NHS
Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
10.30, Thursday 10 November 2022
Cabinet Suite, Shire Hall, Gloucester
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			10.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 13 October 2022**	Approval	Enc 1	10.35
5	**Matters arising from Board meeting held on 13 October 2022**	Assurance		
6	**Patient Story** *Katie Parker-Roberts, Head of Quality*	Information	Presentation	10.40
7	**Chief Executive's Briefing** *Deborah Lee, Chief Executive Officer*	Information	Enc 2	11.00
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	11.15
9	**Trust Risk Register** *Mark Pietroni, Medical Director*	Assurance	Enc 4	11.20
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	11.30
11	**Maternity Reports** *Suzie Cro, Deputy Director of Quality*	Assurance	Enc 6	11.50
12	**Freedom to Speak Up Guardian Annual Report** *Katie Parker-Roberts, Head of Quality and Freedom to Speak Up Guardian*	Assurance	Enc 7	12.05
	Break (12.15-12.30)			
13	**Fit for the Future Programme: Next Steps** *Simon Lanceley, Director of Strategy and Transformation*	Assurance	Enc 8	12.30
14	**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 9	12.45
15	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director*	Assurance	Enc 10	12.55
16	**Any other business**		None	13.05
17	**Governor Observations**			
	Close by 13.15			

Gloucestershire Hospitals NHS Foundation Trust

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 13 October 2022, 10.15, Lecture Hall Redwood Education Centre			
Chair	Deborah Evans	DE	Chair
Present	Alex D'Agapeyeff	ADA	Deputy Medical Director and Director of Safety
	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Robert Graves	RG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director (joined the meeting via Teams)
	Matt Holdaway	MHo	Chief Nurse and Director of Quality
	Mark Hutchinson	MH	Executive Chief Digital and Information Officer
	Karen Johnson	KJ	Director of Finance
	Simon Lanceley	SL	Director of Strategy and Transformation
	Deborah Lee	DL	Chief Executive Officer
	Alison Moon	AM	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director for People and Organisational Development
	Qadar Zada	QZ	Chief Operating Officer
Attending	Chloe Barrett	CB	CT Superintendent (item 6 only)
	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Katie Parker-Roberts	KPR	Head of Quality and Freedom to Speak Up Guardian (item 6 only)
	Alice Prior	AP	General Manager for Radiology (item 6 only)
	Leanne Raybould	LR	Therapy Research Assistant (item 6 only)
	Nicola Turner	NT	Divisional Director for Allied Health Professionals (item 6 only)
Observers	Three governors, staff members and members of the public observed the meeting virtually. Three governors observed the meeting in person.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting. DE advised the Board of her continued visitation of areas within the hospital, and reflected on the welcomes she had received from teams and the dedication and commitment from staff across the whole organisation.
2	**Apologies for absence** Mark Pietroni, Medical Director and Director of Safety.
3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 8 September 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 8 September 2022** All matters arising were noted.
6	**Staff Story**

	The Board received a presentation from three Allied Health Professionals detailing their career journeys, in support of Allied Health Professionals Day on 14 October. The day celebrated innovation, and the Board heard detail on development and practice opportunities for AHP staff. The Board was pleased to hear about the innovation that allowed career progression for staff, and commended the team on their hard work and continued success.
7	**Chief Executive's Briefing** DL briefed the Board as follows: • The Trust remained operationally very busy, however there had been recent improvements in urgent and emergency care. There had been a renewed focus on initiatives and changes that were within the Trust's control, and these had made significant positive differences to ambulance handover delays during the Trust's recent "Reset Week". Aspects of the operating model had been adapted to reduce ambulance handover delays and category two ambulance response times. The Board was advised that there had been no ambulances waiting more than four hours to handover a patient, with the mean time for handover reporting at two hours. Category two responses times had also reduced from a peak of 160 minutes to a mean of 33 minutes within the last week. Although the standard response time was 18-minutes, DL was particularly proud of this significant improvement. • Plans for an additional winter ward were in development, with the team reviewing escalation policies in relation to winter planning. • The Trust's CQC report into the findings of its core services inspection of Surgery and the Well-Led review had been published. Both inspections had resulted in a reduction in ratings, with Surgery moving from *Requires Improvement* to *Inadequate*, and Well-Led from *Good* to *Requires Improvement*. The Trust's overall rating had therefore moved from *Good* to *Requires Improvement*. DL felt that, although the CQC report was disappointing, there was palpable optimism about moving forward and confidence that the report could be used as an opportunity to expedite culture improvements that were already being put in place. CF reflected her disappointment with the CQC report, but shared the collective determination to improve and succeed. CF asked how the Trust was ensuring that all teams were involved and engaged in making sure real culture change happened. MHo advised that all executives were ensuring they were available to all teams to discuss changes and challenges and, in nursing, assuring the wider corporate nursing team that help and support was available. A number of quality improvement projects were ongoing across the organisation, which involved many teams and would have a positive impact on quality and culture within the Trust.
8	**Board Assurance Framework** The Board received the Board Assurance Framework, noting additional analysis and summaries of key changes, including recommended increased risk scores. The Board was advised that executives would review the whole BAF in November/December. DL advised that strategic objectives would be reviewed to ensure they were reflective of the Trust's current position and fully aligned with the revised risks. KC advised the Board that a new risk on external partnerships was in development to reflect delay related harm, urgent and emergency care, and finances at system level. MN asked for additional detail on the reconciliation of risks from the previous Board Assurance Framework to the new version. **Action**
9	**Trust Risk Register** The Board received the report for information, noting a nil return as the Risk Management Group had not met due to the scheduling of CQC staff briefings.

10	**Quality and Performance Committee Report** AM advised the Board of key issues discussed during September's meeting, including concern raised in relation to increased mortality rates; active work was ongoing to provide assurance on the increase, including an internal investigation. The Patient Safety team, and notably the complaints team, continued to be under significant pressure, with high sickness and vacancy rates impacting on the ability to manage the increase in activity; all cases were proactively reviewed and prioritised, however delays to complaints, moderate harm duty of candour letters and PHSO cases were becoming increasingly significant. It was noted that plans were being developed to build capacity into the team. The Committee had been assured by the progress made in relation to the Patient Property Policy, and was pleased to note that the new protocol would be in place by early November. The Committee had also received good assurance on a number of annual reports from Cancer Services, Safeguarding Adults and Children, and Infection Prevention and Control. Other key issues from the Quality Performance Report were highlighted as follows: • The Trust continued to perform well on reducing the number of patients on the waiting list, with 1200 waiting over 52 weeks; this was the lowest in the South West region. There were fifty patients currently waiting 78 weeks and over, but no patients waiting over 104 weeks. • The Trust was actively preparing for winter and was planning to maximise surgical flow during the winter period, particularly orthopaedics, whilst maintaining performance and keeping patients safe. A new winter ward at Cheltenham General Hospital would be key to this achievement. • The Trust had maintained its position on diagnostic endoscopy. Further work was needed to improve the echocardiography pathway. Overall faster diagnosis was improving, however incrementally. • The Board was advised that ambulance delays were reducing, but further work was required across the local health system. High levels of Medically Optimised for Discharge (MOFD) patients remained as a result of pressure within the system. QZ assured the Board that the position was assessed regularly, with colleagues engaged and pathways reviewed to ensure optimal care. RG queried whether there were adequate resources across the system to address the situation, given how difficult the position may become. QZ advised that concentration was moving towards patients on pathway zero, and shifting focus away from beds; resource had not been resolved and even though discussions continued with system partners, it remained an ongoing challenge. The Board was advised that the primary issue related to the lack of domiciliary care, which was driven by workforce issues rather than funding. • The Trust had implemented a system for closely monitoring patients receiving care in corridors, including a robust escalation process. • Level two pressure ulcers had reduced, with improvements made in pressure relieving care from ambulance to ward. • There had been five falls resulting in harm reported in September. • Friends and Family Test feedback scores had increased to 89.8%. • The Board noted the positive improvement work in Stroke care. RG queried the data in relation to fractured neck of femur, which seemed to highlight a worsening position. ADA advised that this was due to a lack of trauma beds and noted that sometimes patients were not able to be admitted to the appropriate ward, which impacted on timeliness to theatre. QZ informed the Board that a dedicated fractured neck of femur bed had been implemented this week, and would be a protected space for this cohort of patients. ADA informed the Board that the team was reviewing each mortality case to identify any potential issues with care or processes within the hospital in order to address the statistically higher than normal mortality rates.
11	**Maternity Report: Perinatal Quality Surveillance and Safety**

