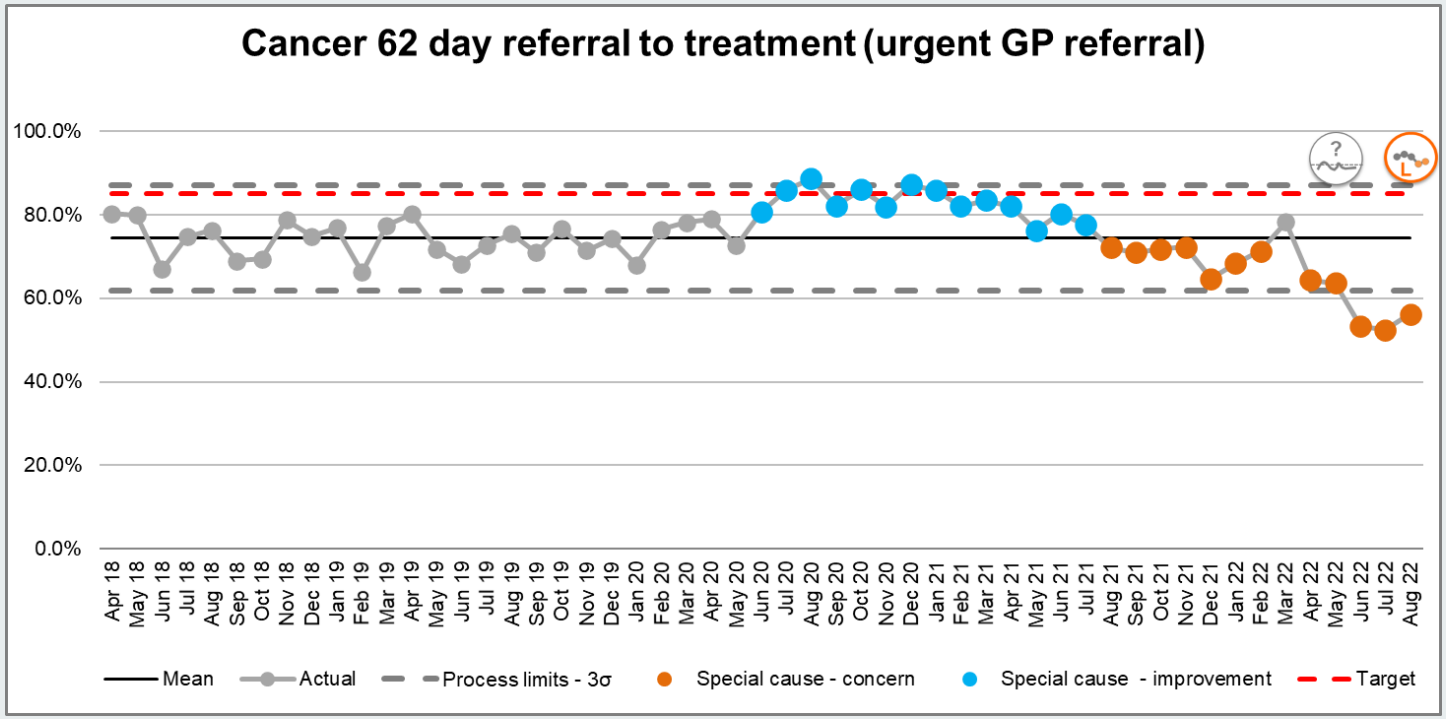
Backlog of patients now significantly reduced with performance improving (2 breaches off meeting target). Sept projected to meet standard.
- General Manager - Cancer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

62 day GP performance (unvalidated)
Standard = 85%
National = 61% /GHFT = 55.1%
Treatments = 213.5, Breaches 93.5 /Urology=49, LGI = 20 Skin = 7

Treatment numbers very high indicating the high demand currently on cancer services. Performance continues to be impacted by prostate pathway now patients have been biopsed and treated. Lower GI pathways continued to be impacted by endoscopy timeframes, outpatient capacity, theatre capacity and complexity of patient.

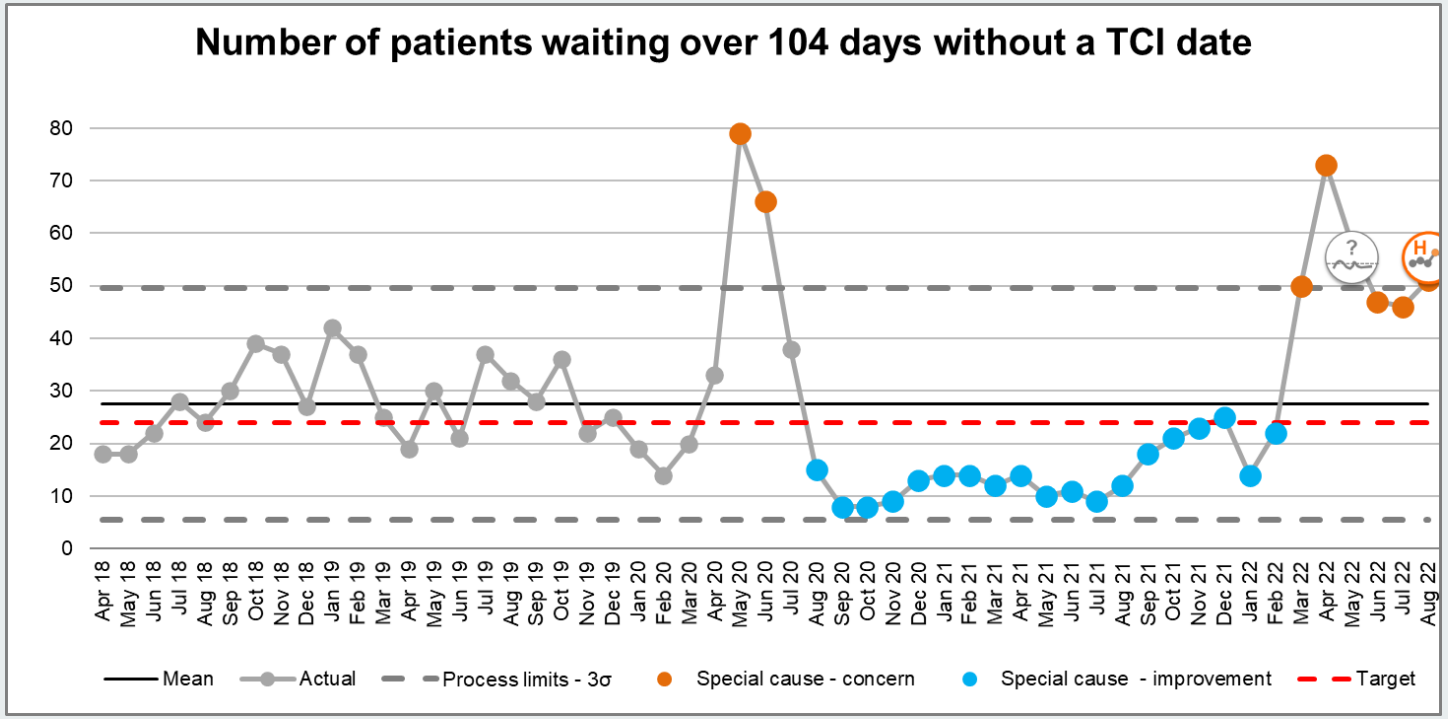
- General Manager - Cancer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Total number of 104 day patients - 51 (down from 70's in July/August)
Total number of patients with a TCI = 15
Total number of patients without a TCI = 36

4 awaiting TCI, 4 awaiting pathology, 15 needing further investigation (no diagnosis), 3 diagnosed - awaiting further investigation, 7 referred late into GHFT, 3 referred out to tertiary centre

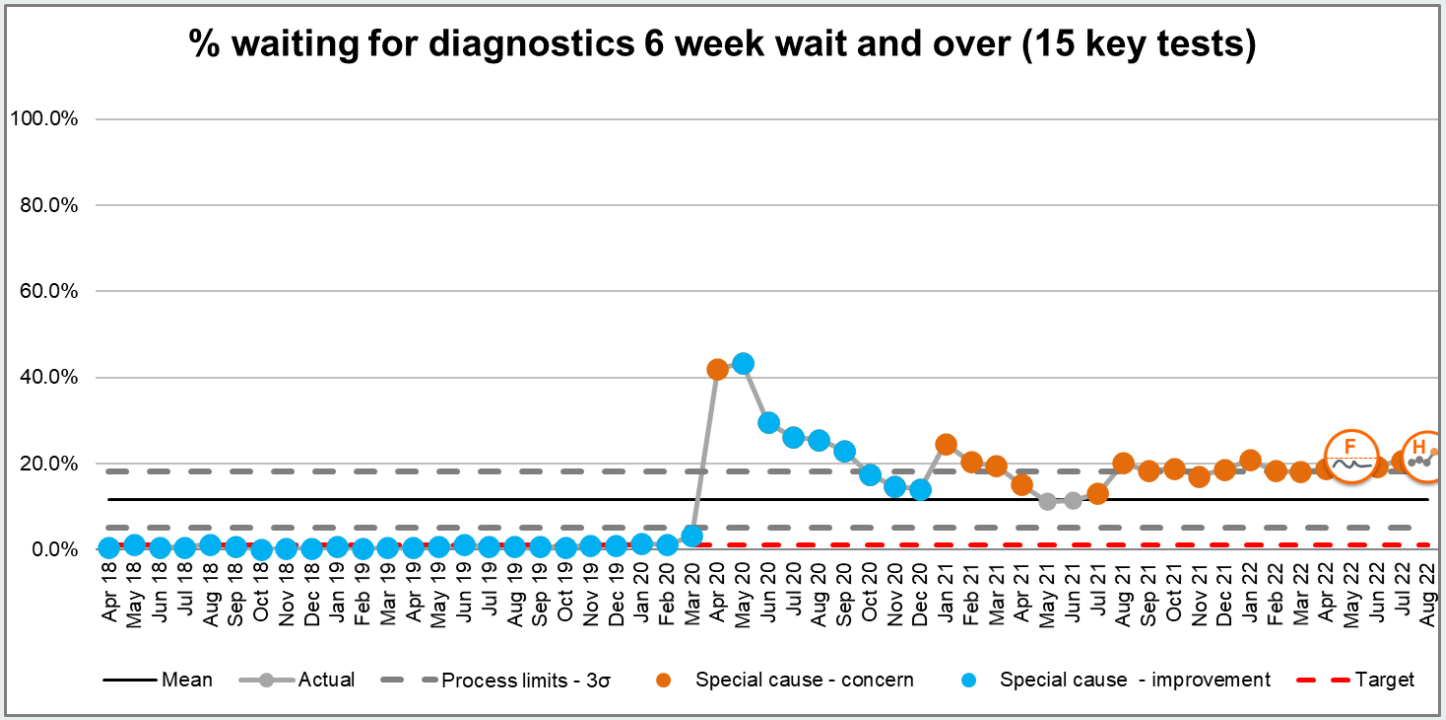
- General Manager - Cancer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Overall diagnostic performance has improved in month and by approximately 2%. This change has been influenced by reductions in NOUS, Endoscopy and Echo. Overall, the total number of patients waiting has reduced in-month by 1,076 and the total number of breaches by 397. This is the largest gain made for some time and the continued gradual improvement in Echo performance is positive.

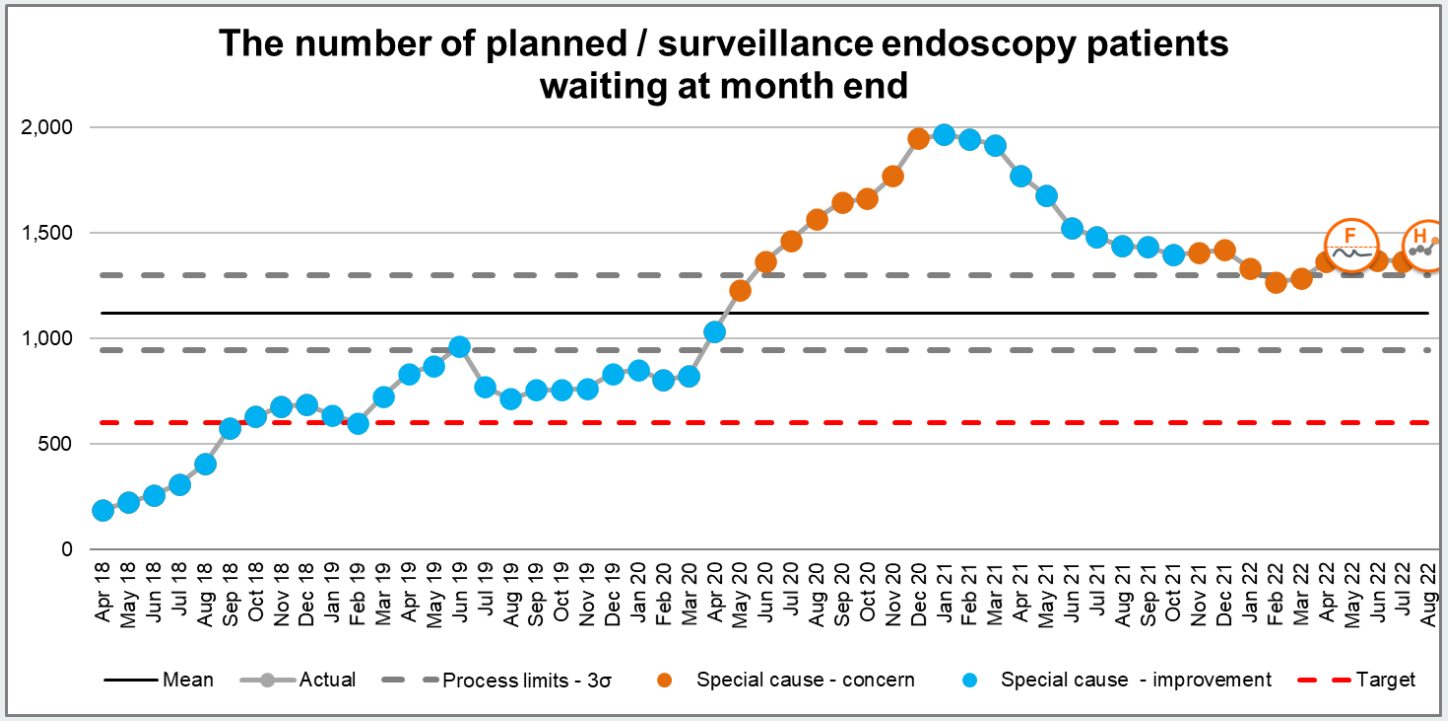
- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 20 data points which are above the line. There are 24 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Breach numbers are high due to baseline demand and capacity gap, and the lower priority level to book cohort in comparison to risk stratified 2WW, BCSP and requirement to meet DM01 target. Planned surveillance endoscopy breaches have increased due to reduction in administrative validation support, but it is suspected to reduce in the coming months one a Surveillance administrator is recruited. In addition with the support of Insourcing activity as part of the elective recovery plan. This will provide sufficient capacity to fill our current gap in demand, enabling reduction of surveillance backlog.

- Deputy General Manager of Endoscopy

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 25 data points which are above the line. There are 23 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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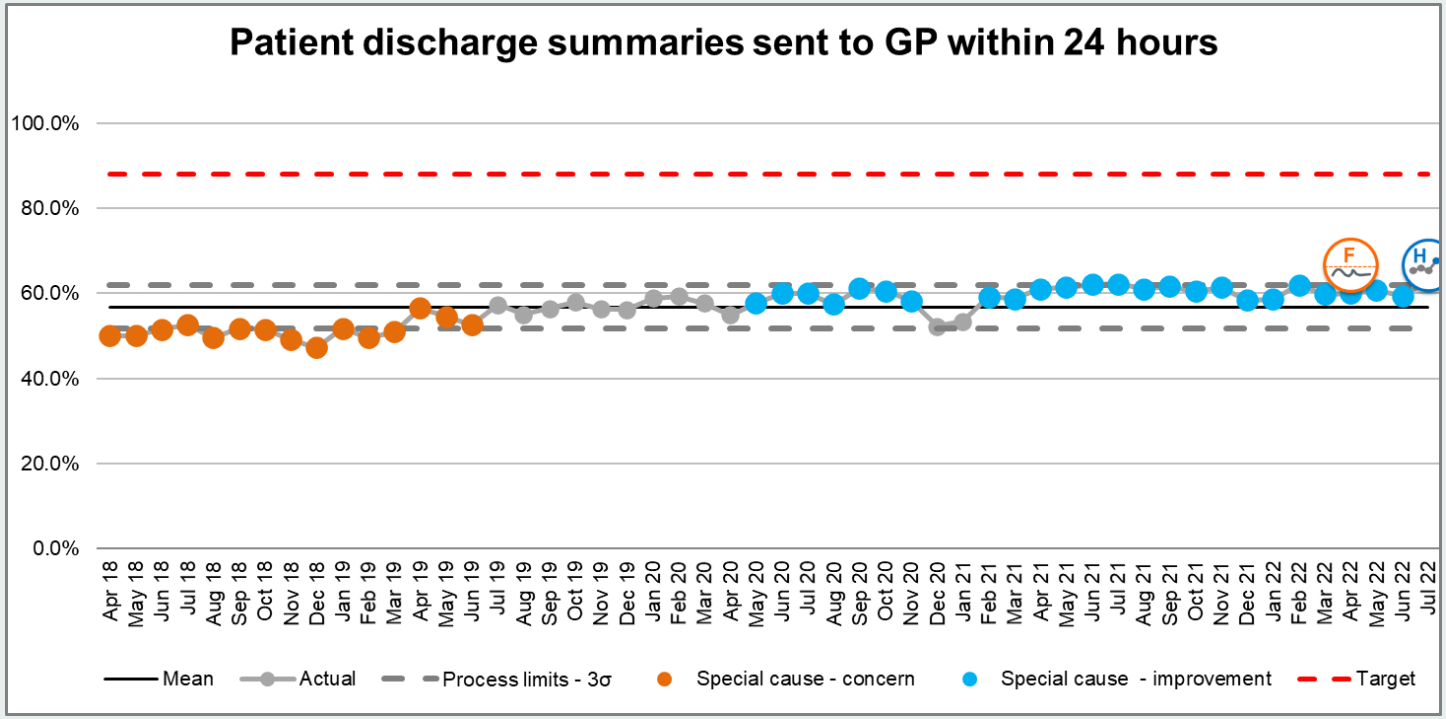

Commentary

This metric continues to be low, limited improvement over the course of the last year. As explained previously – EPMA implementation should make a significant impact on this metric this has been delayed till November. The EPMA role out will lead to discharge summaries being produced on sunrise and should be far more efficient process

- Medical Director

Data Observations

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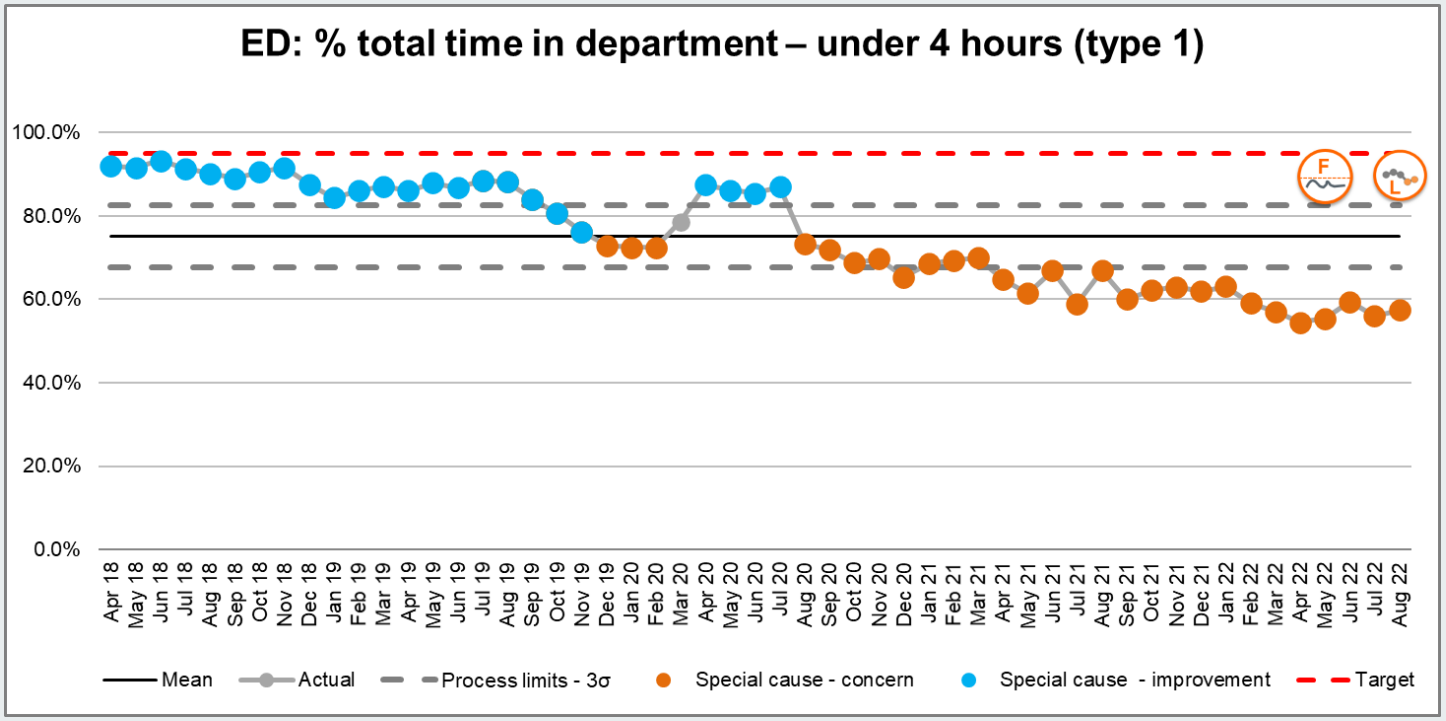

Commentary

Our average 4 hour standard of care data saw an improvement in August by 1.4%. This has been support by identifying appropriate escalations and pre-empts to support and facilitate capacity.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 22 data points which are above the line. There are 18 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
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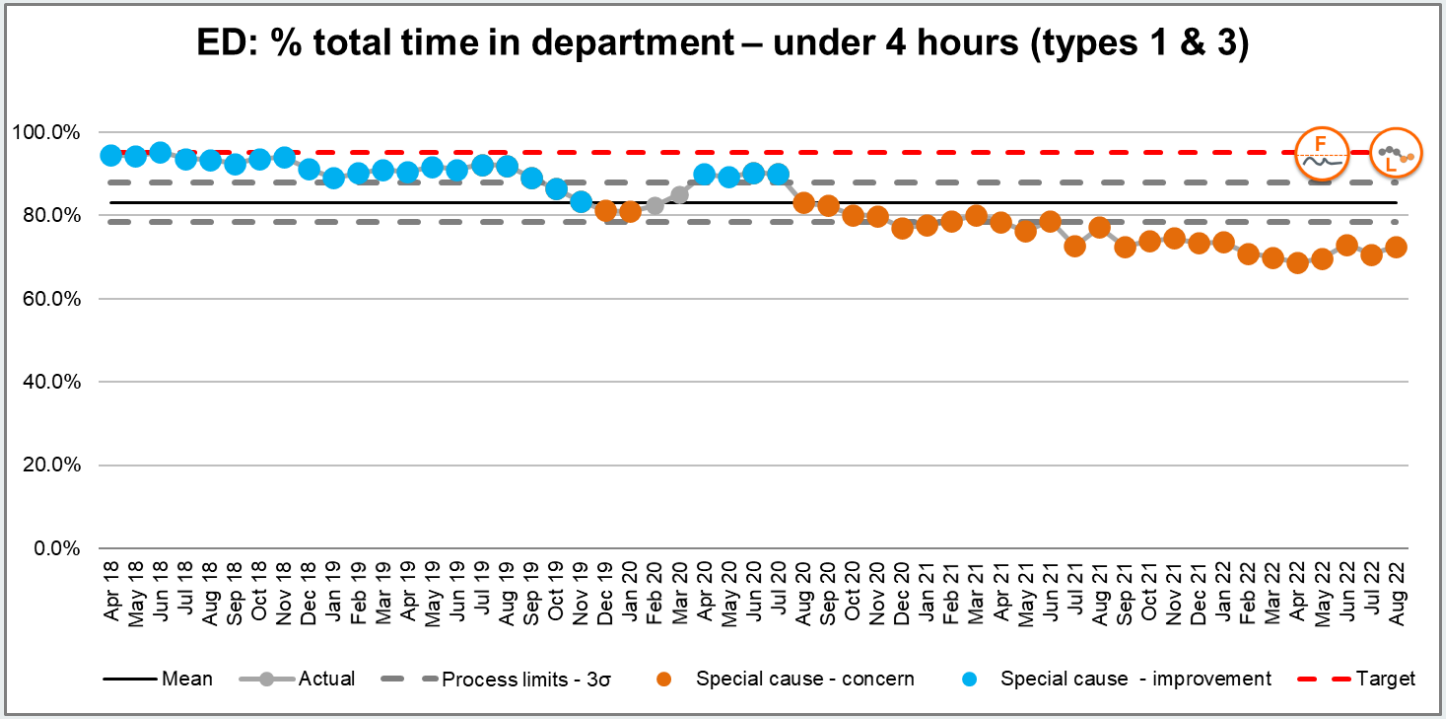

Commentary

Our average 4 hour standard of care data saw an improvement in August by 1.4%. This has been support by identifying appropriate escalations and pre-empts to support and facilitate capacity.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 22 data points which are above the line. There are 17 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
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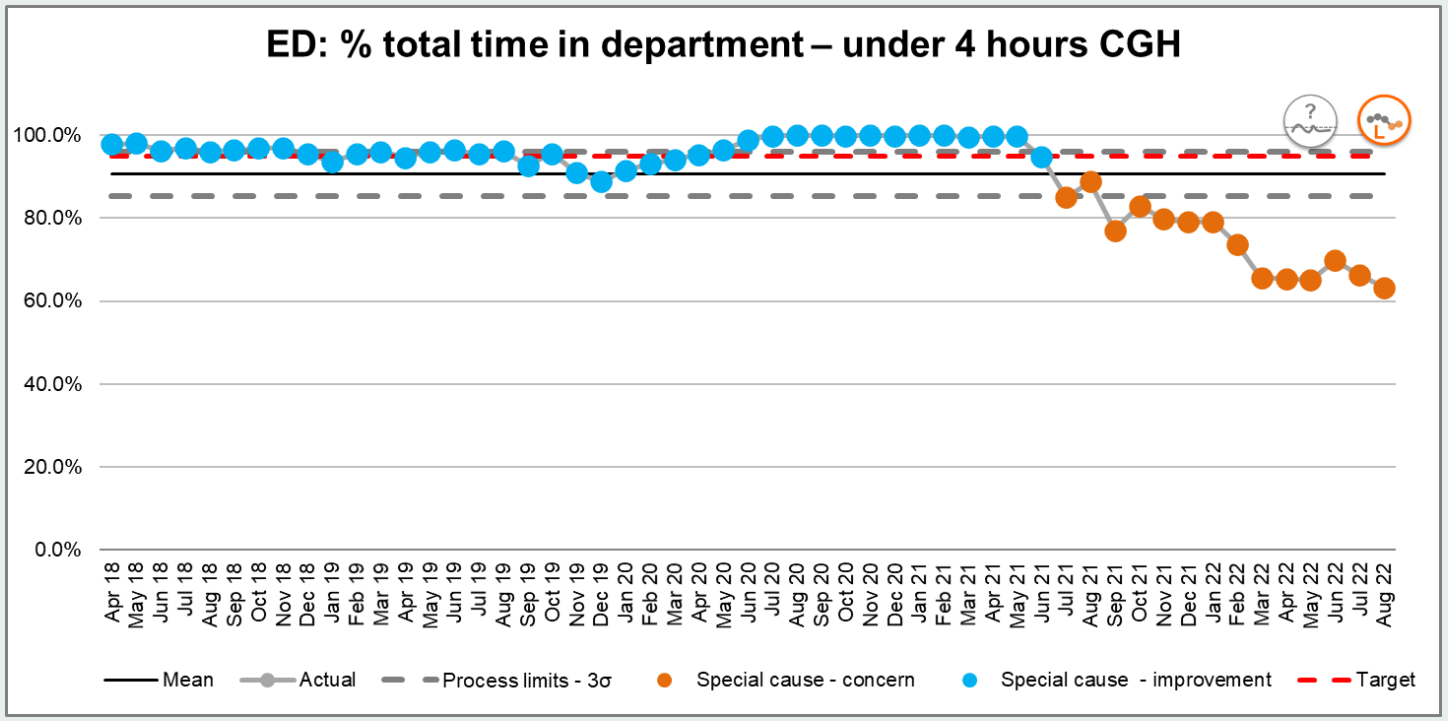

Commentary

CGH continues to experience a number of challenges in terms of flow and capacity resulting in an increase of 9% in time to be seen by clinician since July. We also saw an increase in CGH time to triage with an average total time in ED increasing by 21% in comparison to July.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 23 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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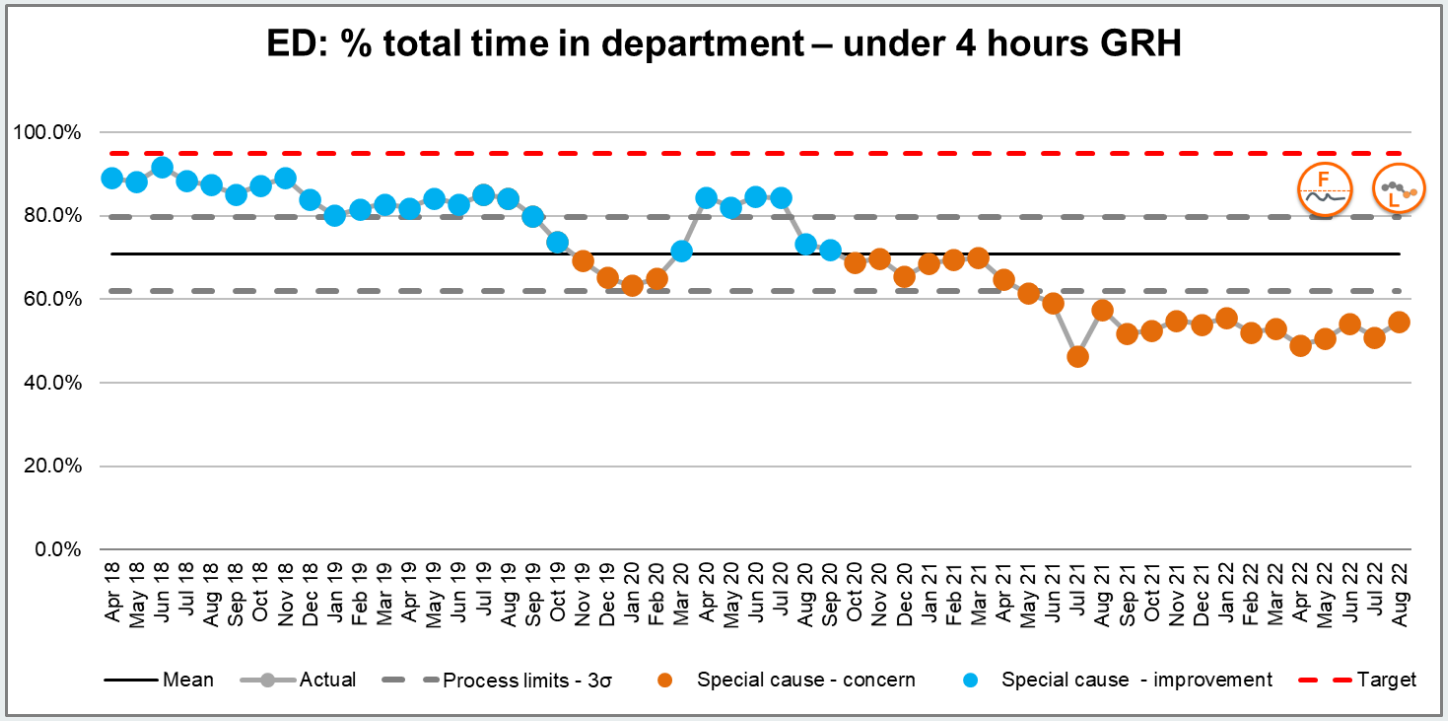