	The Board received the report for information, noting that the Maternity service would commence participation in the NHSEI Safety Support Programme following the Section 29a notice received from the CQC in May 2022. The Maternity service continued to utilise the NHSEI self-assessment tool to review and benchmark its position in relation to quality improvement and safety plans; red-rated areas were linked to concerns around the ability to release staff to complete training, the development of an internal maternity service strategy, and the need for a training needs analysis. The Board was advised that Friends and Family Test scores had remained stable at 81%, and plans were in place to review the data and improvement work in collaboration with the Maternity Voices Partnership. There had been no feedback from staff on safety concerns, although frustrations in relation to the pace of implementation of Badgernet were noted. CF asked how the Trust could be satisfied that the culture within Maternity was positive. MHo reflected on a number of areas of feedback, including maternity safety champions who visit the areas on a regular basis; the Board was advised that the work of safety champions was being changed to focus more clinically. An external review had recently taken place, with the regional Chief Midwife feeding back to the team that culture improvement was palpable and staff were completely committed to providing excellent care to patients. The team regularly reviewed quarterly pulse surveys, and information from exit interviews. A report on Midwifery Staffing was due to be presented through the governance structure in November, and exit interview themes would be included. AM queried the likelihood of the Maternity service achieving mandatory training target compliance by the end of December; MHo would ensure oversight of this in the coming weeks and report progress at Quality and Performance Committee. CF raised a concern in relation to the closure of the Aveta maternity unit; MHo reflected that the staffing position had not changed significantly enough to allow the reopening of the unit and the Trust wanted to be able to sustain opening once it was decided to do so. The Board was advised that a dedicated organisational development colleague was working with midwifery staff to support culture and workforce.
12	**Finance and Digital Committee Report** The Committee had discussed the financial recovery plan in detail as the current position continued to highlight a significant challenge for the Trust. Some good work on productivity was reported through to the Committee, with further discussions to be held at the next meeting. The Committee had received the ICS Digital Strategy and, whilst pleased that a systemwide strategy was in development, had noted a number of areas for improvement. The Committee had been encouraged to hear plans for the implementation of electronic prescribing. RG advised the Board that the Committee had also focused on the Trust's cash balance, which would receive increased attention as the financial position of the Trust evolved. ***Financial Performance Report*** The Board noted the following key points: • The Trust reported a year-to-date deficit of £8.6m, which was 6.6m away from plan. The position included one-off benefits totalling £5m. Key drivers remained the same as last month, including underperformance of out of county contracts, divisional pay pressures and overspend related to temporary staffing. • All partners within the ICS were forecast to deliver breakeven positions, however there were risks associated. • Continued inflationary costs were impacting the financial position. • Non-elective activity levels were lower than 2019-20, however costs had increased. • There were signs of slippage in the capital programme, and KJ highlighted concern to the Board in relation to the month 11 and 12 spend position. The Board was advised that the team was reviewing profile spend

	and whether there were elements of the programme that could be brought forward from next year. Supply chain issues and delays in receiving goods were also having a negative impact. AM asked for information on the £400k that had been allocated to paediatrics to support mental health, as it was good news and should be communicated. MHo advised that the funding supported improved ward safety for patients who had self-harm or suicidal tendencies. DL advised the Board of the plans in place to support staff with the cost-of-living crisis, noting that an assessment of the impact of paying the Real Living Wage was underway and would be discussed in detail at Finance and Digital Committee. CR informed the Board that this would affect 637 staff across the Trust and GMS. ***Digital Transformation Report*** The Board received the report and noted continued positive progress on digital workstreams and projects. Electronic prescribing go-live dates had been confirmed for November, and planning was underway to introduce paper-lite systems for outpatients; four early adopter areas had been identified. The Board was also advised that a pre-assessment patient health questionnaire was now online and in use.
13	**Audit and Assurance Committee Report** The Committee had received an update from external auditors on the conclusion of value for money work, which had been delayed pending receipt of the CQC report. The Committee was expecting an internal audit review report on risk management at the meeting in November. KC advised the Board that external audit work had now concluded, and the Annual Report and Accounts 2021-22 was scheduled to be laid before parliament that day.
14	**Estates and Facilities Committee Report** The Committee had discussed portering as a key concern, and MN stressed to the Board the significance of the issue, with the number and severity of violence and aggression incidents having a negative impact on the experience of and ability to retain porters. MHo reflected that the experiences of porters were shared by a number of other staff involved in the incidents. Two key workstreams had been established to address issues, one to ensure appropriate and robust staff training and equipment, and one to focus on mental health within the organisation, reviewing Registered Mental Health Nurse use and how patients with mental health needs were cared for in the Trust. A report would be prepared to detail the progress of these workstreams to Quality and Performance Committee and Board of Directors. **Action** MAG asked about the correlation between staff leaving the Trust and the implementation of the Real Living Wage. CR replied that there were some complications around pay within GMS, with some staff on subsidiary company terms and conditions and some staff on Agenda for Change, and differing application of pay awards. The Trust was working closely with GMS to ensure as much equity as possible across the staff groups. The Board recognised the significance of the issue, and noted the work that was ongoing to address.
15	**Any other business** None.
16	**Governor Observations** ME provided the following feedback: • Governors continued to be impressed by the conversations held, and the work that the Board had to cover.

Unconfirmed

	• It was good to hear about recovery improvements, and the Council of Governors looked forward to receiving further information on the CQC report. • Governors were pleased to hear that the implementation of the Real Living Wage was being seriously considered for staff. • Electronic prescribing made a significant positive difference, and it was encouraging to hear the progress of the project within the Trust. • ME asked the Trust to consider plans for any potential blackouts in the coming months.
Close	

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Board Assurance Framework	Additional detail on the reconciliation of risks from the previous Board Assurance Framework to the new version would be provided for assurance.	KC Nov 22	Completed
Estates and Facilities Committee Report	A report would be prepared to detail the progress of violence and aggression workstreams to Quality and Performance Committee and Board of Directors.	MHo Nov 22-Jan 23	In progress

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – NOVEMBER 2022

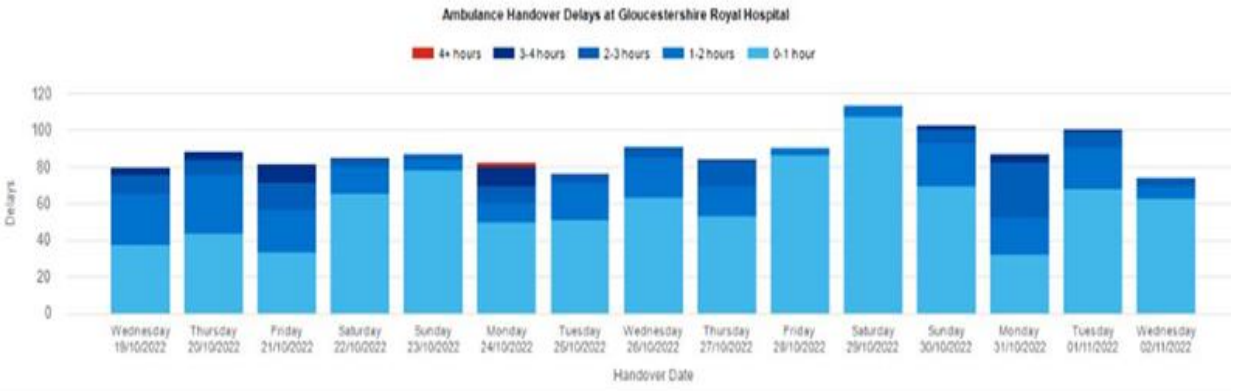
CHIEF EXECUTIVE OFFICER'S REPORT

1 Introduction

1.1 As things settle post publication of the Care Quality Commission inspection findings, I remain heartened by the interest, engagement and support being shown by staff throughout the organisation. We are currently planning for a series of follow-up events to hear more from staff about how they would like to engage with the findings.

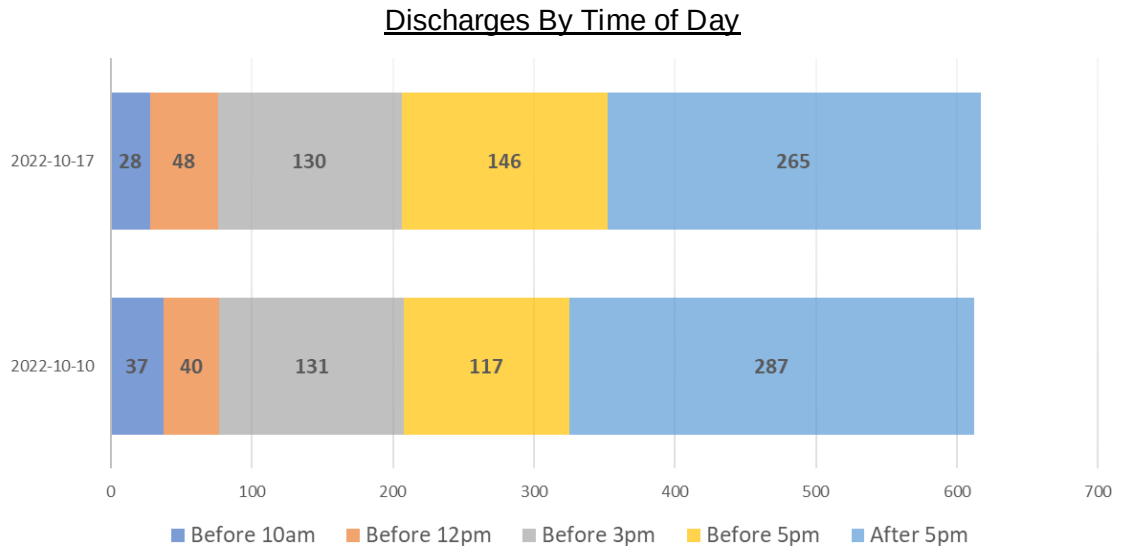
2 Operational Context

2.1 Whilst the Trust remains operationally very busy, recent improvements in urgent and emergency care (UEC) have been maintained. The renewed focus on the things that are in the Trust's gift to control, continue to pay dividends with just one patient waiting more than 4 hours to be offloaded from an ambulance in the last two weeks and 70% of ambulances being handed over within 60 minutes on average in the last seven days. Cat 2 response times continue to improve from the peak of 160 minutes and fall in a range of 27– 80 minutes with a mean of 44 minutes. Of note, there is now limited correlation between hours lost to handover delay and Cat response times and this has been escalated to SWAST (South West Ambulance Service Trust) colleagues. Positively, the Trust is expected to exit Tier 1 of the NHSE/I performance framework by the end of the month, assuming current performance is sustained.



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. 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 was presented to the Quality and Performance Committee last month. Last week there was an average of 21 patients pre-empted across 21 wards at CGH and GRH, a reduction of eight from the prior week. A total of 146 patients were pre-empted last week, compared to 235 in the peak week of 10th October 2022.

2.3 The key areas of operational 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. Despite considerable focus early in the day discharge remains our area of poorest performance with 45% of discharges happening between 5pm and midnight, and just 13% before noon. This work is now being led by the Medical Director reflecting the view that consultants and their juniors have the most to offer with respect to improvement opportunities. It is also hoped that the introduction of electronic prescribing will improve the timeliness of discharge medications which is one reason attributed to delays.



2.4 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. Initial feedback was received last month, reflecting numerous opportunities to reduce the impact at both front and back doors; cumulatively, if fully realised, these have the potential to release demand for more than 100 acute beds. The most significant opportunities lie in "shifting left" patients on Pathway 1 and 2 and better utilisation and productivity of community services such as Rapid Response. There are also additional opportunities for the Trust pursue in relation to diagnostics and improved utilisation of our Frailty Assessment Unit.

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

Official sensitive– not for onward circulation

Summary Dashboard

	104ww+		78ww+		>55ww Cohort (March 78ww)		52ww+		Total Waiting List		Cancer 62 day backlog	RTT
Region	w-e 16 Oct 22 (un-published)	w-e 23 Oct 22 (un-published)	w-e 16 Oct 22 (un-published)	w-e 23 Oct 22 (un-published)	w-e 16 Oct 22 (un-published) >54ww	w-e 23 Oct 22 (un-published >55ww	w-e 16 Oct 22 (un-published)	w-e 23 Oct 22 (un-published)	w-e 16 Oct 22 (un-published)	w-e 23 Oct 22 (un-published)	w-e 23 Oct 22 (un-published)	August 2022
SOUTH WEST	**812**	**780**	**6,206**	**6,272**	**36,771**	**34,438**	**42,399**	**42,646**	**639,951**	**639,808**	**3,493**	**60.8%**
BATH AND NORTH EAST SOMERSET, SWINDON AND WILTSHIRE STP	0	0	260	267	3,647	3,362	4,419	4,451	97,469	97,600	594	*65.8%*
BRISTOL, NORTH SOMERSET AND SOUTH GLOUCESTERSHIRE STP	82	82	1,131	1,178	8,329	7,965	9,502	9,676	113,659	115,273	810	*51.3%*
CORNWALL AND THE ISLES OF SCILLY HEALTH & SOCIAL CARE PARTNERSHIP (STP)	3	2	379	416	2,523	2,406	2,870	2,896	44,788	44,757	117	*60.2%*
DEVON STP	622	597	3,318	3,326	14,810	13,926	16,828	17,044	176,233	175,521	1,042	*51.4%*
DORSET STP	85	79	716	680	4,200	3,752	4,840	4,666	92,038	91,693	393	*62.2%*
GLOUCESTERSHIRE STP	0	0	32	36	920	817	1,214	1,200	66,863	65,907	270	*70.1%*
SOMERSET STP	20	20	370	369	2,342	2,210	2,726	2,713	48,901	49,057	267	*68.1%*

>55WW Cohort (March 78ww): This cohort refers to the patients who will have waited over78 weeks by the end of March if not seen prior to this point

3 | National Elective Recovery Programme Board

Source: WLMDS

3 Key Highlights

3.1 Considerable work has gone into developing the **action plans** required by the Care Quality Commission in relation to statutory breaches identified in their report. These were submitted on the 1st November 2022 and oversight of these plans will be held at Committee level, with assurance back to the Board in the usual way.

3.2 Last week we welcomed the CQC back on-site to undertake an announced inspection of **radiotherapy and brachytherapy services**. The final report is awaited but feedback on the day was positive. Huge thanks for the exhaustive preparation led by Bridget Moore, Radiotherapy Service Manager, Penny Latimer, Head of Radiotherapy Physics and Dr Jess Bailey, Radiotherapy Clinical Lead. Unlike the Core Service inspections, this isn't rated in the usual way but is reflected as "a pass or fail" judgment however written reports are still provided.

3.3 Following concerns raised by myself and other CEOs in relation to the **regulatory risk** associated with addressing ambulance handover delays sitting solely with acute providers, I was pleased to join a meeting of Chief Executives from Trusts in Tier 1. The meeting was Chaired by Pauline Philip, National Director for Urgent and Emergency Care and attended by the new Chief Inspector of Hospitals, Sean O'Kelly and his Deputy along with regional CQC Heads of Inspection and Elizabeth O'Mahoney, SW Regional Director NHSE/I. Trusts were invited to share their concerns and in particular in relation to the siloed nature of inspections and judgements in a model that was responding to system risk. Further work has been agreed and GHFT has volunteered to join the working group.

3.4 This week saw the first phase of roll-out of the Trust's **electronic prescribing system** with the early adopter wards at Cheltenham General ahead of full roll-out to CGH on 9th November and GRH on the 23rd. Early signs are positive with presribers describing the systems as very easy to use and "a massive step forward"; nursing colleagues have been proactive in reporting their ward drug rounds have been "quicker and easier to undertake"

– this is especially good news as these rounds often consume many hours of a qualified nurses' hours on duty. Floor walkers have, again, characterised the roll-out and have been hugely appreciated by all. As usual, learning from these early adopters is being carried in the next phases of roll-out. Huge thanks to Mark Hutchinson and the digital team who are too many to mention.

3.5 In comings and goings, this month we said goodbye to **Vivien Mortimer**, Chief Midwife and Divisional Director of Quality & Nursing Women's and Children's Services. A huge number of colleagues, past and present, attended a surprise tea party to thank and acknowledge the huge contribution that Viv has made over more than two decades to women and children during her time in the Trust. We look forward to welcoming her back as a bank midwife!

3.6 Following a competitive process, I'm pleased to confirm that **Kate Hellier** has been appointed as Deputy Medical Director following the decision by Alex D'Agapeyeff to step down after five years in the role. Kate brings a wealth of clinical and management experience as clinical lead for stroke, specialty director, Chief of Service for Diagnostic and Specialties Division and one of the Trust's first Gloucestershire Safety and Quality Improvement Academy (GSQIA) Gold Coach. More recently, Kate has played a pivotal role in the Trust's digital programme.

3.7 Finally, I am delighted that *One Gloucestershire* was winner in the Health Service Journal (HSJ) Patient Safety Awards in the Safeguarding Category for the work led by Shona Duffy, Homeless Specialist Nurse. This is another in an increasingly long line of national recognitions for this pioneering work.