Commentary

As the Trust continues to respond to the challenges of IPC 'pop-ups' and the resulting closures of inpatient beds, we have continued to focus on appropriate other pathways for patients attending the department. In August we saw a contined raise in our referrals to SDEC.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 22 data points which are above the line. There are 16 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
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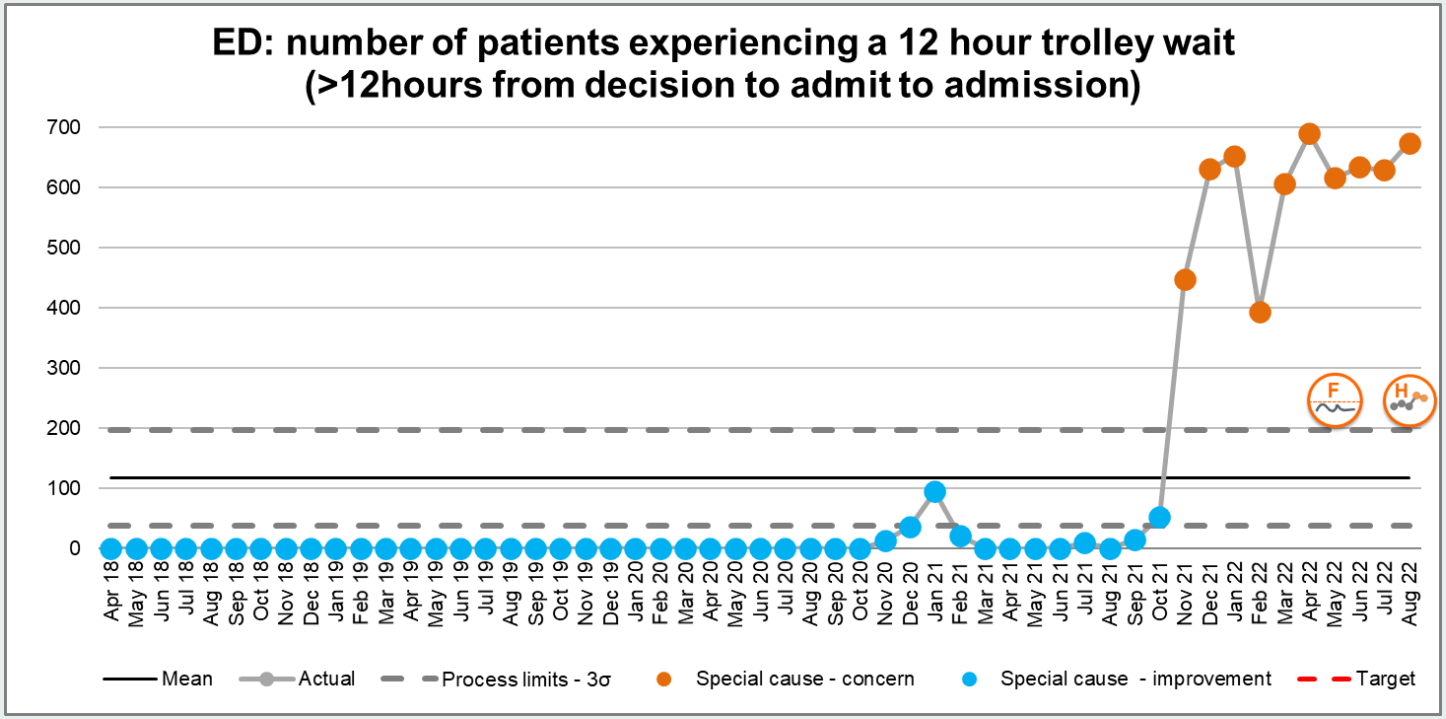

Commentary

Despite flexing into corridor care and downstream ward pre-empts we have seen a raise across the organisation of patients waiting in the Emergency Department for over 12 hours. Coupled with the data we know in regards to the improvement of our 'Time to clinician' and the 1.3% increase in our SDEC pathway zero, the 12 hour wait data has largely been impacted by inpatient capacity.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 10 data points which are above the line. There are 41 data points below the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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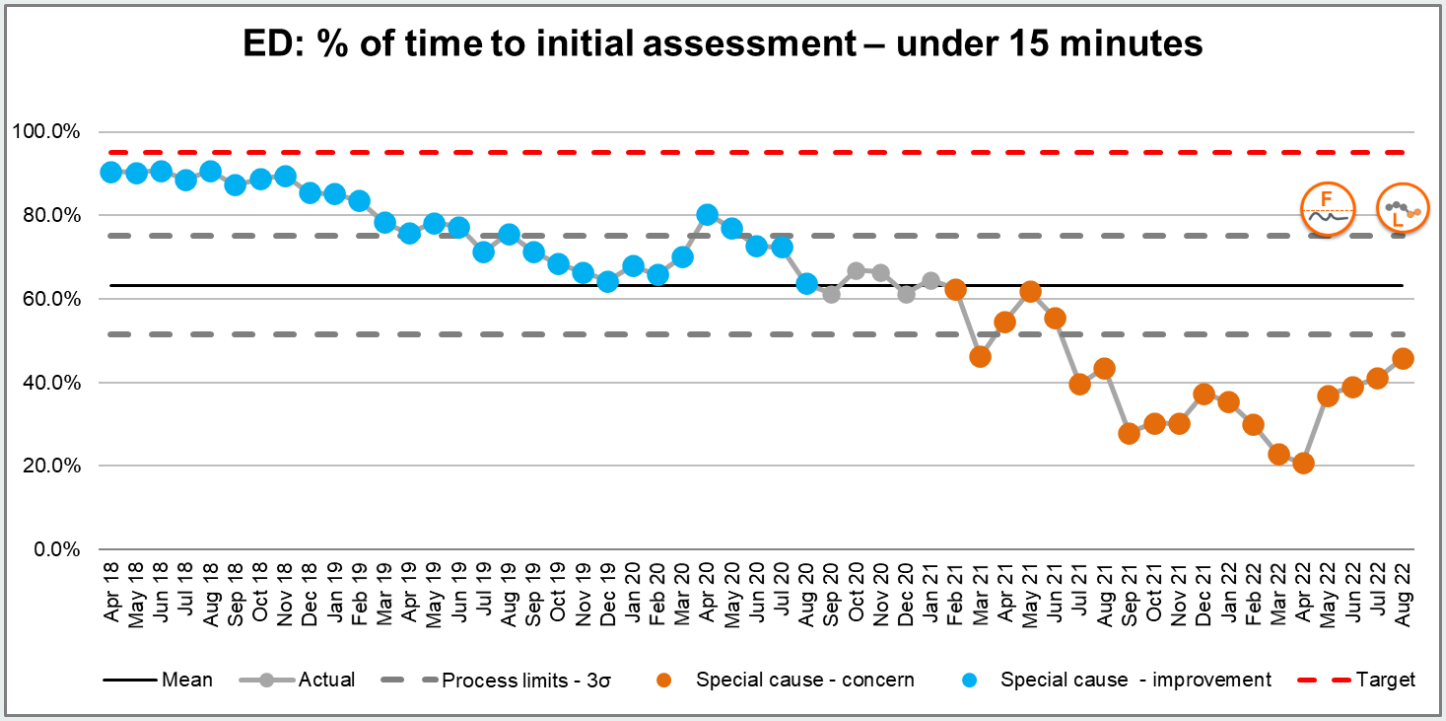

Commentary

There has been an increased focus on the 'Green to Go' stance, whereby staff receiving handovers from Ambulance crew are more proactive in pressing the green button on the electronic patient information screens held by SWAST to denote and timestamp a completed handover. This is evidenced in a raise in this months data in comparison to July.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 18 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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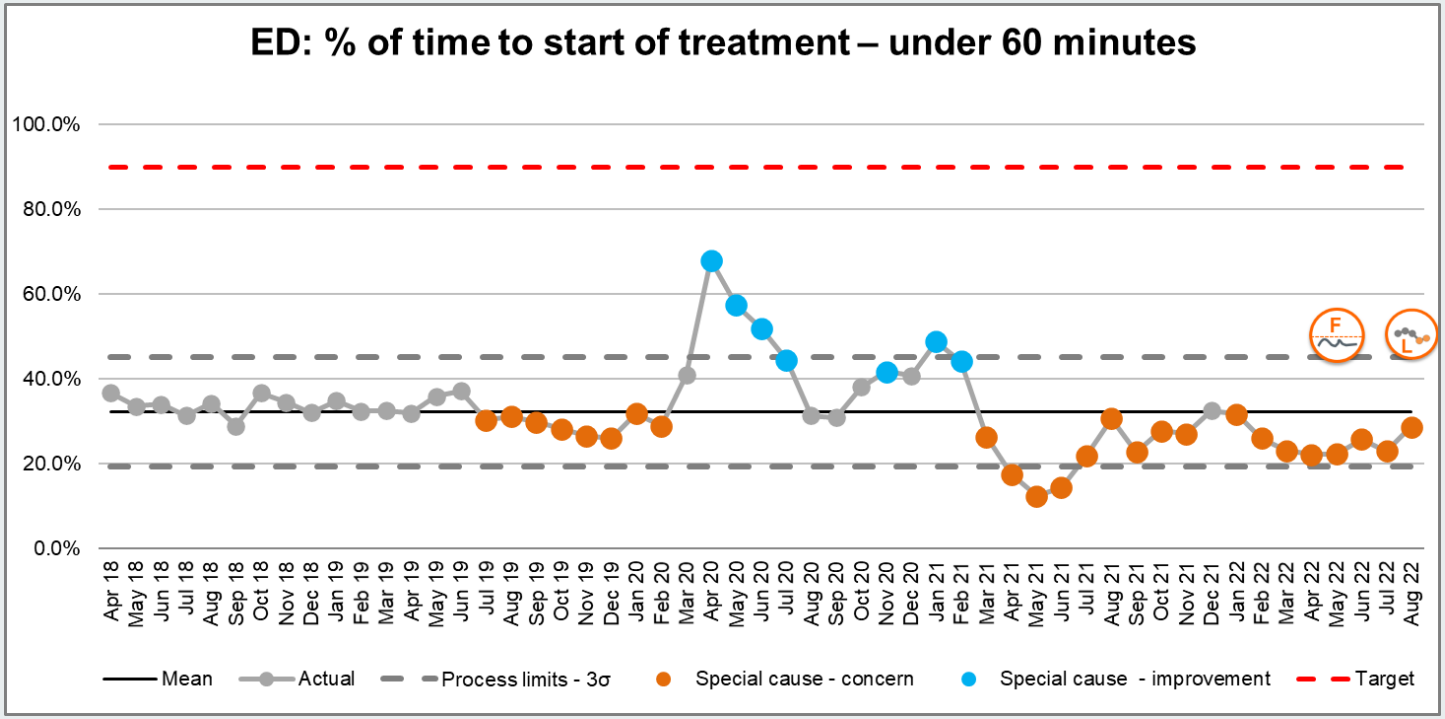

Commentary

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- General Manager of Unscheduled Care

Data Observations

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

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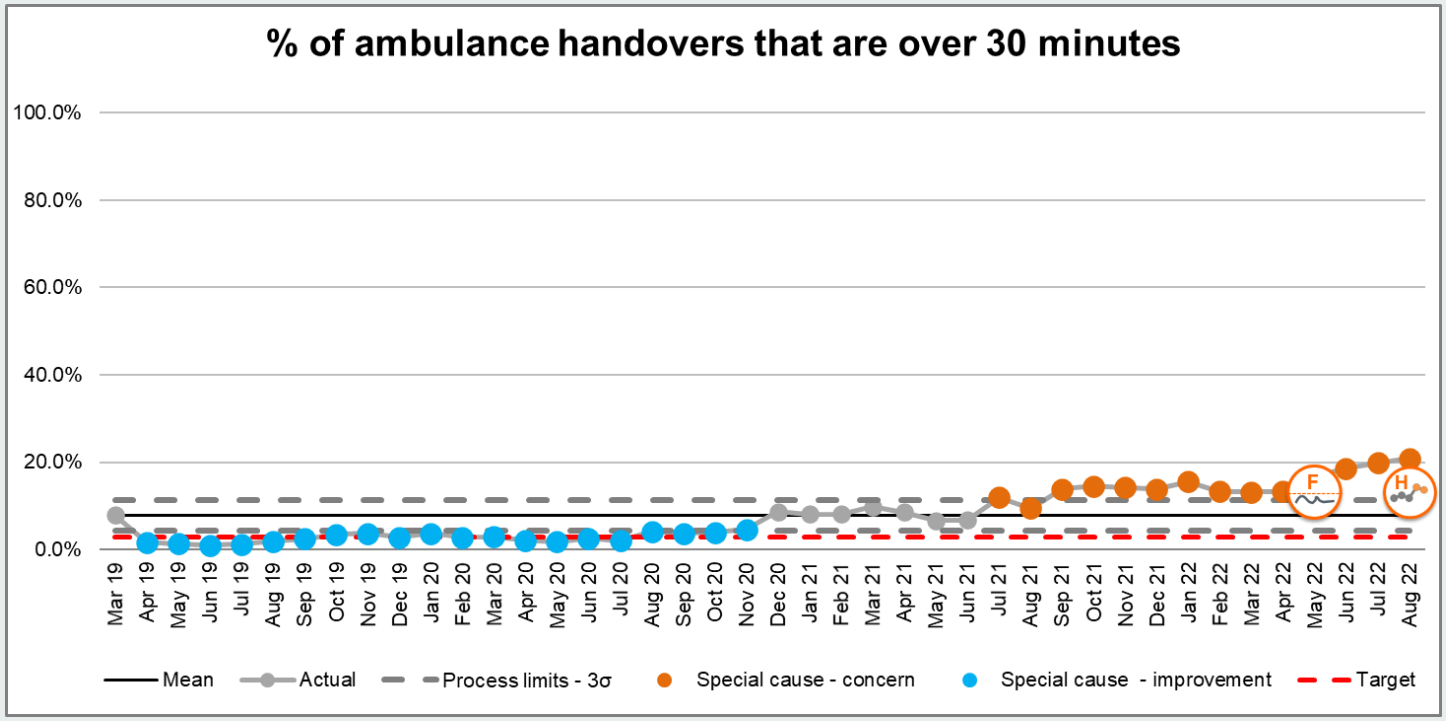

Commentary

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- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 19 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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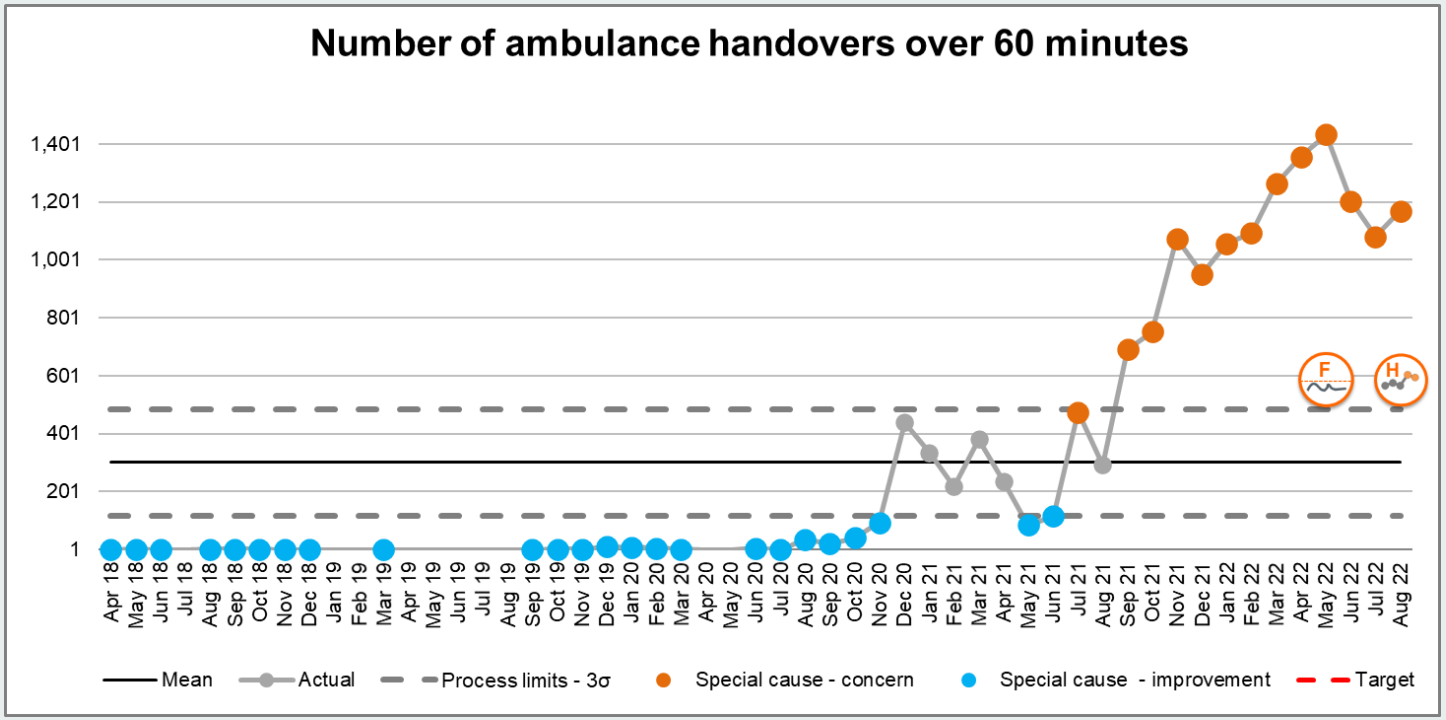

Commentary

The Trust saw an average increase of ambulance handovers over 60 mins by 2.6% compared to July. There was a minimal increase in total ambulance arrivals

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 34 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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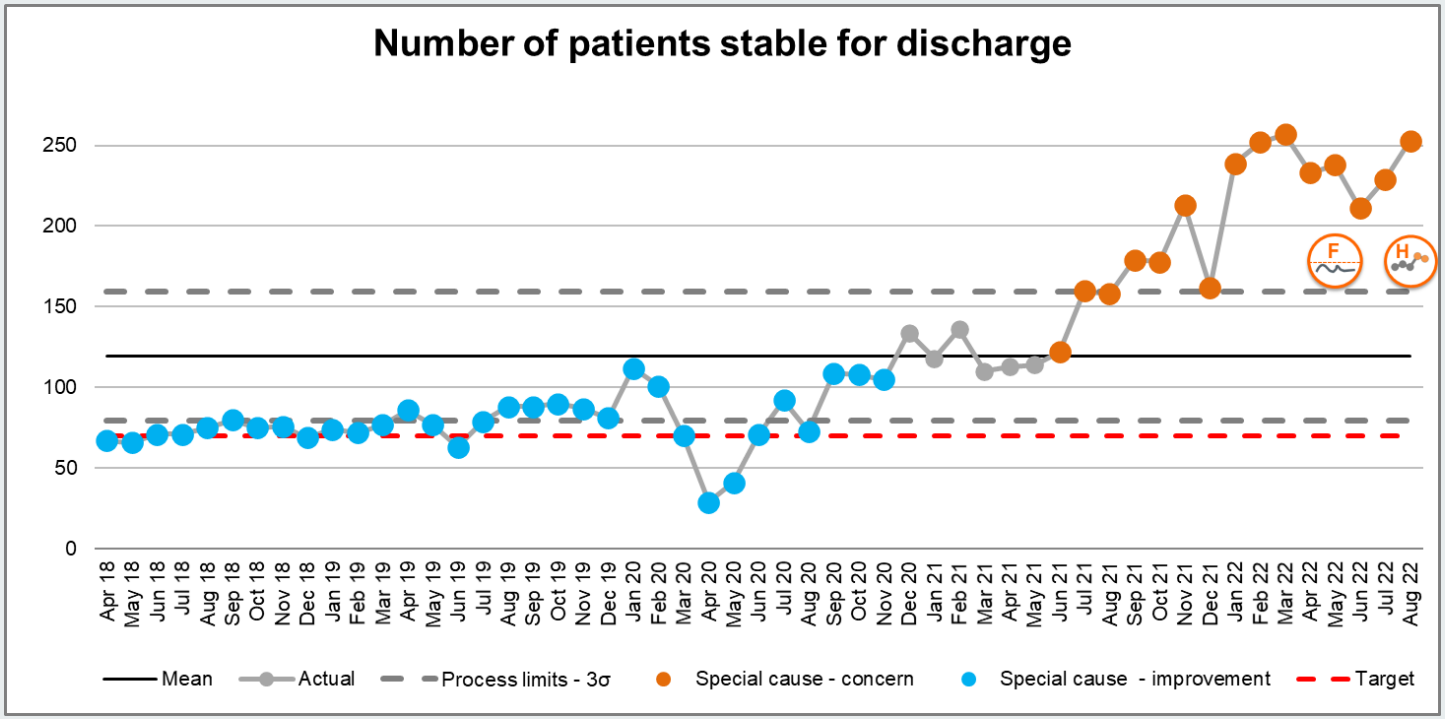

Commentary

Numbers have increased back up to April levels due to a lack of flow within the 3 main discharge pathways, community hospitals, home first and assessment beds. This relates to these three pathways now having their own significant numbers of 'medically stable' patients awaiting onward progression. This issue is well recognised at ICS level and forms a significant part of the Sloman and Winter challenge work.

- Head of Therapy & OCT

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 19 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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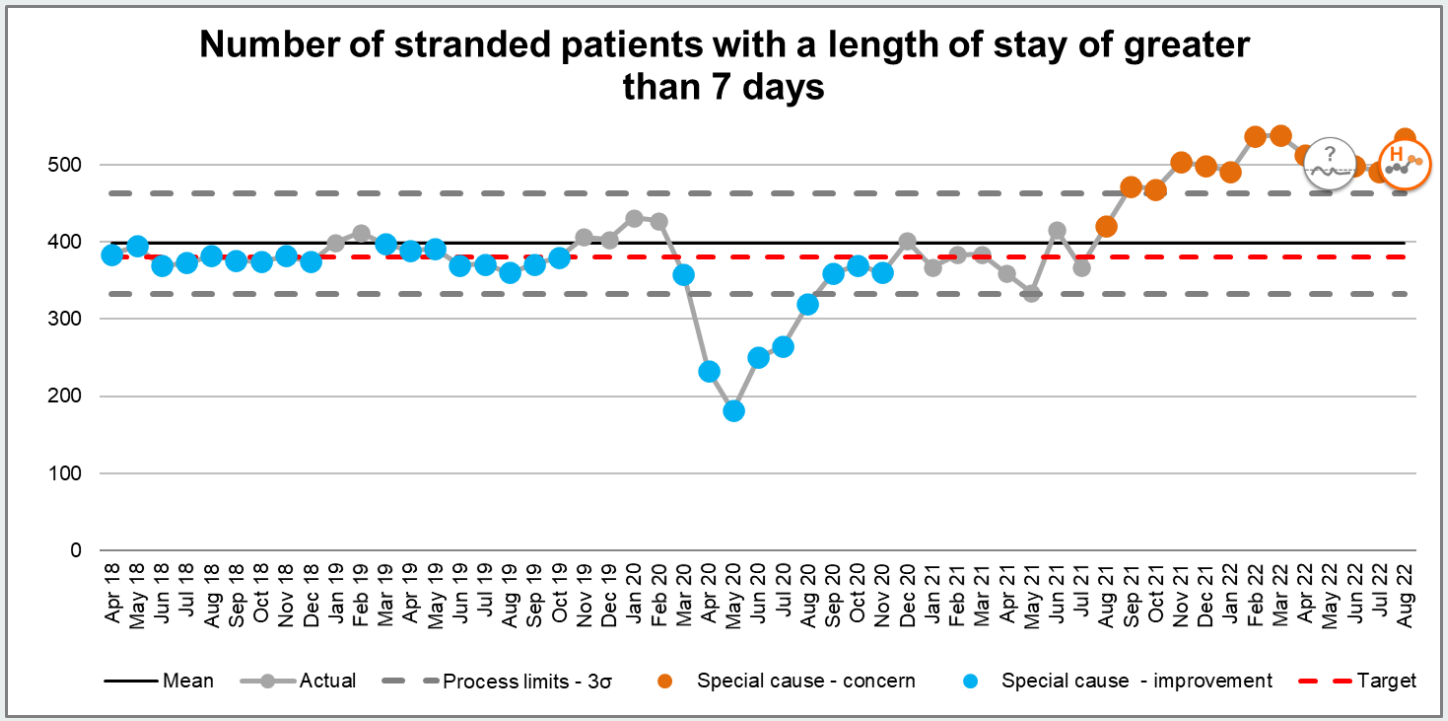

Commentary

This has jumped in month to one its highest positions all year with an extra 43 patients. This is just 4 patients short of the peak experienced in March 2022.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 5 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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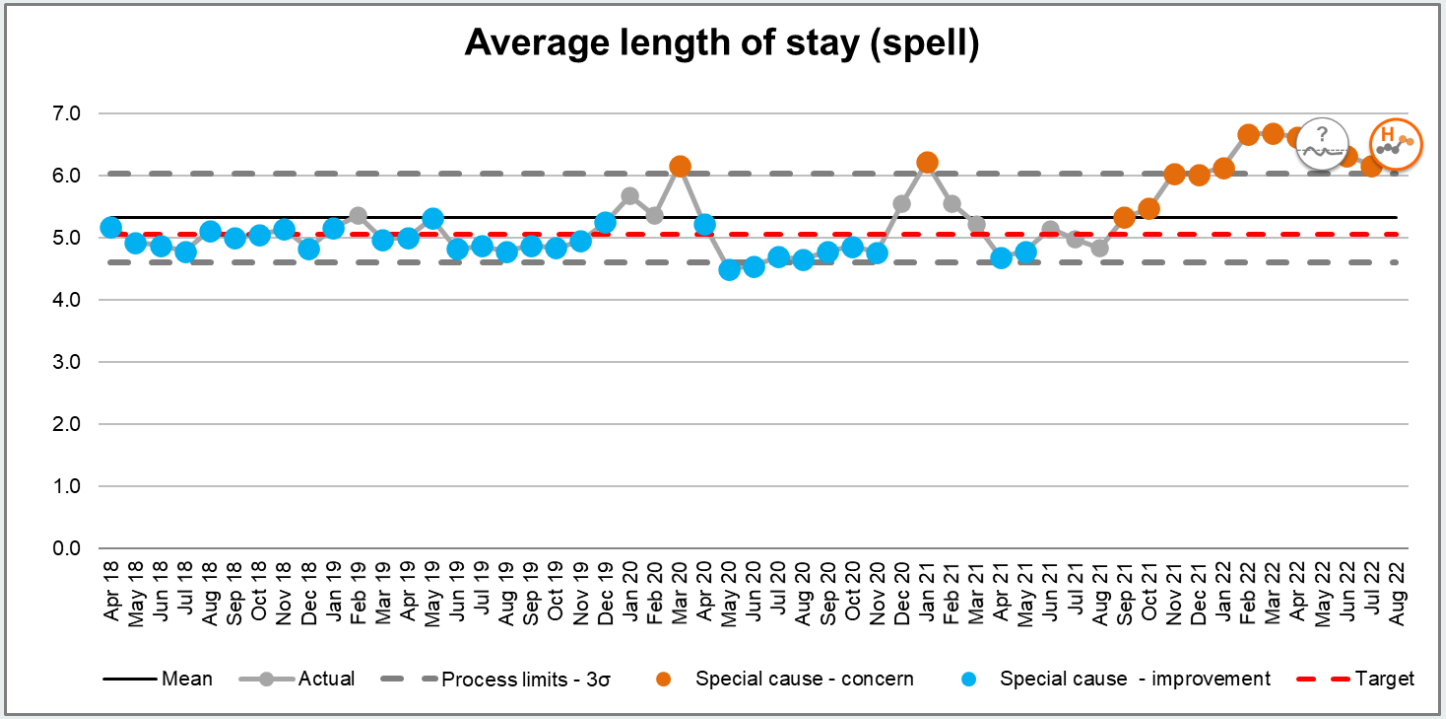

Commentary

ALOS has fallen back in-month, increasing to 6.38 days. This deterioration is likely to be due to the 'Bank Holiday Effect' which may have delayed some progress of some patients. Work is planned to ensure we better mitigate 'seasonal events' which are planned and known; to reduce the negative impact on performance

- Deputy Chief Operating Officer

Data Observations

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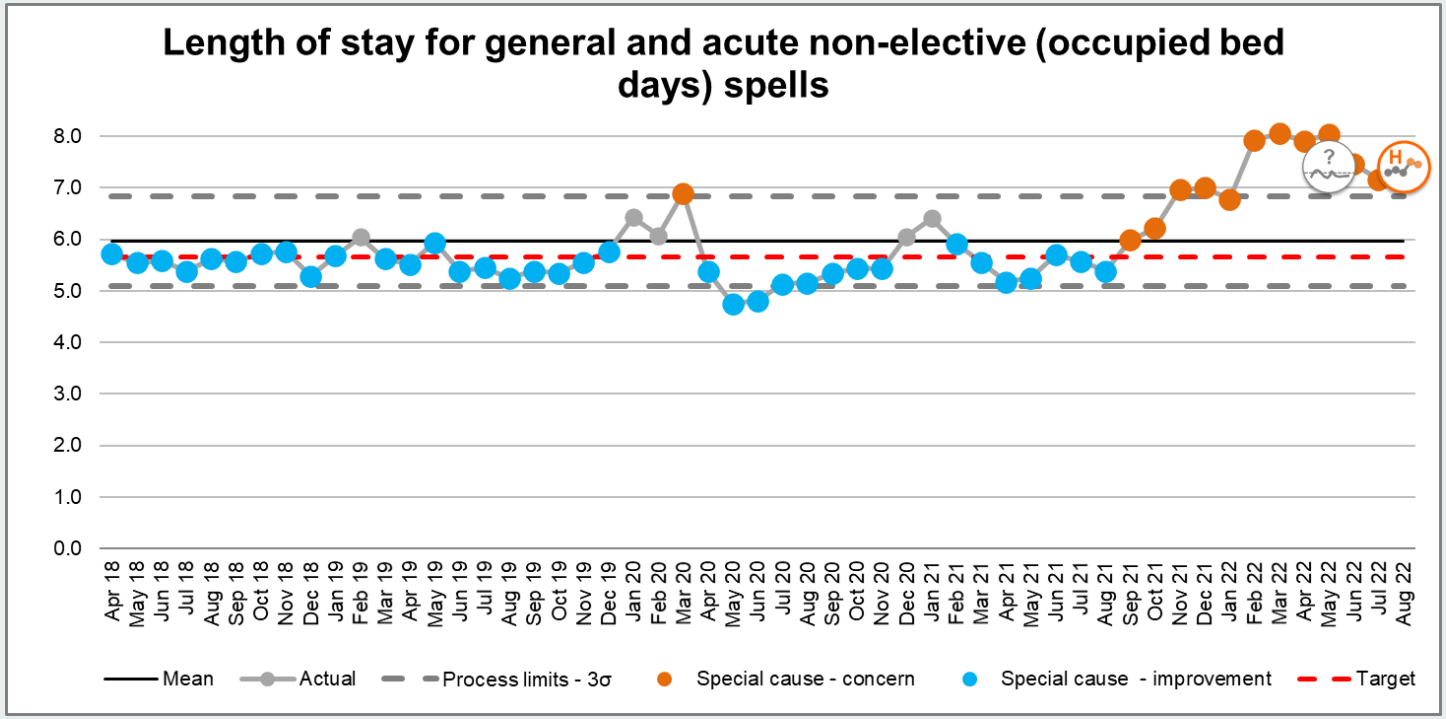

Commentary

Similar to Length of Spell an increase has been experienced in month, moving by +0.4 days. This correlates with an increase in the number of stranded patients.

- Deputy Chief Operating Officer

Data Observations

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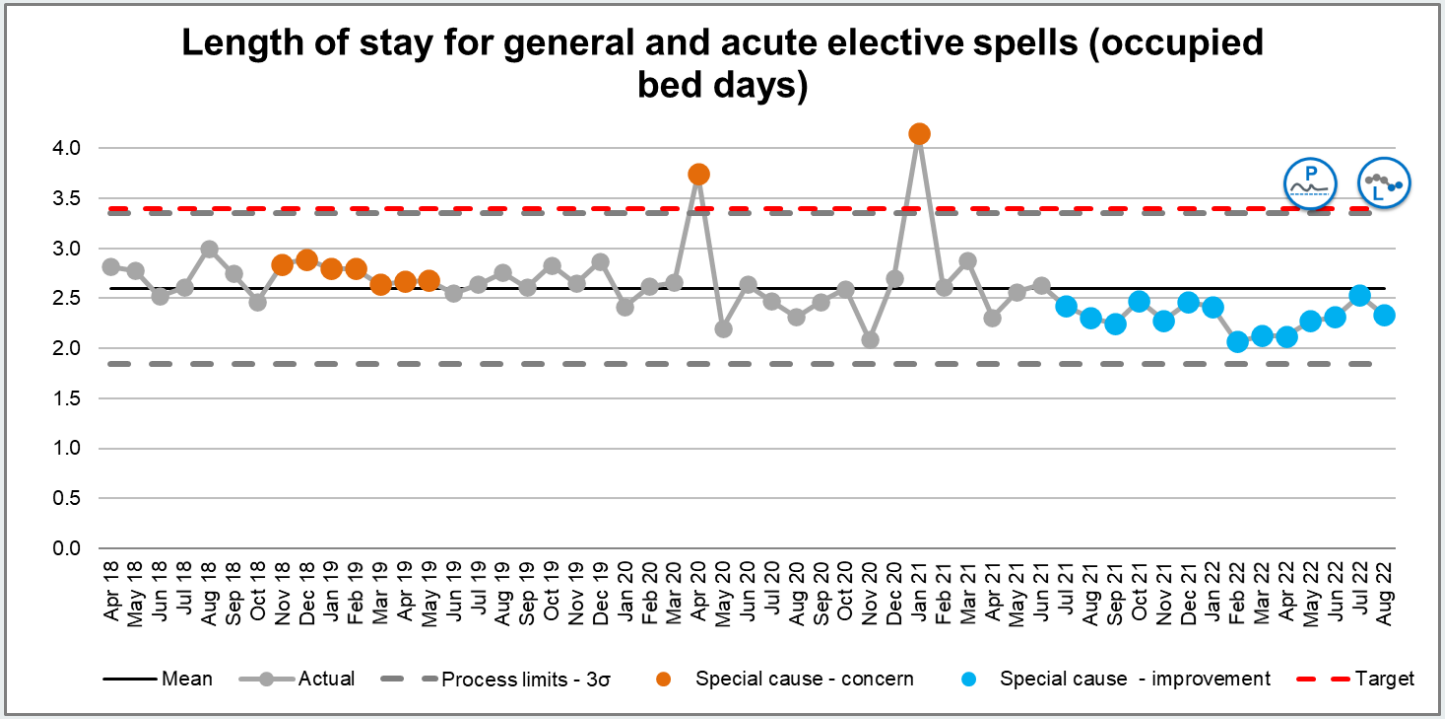

Commentary

An improvement of 0.2 days has occurred in month and continues to remain well within target.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 2 data points which are above the line.
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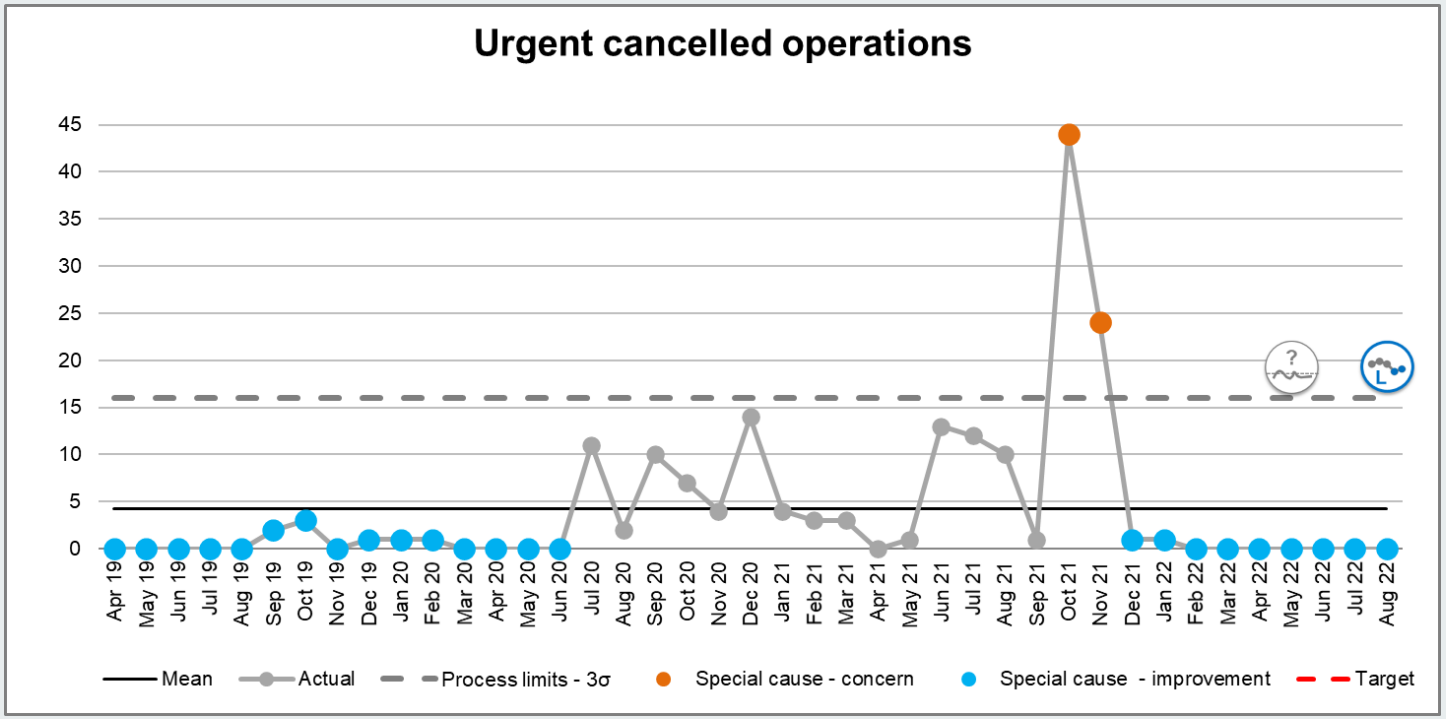

Commentary

Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days,

- Deputy Chief Operating Officer

Data Observations

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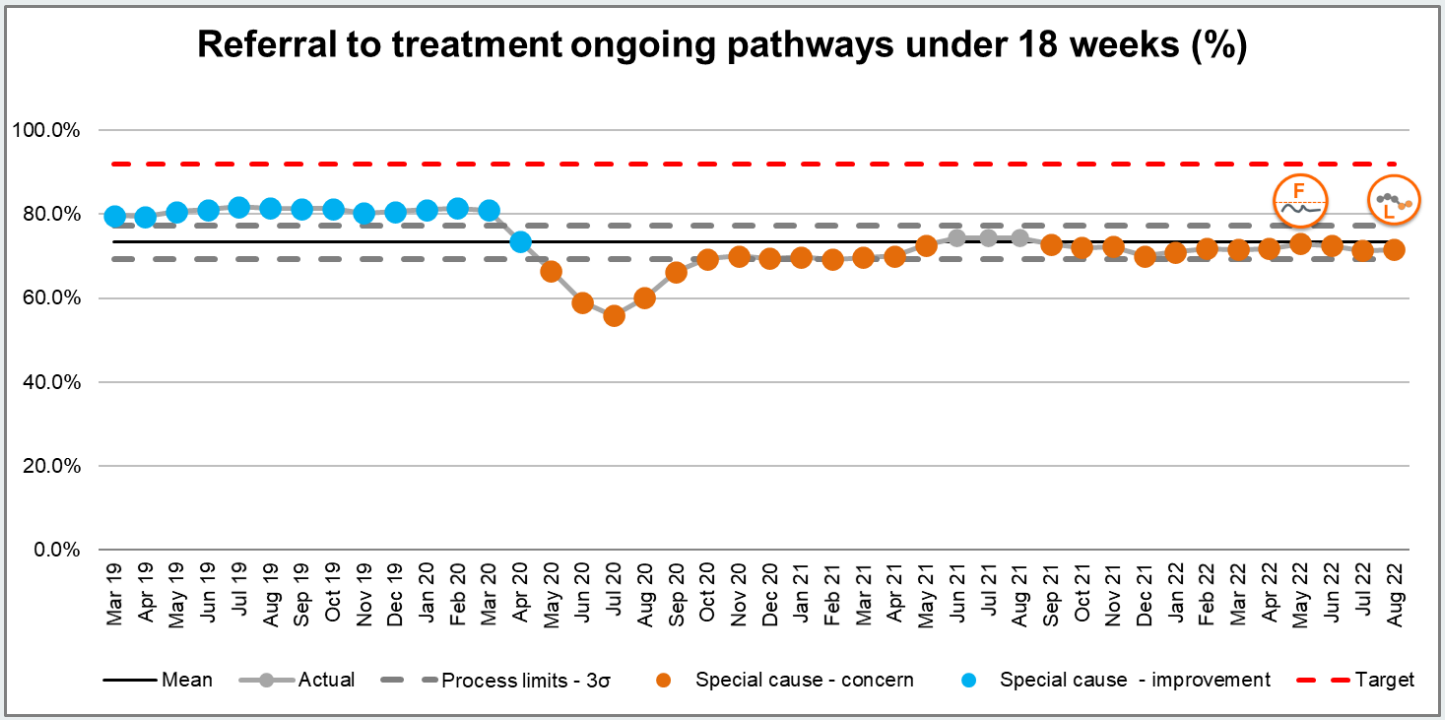

Commentary

See Planned Care Exception report for full details. RTT performance is currently reported as 71.57% and is not anticipated to change significantly prior to submission. Performance has marginally improved in month by just 0.2%. However performance remains stable GHT remains significantly above the national average.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
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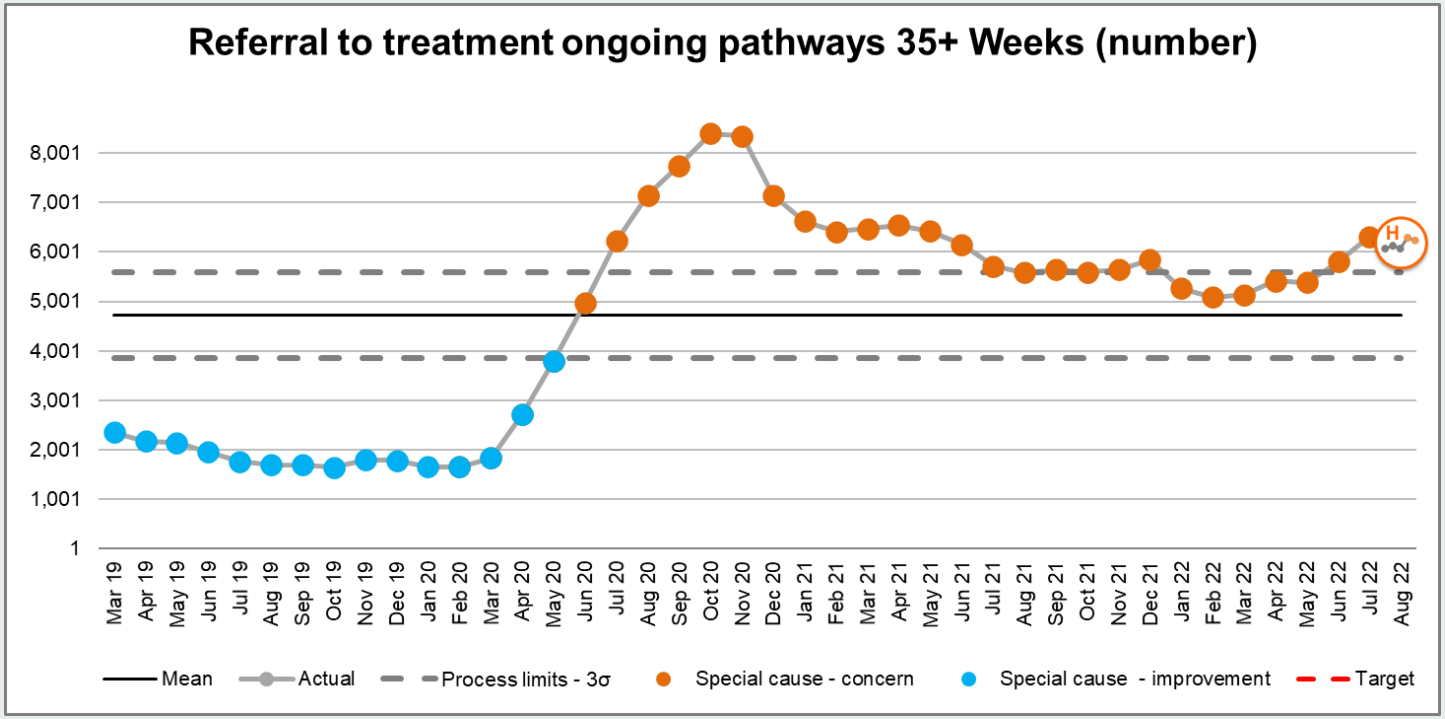

Commentary

The number of patients over 35 weeks has increased in month, by 72 patients. This is now the highest level this financial year.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 21 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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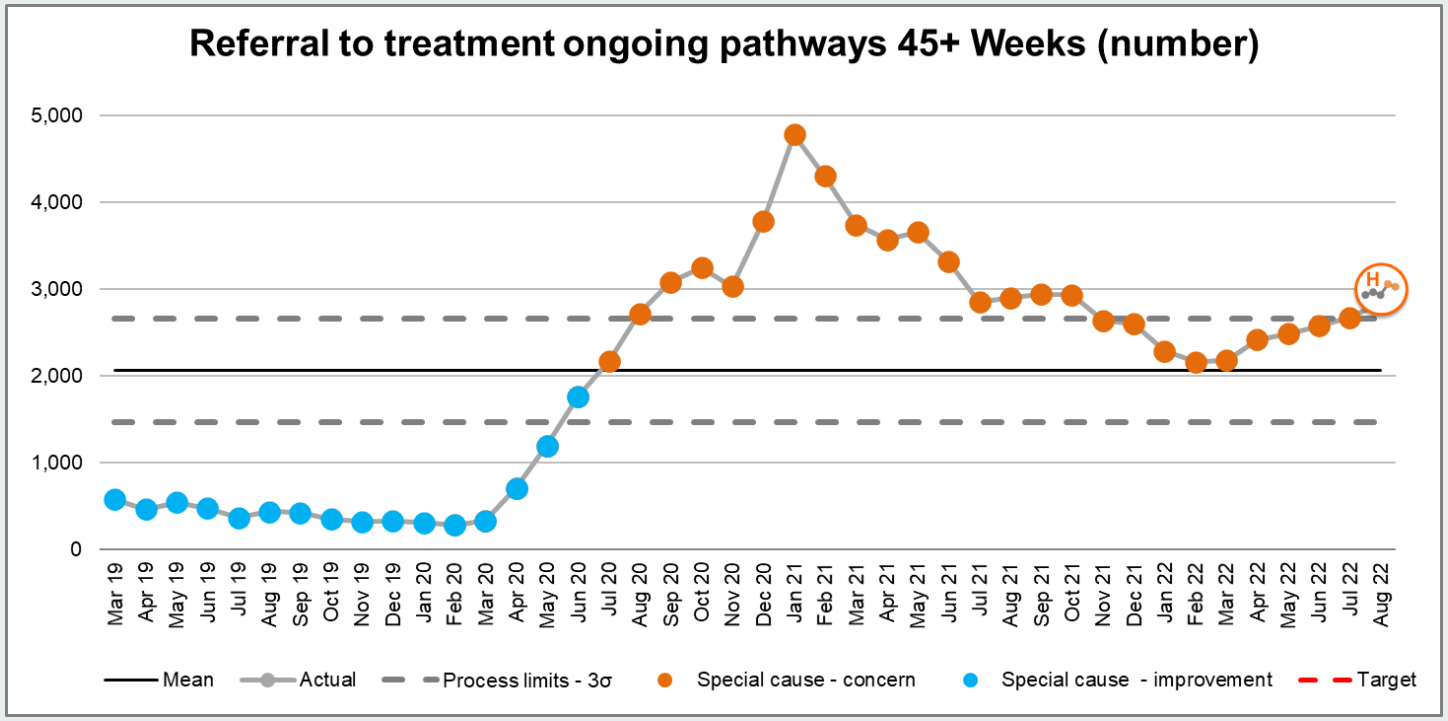

Commentary

This cohort has increased 163 over the past month which continues to the gradual trend that has been observed since February 2022.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 17 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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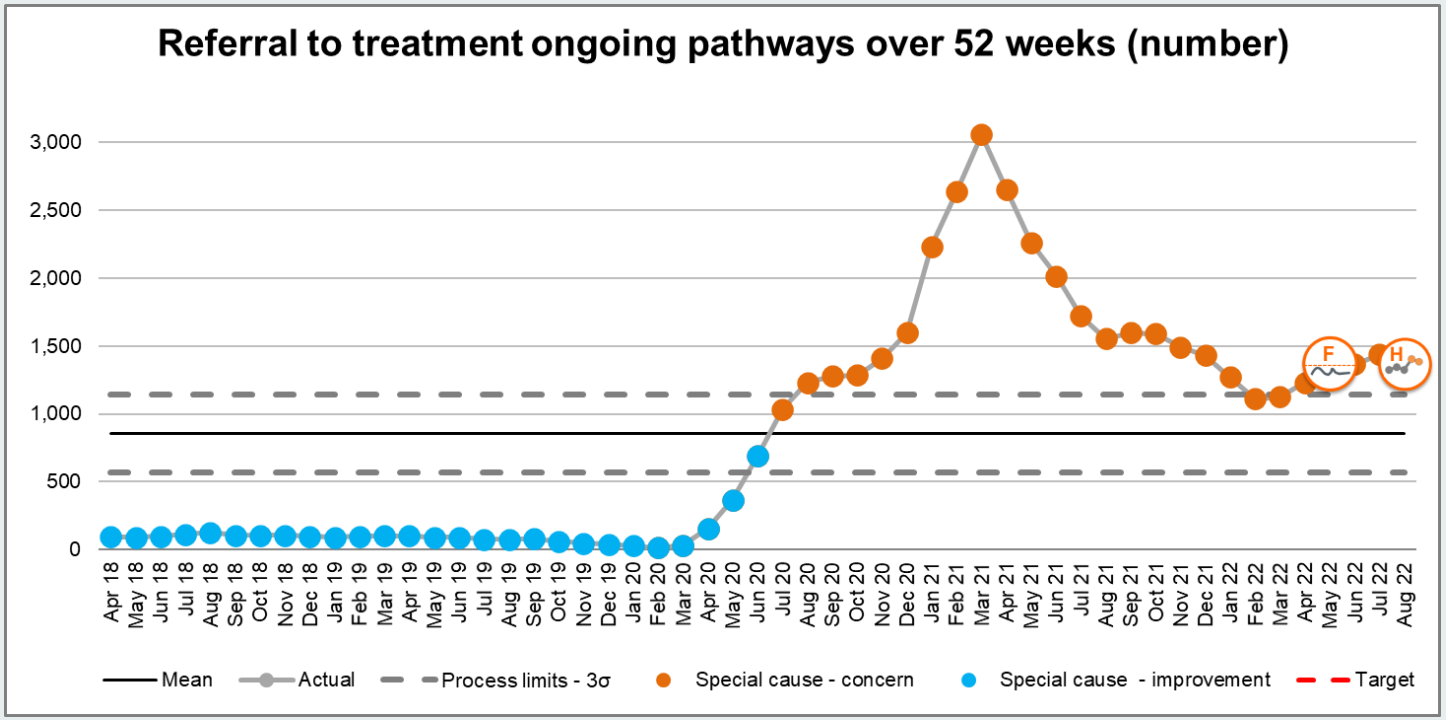

Commentary

See Planned Care Exception report for a full breakdown. Performance in August has seen a slight improvement in 52 week breaches, with a reduction of approximately 40 on last month. The three specialties that have made most gains are Oral Surgery (-91), Ophthalmology (-21) and T&O (-14).

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 23 data points which are above the line. There are 26 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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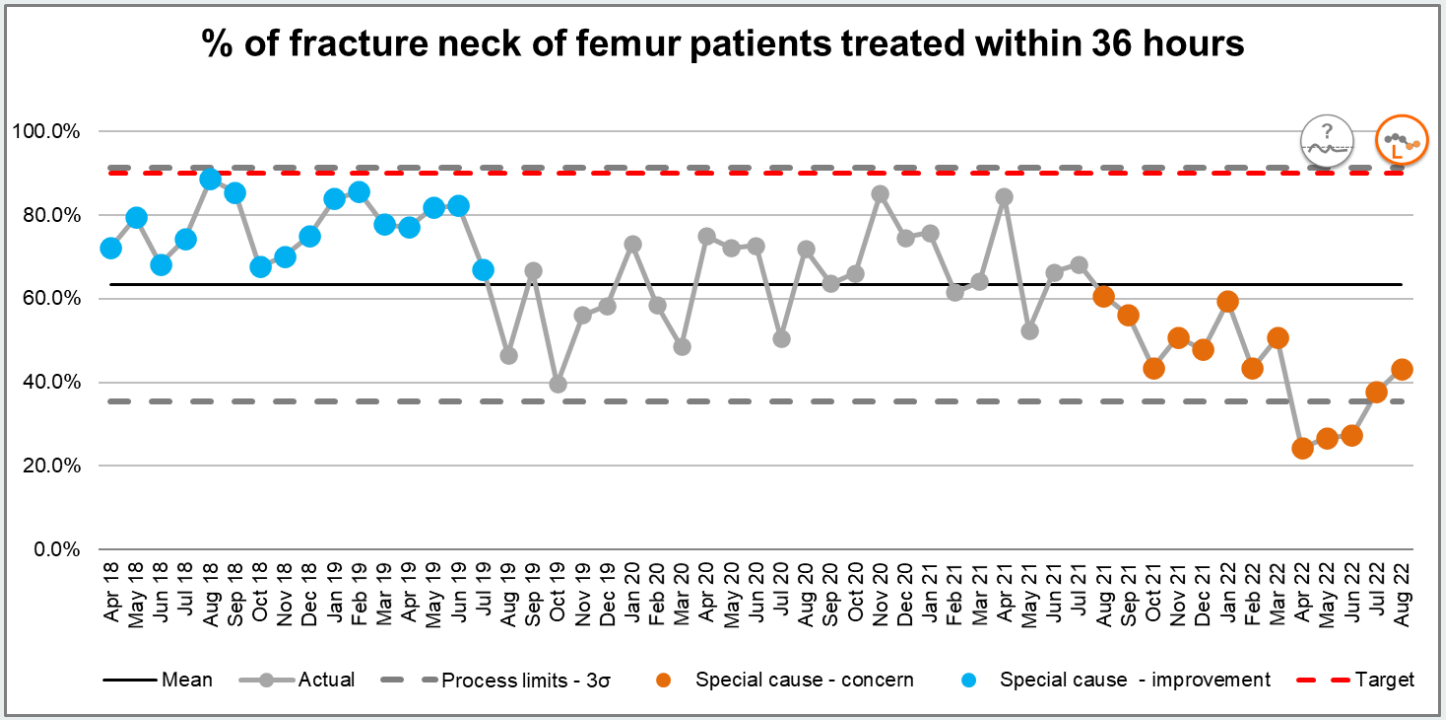


Commentary

The #NOF pathway is a key performance indicator within T&O and Orthogeriatric services, with performance monitored through specialty governance meetings and the Service Line Review report, and data and specific commentary on improvement/deteriorating in month is provided at Exec Review. #NOFs are now cohorted onto the 3rd floor as standard practice, and work is ongoing on a number of actions to support improving performance, including prioritising NOF on triage in ED, NOF admission proforma on EPR and looking to increase therapist funding and radiographer support.

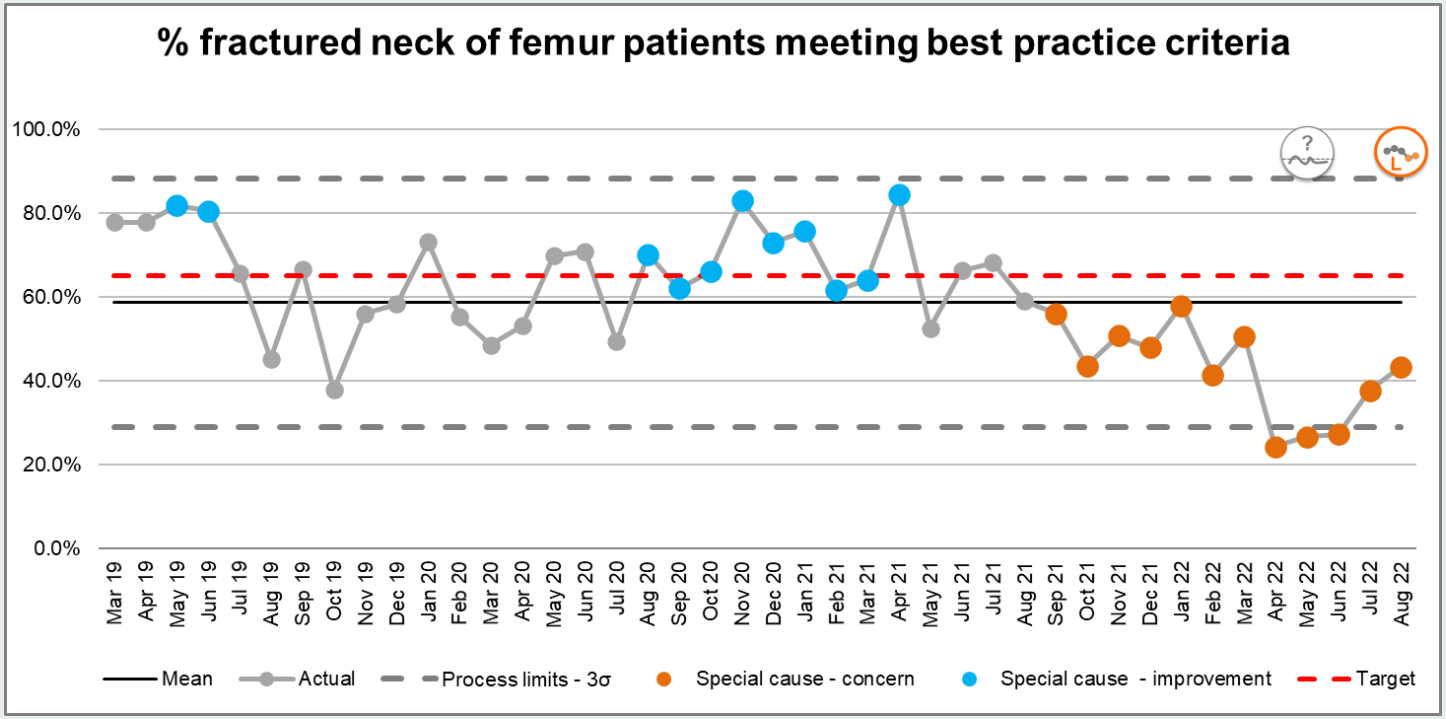
- General Manager - Trauma & Orthopaedics

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The #NOF pathway is a key performance indicator within T&O and Orthogeriatric services, with performance monitored through specialty governance meetings and the Service Line Review report, and data and specific commentary on improvement/deteriorating in month is provided at Exec Review. #NOFs are now cohorted onto the 3rd floor as standard practice, and work is ongoing on a number of actions to support improving performance, including prioritising NOF on triage in ED, NOF admission proforma on EPR and looking to increase therapist funding and radiographer support.