Deborah Lee
Chief Executive Officer
3rd November 2022

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	8	Enclosure Number:	3
Date	10 November 2022		
Title	Board Assurance Framework		
Author /Sponsoring Director/Presenter	Kat Cleverley, Trust Secretary		

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

Summary of Report

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

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

A risk rationalisation exercise had been completed to provide assurance to the Board that risks had been captured within the new BAF or in divisional or Trust risk registers. There was some additional review work to be undertaken on the IT and Digital risks, which would form part of the Executive team review planned for 5 December.

A new external partnerships risk was in progress and would be presented at the next Board meeting for review.

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

Recommendation

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

Enclosures

- Board Assurance Framework November 2022

November 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	Oct 2022	DOP	3x4=12	3x2=6	5x4=20
3. Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other							
SR3	Failure to deliver the Trust's enabling Quality Strategy and implement the Quality Framework	July 2019	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 October 2022

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

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

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ACTIONS PLANNED

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

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

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

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

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

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

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

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

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

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

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

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

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

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

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

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	9	Enclosure Number:	4
Date	10 November 2022		
Title	Trust Risk Register		
Author **Director/Sponsor**	Lee Troake, Head of Risk, Health & Safety Mark Pietroni Medical Director and Director of Safety		

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

Summary of Report

Purpose

The Trust Risk Register (TRR) enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. Following Risk Management Group on 2 November 2022 the following changes to the Trust Risk Register have been made:

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 at 7-11-22

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
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 Recrtuitment 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
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
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
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 proramme 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	31/10/2022	Dobb, Michael	Trust Risk Register
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	30/12/2022	Lanceley, Simon	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.	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	Diagnostics and Specialties	Statutory	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

		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	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														
S2976Breast	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	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
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
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints,	Governance process Reporting structure Patient safety and H&S advisors monitoring the system daily Monthly performance reports on new, overdue risks, partially completed risks, uncontrolled risks and overdue actions etc	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis test risk module Weekly meeting and action plan for DATIX Cloud	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	12/11/2022	Troake, Lee	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	09/11/2022	Rees, Linford	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 rind 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	30/11/2022	Hutchinson, Becky	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
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
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	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 Use of overnight recovery prohibited by Trust following CQC ruling	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	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	19/12/2022	Ball, Natalie	Trust Risk Register

	ward-based care or require care on DCC.	by Trust following CQC rating Recovery asked to contact Silver Command when site are seeking to keep a patient in recovery overnight as of October 2022.	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								Quality Delivery Group			Committee			
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 developoment 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	30/12/2022	Hopewell, Abigail	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	30/11/2022	Stephens, Lisa	Trust Risk Register
M3682Emer	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	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	30/11/2022	McMahon, Rory	Trust Risk Register
WC3685OBS	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	30/11/2022	Harris, Rachael	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
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
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 - Monthly System review and NHSEI Returns -Monthly Management Accounts including detailed forecasts	Development of Divisional Recovery Plan Performance Management of Delivery of Recovery Plans Financial Recovery Plan developed and reported to Finance & Digital Committee	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	18/11/2022	Johnson, Karen	Trust Risk Register
C3898POD	The risk of delayed arrivals, poor candidate experience and withdrawals resulting in an adverse impact on the Trust's overseas nurse recruitment programme and representational harm as a result of the lack of Trust accommodation availability	Trust accommodation provided by Sovereign Housing with contract management provided by Gloucestershire Managed Services. Arrival timescales and cohort sizes provided to Sovereign in advance to enable availability matching.	Establish Trust contract owner Review of existing accommodation documentation Participation in system wide accommodation discussions Develop action plan for releasing accommodation capacity Develop communication approach Process for providing guarantor status for rental agreements	Corporate, Gloucestershire Managed Services	Workforce	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director for People & OD	People and OD Delivery Group	Other	People &OD Delivery Group	People and OD Committee	30/12/2022	Tunnell, Deborah	Trust Risk Register
	The risk of fires caused by lithium battery chargers affecting the safety of	Some of the units are placed in fire-rated hazard rooms.	To review hazard rooms with clinical teams and Fire team Identify any works required for alternative locations Set up lessons learnt event To sign off installation as required standard To review usage and risk report to inform prioritisation To roll-out new SVF process	Corporate, Diagnostics and Specialties, Gloucestershire							Risk Management Group, Trust						

C3930 S&T E&F	battery charger) affecting the safety of all users, but particularly affecting ward environments.	Some of the units have a better level of installation.	To ascertain staff training requirements and roll-out Fire team trainer to add information to mandatory training package Rolling replacement programme for batteries Check required on risk assessments To broker discussions regarding funding impacts Conclude RAG audit of areas across the Trust	Managed Services, Medical, Surgical, Women's and Children's	Safety	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk		Risk Management Group, Trust Health and Safety Committee			Other	30/10/2022	Turner, Bernie	Trust Risk Register
D&S3558PharmEquip	The risk of breakdown of air handling unit (due to age)leading to poorer patient outcomes for oncology and parenteral nutrition patients. The risk of loss of service and that that	Planned preventative maintenance by GMS Outsourcing for some products in place which would reduce impact somewhat however this is not reliable due to	Liaise with GMS AHU motors report of AHU status check on chiller at weekends	Diagnostics and Specialties, Gloucestershire Managed Services	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk		Divisional Board - D & S	Medicines Optimisation Committee		Cancer Services Management Board	28/02/2023	White, Amanda	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 urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams. Development of an Improvement Programme	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
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 4. C.Diff reduction action plan in place	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	15/12/2022	Bradley, Craig	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 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	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 avalability of hoverjacks Set up register of ward training 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 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 #	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	31/10/2022	Bradley, Craig	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 DISN 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 12 months using CCG funding 5) 3 WTE 12 month fixed term dedicated inpatients diabetes nurses	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 Recruitment events and Staff development opportunity to be a DSN	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
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
			Review performance and advise on improvement Review service schedule														

D&S2517PathEquip	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	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)	Possible - Monthly (3)	12	8 -12 High risk	Estates and Strategy	Divisional Board - D & S	Pathology Management Board			31/12/2022	Lewis, Jonathan	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 reolace 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 To update on IGIS programme	Medical, Gloucestershire Managed Services	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
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	30/12/2022	Freebrey, Clare	Trust Risk Register
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 (COTE 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.	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 peressure ulcers 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 camaaian 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 regards to EPR. Implement training programme in management of patient pressure ulcers in ED	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	31/10/2022	Bradley, Craig	Trust Risk Register

			Ward 7a W170891 training with HCA's to allow them to assist registered nurses with assessing patient skin and documenting on EPR														

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 26 October 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 and Emergency Care*** Urgent care remained a key challenge, however progress was being made on ambulance handover times following the Trust's "Reset Week". Additional actions in place to support continued progress included a move towards simple discharges, improved escalation processes and policy, and restructure of site meetings to ensure they were less administrative and more clinically-led. Importance of divisional leadership and ability to focus on multiple priority areas. The Committee expressed some concern in relation to temporary corridor care arrangements. Patients receiving corridor care were closely monitored and regularly risk assessed to ensure optimal care, and the Trust was boarding and pre-empting patients to maximise flow. ***Maternity Services*** Stroud Maternity Unit had been temporarily closed due to ongoing staffing issues within the wider midwifery service. The Committee heard how committed the staff were to the unit, and how upset they were at this temporary closure. Although the Committee was advised of some cultural issues within the service, assurance was provided that a culture improvement plan was in place to address any problems.	The Trust continued to review and improve its own processes, with system discussions ongoing. Assurance on divisional leadership capacity and capability was confirmed and focus on dynamic risk assessments detailed. The service would ensure a link to the Director for People and Organisational Development, and the wider workforce transformation programme that was in place.
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. • The Trust's cancer performance was good, however achievement of 62-day standard continued to be challenged. • An echocardiography recovery plan was in place, however the Trust remained a good performer in this area and the Committee was assured that there was confidence that patients were gaining access to the appropriate pathways. • The Trust was changing its mortality database system to the Summary Hospital-level Mortality Indicator (SHMI) as it was more sensitive and would produce more accurate data. • Friends and Family Test scores had slightly decreased in the Emergency Department. • The Committee was advised that the PALS team was much-improved with a strong team in place, despite continued high contacts. • Some challenges noted with VTE risk assessment compliance.	A deep dive into the Trust's 62-day cancer standard performance was being undertaken. Additional information in relation to nursing and junior doctor leadership and involvement in winter planning and bed base cover would be received as part of the Winter Plan report in November. The implementation of electronic prescribing would result in significant improvement in this area.
Trust Risk Register	No changes had been made to the Risk Register. Good progress continued with Never Event improvement work. Boarding processes for patients receiving corridor care had	A range of executive actions and systems in place were described in relation to boarding, and were