- General Manager - Trauma & Orthopaedics

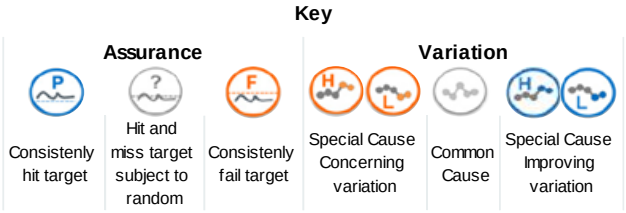
Data Observations

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

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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



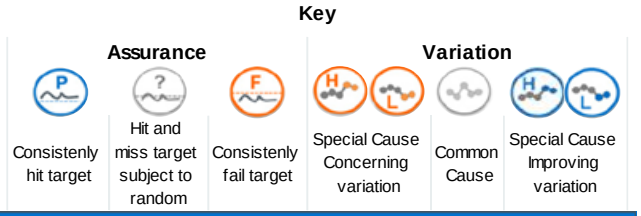
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance			
Friends & Family Test	Inpatients % positive	>=90%	Aug-22	91.2%	Common Cause	
Friends & Family Test	ED % positive	>=84%	Aug-22	71.5%	Common Cause	
Friends & Family Test	Maternity % positive	>=97%	Aug-22	82.1%	Common Cause	
Friends & Family Test	Outpatients % positive	>=94.5%	Aug-22	94.2%	Common Cause	
Friends & Family Test	Total % positive	>=93%	Aug-22	89.8%	Concern (Low)	
Friends & Family Test	Number of PALS concerns logged	No Target	Aug-22	329	Common Cause	
Friends & Family Test	% of PALS concerns closed in 5 days	>=95%	Aug-22	77.2%	Common Cause	
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Aug-22	0	RunChart	
Infection Control	MRSA bacteraemia - infection rate per 100,000 bed days	Zero	Jul-22	3.5	Concern (High)	
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Aug-22	10	Common Cause	
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Aug-22	3	Common Cause	
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Aug-22	7	Common Cause	
Infection Control	Clostridium difficile - infection rate per 100,000 bed days	<30.2	Jul-22	13.9	Common Cause	
Infection Control	Number of MSSA bacteraemia cases	<=8	Aug-22	10	Concern (High)	
Infection Control	MSSA - infection rate per 100,000 bed days	<=12.7	Jul-22	17.4	RunChart	
Infection Control	Number of ecoli cases	No target	Aug-22	6	Common Cause	
Infection Control	Number of pseudomona cases	No target	Aug-22	2	Common Cause	
Infection Control	Number of klebsiella cases	No target	Aug-22	3	Common Cause	
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Aug-22	51	Common Cause	
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No target	Aug-22	59	Common Cause	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance			
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after	No target	Aug-22	29	Common Cause	
Infection Control	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	No target	Aug-22	14	Common Cause	
Infection Control	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	No target	Aug-22	29	Concern (High)	
Maternity	% C-section rate (planned and emergency)	No target	Aug-22	0	Concern (High)	
Maternity	% emergency C-section rate	No target	Aug-22	17.6%	Common Cause	
Maternity	% of women smoking at delivery	<=8.0%	Aug-22	0	Common Cause	
Maternity	% of women that have an induced labour	<=33%	Aug-22	30.0%	Concern (High)	
Maternity	% stillbirths as percentage of all pregnancies	<0.52%	Aug-22	0.22%	Improvement (Low)	
Maternity	% of women on a Continuity of Carer pathway	No target	Aug-22	8.60%	Common Cause	
Maternity	% breastfeeding (initiation)	>=81%	Aug-22	61.8%	Concern (Low)	
Maternity	% PPH >1.5 litres	<=4%	Aug-22	4.3%	Common Cause	
Maternity	Number of births less than 27 weeks	NULL	Aug-22	1	Common Cause	
Maternity	Number of births less than 34 weeks	NULL	Aug-22	8	Common Cause	
Maternity	Number of births less than 37 weeks	NULL	Aug-22	38	Common Cause	
Maternity	Number of maternal deaths	NULL	Aug-22	0	Improvement (Low)	
Maternity	Total births	NULL	Aug-22	466	Improvement (Low)	
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Aug-22	2.10%	Common Cause	
Maternity	% breastfeeding (discharge to CMW)	NULL	Jul-22	59.9%	Concern (High)	
Mortality	Summary hospital mortality indicator (SHMI) - national data	NHS Digital	Apr-22	1.1	Improvement (High)	
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	May-22	113.4	Concern (High)	
Mortality	Hospital standardised mortality ratio (HSMR) - weekend	Dr Foster	May-22	105.6	Improvement (Low)	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

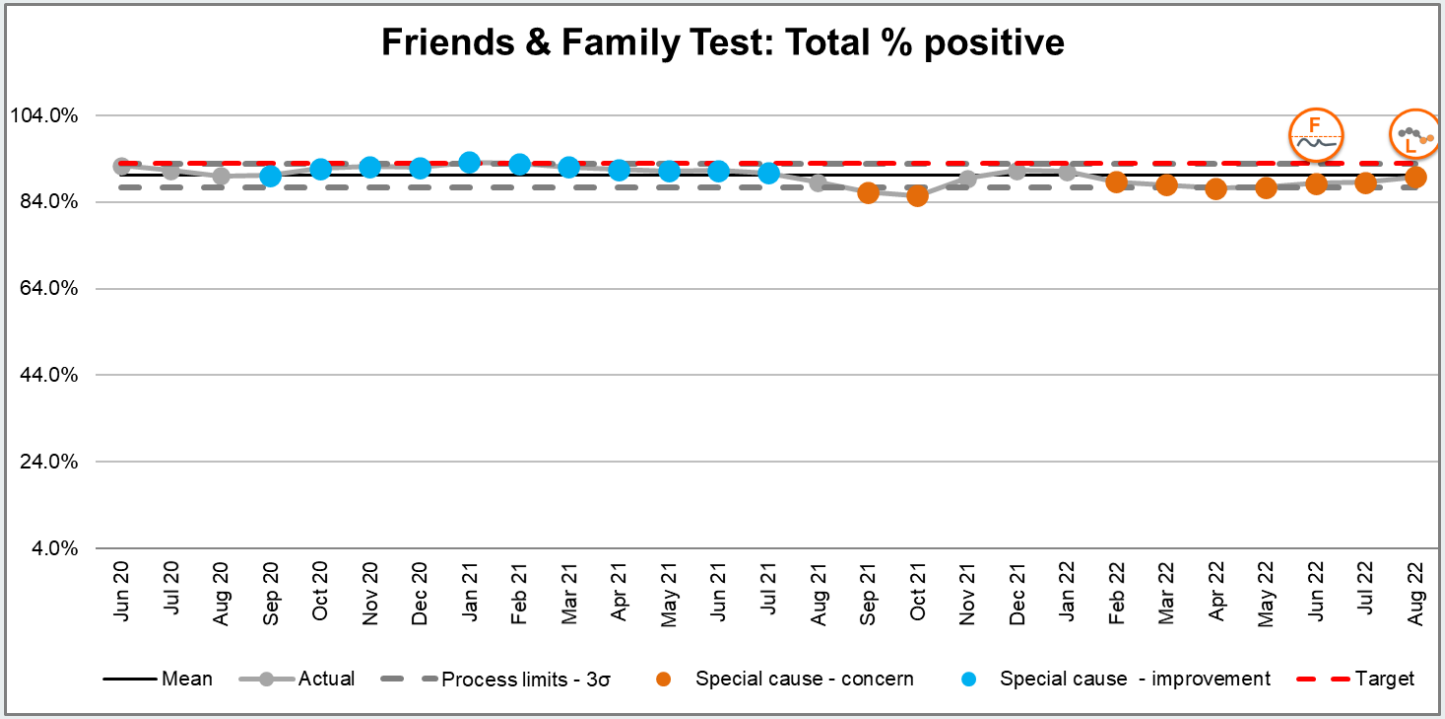


MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	Aug-22	168	Common Cause
Mortality	Number of deaths of patients with a learning disability	No target	Aug-22	0	Common Cause
MSA	Number of breaches of mixed sex accommodation	<=10	Aug-22	47	Concern (High)
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Dec-21	1	Concern (High)
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Aug-22	6	Common Cause
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Aug-22	5	Common Cause
Patient Safety Incidents	Number of patient safety incidents - severe harm (major/death)	No target	Aug-22	13	Concern (High)
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Aug-22	32	Common Cause
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Aug-22	0	Common Cause
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Aug-22	0	Common Cause
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Aug-22	7	Concern (High)
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Aug-22	5	Common Cause
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Apr-21	70%	RunChart
RIDDOR	Number of RIDDOR	SPC	Aug-22	2	Concern (Low)
Safety Thermometer	Safety thermometer - % of new harms	>96%	Mar-20	97.8%	Common Cause
Serious Incidents	Number of never events reported	Zero	Aug-22	0	RunChart
Serious Incidents	Number of serious incidents reported	No target	Aug-22	3	Common Cause

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Serious Incidents	Serious incidents - 72 hour report completed within contract timescale	>90%	Aug-22	100.0%	Improvement (High)
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Aug-22	100%	Common Cause
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Aug-22	87.2%	Common Cause
Safeguarding	Level 2 safeguarding adult training - e-learning package	TBC	Nov-19	95%	RunChart
Safeguarding	Number of DoLs applied for	TBC	Aug-22	72	Common Cause
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	TBC	Aug-22	4	Common Cause
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	TBC	Aug-22	2	Improvement (Low)
Safeguarding	Total admissions aged 0-17 with DSH	TBC	Aug-22	17	Common Cause
Safeguarding	Total ED attendances aged 0-17 with DSH	TBC	Aug-22	61	Common Cause
Safeguarding	Total admissions aged 0-17 with an eating disorder	TBC	Aug-22	10	Common Cause
Safeguarding	Total number of maternity social concerns forms completed	TBC	Aug-22	101	Concern (High)

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Trust had 6529 responses to FFT in August 2022, and the overall Trust FFT positive score has seen an increase in positive score this month of 89.8%. This is largely due to increases in the positive FFT score for unscheduled care (5% increase in positive score at GRH) and a slight increase for outpatients. Comments were mostly around communication, lack of organisation, waiting and delayed appointments.. Divisions provide updates through QDG each quarter on improvement plans happening within divisions, and the patient experience team are reviewing current reporting offer to improve the way that FFT and PALS data is triangulated to support improvement plans.

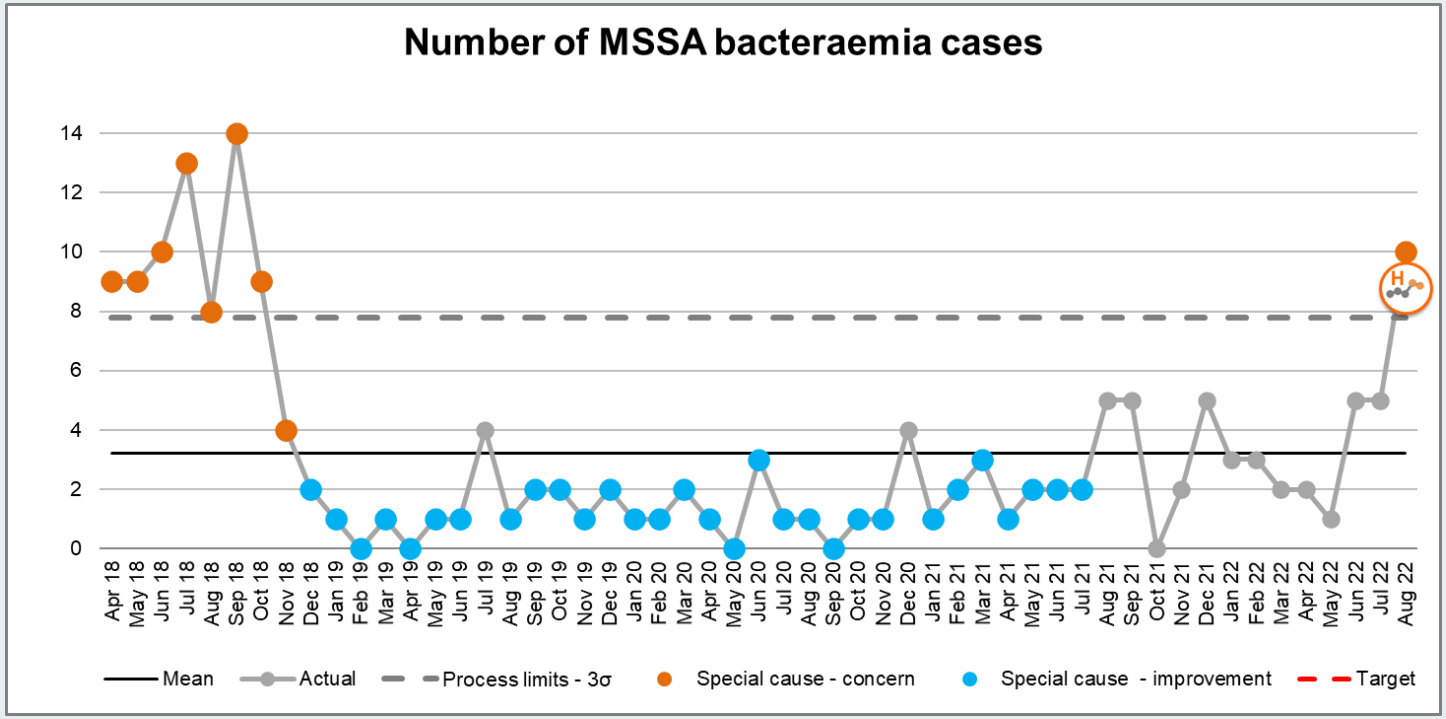
-Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

During August we had 10 health care associated MSSA blood stream infections; 5 hospital onset health care associated (HO-HA) and 5 community onset health care associated cases. All HO-HA cases will be reviewed via rapid post infection review and findings discussed with teams for action; those with moderate or significant harm will be datixed and escalated to risk for review. A IPCT meeting has been organised to review all the cases for August to identify themes and trends for remedial action.

Reducing MSSA bacteraemias continue to be a focus of the IPC strategy 2022/23 specifically related to improving the management and care of invasive devices. There are actions within the programme that will be implemented to ensure we do not breach our internally set annual limit of no more than 30 healthcare associated cases for 2022/23. A trust wide audit IV access device audit is scheduled for September 2022 as these devices have been identified as significant cause of the blood stream infections. It is also noted that there has been a regional increase in MSSA BSIs

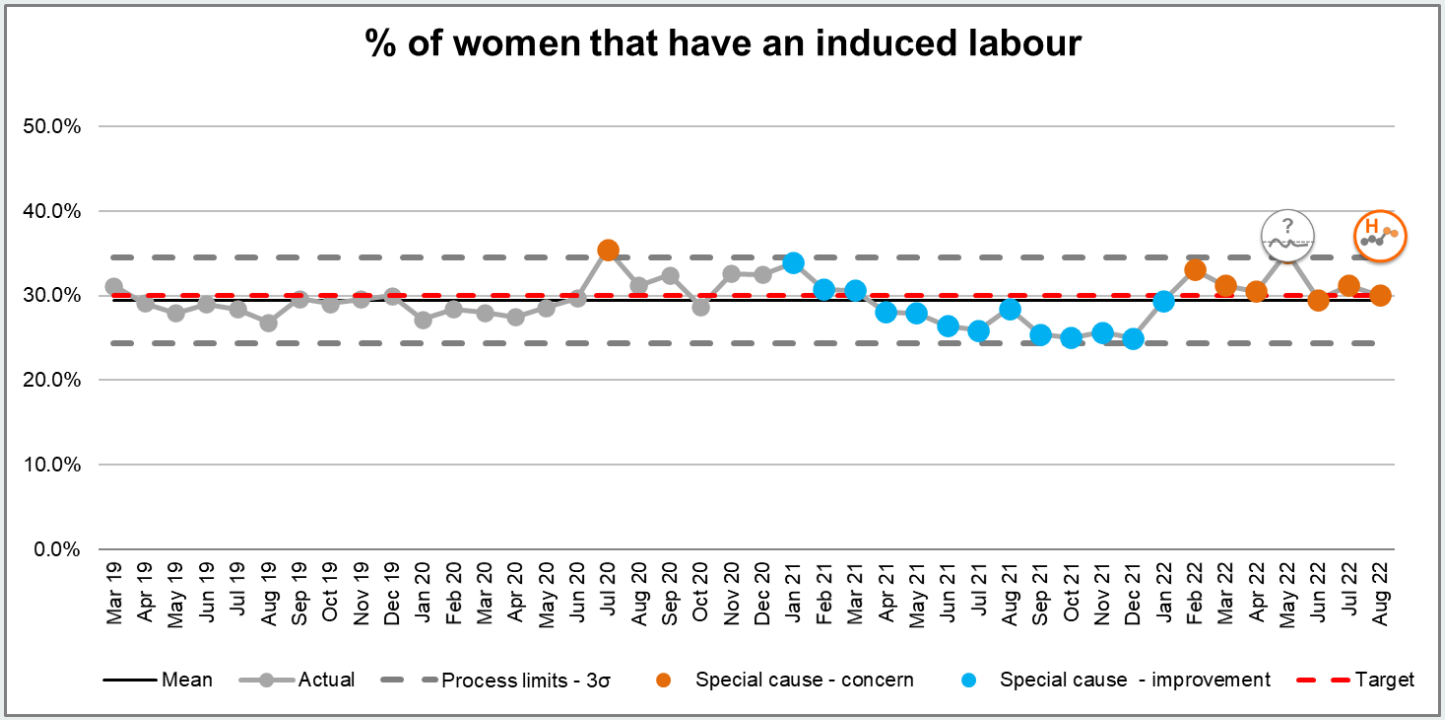
- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line.
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points below the mean.
Rule 4	When more than 15 consecutive points lie within the mean +/- 1σ this process is considered to be out of control.

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review

- Divisional Director of Quality & Nursing and Chief Midwife

Data Observations

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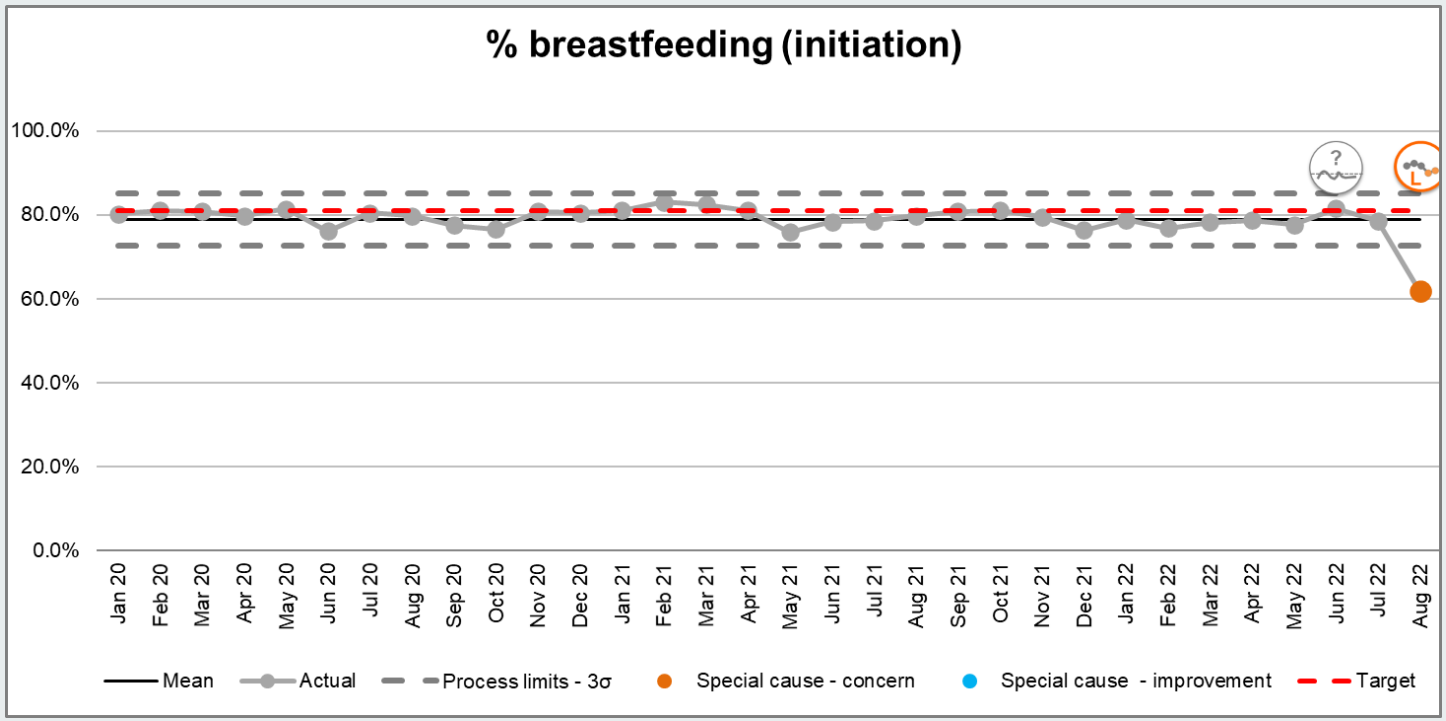
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The service have been auditing practice for our yearly Baby friendly Initiative audit which we need to provide to UNICEF to maintain our accreditation .This was sent at the end of last month and we are waiting for feed back and will develop an action plan as required ,Infant feeding pages on maternity website have been reviewed and updated ,sat morning feeding drop in's run by the Breast feeding network in ante natal clinic are due to be re-instated in October. Joint midwife and Health visitor training to start again in their localities. Both the last 2 items were stopped for the pandemic

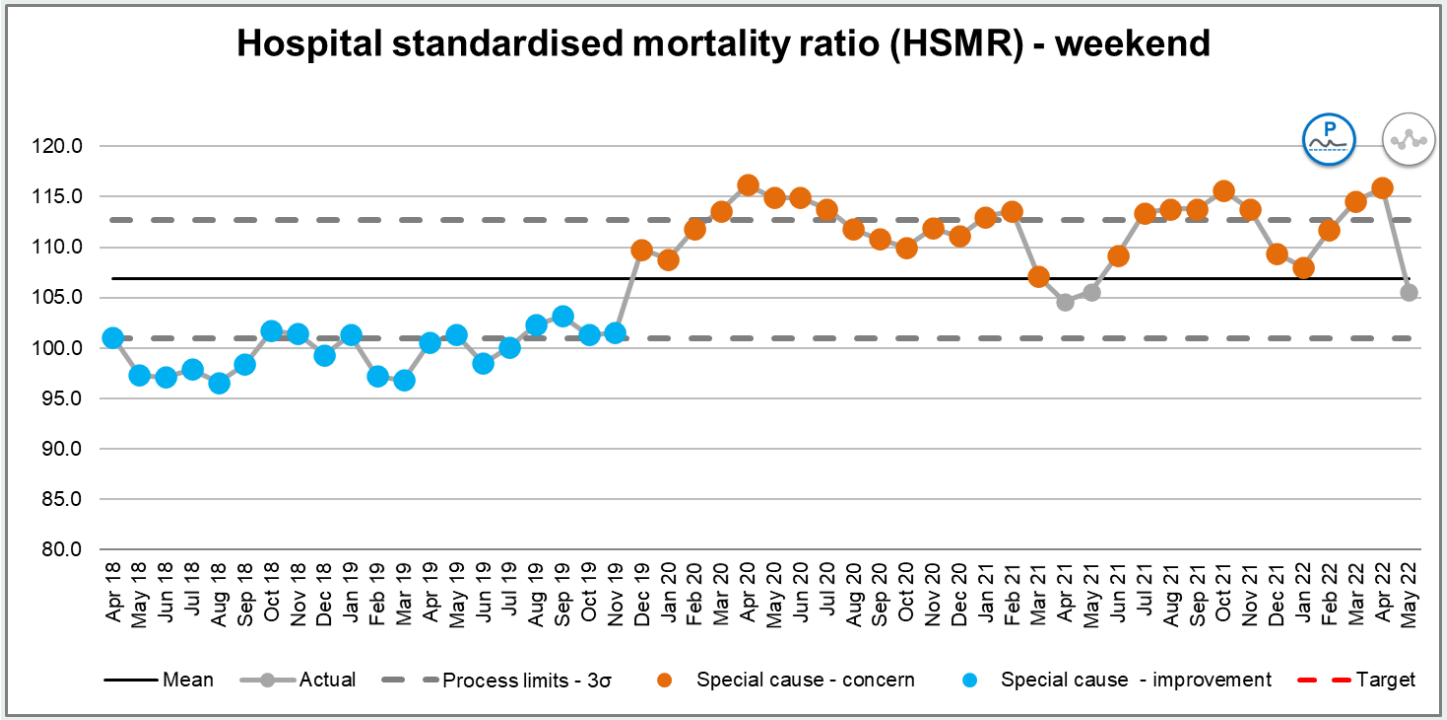
- Divisional Director of Quality & Nursing and Chief Midwife

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 1 data points which are above the line.

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

These metrics have flagged as red for the last three months, these are being investigated in Hospital Mortality Group, there is no clear cut answer to the increase. The biggest concern is it relates to congestion as that will be the hardest to overcome. There will be further investigation in to diagnostic groups that are flagging as increased mortality observed compared to expected. There is also work looking at the comorbidity scoring which has a significant impact into expected mortality rates.

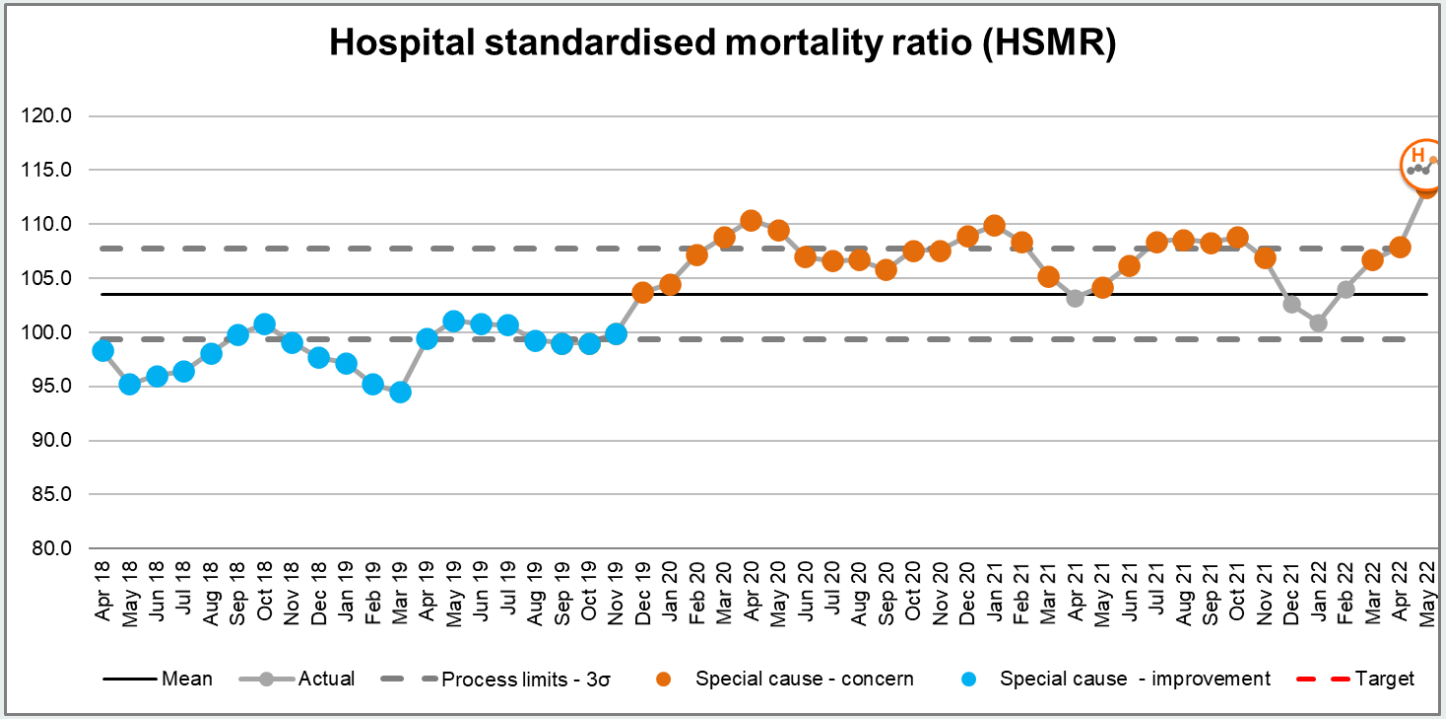
- Deputy Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 14 data points which are above the line. There are 11 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



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- Deputy Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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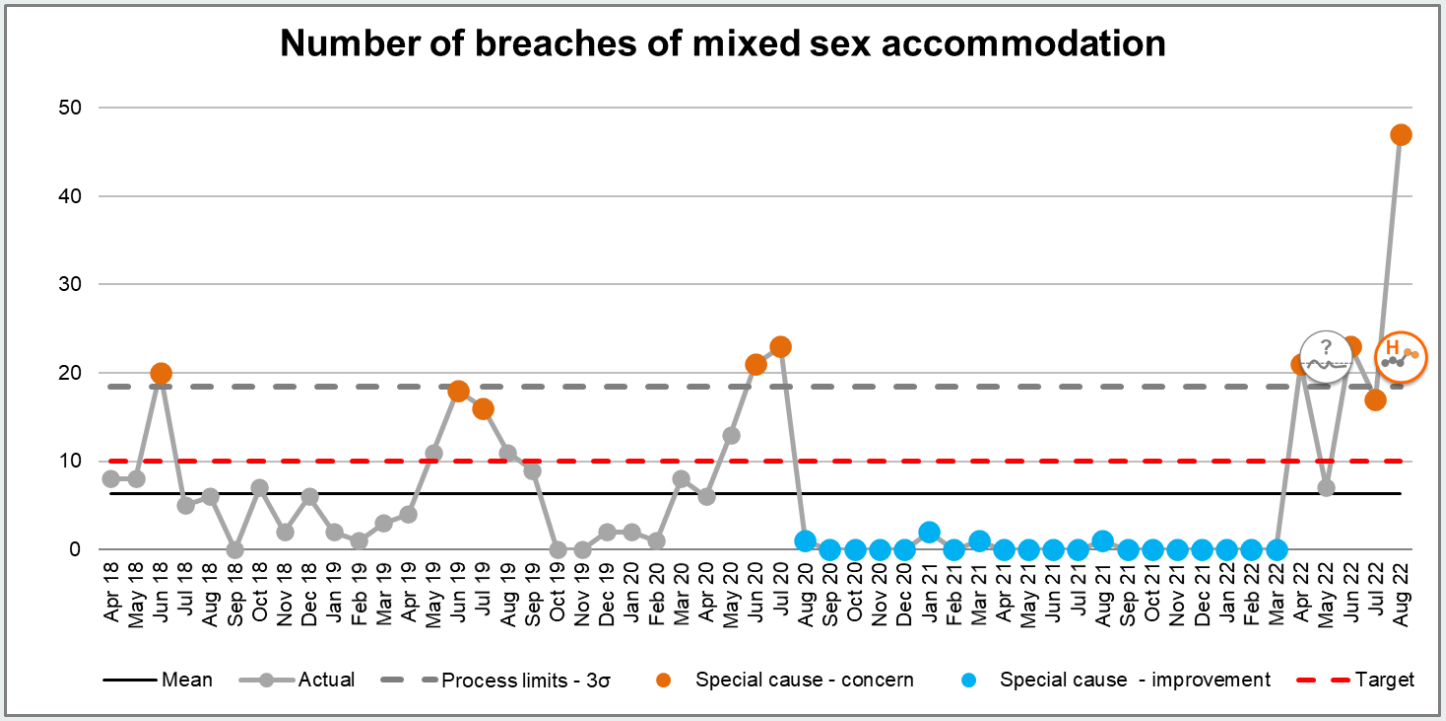
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Trust is reporting mixed-sex accommodation breaches in line with national policy following a period of local agreement with the CCG that resulted in recording the MSA breaches but not reporting them due to operational pressure. All breaches, categorised in accordance with national guidelines, must be authorised by the Chief Nurse or Deputy Chief Nurse. Each month the reasons are reviewed overall, delay in transfers from critical care and recovery areas beyond 4-hours result in an MSA breach. Accurate numbers are now reported to the ICB therefore the increase we are currently observing reflects new oversight.

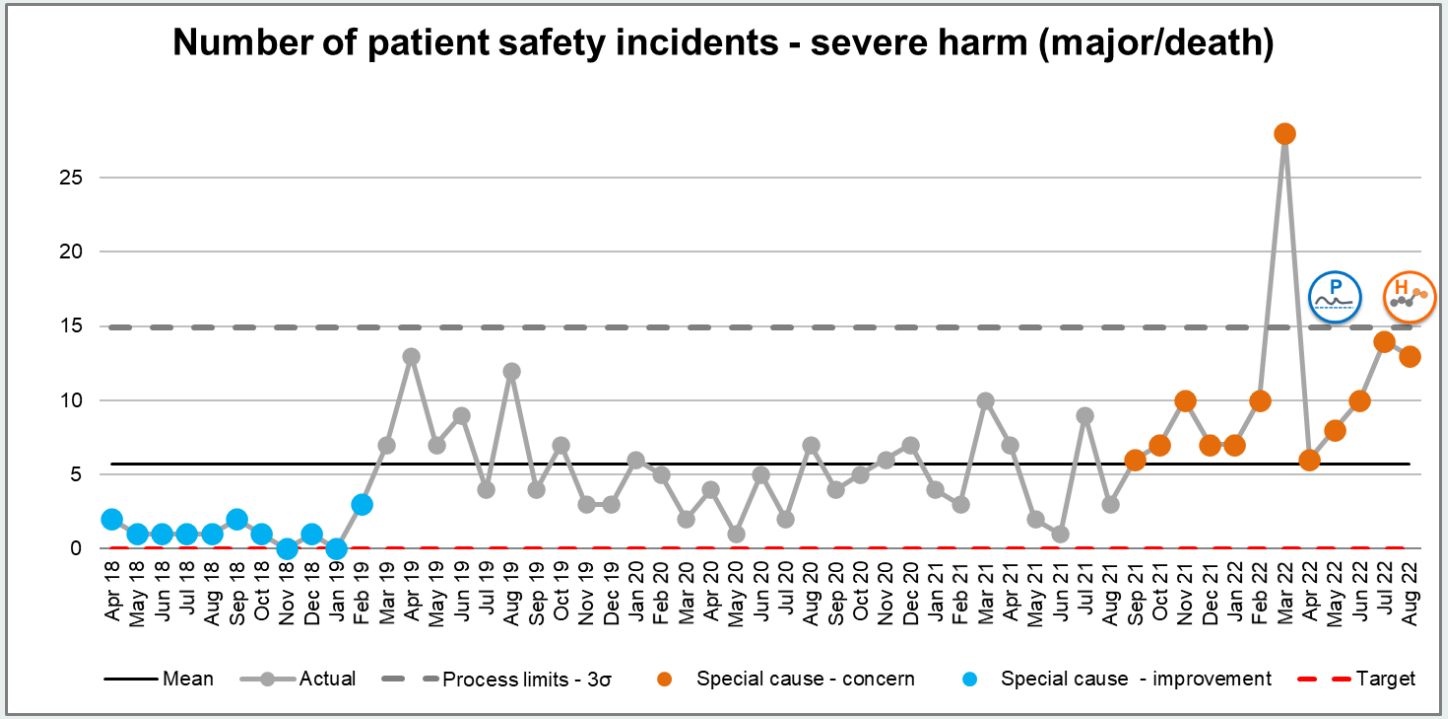
- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

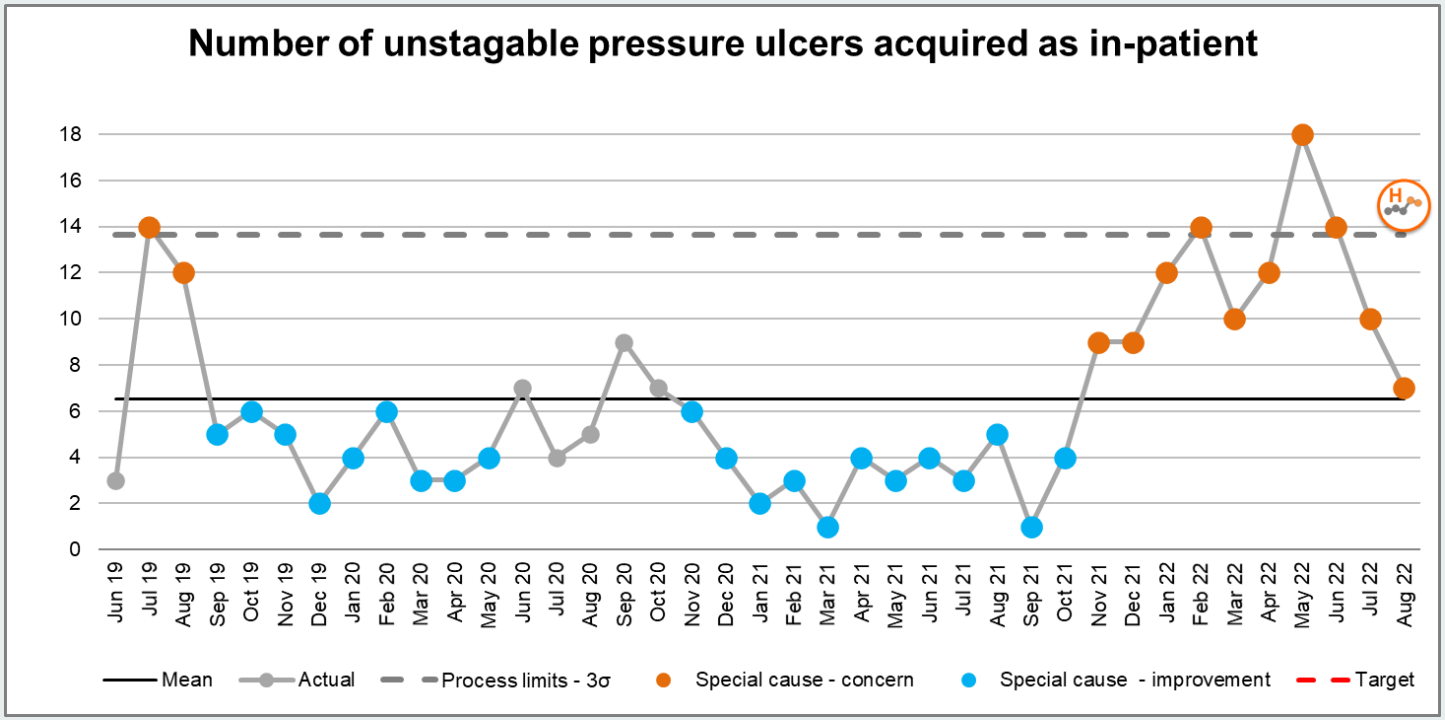
- Quality Improvement & Safety Director

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning. The Tissue Viability Team have worked with SWAST to provide pressure relieving equipment and training on its use to paramedics.
Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers. Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now taking place monthly to increase throughput. It should be noted that we have identified a data quality issue with Datix reporting and some of the pressure ulcers reported as hospital-acquired do not validate as such, this is being investigated by the external provider.

Validation of the data has recently been carried out and an issue with Datix reporting has meant more pressure ulcers are reported as the report has included the unvalidated data, this has now been rectified and the data needs to be re-run.

- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

- Consistenly hit target
- Hit and miss target subject to random
- Consistenly fail target

Variation

- Special Cause Concerning variation
- Common Cause
- Special Cause Improving variation

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

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

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

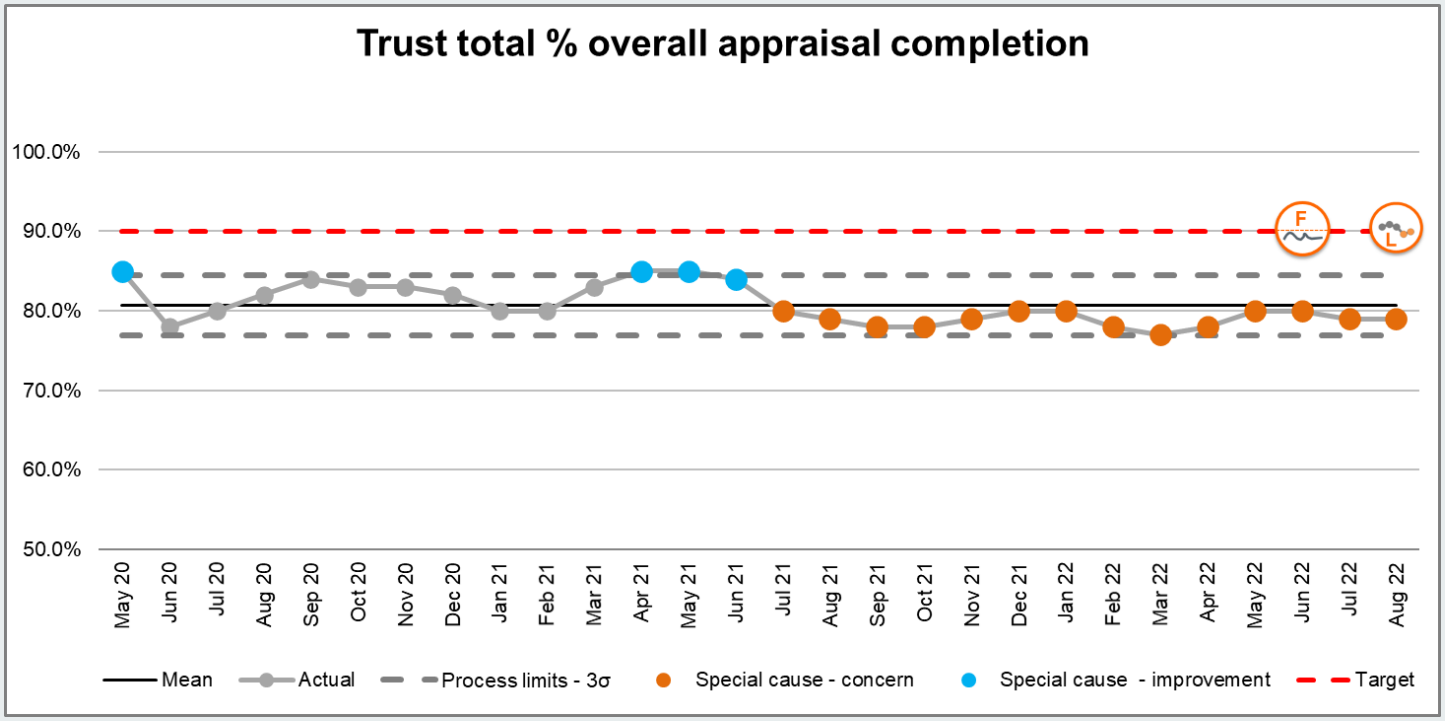
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.

Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance			
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	Aug-22	79%	Concern (Low)	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	Aug-22	87%	Concern (Low)	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	Aug-22	86.6%	Concern (Low)	
Safe Nurse Staffing	% registered nurse day	>=90%	Aug-22	83.6%	Concern (Low)	
Safe Nurse Staffing	% unregistered care staff day	>=90%	Aug-22	86.1%	Concern (Low)	
Safe Nurse Staffing	% registered nurse night	>=90%	Aug-22	92.2%	Concern (Low)	
Safe Nurse Staffing	% unregistered care staff night	>=90%	Aug-22	105.1%	Concern (Low)	
Safe Nurse Staffing	Care hours per patient day RN	>=5	Aug-22	6.1	RunChart	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	Aug-22	3.81	Improvement (High)	
Safe Nurse Staffing	Care hours per patient day total	>=8	Aug-22	10.0	RunChart	
Vacancy and WTE	Staff in post FTE	No target	Aug-22	6963.0	RunChart	
Vacancy and WTE	Vacancy FTE	No target	Aug-22	122.39	Improvement (Low)	
Vacancy and WTE	Starters FTE	No target	Aug-22	86	Common Cause	
Vacancy and WTE	Leavers FTE	No target	Aug-22	69.27	Common Cause	
Vacancy and WTE	% total vacancy rate	<=11.5%	Aug-22	10.1%	Concern (High)	
Vacancy and WTE	% vacancy rate for doctors	<=5%	Aug-22	-652.1%	Improvement (Low)	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	Aug-22	15.0%	Concern (High)	
Workforce Expenditure	% turnover	<=12.6%	Aug-22	14.7%	Concern (High)	
Workforce Expenditure	% turnover rate for nursing	<=12.6%	Aug-22	14.6%	Concern (High)	
Workforce Expenditure	% sickness rate	<=4.05%	Aug-22	4.2%	Concern (High)	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The Trust appraisal rate continues at 79% for a second month. Medicine slight improvement (88%), Surgery (80%) and D&S (78%) Divisions have the highest compliance rates. The lowest Divisional Appraisal rates are Corporate (74%) and Women & Children (69%) and the non-division staffing group at (56%). Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process. Communication is happening with L&OD as to how best support staff to receive a yearly appraisal and for managers to have the ability to undertake them.

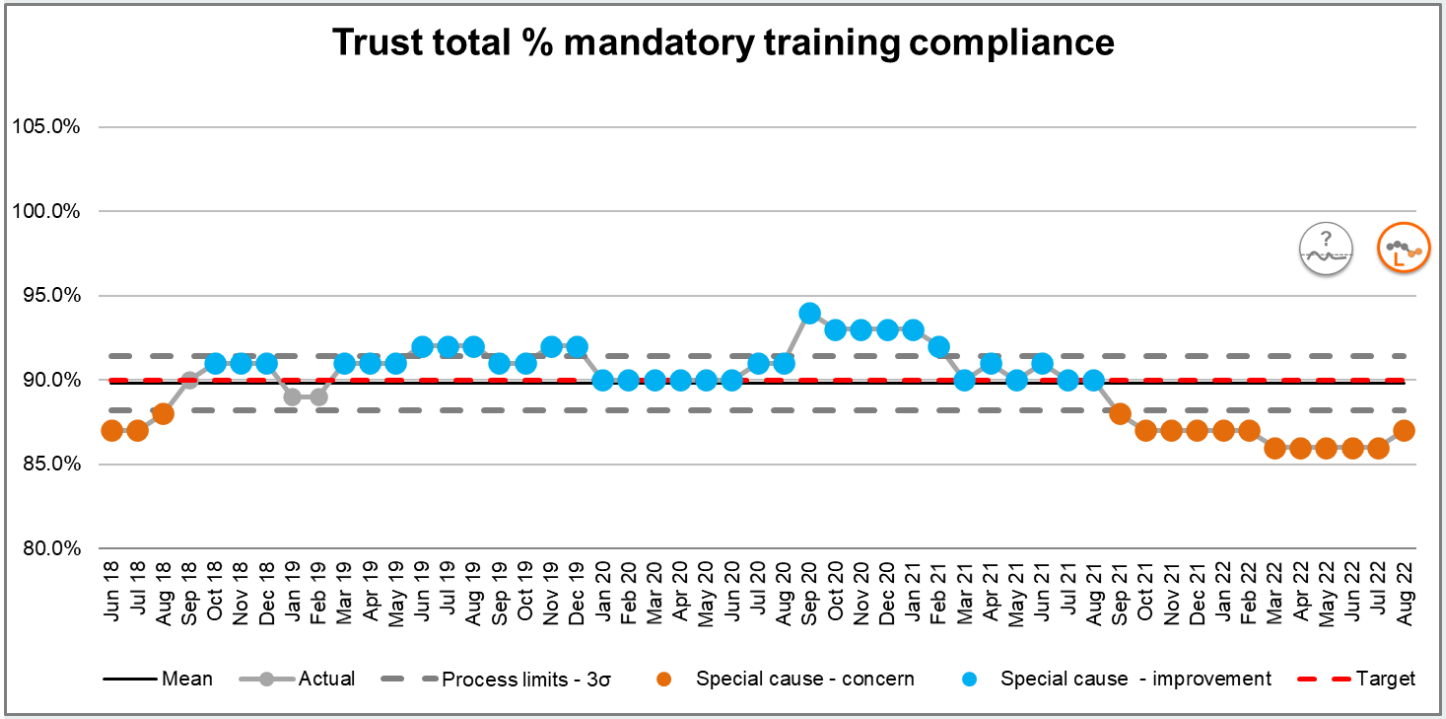
- **Director of Human Resources and Operational Development**

Data Observations

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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Mandatory training compliance remains below the 90% target and has remained at 86% for the last couple of months. It has raised slightly to 87%. Monthly reminders are sent to individuals and line managers, with Divisional performance being scrutinised as part of the Executive Review process. Subject leads are communicated with as to ideas to improve compliance. Safeguarding Adults Level 2 remains the lowest compliance rate. Work with the subject lead as to potential reasons for this.

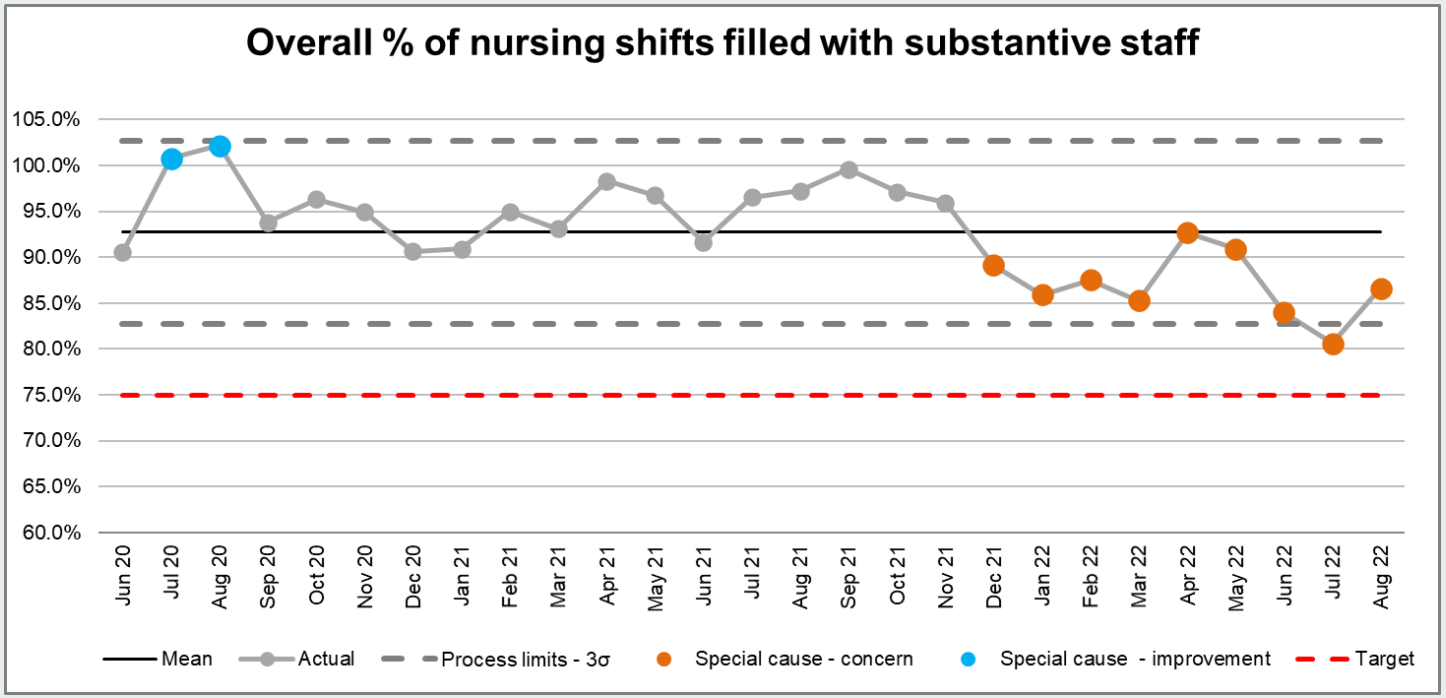
- **Director of Human Resources and Operational Development**

Data Observations

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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review

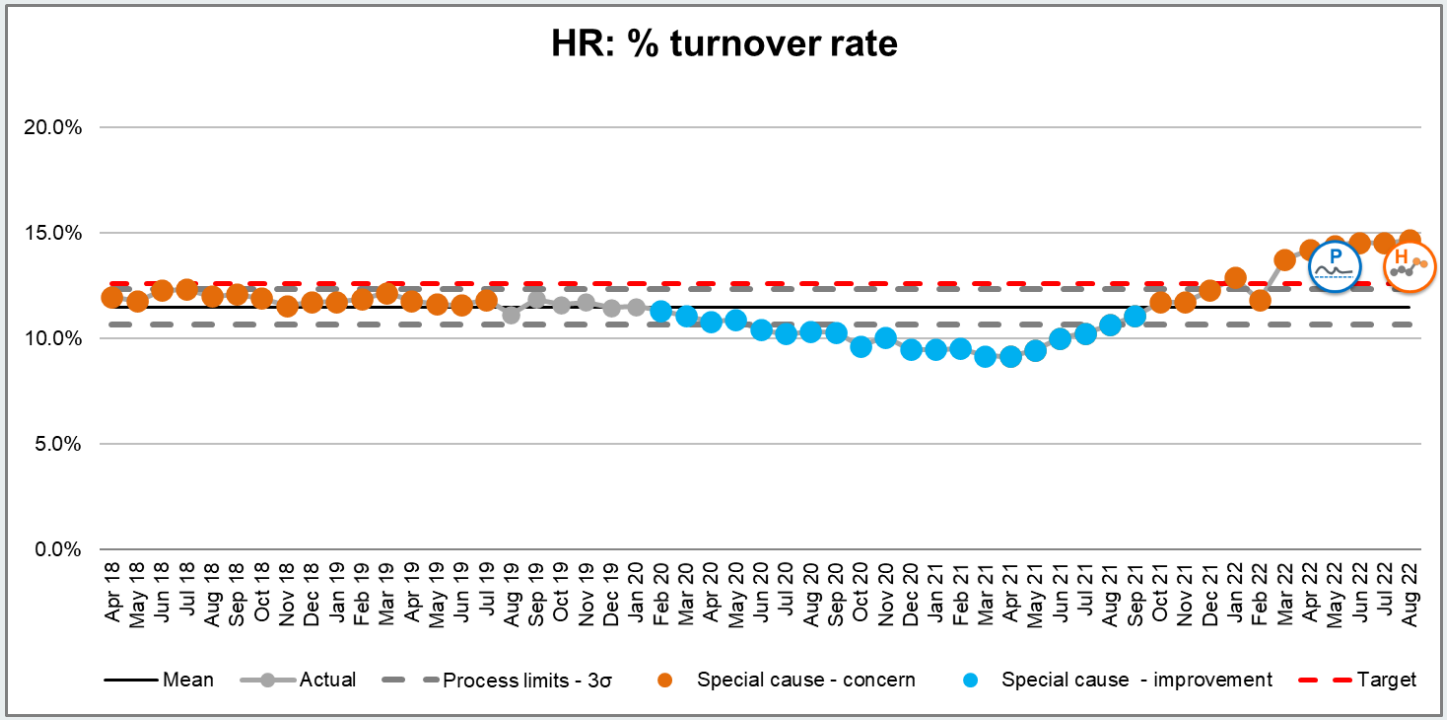
- **Director for People and OD**

Data Observations

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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Turnover continues to be of key focus across all staff groups. Understanding reasons for staff leaving remains a priority in order to support the development of informed retention initiatives.

- **Director for People and OD**

Data Observations

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

People & OD:
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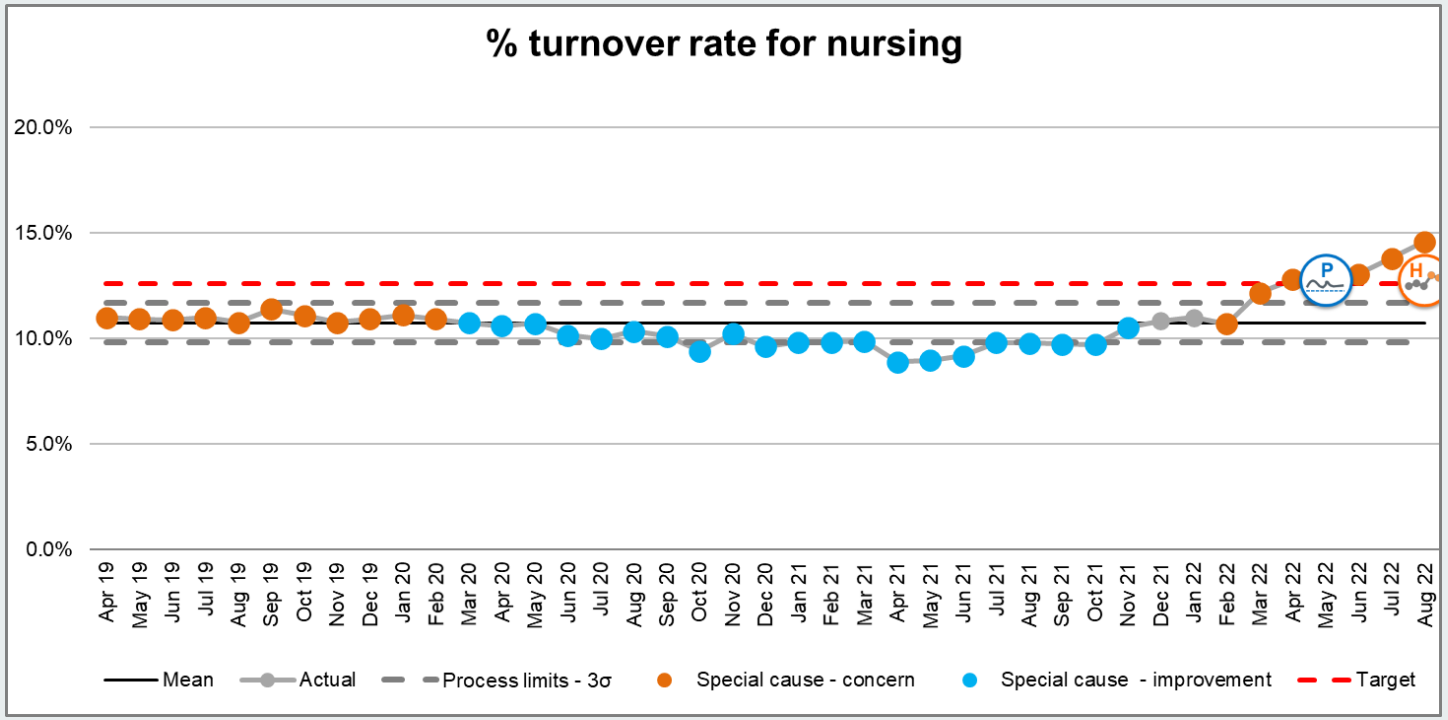


Commentary

Pastoral care and preceptorship for both newly appointed overseas and newly qualified nurses are key in ensuring the Trust invests sufficiently in a structured, quality transition in order to guide and support all new nurses.

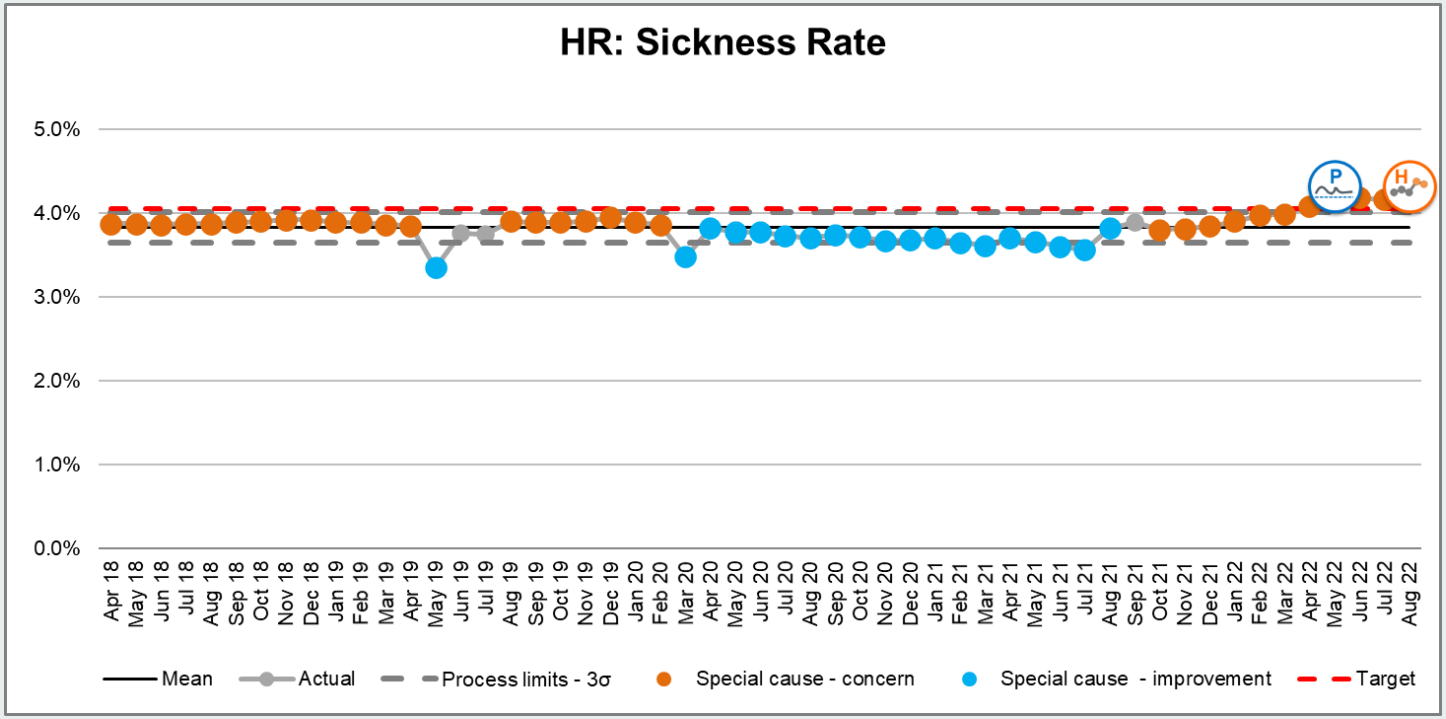
- **Director for People and OD**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 6 data points which are above the line. There are 9 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

A short term post within the P&OD function is being recruited to, supported by NHSE/I funding, with the aim of achieving improved sickness absence levels and developing enhanced support for managers.