	contributed to significantly improved ambulance handover times, however new risks and concerns to these patients had been exposed and were closely monitored and assessed.	confirmed as a significant area of focus. Staff feedback would be sought and considered. Consideration to be given to appropriate format of reporting to committee e.g., numbers of patients, impact, locations, length of stays and staff feedback.
Serious Incidents Report	Three serious incidents had been reported since September. There had been no further Never Events since the last report. Four further HSIB cases had been reported. The ongoing corporate governance review included a full review of committee structures and how assurance fed into Board level committees to ensure risk areas were highlighted from delivery and operational groups to Board level. Staff vacancies, sickness rates and activity levels continued to have a negative impact on completion of complaints, moderate harm Duty of Candour letters, and serious incident investigations.	The wider governance review would contribute towards relieving burdens on the team. The executive team was also due to discuss plans to increase capacity. The Committee discussed aspects of the report in detail and noted the related action plans in place.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Regulatory Update	The Committee received a thorough written report outlining progress against CQC action plans.	The Committee would continue to receive regular updates.
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.		

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors			
Agenda item:	**10**	**Enclosure Number:**	**5**
Date	10 November 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		

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 report summarises the key highlights and exceptions in Trust performance for the September 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 16-25 and a selected number of metrics have been highlighted below.

Number of e-coli cases

During September we had 11 health care associated cases. Reducing E.coli BSI and all Gram negative bacteraemia continue to bea focus of the IPC strategy specifically related to urinary tract infection prevention, improving patient hydration and improving the management and care of invasive device. All patients with a healthcare associated E.coli BSI have a rapid review to understand contributing factors and a subsequent post infection review is completed if there lapses in care that require action

Number of trust apportioned Clostridium

During September there were a total of 9 C. difficile cases associated with health care (2 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.

MSSA infection rate per 100,000 bed days

During September we had 3 health care associated MSSA blood stream infections; compared to 10 health care associated cases in August. 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. It is also noted that there has been a regional increase in MSSA BSIs and the trust plans to support a regional reduction collaborative.

Number of Klebsiella cases

During September we had 3 health care associated cases of Klebsiella blood stream infections. Reducing Klebsiella BSI and all Gram negative bacteraemia continue to be a focus of the IPC strategy specifically related to urinary tract infection prevention, improving patient hydration and improving the management and care of invasive device. All patients with a healthcare associated Klebsiella BSI have a rapid review to understand contributing factors and a subsequent post infection review is completed if there lapses in care that require action

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 ICB 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.

% of adult inpatients who received a VTE risk assessment

The new electronic prescribing system will automatically record the risk assessment for all patients. Results from this will drive any further improvement work, this is likely to be in the new year.

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, we are currently evaluating this initiative however patients are now waiting in an ambulance for much less time. 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.

Falls Update

The number of falls resulting in moderate or severe harm is 9 in September and the 12-month rolling average is 6 per month. All of these cases are reviewed in the weekly Preventing Harm Hub and rapid feedback on safety improvements is given. The Trust Falls Prevention plan is focussed on evidence-based approach to falls risk assessment and interventions. Recently, NHS England carried out an onsite peer review at our request, we are awaiting feedback on their recommendations. It is important for this data to be presented as a rate per 1,000 bed days and that change will be made in the new QPR.

Friends and Family Test

The Trust had 5937 responses to FFT in September 2022, and the overall Trust FFT positive score has seen a slight decrease in positive score this month to 89.2%. This is largely due to decreases in the positive FFT score for unscheduled care. 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 26-38 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.

Urgent and Emergency Care

September continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 72.59%to70.52% compared to the previous month. Ambulance handover delays decreased for 30-60 minutes handovers delays however increased 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

During September the overall diagnostic performance has deteriorated by between 2-3%dropping to an unconfirmed 21.67% compared to 18.8% last month. The key change being a swing in Echo performance, with an additional 275 breaches being recorded in month.

Cancer

For cancer, performance data showed the Trust met 2 out of 9 standards with 6 out of 9 standards above national average clearly showing a challenging month. The Trust did not meet 28 day Faster Diagnosis Standard performance in August on provisional submission but final submission should see it meeting the standard. 2ww performance continued to be impacted by skin and lower GI.62 day standard performance for August was 59.3% which will rise following final submission to above 60% 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. >62 day and >104 day numbers continue to reduce slowly.

Elective Care

For elective care, the RTT performance did not meet the national standard, demonstrating a slight dip in performance in month. The month-end submission is anticipated to be 70.8%, which remains considerably higher than the national average of approx. 60%. The total incompletes has increased slightly in month and the unconfirmed September position is expected to be around 65,500 (compared to 65,035 last month).The number of patients waiting over 52 weeks has decreased, reducing from 1,397 in August to approximately 1,250 in September. Focus continues to be placed on patients on long waiting patients with the recovery plans of Oral Surgery and Clinical Haematology now starting to make a difference. The number of patients waiting 70+ weeks has reduced by approximately 30.The number of patients over 78 weeks has halved, and as of 13 October there are 26 patients in total. The Trusts continues to have zero 104wbreaches.

The Elective Care Hub continues to conclude contact with patients >18 weeks on an open pathway, which has been delayed of late due to staff turnover and vacancies. Postal responses are still being received from patients, later than anticipated and potentially due to the number of postal strikes of late. Work ins ongoing with Ophthalmology to support the review of their FU backlog and this specific project will continue for several months. To dovetail this, the intention is to expand this to other services with FU backlogs, and feedback/comment is awaited from specialties before this can proceed.

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 September 2022 – Dashboard

QPR September 2022 – SPC Document

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period *September* 2022

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

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

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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

Indicator		Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	500	523	467	446	504	330	328	315	449	496	552	587	556
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	692	752	1074	952	1057	1093	1263	1357	1434	1203	1081	1169	1118
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	72.51%	73.80%	74.54%	73.36%	73.67%	70.92%	69.98%	68.67%	69.73%	73.02%	70.62%	72.59%	72.27%
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	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%	55.41%	59.43%	56.00%	57.39%	57.95%
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	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.81%	73.01%	72.52%	71.41%	71.58%	70.66%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	1598	1590	1492	1430	1273	1112	1125	1231	1248	1367	1439	1397	1255
% 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	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.77%	18.99%	19.38%	20.76%	18.83%	21.67%
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	92.00%	93.40%	92.10%	92.20%	87.00%	94.60%	94.00%	89.90%	93.40%	86.50%	87.70%	89.80%	88.60%
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	90.80%	89.80%	88.60%	84.80%	87.40%	93.90%	91.30%	89.70%	95.50%	94.10%	93.70%	89.50%	92.30%
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	95.90%	97.80%	96.10%	94.70%	95.50%	97.70%	98.00%	95.10%	96.80%	94.20%	95.20%	92.70%	93.40%
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%	99.50%	99.50%	99.60%	100.00%	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	99.40%	100.00%	98.80%	100.00%	99.50%	99.50%	100.00%	94.50%	91.10%	74.40%	77.00%	93.70%	87.10%
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	88.10%	91.50%	95.20%	94.30%	88.40%	90.80%	91.00%	88.70%	95.90%	89.70%	84.90%	77.90%	84.50%
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	90.80%	76.50%	85.30%	91.50%	85.90%	80.00%	90.90%	85.20%	79.20%	88.00%	90.00%	91.30%	93.70%
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	72.10%	84.10%	70.60%	73.10%	75.00%	69.70%	80.60%	70.40%	76.90%	62.90%	59.50%	71.70%	67.30%
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	71.00%	71.80%	72.20%	64.70%	68.40%	71.30%	78.30%	64.30%	63.60%	53.30%	52.40%	59.30%	63.00%

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

Measure	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	% growth from previous year Monthly (Sep)	YTD
GP Referrals	8,301	8,148	8,517	7,167	7,919	8,166	9,327	8,275	9,270	9,067	8,970	9,562	9,094	9.6%	6.6%
OP Attendances	52,912	49,516	56,469	47,728	51,666	49,139	57,211	47,641	55,835	51,072	50,150	52,302	52,419	-0.9%	0.1%
New OP Attendances	16,658	15,956	18,297	15,355	16,423	16,109	18,631	15,012	17,715	16,457	16,391	17,004	17,303	3.9%	2.9%
FUP OP Attendances	36,254	33,560	38,172	32,373	35,243	33,030	38,580	32,629	38,120	34,615	33,759	35,298	35,116	-3.1%	-1.2%
Day cases	4,310	4,187	4,536	3,939	4,121	4,202	4,958	4,103	4,719	4,619	4,680	5,198	5,144	19.4%	4.9%
All electives	5,237	5,217	5,492	4,939	4,798	5,049	5,980	4,978	5,789	5,609	5,629	6,146	6,171	17.8%	4.9%
ED Attendances	13,186	13,044	11,988	10,943	11,433	10,545	12,306	11,616	12,551	12,092	12,596	11,915	11,888	-9.8%	0.3%
Non Electives	4,243	3,998	3,867	3,445	3,461	2,948	3,311	3,036	3,370	3,350	3,319	3,091	3,009	-29.1%	-26.7%

Trust Scorecard - Safe (1)

Note that data in the Trust Scorecard section is subject to change.