- **Director for People and OD**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 6 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors			
Agenda item:	**11**	**Enclosure Number:**	**6**
Date	13 October 2022		
Title	Maternity Services Perinatal Quality Surveillance and Safety Report Quarter 1: April-June 2022 (Maternity Incentive Scheme Compliance CNST)		
Author /Sponsoring Director/Presenter	Josette Jones, Women's and Children's Lead for Quality and Governance Vivien Mortimer, W&C's Divisional Director for Quality and Nursing and Chief Midwife Matt Holdaway, Chief Nurse and Director of Quality (Board Maternity and Neonatal Safety Champion)		

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

In response to the need to proactively identify trusts that require support before serious issues arise NHSE/I (2020) developed a new quality surveillance model to provide consistent and methodological review of maternity services. The purpose of this report is to provide assurance to the Quality and Performance Committee and Trust Board that there is an effective system of clinical governance monitoring the safety of our maternity service with clear strategies for learning and improvement. This report covers the period of April - June 2022 – quarter 1 (Q1).

Summary

National Events, Regulatory and NHSE/I Reviews

- On 6 & 7 April 2022 CQC carried out an unannounced focused inspection within the Maternity service, as they had received information giving them concerns about the culture, safety, and quality of the services. As this was a focused inspection, they only inspected safe, well-led and parts of the effective Domains key questions. Following the inspection, they made requests for additional data and spoke to a number of staff after the on-site inspection. The service was then issued a Section 29a warning notice around improvements required to safety, leadership and governance in May 2022. The section 29a warning notice has given the Trust three months to act on the improvements identified. Work on these improvements was started immediately and continues to be actioned. The report is due to be received in the next quarter (July 22nd). In Dec 2021 CQC carried out a focus group with maternity staff, as they had been contacted directly because of concerns raised about staffing and on calls and in Jan 2022 they made requests for additional data.
- NHSE/I are due to review the service against the Ockendon recommendations on 18/19 July 2022 however this was delayed to Sept 2022 due to the heatwave.

- NHSE/I - the service will commence on the NHSE/I Safety Support Programme as the Trust have received a CQC Section 29a Warning Notice and the organisation has received a letter outlining the support offer.

- The NHSE/I self- assessment tool review has been repeated for May (this will be completed quarterly) and we are using this tool to inform our maternity quality improvement and safety plan, and so to keep the trust board and LMNS aware of our 'benchmarked' position.

- The main areas that are assessed as "red" are concerns about the ability to release staff for training, the development of an internal maternity service strategy and the need for a training needs analysis.

Learning from deaths – maternal, perinatal and neonatal mortality

- There were 6 early neonatal deaths 1 of which occurred at Bristol (specialist care required). All babies were premature including a termination of pregnancy where the baby breathed following delivery for a short period and a pair of premature twins.
- There were no maternal deaths.
- There were 5 stillbirths.
- 100% of deaths had the appropriate Perinatal Mortality Review Tool completed.

Maternity training compliance

- Mandatory maternity training compliance for the core competence framework is flagging as an issue at 62% for all staff groups (target set is 90%). The service has an improvement plan to recovery this to 90% by the end of December 2022 by adding in additional days and paying staff bank hours to attend in their own time

Safer staffing

- There is a robust action plan in place to monitor staffing and this is reviewed monthly by the Executive Led Maternity Delivery Group.
- Midwifery staffing remains as a risk on the Trust risk register now scoring 20 (WC35360bs).
- A maternity workforce paper is due to be reviewed by Board in Sept 2022.
- Due to midwifery staffing issues, the decision was made with Board agreement to consolidate care provision. This has meant the Cheltenham Aveta Birth Unit has remained temporarily closed to intrapartum care. There is a plan to review this in October.
  There were no rota gaps in the Obstetric cover

Maternity Service user feedback

- Friends and Family Test scores have remained static at 81% and a plan is in place to review this data and to carry out improvement work supported by the Maternity Voices Partnership.
- The last Picker National Maternity Survey data was provided to the Trust in Sept 2021 and an improvement plan is being developed in response.

Staff feedback to Maternity and Neonatal Safety Champions (MNSCs)

- Staff have fed back no safety concerns however discussions around the digital system Badgernet and frustration of it not being in place. Discussions on Aveta unit of how proud staff were of their service and noting the impact when the unit closes although the midwives understood the reason why it did close.

Clinical Incident Reporting

- **A total of 8 cases were scoped:**
  - 2 met HSIB referral criteria – (1 of which was rejected – the baby had a normal MRI), both also declared as SI's

    - 1 additional case was declared as a Serious Incidents
    - 2 incidents were graded as near misses
    - 1 incident is a Police investigation
    - 2 incidents graded as moderate harm (1 of which is multi-speciality)

- 2 final HSIB investigation reports were received and action plans have been. developed and agreed at the Safety and Experience Review Group (SERG).
- 3 investigations are being carried out by HSIB currently.
- HSIB meet on a quarterly basis with the maternity service and with Executive Leads to share learning and improvement.
- There were no Prevention of Future Death Reports (Coroner regulation 28).

Themes from trainee or staff surveys

- The number of maternity staff agreeing that they would recommend the service was 75%.
- The proportion of trainees rating the quality of supervision as good or excellent was 87.5% and this was last reported in 2019 (the national average was 89.5%). There is currently a new survey in progress.

Progress against NHS Resolution Maternity Incentive Scheme (CNST)

- Due to the ongoing and unprecedented challenges on the 23 December 2021 NHSR sent a letter to all Trusts to pause the reporting procedures for the scheme for a minimum of 3 months.
- In May, the Trust received notification of the unpausing of the scheme and a revised list of safety actions was circulated (appendix 1). Some criteria changed and work is now on-going to adapt to these modifications to the scheme.
- Safety action 6 of the MIS includes CO monitoring at booking and 36 weeks gestation. Due to the inability to record the 36 reading on Trak a paper audit of all women is being undertaken by the service. This is further hindered by a lack of working equipment for a 2-month period resulting in the inability to undertake this assessment until August 2022. Audit has now commenced but is labour intense due to the number of notes required to review.

Recommendation

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

Enclosures

- Perinatal Quality Surveillance Report Q1

Gloucestershire Hospitals
NHS Foundation Trust

Maternity Service
Perinatal Quality Surveillance and Safety Report (Maternity Incentive Scheme Compliance – CNST)

Quarter 1 Apr – June 2022/23

Author:
Women's and Children's Lead for Quality and Governance and Maternity and Neonatal Safety Champion - Josette Jones

Divisional Sponsor
Director of Quality and Chief Midwife – Vivien Mortimore

Executive sponsor:
Director of Quality and Chief Nurse - Matt Holdaway
Executive Maternity and Neonatal Safety Champion

Contents page

Gloucestershire Hospitals NHS Foundation Trust

Perinatal Quality Dashboard – trend data

Gloucestershire Hospitals NHS Foundation Trust

CQC Maternity Ratings	Overall	Safe	Effective	Caring	Well-Led	Responsive
	Good	Requires Improvement	Good	Good	Good	Good

CQC inspection April 2022 Section 29a and draft report received June 2022

Maternity Safety Support Programme	No	If No, enter name of MIA

	2021/22											
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
Findings of review of all perinatal deaths using the real time data	1	0	0	4	1	2	1	2	3	1	1	4
Findings of review all cases eligible for referral to HSIB.	2	0	0	1	1	1	1	0	1 (rejected)	0	1	1
The number of incidents logged graded as moderate or above and what actions are being taken	2 (SI's - these were the cases referred to HSIB	0	1 SI	2 (1 HSIB SI; 1 Moderate)	1 HSIB	2 SI (1 HSIB)	2 SI (1HSIB)	0	0	2 SI (1HSIB). 1 Moderate (joint GYN/Obs)	0	0
Maternity PROMPT Skills Drills		87.9								35.50%		62.50%
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training			85% Trust Target 90%		83% Trust target 90%	81% Trust target 90%		83%	81%	80%	79%	81%
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite & gaps in rotas	0 gaps in registrar rota, , 16 locum shifts covered. 10 gaps in SHO rota (could not fill with locum), with 29 shifts covered by locums	0 gaps in rota. Locum shifts covered 18	0 gaps in rota. Locum shifts covered: 7 SHO, 28 Registrar		0 gaps in rota. Locum shifts covered: 5 SHO, 18 Registrar	0 gaps in rota. Locum shifts covered: 10 SHO, 28 Registrar	0 gaps in rota. Locum shifts covered: 8 SHO; 22 Registrar	0 gaps in rota. Locum shifts covered: 4 SHO; 17 Registrar	0 gaps in rota. Locum shifts covered: 5 SHO; 17 Registrar	0 gaps in rota. Locum shifts Reg 31; 2 SHO	0 gaps in rota. Locum shifts 28; SHO 1	0 gaps in rota. Locum Reg 31; SHO 0
Minimum safe staffing in maternity services to include midwife minimum safe staffing planned cover versus actual prospectively.	All clinical areas: A total of 103 unfulfilled midwifery shifts, 26 MCA shifts and 1 co-ordinator	All clinical areas:A total of 58 unfulfilled midwfery shifts, 21 MCA shifts	All clinical areas: A total of 101 unfulfilled midwifery shifts, 48 MCA, 4 housekeepers	All clinical areas: A total of 97 unfulfilled midwifery shifts, 50 MCA, 13 housekeepers	All clinical areas: A total of 98 unfulfilled midwifery shifts, 48 MCA, 1 band 7 co-ordinator in	All clinical areas: A total of 134 unfulfilled midwifery shifts, 49 MCA, 7 band 7 co-ordinator in	All clinical areas: A total of 154 unfulfilled midwifery shifts, 59 MCA, 7 band 7 co-ordinator in charge shift	All clinical areas: A total of 126 unfulfilled midwifery shifts, 23 MCA	All clinical areas: A total of 72 unfulfilled midwifery shifts, 38 MCA			
Service User Voice feedback	91%	84.80%	87.70%	81.2	89.90%	84.30%	94.10%	91.90%	85.70%	78.20%	85.20%	88.90%
Staff feedback from frontline champions and walk-abouts	nil	nil	nil	nil	nil	nil	nil	nil	nil			IT & Aveta
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with Trust	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil	Section 29a	Section 29a
Coroner Reg 28 made directly to Trust	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil	nil
Progress in achievement of CNST 10	completed											

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annuallly)	75% (Divisional total nursing and midwifery
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	Reported from 2019 results 87.5%. National average 89.54%

BOARD October 2022

REPORT ON THE SAFETY OF MATERNITY SERVICES

Perinatal Quality and Safety Report – Quarter 1 2022/23

1. Purpose of report

1.1 In response to the need to proactively identify trusts that require support before serious issues arise NHSE/I (2020) developed a new quality surveillance model to provide consistent and methodological review of maternity services. The purpose of this report is to provide assurance to the Quality and Performance Committee and Trust Board that there is an effective system of clinical governance monitoring the safety of our maternity service with clear strategies for learning and improvement. This report covers the period of April to June 2022 – quarter 1 (Q1).

2. Perinatal quality surveillance narrative summary and exception report Q1

2.1 Maternity Perinatal Quality Surveillance Q1 narrative (see dashboard for data)

2.1.1 National Events, Regulatory and NHSE/I Reviews

- On 6 & 7 April 2022 **CQC** carried out an unannounced focused inspection within the Maternity service, as they had received information giving them concerns about the culture, safety, and quality of the services. As this was a focused inspection, they only inspected safe, well-led and parts of the effective Domains key questions. Following the inspection, they made requests for additional data and spoke to a number of staff after the on-site inspection. The service was then issued a Section 29a warning notice around improvements required to safety, leadership and governance in May 2022. The section 29a warning notice has given the Trust three months to act on the improvements identified. Work on these improvements was started immediately and continues to be actioned. The report is due to be received in the next quarter (July 22nd). Although this report covers Q1 at the service had received a draft report in June and the final rating was confirmed in July 2022 as inadequate.
- **NHSE/I** are due to review the service against the Ockendon recommendations on 18/19 July 2022.

2.1.2 NHSE/I Maternity Safety Support Programme

- The service will commence on the NHSE/I Safety Support Programme as the Trust have received a CQC Section 29a Warning Notice and the organisation has received a letter outlining the support offer.
- The NHSE/I self- assessment tool review has been repeated for May and we are using this tool to inform our maternity quality improvement and safety plan, and so to keep the trust board and LMNS aware of our 'benchmarked' position.
- The main areas that are assessed as "red" are concerns about the ability to release staff for training, the lack of an internal maternity service strategy and the need for a training needs analysis.

Table: NHSE/I Self-assessment compliance – May 2022

Self-assessed compliance	16 Feb 2022	May 2022

Self-assessed compliance	16 Feb 2022	May 2022
Green	111	105
Amber	42	44
Red	5	11
Total number of elements	158	160

2.1.3 Learning from deaths – maternal, perinatal and neonatal mortality

- There were 6 early neonatal deaths 1 of which occurred at Bristol (specialist care required). All babies were premature including a termination of pregnancy where the baby breathed following delivery for a short period and a pair of premature twins.
- There were no maternal deaths.
- There were no stillbirths.
- 100% of deaths had the appropriate Perinatal Mortality Review Tool completed.
- See also NHS Resolution (NHSR) safety action 1 for more information at appendix 2.

2.1.4 Maternity training compliance

- Mandatory maternity training compliance for the core competence framework is flagging as an issue at 62% for all staff groups (target set is 90%). The service has an improvement plan to recovery this to 90% by the end of December 2022 by adding in additional days and paying staff bank hours to attend in their own time
- See also NHSR safety action 8 for more information at appendix 2.

2.1.5 Safer staffing

- There is a robust action plan in place to monitor staffing and this is reviewed monthly by the Executive Led Maternity Delivery Group.
- Midwifery staffing remains as a risk on the Trust risk register now scoring 20 (WC35360bs).
- A maternity workforce paper is due to be reviewed by Board in Sept 2022.
- Due to midwifery staffing issues, the decision was made with Board agreement to consolidate care provision. This has meant the Cheltenham Aveta Birth Unit has remained temporarily closed to intrapartum care. There is a plan to review this in October.
- There were no rota gaps in the Obstetric cover.
- See also NHSR safety action 4 & 5 for more information appendix 2.

2.1.6 Maternity Service user feedback

- Friends and Family Test scores have remained static at 81% and a plan is in place to review this data and to carry out improvement work supported by the Maternity Voices Partnership.
- The last Picker National Maternity Survey data was provided to the Trust in Sept 2021 and an improvement plan is being developed in response.
- See also NHSR safety action 7 for more information appendix 2.

2.1.7 Staff feedback to Maternity Service Champions

- Staff have fed back no safety concerns however discussions around the digital system Badgernet and frustration of it not being in place. Discussions on Aveta unit of how proud staff were of their service and noting the impact when the unit closes although the midwives understood the reason why it did close.
- See also NHSR safety action 10 for more information at appendix 2.

2.1.8 Clinical Incident Reporting

- **A total of 8 cases were scoped:**
  - 2 met HSIB referral criteria – (1 of which was rejected – the baby had a normal MRI), both also declared as SI's
  - 1 additional case was declared as a Serious Incidents
  - 2 incidents were graded as near misses
  - 1 incident is a Police investigation
  - 2 incidents graded as moderate harm (1 of which is multi-speciality)

- 2 final HSIB investigation reports were received and action plans have been. developed and agreed at the Safety and Experience Review Group (SERG).
- 3 investigations are being carried out by HSIB currently.
- HSIB meet on a quarterly basis with the maternity service and with Executive Leads to share learning and improvement.
- There were no Prevention of Future Death Reports (Coroner regulation 28).
- See also NHSR safety action 10 for more information appendix 2.

2.1.9 Themes from trainee or staff surveys

- The number of maternity staff agreeing that they would recommend the service was 75%.
- The proportion of trainees rating the quality of supervision as good or excellent was 87.5% and this was last reported in 2019 (the national average was 89.5%). There is currently a new survey in progress.

2.1.10 Progress against NHS Resolution Maternity Incentive Scheme (CNST)

- Due to the ongoing and unprecedented challenges on the 23 December 2021 NHSR sent a letter to all Trusts to pause the reporting procedures for the scheme for a minimum of 3 months.
- In May, the Trust received notification of the unpausing of the scheme and a revised list of safety actions was circulated (appendix 1). Some criteria changed and work is now on-going to adapt to these modifications to the scheme.
- Safety action 6 of the MIS includes CO monitoring at booking and 36 weeks gestation. Due to the inability to record the 36 reading on Trak a paper audit of all women is being undertaken by the service. This is further hindered by a lack of working equipment for a 2-month period resulting in the inability to undertake this assessment until August 2022. Audit has now commenced but is labour intense due to the number of notes required to review.

  Safety Actions progress can be seen at appendix 2
  Action 1 National Perinatal Mortality Review Tool
  Action 2 Maternity Service Data Set (MSDS)
  Action 3 Transitional Care Services in place
  Action 4 Workforce planning in place to the required standards
  Action 5 Midwifery workforce planning in place
  Action 6 Saving babies lives care bundle (SBLCBv2)
  Action 7 Service user feedback and work with MVP to coproduce maternity services
  Action 8 Local training plan in place to meet all 6 core modules of the core competency framework
  Action 9 Maternity Safety Champions
  Action 10 HSIB and NHSR reporting

3 Recommendation

The Maternity Delivery Group, Quality and Performance Committee and Board are asked to note the contents of the report and support the improvement plans. This report will be submitted to the Local Maternity and Neonatal System (LMNS) for assurance.

4 Appendix 1 - Maternity Incentive Scheme (MIS) Progress Report Q1

Introduction – what are we trying to accomplish?
Maternity incidents can be catastrophic and life-changing, with related claims representing the Clinical Negligence Scheme for Trusts' (CNST) biggest area of spend. The Maternity Safety Strategy set out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety. NHS Resolution support this work through the Maternity Incentive Scheme. The scheme supports the delivery of safer maternity care through an incentive element to trust contributions to the CNST. The scheme rewards Trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services. In the fourth year, the scheme further incentivises the 10 maternity safety actions from the previous year with some further refinement. Year four of the scheme began on 9 August 2021.

Due to the Covid-19 pandemic, in December 2021, a decision was made by the scheme's Clinical Advisory Group (CAG) to pause the reporting for year 4 of the scheme. Trusts were asked to continue to apply the principles of the scheme and to continue to report to MBRRACE-UK, NHS Digital and HSIB. The scheme's CAG reconvened on 28 February 2022 and a decision was made to relaunch the scheme on 6 May 2022.

How will we know if a change is an improvement?
As in year two, the scheme incentivises ten maternity safety actions. We need to demonstrate that we have achieved all of the ten safety actions so that we will recover the element of our contribution to the CNST maternity incentive fund and so that we can also receive a share of any unallocated funds.
Whilst the maternity incentive scheme is a self-certified scheme, with all scheme submissions requiring sign-off by our trust Board following conversations with trust commissioners, all submissions also undergo an external verification process and are sense-checked by the Care Quality Commission (CQC). The Trust must submit our completed declaration by 5 Jan 2023. This section updates our progress so far.

Table: Progress summary of all 10 safety actions in preparation for scheme to restart

Action	RAG Rating and current position	Actions required
Action 1 using the National Perinatal Mortality Review Tool	a) i 100% of perinatal deaths are notified within 7 working days and the surveillance form is completed within 7 days. ii Reviews are commenced within 2 months. b) At least 50% of deaths are reviewed with the PMRT by MDT c) 95% of parents have been told that a review will take place and that their perspective has been considered. d) Quarterly reports have been received by the Board from 6 May onwards and the reports have been discussed with the maternity safety champions	Quarterly reports to be received by Maternity Safety Champions and Trust board from 6 May 2022 onwards (add to MSC and Board planner).
Action 2 submitting data to the Maternity Service Data Set (MSDS)	By Oct 2022 Trust to have up to date digital strategy for our maternity service which aligns with the Trusts Digital strategy and reflects the 7 success measures and has been signed off by the LMNS. 9/11 Clinical Quality Improvement Metrics (CQIMs) will have passed the associated data quality criteria in July 2022 (published	The Maternity Service Digital strategy will be incorporated into the Maternity Strategy and is to be received in Aug/Sept 2022. This CQIMs data will be added to the QPR and the Maternity Service dashboard and be shared with MDG/MSCs.

Action	RAG Rating and current position	Actions required
	Oct 2022.	Trust Board to confirm that they have passed the data quality criteria by self-declaration (the data will be published in the Maternity Services Monthly Statistics publication in Oct 2022).
Action 3 Transitional Care Services in place	Atain reports received by Board Level Maternity Safety Champions.	Quarterly reports to be received by the Maternity Safety Champions meeting that meet all the correct defined criteria and action plans are developed for any metrics not meeting targets.
Action 4 Workforce planning in place to the required standards	On track report received by March Board 2022 and to be presented again in Sept 2022 (once RCOG staffing audit completed)	Board report received at March 2022 meeting and next report due Sept 2022. Audit to be completed on Consultant attendance in specified circumstances
Action 5 Midwifery workforce planning in place	On track - staffing report received by March 2022 Board and Birth rate plus review underway	Board report received at March 2022 meeting and next report due Sept 2022.
Action 6 The 5 elements of the saving babies lives care bundle have been implemented	The quarterly care bundle surveys are being completed and the service has fully implemented SBLv2 including the data submission requirements. Our current data does not meet target compliance in elements 1-4 we are not meeting the minimum requirements and no action plans have been received by MDG. An action plan will be submitted to MDG	Trust will fail Safety Action 6 if the process indicator metric compliance is less than target and there are no action plans in place. Element 1-4 are amber rated and require action plans Element 1 – CO monitoring at 36/40 difficult to achieve due to the inability to pull data from Trak and requires manual notes audit. CO monitors were not available for a number of months due to the equipment coming to end of life and new equipment was purchased. This has now been completed but the restarting of the programme needs embedding. Notes audit has commenced to demonstrate compliance. This is a large paper based audit as the denominator is all women at 36/40 gestation. Due to the nature of the handheld records this means that the records are not returned to the department for a number of weeks post delivery therefore delaying the audit process. (Element 5 – is green and meeting target compliance).
Action 7 mechanisms for gathering service user feedback and work with Maternity Voices Partnership (MVP) to coproduce maternity services	MVP meetings are going ahead. MVP has a work programme Monitor MVP chair is attending Maternity Clinical Governance meeting (MCG) EM Improvement plan Complaints are shared with MVP.	MDG to seek assurance that MVP Chair attending MCG – invited but unable to attend meetings on a Friday. Minutes to be shared with MVP Chair MDG to see the Ethnic Minorities improvement plan. Check complaints are shared with MVP.
Action 8 local training plan in place to meet all 6 core modules of the core competency framework	**Training compliance decreased to 62% (compliance target is 90%)** Local training plan includes all six core modules of the Core Competency Framework (CCF)	Educational review taking place and should include the plans for the remaining 2 components of the CCF - Personalised care

Action	RAG Rating and current position	Actions required
	1. Saving Babies Lives Care Bundle 2. Fetal surveillance in labour 3. Maternity emergencies and multi-professional training. 4. Personalised care 5. Care during labour and the immediate postnatal period 6. Neonatal life support Training compliance has decreased due to sessions being cancelled and Midwives only being able to attend if undertaken as bank payment rather than as part of substantive hours; reduction in staffing in Practice development due to leavers. Band 6 hours recruited into both substantively and as a 6 month secondment to provide some additional hours. Band 6 PDM released into posts. However, one of the 2 midwives was successfully appointed into the 0.5WTE Band 7 job share position for |PDM which has resulted in a gap in overall hours again. Recruitment into these hours will commence in the autumn to minimise the loss of clinical staff.	- Care during labour Training compliance to be 90% by Dec 2022 (CNST will measure compliance over 18 month period). EWS (MEOWs and NEWTT) audits have been completed and a new monthly audit is sin place.
Action 9 Trust maternity Safety Champions are meeting bi monthly with the Board level champions	Safety intelligence pathway from ward to Board needs refresh to include **Perinatal Quality Surveillance** Model Report. Board level maternity service champions to present local PQS report and dashboard to Board quarterly. MCoC action plan to be reviewed by MSCs (paused/reviewed due to Covid and Ockendon 2022 IEAs) Oversight of the Neonatal Critical Care Recommendations Maternity Safety culture measurements and improvement plan.	Structure for Maternity reporting ward to Board to be reviewed by MSC meeting. Quarterly PQS Reports and dashboard to be presented to the Board by the Board MSC from June 2022 (this report) To include - SIs - Claims data - Walkabout data - Training compliance - Staffing - MatNeoSiP MSCs to have at least quarterly engagement meetings MSCs to review Midwifery Continuity of Care action plan MSC to review how the service is implementing the National Neonatal Critical Care Review
Action 10 Reported 100% of qualifying cases to HSIB and to NHSR	On track all cases reported.	

Table: Key for BRAG rating

Blue	Action complete and assurance provided
Red	Action not on track with major issues

Amber	Action mainly on track with some minor issues (mitigating activities should be identified)
Green	Action on track

5 Appendix 2 - NHSR MIS Safety Action Update

Safety action 1 – Perinatal Mortality Review Tool (PMRT)

The Trust has been able to continue to report to MBRRACE as advised by NHSR. All notifications are made and surveillance forms completed using the MBRRACE-UK reporting website. All (100%) of our stillbirths and early neonatal deaths are reviewed through the use of the national standardised Perinatal Mortality Review Tool (PMRT) which adopts a systematic, multidisciplinary, high quality review of the circumstances and care leading up to and surrounding each stillbirth and neonatal death.

The speciality hold a multidisciplinary Mortality and Morbidity (M&M) Reviews and also engage with the M&M reviews of cases referred to the tertiary units when necessary. Work is in progress to ensure external opinion from the Local Maternity and Neonatal System (LMNS) from Bath, Swindon and North Somerset is also available at this meeting to achieve compliance with the Ockenden (Dec 2021) Immediate and Essential Action 1.

Table: Numbers of deaths in Q1

Deaths	Numbers
Early neonatal	6 (1 at Bristol)
Maternal	0
Stillbirths	5

Table: Perinatal mortality reviews April - June 2022 and action plans

MAT MRN	PMRT GRADE A		PMRT GRADE B		PMRT GRADE C or D		Action plans following PMRT reviews.
	AN	PN	AN	PN	AN	PN	
April 2022							
0931242	N/A*	√					* N/A (Concealed pregnancy). No actions identified.
1158556		√			C√		**Action:** Pregnancy booking proforma to be changed and to include a section to be completed by the booking midwife - 'increased risk SGA (Aspirin and Growth Scans recommended)' Approved at GOGG meeting June 2022.
4259642	√	√					No actions identified.
May 2022							
0731573		√	√				**Action:** 1. Communication to community team regarding the importance of continued midwifery care in addition to obstetric antenatal appointments/specialist fetal medicine input. 2.Repeat antiphospholipid screen at 12 weeks (REJ to write to patient).
June 2022							

4260758		√	√				1. Booking proforma to be changed to include a section to be completed by the booking midwife - 'increased risk SGA (Aspirin and Growth Scans recommended)' Approved at GOGG meeting June 2022. JB 2. Check with audit midwife that the forthcoming Audit on SGA, will look at smoking and aspirin. Completed 28/06/22 JB. 3. SGA risk assessment tool to be enlarged and laminated for display in clinical areas as a reminder to use the tool and follow the actions for risk factors identified. JB to contact smoking cessation midwife if she can help with this. 4. JB to email community matron with regard to how to highlight to the CMWs the importance of completing the SGA risk assessment tool to ensure all mothers are on the correct pathway for care if risk factors are identified.
3324424			√		C√		Actions same as for case above MRN4260758
0677258		√	√				No actions identified.

PMRT Grading: (split into antenatal and postnatal)
A. No issues with care identified
B. Care issues that would have made no difference to the outcome
C. Care issues which may have made a different to the outcome
D. Care issues which were likely to have made a difference to the outcome

Table: Perinatal Mortality Review Tool and Trust compliance with statements

Statement		Trust compliance
a)	**i.** 100% of perinatal deaths eligible to be notified to MBRRACEUK from 1 September 2021 onwards must be notified to MBRRACE-UK within seven working days and the surveillance information where required must be completed within one month of the death. **ii**. A review using the Perinatal Mortality Review Tool (PMRT) of 95% of all deaths of babies, suitable for review using the PMRT, from 8 August 2021 will have been started within two months of each death (100% of factual question answered). This includes deaths after home births where care was provided by your Trust.	100% 100%
b)	At least 50% of all deaths of babies (suitable for review using the PMRT) who were born and died in your Trust, including home births, from 8 August 2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated by the tool within four months of each death and the report published within six months of each death.	100%
c)	For at least 95% of all deaths of babies who died in your Trust from 8 August 2021, the parents will have been told that a review of their baby's death will take place, and that the parents' perspectives and any questions and/or concerns they have about their care and that of their baby have been sought. This includes any home births where care was provided by your Trust staff and the baby died either at home or in your Trust. If delays in completing reviews are anticipated parents should be advised that this is the case and be given a timetable for likely completion. Trusts should ensure that contact with the families continues during any delay and make an early assessment of whether any questions they have can be addressed before a full review has been completed; this is especially important if there are any factors which may have a bearing on a future pregnancy. In the absence of a bereavement lead ensure that someone takes responsibility for maintaining contact and for taking actions as required.	100% of parents advised of review

**A recent change has been made with regard to gaining parents' perspectives/questions for PMRT. Parents are offered to complete an MBRRACE feedback form, and this then enables the parent's perspectives/questions to be addressed at the Perinatal Mortality Review of their case. The PMRT report is then completed in draft form within 1-2 weeks of the review. This is then available for the de-brief/counselling appointment between the parent's and the consultant to discuss the review findings and their perspectives/questions. This change has been made as a result of the Sands survey 2021 of parents' experiences of hospital reviews into their care and the recommendations made*	

Improvement action

To meet the NHSR MIS Standard a report should be received every quarter by the Board and the report should include details of the deaths reviewed and the consequent action plans. The quarterly reports will also need to be discussed with the Maternity Safety Champions and the Board Level Safety Champions.