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Infection Control																
COVID-19 community-onset - First positive specimen <=2 days after admission	117	191	126	131	182	155	218	147	64	92	127	62	38	303	No target	
COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 days after admission	12	17	28	52	64	86	120	126	58	32	91	32	77	216	No target	
COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-14 days after admission	0	1	1	22	21	36	49	37	30	25	53	15	82	92	No target	
COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=15 days after admission	1	9	5	25	31	75	78	68	41	29	90	31	121	138	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	1	0	0	0	0	0	1	0	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	7	4	12	8	3	7	8	15	8	12	4	10	9	35	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	4	1	8	5	2	5	6	10	6	7	2	7	7	23	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	3	3	4	3	1	2	2	5	2	5	2	3	2	12	<=5	
Clostridium difficile - infection rate per 100,000 bed days	23.5	13	40.6	27.3	10.2	25.9	27	53.9	27.6	42.9	13.9	37	25.9	41.3	<30.2	
Number of MSSA bacteraemia cases	5	0	2	5	3	3	2	2	1	5	5	10	3	8	<=8	
MSSA - infection rate per 100,000 bed days	16.8		6.8	17	10.2	11.1	6.8	7.2	3.5	17.9	17.4		11.1	9.4	<=12.7	
Number of ecoli cases	3	5	7	5	5	5	2	9	4	4	7	6	11	17	No target	
Number of pseudomona cases	1	0	1	0	0	0	0	0	1	0	1	2	1	1	No target	
Number of klebsiella cases	4	2	2	2	0	0	1	1	3	0	1	3	3	4	No target	
Number of bed days lost due to infection control outbreaks	1	93	176	453	444	637	335	74	2	12	52	51	81	88	<10	>30

Trust Scorecard - Safe (2)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Patient Safety Incidents																
Number of patient safety alerts outstanding	0	0	1	1											Zero	
Number of falls per 1,000 bed days	7	6.7	7	6.7	7.3	7.6	8.2	7.5	6.9	7.6	7.5	6	6.7	7.3	<=6	
Number of falls resulting in harm (moderate/severe)	5	5	3	9	5	10	9	4	4	4	5	5	9	12	<=3	
Number of patient safety incidents - severe harm (major/death)	6	7	10	7	7	10	28	6	8	10	14	13	12	24	No target	
Number of category 2 pressure ulcers acquired as in-patient	19	22	41	43	37	40	50	46	39	34	24	32	26	119	<=30	
Number of category 3 pressure ulcers acquired as in-patient	0	1	2	4	2	1	2	2	3	1	1	0	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	1	4	9	9	12	14	10	12	18	14	10	7	8	44	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	6	1	7	12	13	7	8	12	21	10	2	5	7	43	<=5	
RIDDOR																
Number of RIDDOR			3	5	10	10	8	5	10		10	2	2		SPC	
Safeguarding																
Number of DoLs applied for	69	53	48	68	64	53	69	47	67	69	55	72	76	183	TBC	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	4	6	1	5	2	3	4	3	7	6	3	4	3	16	TBC	
Total attendances for infants aged < 6 months, other serious injury	0	0	0	0	0	1	0	0	0	0	1	2	0	0	TBC	
Total admissions aged 0-17 with DSH	18	35	39	18	46	24	35	32	29	34	29	17	31	95	TBC	
Total ED attendances aged 0-17 with DSH	73	102	115	54	125	69	113	90	75	93	87	61	92	258	TBC	
Total number of maternity social concerns forms completed	72	58	65	52	67	70	71	72	72	80	78	101	46	222	TBC	
Total admissions aged 0-17 with an eating disorder	9	11	5	8	5	7	10	7	10	11	12	10	7	28	TBC	

Trust Scorecard - Safe (3)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Serious Incidents																
Number of never events reported	0	1	1	2	1	2	0	0	0	1	0	0	0	1	Zero	
Number of serious incidents reported	6	4	4	4	4	3	4	6	5	4	6	3	4	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	92.0%	92.3%	90.7%	90.9%	87.5%	87.1%	90.7%	90.8%	88.5%	80.8%	79.9%	87.2%	82.3%	86.8%	>95%	

Trust Scorecard - Effective (1)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Maternity																
% of women on a Continuity of Carer pathway	10.90%	11.80%	10.30%	9.60%	10.20%	14.70%	12.60%	10.10%	9.10%	9.30%	8.70%	8.60%	10.40%	9.10%	No target	
% C-section rate (planned and emergency)	30.42%	31.59%	31.63%	32.44%	33.19%	31.45%	33.48%	34.48%	35.65%	37.93%	35.34%	34.71%	35.33%	36.06%	No target	
% emergency C-section rate	16.76%	17.76%	17.05%	15.61%	17.77%	15.72%	18.03%	19.08%	19.57%	21.55%	19.40%	17.79%	19.96%	20.09%	No target	
% of women booked by 12 weeks gestation	88.8%	91.0%	91.7%	92.6%	91.1%	90.5%	92.1%	90.0%	92.2%	89.4%	89.1%	92.6%	88.2%	90.6%	>90%	
% of women that have an induced labour	25.41%	25.00%	25.66%	24.95%	29.42%	33.09%	31.21%	30.52%	35.14%	29.49%	31.21%	29.89%	26.89%	31.73%	<=33%	>30%
% stillbirths as percentage of all pregnancies	0.00%	0.19%	0.00%	0.00%	0.43%	0.00%	0.64%	0.00%	0.00%	0.00%	0.22%	0.22%	0.40%	100.00%	<0.52%	
% of women smoking at delivery	10.16%	10.07%	8.80%	11.86%	12.58%	10.78%	11.46%	8.88%	9.11%	8.76%	9.13%	12.47%	8.57%	8.92%	<=8.0%	
% breastfeeding (discharge to CMW)	53.9%	48.0%	50.3%	48.1%	47.1%	46.0%	46.3%	45.5%	48.8%	59.8%	59.9%		62.1%	60.4%		
% breastfeeding (initiation)	80.8%	81.1%	79.5%	76.3%	78.8%	76.8%	78.2%	78.7%	77.6%	81.5%	78.6%	61.8%	78.8%	79.3%	>=81%	
% PPH >1.5 litres	4.9%	4.5%	3.4%	4.9%	3.6%	2.2%	3.9%	3.5%	2.4%	4.0%	4.5%	4.3%	3.5%	3.2%	<=4%	
Number of births less than 27 weeks	1	2	2	0	1	0	1	3	0	4	0	1	2	7		
Number of births less than 34 weeks	18	13	9	10	7	4	9	13	8	15	4	8	11	36		
Number of births less than 37 weeks	47	49	32	44	33	19	43	49	35	50	38	38	44	134		
Number of maternal deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
Total births	558	546	537	497	471	413	473	442	465	475	471	466	514	1,384		
Percentage of babies <3rd centile born > 37+6 weeks	1.4%	1.1%	1.9%	2.4%	3.2%	1.7%	4.2%	1.4%	2.4%	0.6%	2.1%	2.1%	2.5%	1.4%		
Mortality																
Summary hospital mortality indicator (SHMI) - national data	1	1	1	1.1	1.1	1.1	1.1	1.1							NHS Digital	
Hospital standardised mortality ratio (HSMR)	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	115.6	113.8	109.4	108	111.7	114.6	115.9	105.6						Dr Foster	
Number of inpatient deaths	163	183	191	189	218	183	179	185	174	172	170	169	167	531	No target	
Number of deaths of patients with a learning disability	2	2	4	1	3	1	1	3	2	2	1	0	5	7	No target	

Trust Scorecard - Effective (2)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Readmissions																
Emergency re-admissions within 30 days following an elective or emergency spell	9.04%	8.18%	8.10%	8.10%	8.05%	7.32%	7.06%	7.52%	7.49%	7.78%	7.49%	6.89%		7.60%	<8.25%	>8.75%
Research																
Research accruals	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%	79.4%	69.3%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	84.9%	66.7%	72.7%	75.4%	46.3%	91.0%	96.3%	97.7%	97.3%	96.3%	98.3%		100.0%	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%	82.40%	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%	73.50%	72.00%	>=75%	<65%
Trauma & Orthopaedics																
% of fracture neck of femur patients treated within 36 hours	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%
% fractured neck of femur patients meeting best practice criteria	56.10%	43.55%	50.77%	47.95%	57.97%	41.51%	50.68%	24.32%	26.67%	27.27%	37.74%	43.33%		25.93%	>=65%	<55%

Trust Scorecard - Caring (1)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Friends & Family Test																
Inpatients % positive	86.4%	85.0%	88.0%	87.8%	89.1%	87.1%	88.3%	88.0%	87.2%	87.2%	90.0%	91.2%	89.5%	87.5%	>=90%	<86%
ED % positive	60.9%	66.7%	68.0%	78.8%	78.6%	67.6%	63.5%	62.7%	66.9%	69.8%	68.1%	71.5%	68.6%	66.5%	>=84%	<81%
Maternity % positive	87.7%	82.4%	89.7%	84.3%	94.1%	91.9%	85.7%	78.2%	85.2%	88.9%	91.8%	82.1%	88.4%	83.6%	>=97%	<94%
Outpatients % positive	93.2%	93.3%	93.9%	94.7%	94.3%	93.4%	93.2%	93.1%	92.8%	93.2%	93.0%	94.2%	94.1%	93.0%	>=94.5%	<93%
Total % positive	86.2%	85.4%	89.4%	91.2%	91.0%	88.6%	88.0%	87.2%	87.4%	88.3%	88.5%	89.8%	89.2%	87.6%	>=93%	<91%
Number of PALS concerns logged	264	274	248	230	266	248	254	229	253	231	285	329	312	713	No Target	
% of PALS concerns closed in 5 days	76%	65%	78%	71%	65%	73%	78%	67%	75%	77%	70%	77%	72%	73%	>=95%	<90%
MSA																
Number of breaches of mixed sex accommodation	0	0	0	0	0	0	0	21	7	23	17	47	56	51	<=10	>=20

Trust Scorecard - Responsive (1)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Cancer																
Cancer - 28 day FDS (all routes)	78.3%	81.0%	78.4%	78.8%	73.7%	82.9%	81.7%	78.4%	79.8%	73.5%	76.7%	74.5%	80.7%	77.1%	>=75%	
Cancer - urgent referrals seen in under 2 weeks from GP	92.0%	93.4%	92.1%	92.2%	87.0%	94.6%	94.0%	89.9%	93.4%	86.5%	87.7%	89.8%	88.6%	90.1%	>=93%	<90%
Cancer - 2 week wait breast symptomatic referrals	90.8%	89.8%	88.6%	84.8%	87.4%	93.9%	91.3%	89.7%	95.5%	94.1%	93.7%	89.5%	92.3%	93.2%	>=93%	<90%
Cancer - 31 day diagnosis to treatment (first treatments)	95.9%	97.8%	96.1%	94.7%	95.5%	97.7%	98.0%	95.1%	96.8%	94.2%	95.2%	92.7%	93.4%	95.4%	>=96%	<94%
Cancer - 31 day diagnosis to treatment (subsequent – drug)	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%	100.0%	>=98%	<96%
Cancer - 31 day diagnosis to treatment (subsequent – surgery)	88.1%	91.5%	95.2%	94.3%	88.4%	90.8%	91.0%	88.7%	95.9%	89.7%	84.9%	77.9%	84.5%	91.1%	>=94%	<92%
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	99.4%	100.0%	98.8%	100.0%	99.5%	99.5%	100.0%	94.5%	91.1%	74.4%	77.0%	93.7%	87.1%	88.5%	>=94%	<92%
Cancer - 62 day referral to treatment (urgent GP referral)	71.0%	71.8%	72.2%	64.7%	68.4%	71.3%	78.3%	64.3%	63.6%	53.3%	52.4%	59.3%	63.0%	61.2%	>=85%	<80%
Cancer - 62 day referral to treatment (screenings)	90.8%	76.5%	85.3%	91.5%	85.9%	80.0%	90.9%	85.2%	79.2%	88.0%	90.0%	91.3%	93.7%	82.1%	>=90%	<85%
Cancer - 62 day referral to treatment (upgrades)	72.1%	84.1%	70.6%	73.1%	75.0%	69.7%	80.6%	70.4%	76.9%	62.9%	59.5%	71.7%	67.3%	70.4%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	9	10	4	3	2	2	5	2	2	15	12	12	12	19	Zero	
Number of patients waiting over 104 days without a TCI date	18	21	23	25	14	22	50	73	58	47	46	51	48	178	<=24	
Diagnostics																
% waiting for diagnostics 6 week wait and over (15 key tests)	18.26%	18.83%	17.03%	18.60%	20.87%	18.27%	18.03%	18.77%	18.99%	19.38%	20.76%	18.83%	21.67%	19.38%	<=1%	>2%
The number of planned/surveillance endoscopy patients waiting at month end	1,435	1,397	1,410	1,422	1,334	1,269	1,286	1,365	1,367	1,371	1,367	1,384	1,401	1,368	<=600	
Discharge																
Patient discharge summaries sent to GP within 24 hours	61.70%	60.5%	61.4%	58.4%	58.7%	62.0%	59.8%	60.1%	60.7%	59.5%	62.7%	64.3%		60.1%	>=88%	<75%

Trust Scorecard - Responsive (2)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Emergency Department																
ED: % total time in department - under 4 hours (type 1)	60.00%	62.17%	62.96%	61.97%	63.17%	59.14%	57.07%	54.52%	55.41%	59.43%	56.00%	57.39%	57.95%	56.46%	>=95%	<90%
ED: % total time in department - under 4 hours (types 1 & 3)	72.51%	73.80%	74.54%	73.36%	73.67%	70.92%	69.98%	68.67%	69.73%	73.02%	70.62%	72.59%	72.27%	70.52%	>=95%	<90%
ED: % total time in department - under 4 hours CGH	77.05%	83.00%	79.80%	79.03%	79.17%	73.72%	65.48%	65.44%	65.10%	69.81%	66.22%	63.29%	65.97%	66.78%	>=95%	<90%
ED: % total time in department - under 4 hours GRH	51.82%	52.48%	54.91%	53.96%	55.55%	52.12%	52.88%	49.00%	50.54%	54.23%	50.84%	54.51%	54.10%	51.28%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	15	53	448	631	653	394	606	690	616	634	629	674	642	1,940	Zero	
ED: % of time to initial assessment - under 15 minutes	28.0%	30.3%	30.2%	37.4%	35.4%	30.0%	22.9%	20.7%	36.9%	39.1%	41.1%	45.8%	41.0%	39.1%	>=95%	<92%
ED: % of time to start of treatment - under 60 minutes	22.8%	27.8%	27.1%	32.6%	31.8%	26.1%	23.1%	22.2%	22.3%	25.8%	23.0%	28.7%	30.2%	25.8%	>=90%	<87%
Number of ambulance handovers over 60 minutes	692	752	1,074	952	1,057	1,093	1,263	1,357	1,434	1,203	1,081	1,169	1,118	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%	15.63%	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%	33.59%	25.76%	>=95%	
% of ambulance handovers 30-60 minutes	13.85%	14.55%	14.21%	13.90%	15.56%	13.25%	13.17%	13.32%	16.72%	18.66%	19.80%	20.90%	21.15%	16.34%	<=2.96%	
% of ambulance handovers over 60 minutes	19.16%	20.92%	32.67%	29.68%	32.62%	43.90%	50.70%	57.38%	53.39%	45.26%	38.77%	41.60%	42.53%	51.81%	<=1%	>2%
Operational Efficiency																
Cancelled operations re-admitted within 28 days	80.60%	73.75%	74.03%	80.23%	71.60%	93.48%	95.59%	76.90%	81.48%	78.05%	87.18%	61.20%	77.10%	78.50%	>=95%	
Urgent cancelled operations	1	44	24	1	1	0	0	0	0	0	0	0	0	0	No target	
Number of patients stable for discharge	179	178	212	161	238	251	256	233	238	211	229	253	227	227	<=70	
Number of stranded patients with a length of stay of greater than 7 days	472	467	502	498	490	536	537	512	492	497	490	532	564	500	<=380	
Average length of stay (spell)	5.32	5.47	6.03	6.02	6.13	6.67	6.68	6.62	6.68	6.32	6.16	6.37	6.33	6.54	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.99	6.22	6.97	7	6.78	7.93	8.06	7.91	8.03	7.46	7.16	7.54	7.76	7.79	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	2.25	2.48	2.28	2.46	2.42	2.07	2.13	2.13	2.27	2.32	2.53	2.33	1.83	2.24	<=3.4	>4.5
% day cases of all electives	82.28%	80.24%	82.57%	79.73%	85.87%	83.20%	82.89%	82.40%	81.50%	82.33%	83.12%	84.56%	83.34%	82.07%	>80%	<70%
Intra-session theatre utilisation rate	85.06%	87.48%	85.45%	83.11%	86.38%	84.99%	87.36%	87.57%	87.94%	85.22%	85.17%	88.54%	88.09%	86.90%	>85%	<70%