Safety action 2 - Maternity Service Data Set (MSDS)

This relates to the quality and completeness of our submission to the Maternity Services Data Set (MSDS) and ongoing plans to make improvements. Currently we are developing are digital strategy for approval by the LMNS and this should be submitted to MDG in August 2022.

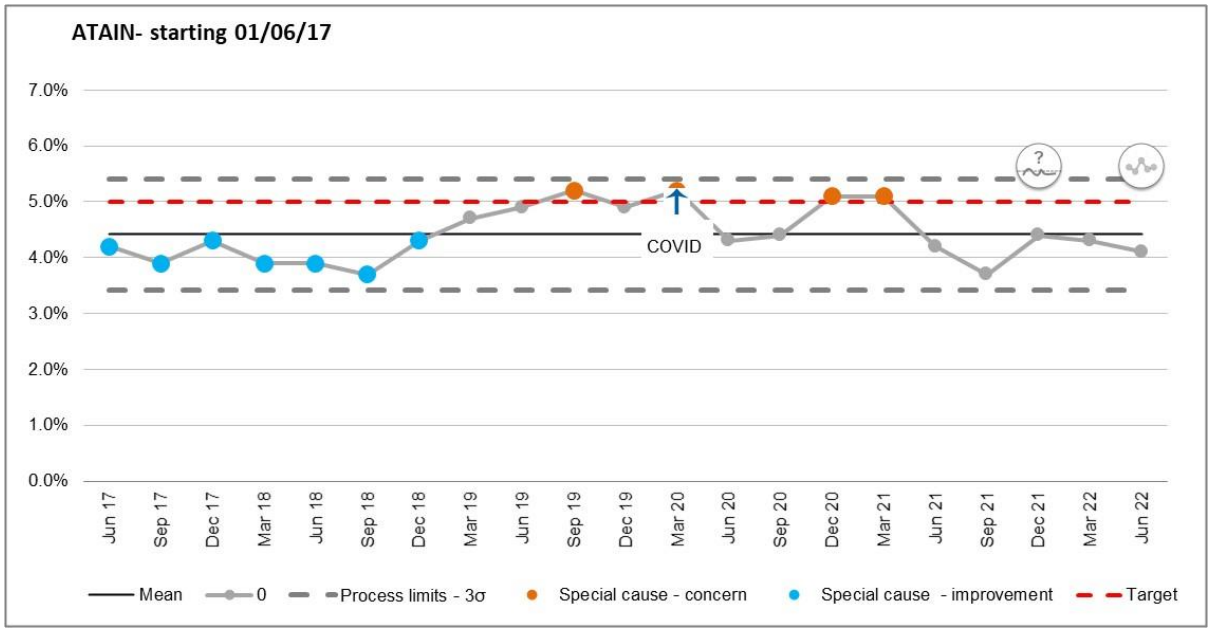
Improvement action

In July 2022, we will submit our data and then in Oct 2022 we will receive a file in the Maternity Services Monthly Statistics publication to confirm that we are meeting at least 9/11 Clinical Quality Improvement Metrics.

Safety action 3 - Transitional care services

Transitional care services in place to minimise separation of mothers and their babies and to support the recommendations made in the Avoiding Term Admissions into Neonatal units (ATAIN) Programme. We have developed pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

Graph: Data demonstrates that we are currently below the National target of 5%



Improvement action

Progress with our ATAIN action plans will be shared with the maternity, neonatal and Board level safety champions, LMNS and our ICS quality surveillance meeting.

Safety action 4 & 5 demonstrate clinical workforce planning

The Board received a maternity workforce report in March 2022 and the next report is due in September 2022.

Maternity Unit temporary closures

There were no whole unit emergency closures during Q1 of maternity services. However, due to staffing issues Aveta Birth Unit remains closed to intrapartum care; clinics and DAU work continues to operate from the freestanding birth unit during the day. This action will be reviewed in October.

Improvement action

The next Maternity Workforce report is due to be received by Board in Sept 2022. The Maternity Birthrate Plus review will commence in quarter 1 2022 and the report and recommendations will be received by Board within this next report.

Safety action 6 - demontrate compliance with all five elements of the Saving Babies Lives Care Bundle Version 2 (SBLCBv2)

Version two of the Saving Babies' Lives Care Bundle (SBLCBv2), has been produced to build on the achievements of version one. This version aims to provide detailed information on how to reduce perinatal mortality. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice. The new fifth element is reducing pre-term birth. This is an additional element to the care bundle developed in response to the Department of Health's 'Safer Maternity Care' report which extended the 'Maternity Safety Ambition' to include reducing preterm births from 8% to 6%. This new element focuses on three intervention areas to improve outcomes which are

prediction and prevention of preterm birth and better preparation when preterm birth is unavoidable. While the majority of women receive high quality care, there is around a 25 per cent variation in the stillbirth rates across England. The Saving Babies' Lives Care Bundle addresses this variation by bringing together five key elements of care based on best available evidence and practice in order to help reduce stillbirth rates. Our Q1 data has been summarised in the dashboard below. Ongoing audits to demonstrate compliance being prioritised. There is no permanent audit midwife in post -work and so work is being undertaken by bank midwife.

Picture: SBLCBv2 dashboard

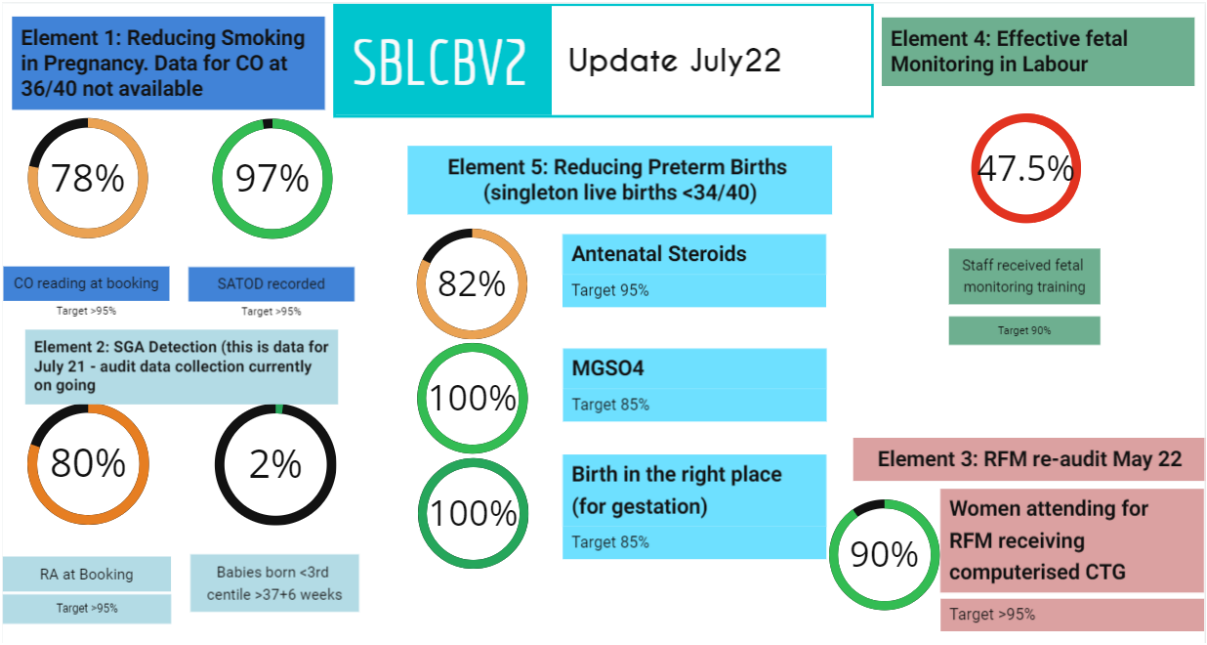


Table: SBLCBv2 element, BRAG rating and improvement plan

Element	BRAG rating	Improvement plan
Element 1 - Reducing smoking in pregnancy		CO_2 monitoring at 36/40 – data not available on Trak resulting in notes audit being undertaken. Compliance remains low on latest audit demonstrating 50% compliance. Smoking Cessation midwife working with community leads to address the issue and undetake teaching sessions locally with midwives. Replacement of CO monitors has delayed the ability to commence the audit as monitors were not available for staff to undertake the recording. These are now replaced. This also affected the compliance with CO monitoring at booking which fell to circa 60%. Latest data has now increased to 78% and the service will continue to monitor this to ensure compliance. Audit now comenced to monitor recording at 36/40
Element 2 - Risk assessment and surveillance for fetal growth restriction		Audit commenced
Element 3 – Raising awareness of reduced fetal movement		Audit demonstrates 90% compliance for computerised CTG's undertaken.
Element 4 – Effective fetal monitoring during labour		Fetal monitoring study days now recommenced and a plan to ensure >90% compliance being developed by the leads

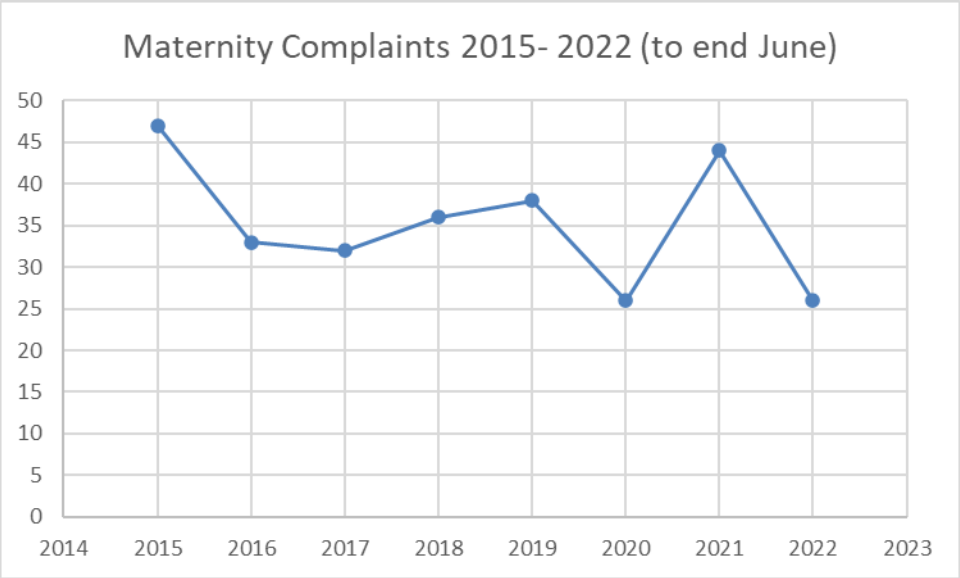
Element	BRAG rating	Improvement plan
Element 5 – Preterm care		

Safety action 7 - service user feedback

Complaints

The following chart displays the number of complaints for both maternity and neonatal services since 2015. There were no complaints specifically attributed to Covid although it should be acknowledged that staffing factors and service delivery alterations throughout the pandemic will have impacted on the level and category of complaints received. There was a total of 14 complaints for the maternity service in Q1 a 27% increase from Q4.

Table: Total number of complaints by year



The complaints team triage complaints as either standard or serious dependent on the complexity of individual complaints. Standard complaint response time 35 days, serious complaints 65 days. There were 5 serious complaints for the maternity service during Q1. This is an increase from 2 in the preceding quarter. All of the serious complaints were related to the Maternity Ward.

Table: Detail of the 5 serious complaints

Date received	Specific Location	Brief description of Patient Experience	Subject	Sub-subject	Subject notes
04/05/2022	Maternity Ward Obstetrics	Medics - lack of ack of very anxious mother. Lack of referral to Perinatal Mental Health. Nursing -attitude, lack of care.	Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Medics - lack of ack of very anxious mother.
			Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Nursing -attitude
			Appointments	Referral - Failure	Lack of referral to Perinatal Mental Health.
			Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Nursing - lack of care.
18/05/2022	Maternity Ward Obstetrics	Lack of referral to ACRT. Lack of obs & meds. Issue re discharge paperwork. Lack of assistance from feeding specialist-baby had cleft palette	Patient Care (Nursing)	Failure to provide adequate care (inc. overall level of care provided)	Lack of referral to ACRT. Lack of obs & meds. Issue re discharge paperwork. Lack of assistance from feeding specialist-baby had cleft palette
17/05/2022	Maternity Ward Obstetrics	Why imposed consultant care which would result in imposed induction which pt did not want. Poor attitude of consultant and Lack of info. Midwifery - Poor communication. Pt unable to access birth Unit -door not answered. Room dirty. Attitude & behaviour of midwife. Partner had to leave. Pt not given breakfast. Lack of physio. Poor exp with Health visitor (GHC)	Values and Behaviours (Staff)	Attitude of Medical Staff	Poor attitude of consultant
			Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Lack of physio.
			Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Midwifery Why imposed consultant care which would result in imposed induction which pt did not want. - Poor communication. Pt unable to access birth Unit -door not answered. Attitude & behaviour of midwife. Partner had to leave. Pt not given breakfast.
			Consent	Insufficient information provided prior to consent	Pt did not want induction
			Communications	Communication with patient	Consultant - Lack of info.
26/05/2022	Maternity Ward Obstetrics	Poor communication from Dr and lack of promised debrief, nurses and lack of promised debrief and between staff. Dr -lack of treatment. Midwife - poor care to mum & twin 1, lack of knowledge, meds not given but signed as being given, poor attitude towards partner, expressed milk mislaid, lack of required blood transfusion. Lack of and incorrect notes. Cannula tissued. Lack of staff. Pt & MCA had to clean room and change sheets. Lack of visit from community m/w. Parking charges.	Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Dr -lack of treatment.
			Trust admin/policies/ procedures including patient record management	Accuracy of health records (e.g. errors, omissions, other patient's records in file)	Midwife - meds not given but signed as being given, Lack of and incorrect notes.
			Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Midwife - meds not given but signed as being given,
			Patient Care (Nursing)	Cannula management	Midwife - Cannula tissued.
				Failure to provide adequate care (inc. overall level of care provided)	Midwife - poor care to mum & twin 1, lack of knowledge,lack of visit from community m/w. Lack of required blood transfusion.Pt & MCA had to clean room and change sheets.
			Communications	Communication failure between departments	Poor communication between staff.
				Communication with patient	Poor communication from nurses and lack of promised debrief
					Poor communication from Dr and lack of promised debrief,
			Facilities	Car parking - cost	Parking charges.
				Cleanliness Clinical (all aspects, all areas)	Pt & MCA had to clean room and change sheets.
			Staff numbers	Staffing Levels	Midwife - Lack of staff.
			Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Midwife - poor attitude towards partner,
19/05/2022	Maternity Ward Obstetrics	Attitude of doctor and delay in c-section	Values and Behaviours (Staff)	Attitude of Medical Staff	Attitude of doctor
					Delay in c-section

There were a further 9 complaints triaged as standard in the Maternity Service. This is the same number as the preceding quarter.

Table: Details of the 9 complaints

Date received	Specific Location	Brief description of Patient Experience	Subject	Sub-subject	Subject notes
11/04/2022	Maternity Ward Obstetrics	Multiple issues with treatment in maternity. A&E and Gynae.	Clinical treatment	Mismanagement of labour	Patient unhappy with care while in labour
			Patient Care (Nursing)	Food and Hydration - Failure to monitor / provide fluid during period of admission	Failure to provide food and hydration.
			Admission and discharges	Discharge Arrangements (inc lack of or poor planning)	discharge arrangements poor planning
			Clinical treatment	Delay or failure in treatment or procedure (including delay in giving medication)	Given conflicting information by two doctors regarding iron infusion
			Values and Behaviours (Staff)	Attitude of Medical Staff	Poor attitude of doctor.
	Emergency Department		Privacy, Dignity and Wellbeing	Patient left in dirty/soiled condition	As above.
			Prescribing	Adverse drug reactions	Patient was not made aware of side effects to drugs administered.
27/06/2022	Antenatal Clinic	Vaccination hub nurses approached complainant in antenatal clinic enquiring if she had had her Covid vaccination. Complainant found the members of staff to be confrontational in their approach - they were not wearing identity badges. They were not socially distancing from the patient and they were not wearing their masks correctly. The	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Vaccination staff found to be confrontational.
			Patient Care (Nursing)	Failure to adopt infection control measures	Failure to socially distance and wear masks correctly
			Communications	Communication with patient	Identity badges not visible to complainant.
				Communication failure between departments	Breakdown in communication between vaccination hub and community team.
25/05/2022	Outpatients	Poor communication and poor record keeping and inaccurate information. Unhappy with treatment of midwife causing emotional distress to the patient	Communications	Communication with patient	Letter received inaccurate details regarding patient.
			Clinical treatment	Failure to follow up on observations / recognise deteriorating patient	Lack of communication
01/04/2022	Maternity Ward Obstetrics	Unhappy with care his wife received prior to her C Section - 6 day wait on the ward prior. Feels wife and child were discharged too	Clinical treatment	Mismanagement of labour	Patient unhappy management of labour
			Admission and discharges	Discharged too early	Patient feels that she was discharged too early due to babys jaundice.
24/05/2022	Maternity Ward Obstetrics	Unpleasant experience during childbirth and aftercare. Medical records incorrect stating time of birth.	Clinical treatment	Inadequate pain management	Inadequate pain management
				Failure to follow up on observations / recognise deteriorating patient	query regarding cervical checks.
				Delay or failure in treatment or procedure (including delay in giving medication)	Delay in blood transfusion.
			Trust admin/policies/ procedures including patient record management	Accuracy of health records (e.g. errors, omissions, other patient's records in file)	Incorrect time of birth recorded
01/06/2022	Maternity Ward Obstetrics	Poor catheter care. Intake of fluid not monitored. Poor record keeping.	Patient Care (Nursing)	Catheter care	Poor catheter care. Intake of fluid not monitored
			Communications	Inadequate record keeping	Inadequate record keeping
20/05/2022	Maternity Ward Obstetrics	Complainant overheard a conversation between a midwife and another patient and feels that it was racist	Values and Behaviours (Staff)	Attitude of Nursing Staff/midwives	Complainant overheard a conversation between a midwife and another patient and feels that it was racist
21/04/2022	Antenatal Clinic	Queries in relation to appointments, Unable to contact Consultant or registrar.	Appointments	Appointment - failure to provide follow-up	Failure to provide follow up appointments. Patient had to organise these herself
			Communications	Communication with patient	Patient could not get in touch with either a registrar or Consultant.
08/06/2022	Maternity Ward Obstetrics	Patient unhappy with lack of communication and treatment by consultants.	Communications	Insufficient information provided	Poor communication between consultants & Parents.

Friends and family test

Friends & Family has recently been expanded to include further questions relating to Continutiy of Carer and also to endure feedback is attribital to the actual place of birth and not amalgamated into feedback on the postnatal ward these questions have been seperated. An improvement in scores was seen at the start of the year with positive results of above 90% in both January and February. However, this has decreased again to an average of 84% over the Q1

Improvement Plan

The Maternity Voices Partnership (MVP) have a plan for improvement and our patient action plan will co-designed with the MVP. Attendance at that meeting has been reduced due to staffing shortages.

Safety action 8 - evidence of local training plan is in place to ensure that all six core modules of the Core Compentency Framework

The service has fallen below target levels with mandatory training. Mandatory training including PROMPT and Midwives mandatory study days were cancelled in January. Midwives have been asked to undertake mandatory training as bank work.

Picture: Maternity service mandatory training rates (target 90%)

Table: current PROMPT compliance – 2021-22 for training year commencing Sept 21

% Compliance for different elements PROMPT			
	Part 1 Virtual Update	Part 2 Skills Drills	Both elements completed
Midwives (incl. bank)	80	75	77.5
*Obs Drs	74	70	72
**Anaes Drs	58	45	51.5
MCAs/MSWs	57	41	49
Theatre Staff	63	59	61

Table: Compliance with Midwives and MCA/MSW Mandatory Training

		Midwives Mandatory Update
Total required to meet 90%		79
% Attendance Midwives		65

	% Attendance
Total required to meet 90%	29
% Attendance MCA/MSW	61

Improvement plan

Additional study days have been added in to the Training Plan. An educational training review has been commissioned to review the current requirements to make sure that we are making best use of opportunities. The plan is to have increased compliance to 90% by Dec 2022.

Safety action 9 - processes in place to provide assurance to the Board on Maternity and neonatal safety and quality issues

Maternity Safety Champions (MSCs) work at every level – trust, regional and national – and across regional, organisational and service boundaries. Safer maternity care called on maternity providers to designate and empower individuals to champion maternity safety in their organisation. The board-level maternity safety champion will act as a conduit between the board and the service level champions.

The role of the maternity safety champions is to support delivering safer outcomes for pregnant women and babies. Maternity Service Champions build the maternity safety movement in our service locally.

The Trust Maternity Safety Champions have been meeting on a monthly basis.

Improvement action

- A Safety intelligence pathway from ward to Board needs to be refreshed to include the **Perinatal Quality Surveillance** (PQS) Model.
- The Board level maternity service champion will present the PQS Dashboard and Report to Board quarterly.
- Our MCoC action plan is to be reviewed by MSCs.
- The MSCs are to have oversight of the Neonatal Critical Care Review Recommendations.
- The MSCs should support the safety culture improvement plan.

Safety Action 10 - reported 100% qualifying cases to Health Care Safety Investigation Branch (HSIB) and to the NHS Resolution's Early Notification schemes

Serious incidents

The purpose of serious incident reporting and learning is to demonstrate good governance and safety for the most serious incidents. The aim of this Q4 update is to provide assurance to the Board that the maternity service is compliant with the contractual standards for investigations, that immediate learning happens (72 hour reports) and that recommendations made are developed in action plans which are then implemented. Where the incident meets the HSIB criteria these are referred to them to investigate.

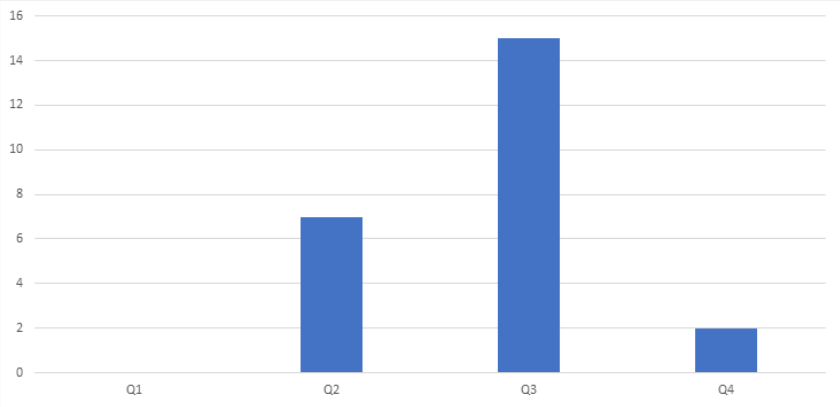
Governance

At the service level, the Maternity Clinical Governance Meeting has oversight of the serious incident management process. The Division reports through to the Trust level the Safety and Experience Review Group as they have detailed oversight escalating any concerns to the Quality Delivery Group. All incidents that have been scoped within maternity are presented to the weekly SI panel.

Serious incident reporting

Serious incidents must be declared as soon as possible and in order to do this incident that have been identified as serious in nature undergo a scoping exercise. In Q1 there were a total of 8 incidents scoped, 2 of which were classified as serious incidents.

Table: Total number of incidents scoped 2021-22



Also, the Trust is required to report all qualifying cases to the HSIB and of the 8 incidents scoped 2 were reported to HSIB, 1 of which was rejected

Table: Details of incidents scoped in Q1

Incident Number	Speciality	Incident Summary	Immediate actions including level of harm/referral to HSIB
W178036	Obstetrics	T+13, Undiagnosed breech- attended triage at fully dilated with SRM and mec. CAT 1 LSCS- fetal bradycardia. Born in poor condition and transfer Southmead cooling- HIE 3.	HSIB/SI Immediate Safety Act's: LASER circulated
W182519	Obstetrics	Term Baby. Planned home delivery. 15 minutes shoulder dystocia, apgars 0,1 & 7 @26 mins. Cooling	SI (rejected by HSIB) Immediate Safety Act's: No immediate safety actions identified
W178438	Obstetrics	29+5 CAT 1 LSCS for chronic hypoxic CTG- baby born in poor condition and transfer to St Michael's- died on day 5 following reorientation of care. Datix regarding delay in Triage assessment. RIP baby	SI Immediate Safety Act's: -Review of Triage staffing -Triage to be risk assessed -Consultant ward rounds to incorporate Triage -consideration of MCA redeployment to Triage -Huddle checklist to include documentation of Triage cases
W177888	Obstetrics	IUD at 24/40 confirmed. Mife given, calls to ?CDS contracting- wishing to stay at home. Call made to Paramedics when contracting strongly- unable to attend, BBA	Near Miss Immediate Safety Act's: None identified
W178883	Obstetrics	IOL for OC, high head, uss by Band 7 - ceph pres, controlled ARM by band 7, EMCS for breech	Near Miss Immediate Safety Act's: None identified
W179874	Obstetrics	34/40 BBA RIP - SG	Police Investigation:

			Immediate Safety Act's: None identified
W179473	Obstetrics/Gynae/ED	16/40 scar ectopic with placenta embedded in cervix	Moderate Harm Immediate Safety Act's: -LASER -urgent discussion Deputy Chief Nurse/Director of Nursing/Gynae Spec Director -Link to risk on register
W177128	Obstetrics	Readmission to theatre with PPH - retained placental tissue - decision made no harm	No Harm Immediate Safety Act's: Discussion with staff member involved re documentation

HSIB Cases

The HSIB Maternity investigation programme is part of a national plan to make maternity care safer. HSIB investigate incidents that meet the HSIB and MBRRACE-UK criteria. HSIB investigations replace internal serious incident investigations. HSIB involve the Trust and share the investigation reports once they are completed. The Trust continue to investigate maternity events that fall outside the HSIB specified criteria.

Governance

The maternity service remains responsible for Duty of Candour, 72-hour reports and reporting via the Strategic Executive Information System (STEIS). HSIB provide 2 weekly investigation progress reports to the Trust and meet with the Trust on a quarterly basis to share learning, themes and trends.

Table: Total HSIB investigation activity since April 2018

Cases to date	
Total referrals	44
Rejected (not including duplicate referrals)	14
Total investigations to date	30
Total investigations completed	27
Current active cases	3
Exception reporting to DHSC	0

Graph: Maternity investigation categories

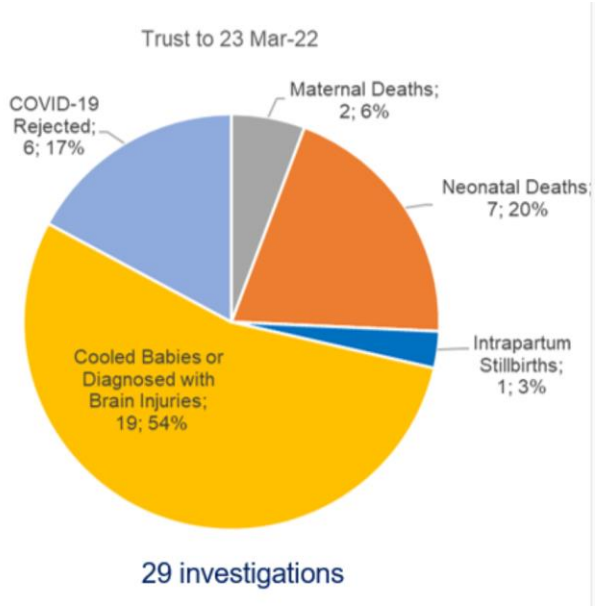


Table: HSIB activity in Q1

HSIB case number	Qualifying criteria	Investigation progress	Improvement
MI-003319	Maternal Death/massive PPH (March 2021)	Final report received	Action plan agreed and presented at SERG.
MI-003835	HIE3 (July 21)	Final report received.	Action plan agreed and presented at SERG.
MI-03888	Cooling/HIE3 (July 21)	Final report received	Action plan agreed and presented at SERG.
MI-004519	Maternal Death–@ 11/40 (October 21)	Final report received	No recommendations made
MI-005438	Cooling. Head MRI normal (December 21)	Final report received	No recommendations made
MI-006101	HIE/Cooling 37+0 Contractions/Abdo Pain, Pathological CTG, Cat 1 EMCS, Uterine Rupture. (January 22)	Draft report received (4 recommendations made) .	
MI-008110	HIE/Cooling T+14 undx breech, EMCS	Report in process of being drafted. HSIB report panel scheduled 18/8, after which report will be shared for factual accuracy checking	

Table: Details of family involvement in HSIB investigations

Date range	Families not agreeing to contact from HSIB	Families contacted by HSIB but not agreeing to participate	Families engaging with HSIB
Q1 20/21	7.2%	8.6%	84.2%
Q2 20/21	7.3%	10.5%	82.2%
Q3 20/21	7.9%	7.1%	85.1%
Q4 20/21	7.4%	3.5%	89.1%
Q1 21/22	6.2%	6.2%	87.7%
Q2 21/22	6.7%	6.7%	86.6%
Q3 21/22	7.6%	8.5%	83.9%

NHS Resolution Early Notification Scheme

The scheme aims to provide a more rapid and caring response to families whose babies may have suffered harm. On completion of the HSIB safety investigation, where a case has progressed following referral for potential severe brain injury, a copy of the final report is shared with NHSR for them to review and decide whether there is any evidence that could potentially result in compensation.

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance and Digital Committee, 29 September 2022

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
Financial Performance Report	Key points were highlighted as follows: • The Trust reported a deficit of £8.6m, which was £6.6m adverse to plan. • The deficit was driven by a number of pressures, including underperformance of out of county contracts, underperformance on passthrough drugs and devices, divisional pay pressure due to use of temporary staff, non-pay pressures due to clinical supplies, outsourcing and laboratory reagents costs, financial sustainability and GMS inflation. • Cash balance was reduced from last month, due to the timing of capital payments and continued high run-rate of pay spend.	The financial position continued to highlight a significant challenge to the Trust. The Financial Recovery Plan set out objectives and actions to mitigate against the Trust's position.
Financial Recovery Plan	The plan set out five key objectives: • Review the significant increase in whole-time equivalents from 2019-20 to 2022-23 and recommend reassessments. • Incorporate divisional recovery plans, including difficult decisions required to improve the financial position. • Undertake a review of temporary staffing controls with a view to reducing spend. • Review all agency spend on non-clinical areas. • Continue to identify additional schemes to meet the overall financial sustainability programme and income targets.	The Committee acknowledged the significant pressure that the Trust was experiencing, both operationally and financially. Further information would be received on productivity at the next meeting. The Committee reflected that allowing operational colleagues the space to implement positive change would make a significant difference to both culture and sustainability.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
ICS Digital Strategy	Local health system partners had been worked together to develop an ICS-wide digital strategy to provide direction, measurable targets and clear patient benefits for the next five years. The strategy was developed and produced by an external company, following facilitated workshops with representatives from across Gloucestershire's health and care system.	The Committee acknowledged the creation of the strategy and the engagement process, however noted that there was no clarity on leadership or decision-making or a focus on local aspirations or benefits. The strategy would need to include robust timescales and planning to achieve its ambitions.
Financial Sustainability Report	The target for the Trust was £19m. The report detailed that £7.7m was unidentified and was phased to be delivered in the latter part of the year. This meant that the efficiency requirement would become higher as the year progressed. The Trust's reported month five position was delivery of £5.4m year-to-date against a target of £6.2m, which resulted in an under-delivery of £0.8m.	Productivity work was well established within the Trust, with divisional level productivity replicated at specialty level in order to use the information as a key enabler of financial sustainability. The Committee noted plans to generate new ideas which were being developed for implementation in October.

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.

Capital Programme	The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.5m. The Trust had been awarded £0.4m of additional funding in month five for improvements to the paediatric ward at GRH to help improve care for children and young patients who required mental health support. As of the end of month five, the Trust had goods delivered, works done or services received to the value of £14.6m, which was £4.3m behind plan. The key driver behind this position was the Trust's Strategic Site Development project.	The Committee supported the "at risk" element of the demand and capacity schemes, and supported the acceptance of the Salix grant.
Whole Time Equivalent Growth Report	A detailed analysis of the Trust's operating plans had been undertaken in response to a letter received from NHSEI in relation to material increases in WTE and limited evidence of increases in elective recovery. The exercise had been undertaken and the report detailed identified changes in WTE workforce in 2019-20 and 2022-23.	The Committee noted the work being undertaken to establish strengthened controls and governance.

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Private Patients Review	The report forecast the best income projection by year-end, since 2009-10.	None.
Digital Transformation Report	Key points were highlighted as follows: • Go-live dates for electronic prescribing had been confirmed for November. • Pre-assessment patient health questionnaires were online and in use. • Planning was underway for paper-lite outpatients, with four early adopter areas identified. • Scoping for internal referrals on the EPR was underway. • The cyber action plan was progressing well.	None.

Items not Rated				
Terms of Reference	Digital Risk Register	ICS Update	Legal Case	Averting Disasters

Investments			
Case	**Comments**	**Approval**	**Actions**
Cardinal Health Tympanic Thermometers	Approved at Trust Leadership Team	Approved	None

Impact on Board Assurance Framework (BAF)
SR7 had been fully updated in September, with a recommended increased risk score of 20.

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	12	Enclosure Number:	7
Date	13 October 2022		
Title	M5 Financial Performance Report		
Author /Sponsoring Director/Presenter	Hollie Day, Craig Marshall Karen Johnson		

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

Summary of Report

Purpose

This purpose of this report is to present the financial position of the Trust at Month 5 to the Trust Board.

Month 5 overview

- The Trust is reporting a year-to-date deficit of £8.6m deficit which is £6.6m adverse to plan. This includes one-off benefits of £5m.
- The Trust is maintaining the planned forecast breakeven position.
- The ICS is required to breakeven for the year. At month 5, all organisations within the system are forecasting to deliver to a breakeven financial position at year-end in line with the plan, however there are risks in these forecasts.
- The ICS year-to-date (YTD) deficit position of £8.2m is £6.4m adverse to plan and is the result of a £6.6m adverse to plan position from GHFT, and a small YTD surplus position at GHC.

22/23 Capital

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m. The Trust has been awarded £0.4m of additional funding in month 5 for improvements to the paediatric ward at GRH to help improve care for children and young patients who need mental health support.

As of the end of August (M5), the Trust had goods delivered, works done or services received to the value of £14.6m, £4.3m behind plan.

Key issues to note

The deficit is driven by:

- Underperformance on out of county contracts of £1.5m
- Divisional pay pressures of £3.8m pay overspend due to use of temporary staff to cover vacancies, provide RMN support and meet unscheduled care demands
- Non pay pressures of £2.3m due to clinical supplies, outsourcing and laboratory reagent costs.

- Financial Sustainability pressure of £2.6m
- Corporate underspends of £1m
- 50% of well-being day released in M3 £1.3m

Next Steps

The financial position at month 5 continues to highlight a significant challenge and the pressures are forecast to continue unless mitigating actions are implemented. A Financial Recovery Plan has been developed and was presented to Finance and Digital Committee in September.

The Financial Recovery Plan included recommendations to:

- Review the significant increase in WTE from 19/20 to 22/23 and makes recommendations for where growth should be re-assessed
- Incorporate divisional recovery plans including highlighting the difficult decisions required to improve the financial position
- Undertake a review of temporary staffing controls with a view to reducing spend.
- Review all agency spend on non-clinical areas
- Continuing to identify additional schemes to meet the overall financial sustainability programme and income targets.

Conclusions

The Trust is reporting a year-to-date deficit of £8.6m deficit which is £6.6m adverse to plan. A Financial Recovery Plan with mitigations and key actions identified has been reported to Finance & Digital Committee in September 2022.

Recommendation

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

Enclosures

- Finance Report

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Financial Performance Report
Month Ended 31st August 2022

Gloucestershire Hospitals
NHS Foundation Trust

Revenue & Balance Sheet

Director of Finance Summary

System Overview

The ICS is required to breakeven for the year. At month 5, all organisations within the system are forecasting to deliver to a breakeven financial position at year-end in line with the plan, however there are significant risks in these forecasts.

The ICS year-to-date (YTD) deficit position of £8.2m which is £6.4m adverse to plan. This is the result of a £6.6m adverse to plan position from GHFT, and a small £0.2m YTD surplus position at GHC.

Key risks in the ICS's financial position are:

- Medicines Management pressures - inflation & growth exceeds assumptions
- Elective Recovery also covering Specialist Commissioning and including Clawback
- CHC increases in inflation and activity
- Pay Award funding lower than anticipated cost
- Pressures within GHFT relating to a number of factors including high number of vacancies, urgent care escalations, loss of OOC income, gap on current financial sustainability programme and other factors.

Month 5

M5 Financial position is reporting a deficit of £8.6m which is £6.6m adverse to plan.

The deficit is driven by :

- Underperformance on out of county contracts of £1.5m
- Underperformance on pass-through drugs & devices overhead income £0.6m
- Divisional pay pressures of £3.8m pay overspend due to use of temporary staff to cover vacancies, provide RMN support and meet unscheduled care demands. Of this, £3.5m is for RMNs and escalation.
- Non pay pressures of £2.3m net due to clinical supplies, outsourcing and laboratory reagent costs.
- Financial Sustainability pressure of £2.6m
- GMS inflation pressure of £0.6m
- Corporate underspends of £1m
- Non recurrent benefits of £5m

The Financial Sustainability Plan (FSP) target for the Trust is £19m, of which £7.8m is still unidentified and is phased to be delivered in the latter part of the year meaning the efficiency requirement will become higher as the year progresses. The M5 position includes FSP delivery of £5.4m YTD against a target of £6.2m which is an under-delivery of £0.8m.

Director of Finance Summary

Activity remains below 19/20 levels across all points of delivery including ED attendances and Non-Elective activity whilst our spend is significantly higher.

The financial position currently includes the following assumptions in regards to mitigations:

- No contingent reserves available for release
- No assumed ESRF income
- No adjustment for future benefits from sustainability schemes – currently the balance of non-divisional identified schemes is showing as an unmitigated overspend
- No impact on winter in particular around flu and covid pressures
- No reflection of any system benefits
- A Financial Recovery Plan has been developed which will be discussed in the September Finance and Digital Committee meeting.

We will continue to work with system partners to explore opportunities to manage the financial position across the system.

Month 5 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £8.6m deficit		M5 Financial position is reporting a deficit of £8.6m which is £6.6m adverse to plan.
Income is £276.7m YTD which is £5.8m adverse to plan		M5 overall income position is reporting £276.7m income which is £5.8m adverse to plan. The income variance is driven by income plan shortfall of £3.7m (which is offset by provision released against non pay), underperformance of activity on out of ICS contracts c£1.5m and less than expected pass through drugs c£1.9m which sees a corresponding underspend in divisional expenditure budgets.
Pay costs are £176.5m YTD which is £1.4m adverse to plan		Pay costs are £176.5m YTD which is £1.4m adverse to plan. The YTD position includes a one off benefit of c£1.45m. Without this pay would be overspent by £2.85m YTD, driven by the usage of temporary staffing in both Medicine and Surgery Divisions for Nursing and Medical staff. The month 5 position (excluding one off benefit) includes Substantive staff underspend of £20.2m offset by overspends in Agency (£7.9m) and Bank/Locum (£13.6m) The total contracted vacancies in month 5 are 733 WTE.
Non Pay costs are £108.8m YTD which is £0.5m favourable to plan		Non Pay costs (including non-operating costs) are £108.8m YTD which is £0.5m favourable to plan. The YTD month position includes a one off benefit of £3.6m. Without this non pay would be overspent by £3.1m YTD. The main drivers of the non pay overspends are inflation £0.7m, clinical supplies £1m and FSP shortfall £2.6m. Drugs costs are favourable to plan at £0.8m.
Total Financial Sustainability schemes need to be allocated out to Divisions		Total efficiencies for the Trust are £19m which consist of £4.5m Covid reduction, £1.3m GMS savings and £113m Trust wide efficiencies. At month 5, £5.4m efficiencies have been delivered YTD. Forecast delivery is £11.3m which is a shortfall of £7.8m due to unidentified schemes.
The cash balance is £68.9m		The reduction in cash balances from the prior month represents an increase in capital expenditure payments and the impact from the current revenue run rate that is above funding received.

M5 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of August 2022 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 July the Group's consolidated position shows a deficit of £8.6m which is £6.6m adverse to plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 5 Financial Position	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	258,318	251,069	(7,249)			0	258,318	251,069	(7,249)
PP, Overseas and RTA Income	2,655	1,896	(759)			0	2,655	1,896	(759)
Other Income from Patient Activities	5,359	5,338	(21)			0	5,359	5,338	(21)
Operating Income	15,161	17,027	1,866	26,890	22,238	(4,652)	16,149	18,413	2,264
Total Income	**281,493**	**275,331**	**(6,162)**	**26,890**	**22,238**	**(4,652)**	**282,481**	**276,716**	**(5,765)**
Pay	(166,182)	(167,449)	(1,266)	(8,976)	(9,086)	(110)	(175,158)	(176,535)	(1,377)
Non-Pay	(113,299)	(113,704)	(404)	(16,716)	(12,474)	4,242	(104,113)	(105,325)	(1,212)
Total Expenditure	**(279,482)**	**(281,152)**	**(1,671)**	**(25,692)**	**(21,561)**	**4,131**	**(279,271)**	**(281,860)**	**(2,589)**
EBITDA	**2,011**	**(5,822)**	**(7,833)**	**1,198**	**678**	**(521)**	**3,210**	**(5,144)**	**(8,354)**
EBITDA %age	**0.7%**	**(2.1%)**	**(2.8%)**	**4.5%**	**3.0%**	**(1.4%)**	**1.1%**	**(1.9%)**	**(3.0%)**
Non-Operating Costs	(4,010)	(2,791)	1,219	(1,198)	(678)	521	(5,208)	(3,469)	1,739
Surplus / (Deficit)	**(1,999)**	**(8,613)**	**(6,614)**	**0**	**0**	**(0)**	**(1,998)**	**(8,613)**	**(6,615)**
Dontated Asset Adjustment	184	0	(184)					0	0
Adjusted Surplus / (Deficit)	**(1,815)**	**(8,613)**	**(6,798)**	**0**	**0**	**(0)**	**(1,998)**	**(8,613)**	**(6,615)**

* Trust position excludes £16m of Hosted Services income and costs. This relates to GP Trainees
** Group position excludes £21m of inter-company transactions, including dividends

Balance Sheet

Gloucestershire Hospitals
NHS Foundation Trust

	Group Closing Balance 31st March 2022 £000	GROUP Balance as at M5 £000	B/S movements from 31st March 2022 £000
Non-Current Assests			
Intangible Assets	13,760	12,581	(1,179)
Property, Plant and Equipment	304,585	334,787	30,202
Trade and Other Receivables	4,414	4,360	(54)
Investment in GMS	0	0	0
Total Non-Current Assets	**322,759**	**351,728**	**28,969**
Current Assets			
Inventories	9,370	9,799	429
Trade and Other Receivables	26,360	22,143	(4,217)
Cash and Cash Equivalents	71,530	68,920	(2,610)
Total Current Assets	**107,260**	**100,862**	**(6,398)**
Current Liabilities			
Trade and Other Payables	(80,104)	(87,392)	(7,288)
Other Liabilities	(14,401)	(12,313)	2,088
Borrowings	(3,626)	(3,975)	(349)
Provisions	(24,089)	(25,678)	(1,589)
Total Current Liabilities	**(122,220)**	**(129,358)**	**(7,138)**
Net Current Assets	**(14,960)**	**(28,496)**	**(13,536)**
Non-Current Liabilities			
Other Liabilities	(5,971)	(5,744)	227
Borrowings	(34,064)	(58,336)	(24,272)
Provisions	(3,600)	(3,600)	0
Total Non-Current Liabilities	**(43,635)**	**(67,680)**	**(24,045)**
Total Assets Employed	**264,164**	**255,552**	**(8,612)**
Financed by Taxpayers Equity			
Public Dividend Capital	361,345	361,345	0
Equity	0	0	0
Reserves	19,823	19,823	0
Retained Earnings	(117,004)	(125,616)	(8,612)
Total Taxpayers' Equity	**264,164**	**255,552**	**(8,612)**

The table shows the M5 balance sheet and movements from the 2021-22 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 22-23 financial year totalling £67.5m. The Trust has been awarded £0.4m of additional funding in month 5 for improvements to the paediatric ward at GRH to help improve care for children and young patients who need mental health support.

YTD Position

As of the end of August (M5), the Trust had goods delivered, works done or services received to the value of £14.6m, £4.3m behind plan.

A breakeven forecast outturn has been reported to NHSI in the M5 Provider Financial Return (PFR).

22/23 Programme Funding Overview

Gloucestershire Hospitals
NHS Foundation Trust

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.5m. The Trust has been awarded £0.4m of additional funding in month 5 for improvements to the paediatric ward at GRH to help improve care for children and young patients who need mental health support.

The current agreed programme can be divided into the following components; Operational System Capital (£25.0m), STP Capital – GSSD (£21.3m), National Programme (£3.7m), Right of Use Assets (£15.4m), IFRIC 12 (£0.8m) and Government Grant/Donations (£1.3m)

There have been other funding awards that are nearing full approval that are not reflected in the month 5 position that will be added to the M6 reported position if full approval is gained.

in £000's	Allocation	Forecast	Variance
Operational System Capital	25,014	25,014	0
National Programme	3,712	3,712	0
STP Capital - GSSD	21,280	21,280	0
Donations via Charitable Funds	1,281	1,281	0
IFRIC 12	817	817	0
Right of use assets adjustment	15,355	15,355	0
Total Capital	**67,458**	**67,458**	**0**

22/23 Programme Spend Overview

Gloucestershire Hospitals NHS Foundation Trust

As of the end of August (M5), the Trust had goods delivered, works done or services received to the value of £14.6m, £4.3m behind plan. The expenditure by programme area is shown below.

in £000's

		In Month			Year to date			Forecast Outturn		
Programme Area	**Funding**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Allocation**	**Actual**	**Variance**
Medical Equipment	Operational System Capital	304	150	154	989	1,030	(42)	2,223	2,223	0
Digital	Operational System Capital	438	131	308	2,272	2,036	236	5,634	5,634	0
Estates	Operational System Capital	449	339	109	1,610	832	777	16,548	16,548	0
IDG Contingency	Operational System Capital	0	0	0	0	0	0	609	609	0
National Programme - Digital	National Programme	137	356	(219)	427	882	(455)	3,350	3,350	0
National Programme - Non Digital	National Programme	0	0	0	0	0	0	362	362	0
STP Programme - GSSD	STP Capital - GSSD	2,851	1,639	1,212	13,077	9,491	3,586	21,280	21,280	0
Donations Via Charitable Funds	Donations via Charitable Funds	75	0	75	245	0	245	1,281	1,281	0
IFRIC 12	IFRIC 12	68	68	0	340	340	0	817	817	0
Right of Use Asset	Right of use assets adjustment	0	0	0	0	0	0	15,355	15,355	0
Gross Capital Expenditure		**4,321**	**2,683**	**1,638**	**18,960**	**14,611**	**4,349**	**67,458**	**67,458**	**0**

The main contributor (£3.6m) to this is the Gloucestershire Hospitals Strategic Site Development project which has been reported previously. A revised forecast profile for the project has been calculated with the contractor confident with much of the differential being recovered over the subsequent months and any forecast slippage being reviewed by the Estates team and mitigations being explored.

A breakeven forecast outturn has been reported to NHSI in the M5 Provider Financial Return. Although there are concerns about slippage materialising and further funding awards that will increase the back-ended nature of the programme and concerns about deliverability and risk.

A breakeven forecast outturn has been reported to NHSI in the M5 Provider Financial Return (PFR)

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- Note the Trust capital position as at the end of September 2022.

Authors:	**Craig Marshall, Project Accountant** **Hollie Day, Associate Director of Financial Management**
Presenting Director:	**Karen Johnson, Director of Finance**
Date:	**October 2022**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	12	**Enclosure Number:**	7
Date	13 October 2022		
Title	Digital Transformation Report		
Author /Sponsoring Director/Presenter	Anna Morton, Programme Director - Digital Mark Hutchinson, Executive Chief Digital & Information Officer		

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

Summary of Report

This paper provides an update on projects being delivered and overseen by the Digital Transformation Office. Highlights include:

- Electronic prescribing ePMA go-live dates have been confirmed for November.
- Pre-assessment patient health questionnaire is now online and in use.
- Planning is underway for paper-lite outpatients with four early adopter areas.
- Scoping for internal referrals on EPR is underway.
- Cyber action plan is progressing.

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

Recommendation

The Committee is asked to note the report

Enclosures

Digital Transformation Report
Appendix 1 - Digital Projects RAG Report
Appendix 2 - Information Governance Report
Appendix 3 - Cyber Assurance Report

FINANCE & DIGITAL COMMITTEE – SEPTEMBER 2022

DIGITAL TRANSFORMATION REPORT

1. Executive Summary

This paper provides Finance & Digital Committee with updates on projects being delivered and overseen by the Digital Transformation Office. This now also includes EPR programmes.

2. Highlights this Period

ePMA

The yellow drug chart is moving onto Sunrise EPR this autumn. This impacts anyone who prescribes, reviews or administers medications working in adult inpatients (not maternity), theatres and ED.

The implementation in planned for November and the Project Board and EPR Programme Delivery Group have decided the go-live will be phased. Additional resource is being provided to support pharmacy teams and regular updates are in place to progress the programme.

The dates for moving onto EPR have now been confirmed as a phased approach to provide targeted support:

2nd November	Early Adopter Wards going live (Lilleybrook, Woodmancote, Rendcomb)
9th November	Cheltenham live across all adult inpatients, theatres, ED
23rd November	Gloucester live across all adult inpatients, theatres, ED

A risk assessment of the new dates was reviewed at the Clinical Safety Group week commencing 29/08/22. It was agreed that the improved safety benefit of having higher volume floorwalking support on each site outweighs the disbenefit of transcribing from digital areas to paper. Small numbers of patients will be impacted by this and a full risk assessment carried out. Detailed and clear communications are being planned. The programme is also liaising closely on ED site moves.

Training was made available during the week of 19th September on the staff e-learning system, with a full programme of communications to ensure completion ahead of go live. It will be supported by videos, printed guides and face to face sessions where needed.

New medication carts with built in computers have been distributed to inpatient wards, giving areas plenty of time to start using them before go live. The rollout of the carts to date has been successful.

A review of business continuity processes is underway and being refined ahead of go live, working closely with the EPRR team. A downtime simulation will take place during October to test the equipment and business continuity reports.

Pre-Assessment Patient Health Questionnaire

The applications team has been working closely with the pre-assessment team to move a key patient questionnaire to an electronic form. The Pre-Operative Health Questionnaire is given to patients who are on a surgical waiting list to complete before their assessment takes place. This change impacts the specialities that use the anaesthetic pre-assessment clinic process (Local and General Anaesthetics).

In the past the amount of completed forms has been limited due to patients taking them home or forgetting to fill them in. Patients now receive a questionnaire via a text or email link once they are added to an Inpatient wait list in TrakCare (for specialties that use the anaesthetic pre-assessment service.) This change has increased the number of forms completed by patients, which supports Pre-op nurses with triage and will in turn reduce on-the-day surgery cancellations. Benefits assessment is now taking place; however, prior to the move to online the pre-assessment team were receiving around 100 paper questionnaires a week. Within the first 3 weeks they received 852 back.

3. Programme of Work - Updates

The projects are categorised as four digital delivery areas:

- Electronic Patient Record (Sunrise EPR)
- Clinical Systems Optimisation
- Infrastructure & Cyber
- Business Intelligence

Projects prioritised for 2022/23 must meet the following requirements*:

- Meet existing Digital Strategy and contribute to the journey to HIMSS level 6.
- Provide significant patient care and/or safety benefits – reduce risk.
- Develop and enhance EPR for users as part of a continuous improvement, responding to clinical demand.
- Support wider organisational journey to outstanding.

**Or be self-funded to cover all costs including implementation and project management.*

The current status of projects:

EPR	Clinical Systems Optimisation	Infrastructure & Cyber	Business Intelligence
8	15	19	9

Complete or in closure	On Hold	Red Rated	Amber Rated	Green Rated	Discovery Phase
9	1	11	14	8	8

Red	Significant issues with the project – scope, time or budget is beyond tolerance level
Amber	Issue/s having negative impact on the project performance, project is close to tolerance level
Green	Project is on track
Blue	Complete & Closed (or In Closure)

Since the last report, two projects have been completed and closed and two projects have gone into closure.

Projects Closed this Period

- Patient Level Information Costing System (PLICS)
- TIE Migration & Consolidation

4. Countywide IT service Update

This report provides an update on performance against key indicators and is shared with all CITS partners. Performance is reported monthly to DCDG in arrears; therefore, this report covers July 2022. Highlights this month:

- Although a lower overall number of calls/requests to the service desk in July, it was a busy month in other areas of CITS.
- The server team in particular have a high number of issues, however, this is related to proactive cyber security work underway and is part of a planned programme.
- CITS staff continue to support internal moves, GP surgery moves and the distribution of devices for the ePMA project.

5. Monitoring of systems

A presentation was given to Digital Care Delivery Board and Finance & Digital Committee during September providing assurance on the IT systems monitoring in place across the Trust. The presentation also demonstrates a number of incidents in which potential disasters were averted thanks to ongoing monitoring. Associate CIO Steve Hardy will be sharing the presentation with senior leaders across the Trust.

Key highlights include:

- We continue to learn from any IT incidents that occur both here and across the NHS.
- Full root cause analysis takes place when issues occur.
- Investment in infrastructure resiliency and monitoring solutions is key.
- Better monitoring enables us to alert staff early – which means we identify the right team, first time, to fix the issues.
- Training and knowledge sharing is key.

6. Information Governance

Information governance incidents are reviewed and investigated throughout the year and reported internally. Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the UK General Data Protection Regulation (UK GDPR) and guidance from the Information Commissioner's Office (ICO), are reported to the ICO through the DSP Toolkit where they may also be monitored by NHS England.

Six incidents have been reported to the ICO during the 2022/2023 financial year reporting period to date. A summary of the incidents together with a description of controls in place are included in the trusts annual report. A more detailed IG report is considered monthly by Digital Care Delivery Group and Finance & Digital Committee.

7. Cyber Security

A monthly assurance report on cyber security actions and support provided to GHT, CCG and GHC is produced as part of the wider service level agreement in CITS. This overview summary report is provided to ICS Digital Execs and GHT's Digital Care Delivery Group. More detailed operational reporting, including analysis of threats and issues, is discussed at the Cyber Security Operational Group. The report is attached at Appendix 3. Key highlights this month:

- The team continuous to work to the agreed cyber audit action plan, reducing risk and updating systems, work is progressing at pace.
- GHT network switch upgrades in preparation for enabling 802.1x to support network access control is complete and configuration to implement closed mode is now underway.
- One high severity alert action completed and risk closed on the NHS cyber alert service portal within this reporting period.
- One new High severity alert published with new risk mitigated with follow up action by 3rd part supplier required.
- A paper setting out SIEM position is being submitted to September ICS Cyber security operational group.

8. Conclusion

There are a significant number of digital projects underway across the organisation, all supporting the organisation's commitment to reaching HIMSS Level 6; as well as increasing efficiency, realising quality benefits and improving patient safety and care.

All of our programmes underpin our commitment to using Sunrise EPR to transform the way that we deliver care and make the most of the clinical and operation intelligence it now provides.

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Audit and Assurance Committee, 7 September 2022

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
None.		

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit Progress Report	One audit review had been completed since July, with fieldwork underway for an additional four reviews. The Committee discussed the overall internal audit plan for the year, and was concerned at the slippage of a number of planned dates. Full ownership of the reviews would be reiterated with teams within the Trust to ensure no further slippage. ***Follow Up Report*** There were 21 recommendations outstanding. The team was working with the Trust to update and, where necessary, escalate. A report into the Datix project was due to be presented at Risk Management Group.	Ensure continued incorporated learning from internal audit reviews, including distribution of learning and best practice throughout the organisation. Ownership of each of the reviews within the internal audit plan for 2022-23 would be confirmed to ensure there was no further slippage.
HFMA Financial Sustainability Audit	Scoring for the self-assessment had been completed by a number of teams within the organisation. A review of the self-assessment had been undertaken, with action plans in place for areas scored at Level 3.	The Committee approved the terms of reference.
External Audit Progress Report	The Committee was informed that the timetables for GMS and Charity audit work had been finalised. Value for Money work for the Trust was ongoing and due to be concluded by the end of September/early October. The deadline to conclude the Value for Money work had extended due to the need to receive final CQC reports.	External auditors would present to Council of Governors in September. A lessons learned report would be discussed at November's meeting.
Counter Fraud Report	The Committee received the report, noting particularly the red rated assessment for fraud, bribery and corruption. The Trust had been red rated for the last two years and the team was actively seeking to improve during 2022-23.	None.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
Emergency Preparedness, Resilience and Response Report	The Trust had self-assessed against 63 core standards; the Trust was fully compliant against 57, with 6 partially compliant. The Trust was therefore substantially compliant for 2022-23.	The report would be recommended for approval at October's Board meeting.
Losses and Compensations Report	The Committee was assured by the management of the process of losses and compensations, and approved the write off of five ex-gratia payments totalling £1,536.00.	The Patient Property Policy was due to be presented to Quality and Performance Committee in September.
Single Tender Actions Report	A total of four waivers had been received at a value of £116,495. Two of the waivers had been retrospective.	None.
GMS Report	External audit was progressing well, with some final reviews of financial statements taking place. It was expected that approval of accounts would take place at GMS Board in September. No significant issues had been raised.	None.

Items not Rated

None.

Impact on Board Assurance Framework (BAF)

Risk rationalisation continued, with good progress being made.

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.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Estates and Facilities Committee, 22 September 2022		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
None.		
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
GMS Chair's Report	Portering had been a key focus of the recent GMS development session, with particular concern reiterated in relation to porter involvement in serious violence and aggression incidents and involvement in suicide attempts. In July, GMS had forecast a £300k deficit against a budget of £2.1m dividend to the Trust. Pay award funding had impacted on GMS' ability to deliver the forecast, and a reduced dividend would be reported over the coming month. However, GMS was actively working with the Trust to address.	Additional assurance and visibility would be received on agency spend and GMS plans to reduce temporary staffing. An executive discussion would be held in relation to the oversight and ownership of violence and aggression.
GMS Contract Mgt Group Exception Report	Key points were noted as follows: • A national action plan was in place to address gaps in national cleaning standards. • Staff parking permits would be reintroduced at the beginning of the next financial year. • Bulk buying of materials had been driven by anxiety created by marketplace demand; stock management processes needed to be strengthened within the organisation to prevent this. • There were some fire issues raised, mainly in relation to areas of storage and clutter. A warehouse had been purchased in order to resolve this, and a standard operating procedure was now in place to ensure the warehouse was utilised appropriately. The Committee was advised that there should be four fire safety officers in post in the Trust, but there was currently only one with some part-time support. The team was reviewing mitigation plans. • Lessons had been learned in relation to battery charges at ward entrances which may present a hazard. Further work would be done to address this. • A discussion had also been held in relation to a portering recovery plan and what could be controlled within the Trust.	The Committee noted the plans in place to address the issues raised.
Parking Contract Management Report	Monthly and quarterly contract management meetings had been established, along with an invoice validation system. The team was now also carrying out dip samples on training records to ensure compliance. The Committee was advised that a data management agreement with GMS was in development. A meeting had also been arranged to discuss suicide prevention.	The Committee was assured by the systems now in place to strengthen monitoring of the contract.
GMS Workforce Plan	Proposals for a pay increase had been developed; figures were being revisited to determine if the national pay rise would have an impact. There may be some specific interventions for particular catering and electrical roles.	Information on job roles that were being lost to other Trusts would be provided to inform a conversation with the local health system.
GSSD Progress Report	Contractors had recently experienced workforce and supply chain issues, however a confirmation date for completion of the Emergency Department had been received. The Trust had also received confirmation of funding for the Quayside development of the community diagnostic centre.	Ensure effective project management of funding bids, and awareness of pressures this puts on existing teams to efficiently manage successful bids.

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.

Electrical Infrastructure Update	Existing electrical supply and infrastructure was not fully compliant at either hospital; with growing demand and redevelopment at both sites, the need for more sophisticated infrastructure was required. The Committee was advised of the preferred option to undertake works in a planned and prioritised approach, which was supported by a robust action plan. Budget costs had been identified and would require ongoing review.	The Committee supported the implementation of option 3.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None.		
Items not Rated		
Integrated Care System Update	Risk Register	Capital Programme Report
Impact on Board Assurance Framework (BAF)		
The risks would be reviewed to determine whether they could be combined to form a single risk.		