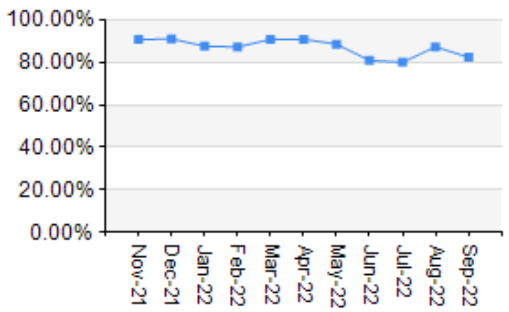
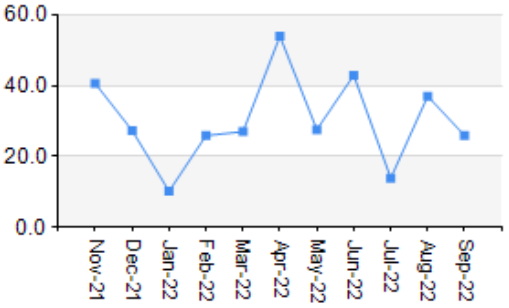
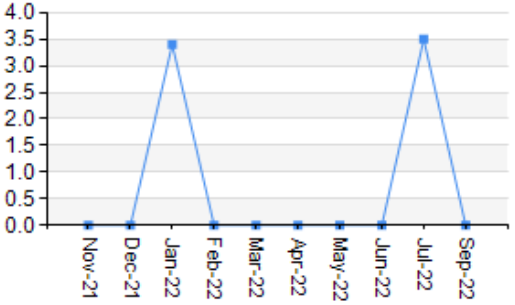
Trust Scorecard - Responsive (3)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Outpatient																
Outpatient new to follow up ratio's	2	1.94	1.93	1.96	1.95	1.88	1.95	2.03	2.02	1.96	1.96	1.97	1.91	2	<=1.9	
Did not attend (DNA) rates	7.15%	7.17%	7.03%	7.23%	7.62%	7.01%	7.30%	7.42%	6.83%	6.62%	6.72%	6.32%	6.80%	6.95%	<=7.6%	>10%
RTT																
Referral to treatment ongoing pathways under 18 weeks (%)	72.85%	72.04%	72.27%	70.03%	71.05%	71.84%	71.62%	71.81%	73.01%	72.52%	71.41%	71.58%	70.66%	72.45%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	5,642	5,593	5,642	5,847	5,272	5,087	5,135	5,419	5,386	5,806	6,312	6,384	6,210	5,537	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,946	2,935	2,641	2,605	2,292	2,165	2,182	2,421	2,490	2,579	2,678	2,841	2,841	2,497	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,598	1,590	1,492	1,430	1,273	1,112	1,125	1,231	1,248	1,367	1,439	1,397	1,255	1,282	Zero	
Referral to treatment ongoing pathway over 70 Weeks (number)	403	295	228	205	207	185	148	128	145	125	172	169	141	133	0	

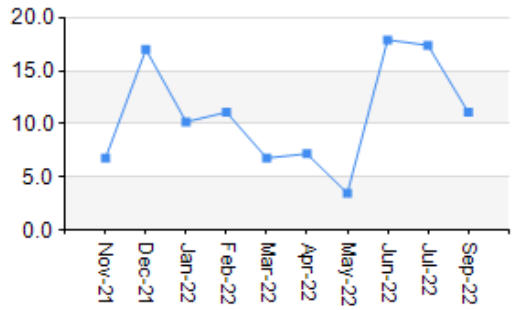
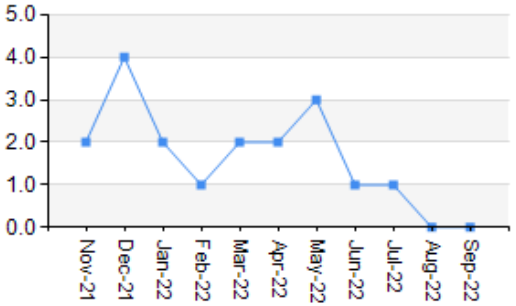
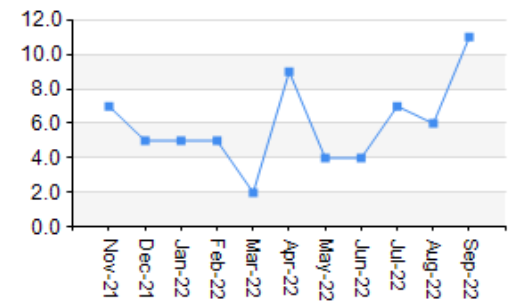
Trust Scorecard - Well Led (1)

	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	22/23 Q1	Standard	Threshold
Appraisal and Mandatory Training																
Trust total % overall appraisal completion	78.0%	78.0%	79.0%	80.0%	80.0%	78.0%	77.0%	78.0%	80.0%	80.0%	79.0%	79.0%	77.0%	80.0%	>=90%	<70%
Trust total % mandatory training compliance	88%	87%	87%	87%	87%	87%	86%	86%	86%	86%	86%	87%	86%	86%	>=90%	<70%
Safe Nurse Staffing																
Overall % of nursing shifts filled with substantive staff	99.61%	97.11%	95.93%	89.16%	85.93%	87.53%	85.28%	92.70%	90.90%	83.97%	80.60%	86.63%	93.16%	89.09%	>=75%	<70%
% registered nurse day	98.11%	95.49%	94.07%	87.59%	84.20%	85.30%	82.60%	89.11%	89.31%	81.76%	78.48%	83.63%	91.44%	86.63%	>=90%	<80%
% unregistered care staff day	96.58%	95.82%	95.07%	84.77%	83.85%	83.66%	74.95%	89.59%	88.03%	81.86%	77.73%	86.10%	88.02%	86.39%	>=90%	<80%
% registered nurse night	102.46%	100.10%	99.31%	91.99%	89.02%	91.54%	90.13%	99.35%	93.78%	88.03%	84.51%	92.23%	96.22%	93.59%	>=90%	<80%
% unregistered care staff night	111.67%	105.90%	103.45%	94.98%	95.26%	97.78%	91.50%	103.36%	101.17%	100.46%	92.96%	105.05%	108.81%	101.63%	>=90%	<80%
Care hours per patient day RN	4.6	5	5.2	5	4.9	4.8	4.8	5.2	5.1	5.5	4.7	5.4	6	5.2	>=5	
Care hours per patient day HCA	3.5	3.2	3.1	3.1	3	2.9	2.8	3.2	3.1	2.7	2.9	3.4	3.6	3.1	>=3	
Care hours per patient day total	8.1	8.1	8.3	8.1	7.9	7.8	7.6	8.4	8.2	8.2	7.7	8.7	8.3	8.3	>=8	
Vacancy and WTE																
% total vacancy rate	6.82%	6.39%	7.37%	8.09%	11.16%	10.68%	10.45%	10.79%	10.61%	10.97%	10.66%	10.12%	10.36%		<=11.5%	>13%
% vacancy rate for doctors	7.41%	6.74%	7.45%	7.05%	8.88%	8.35%	7.99%	7.91%	7.79%	7.75%	7.98%	-652.05%	1.47%		<=5%	>5.5%
% vacancy rate for registered nurses	7.89%	7.87%	8.17%	8.64%	14.46%	14.29%	14.09%	14.34%	14.60%	15.05%	14.54%	15.02%	13.71%		<=5%	>5.5%
Staff in post FTE	6730.66	6718.8	6686.83	6627.94	6648.33	6678.52	6707.09	6683.74	6683.28	6659.49	6688.51	5972.01	5998.97		No target	
Vacancy FTE	491.56	457.02	530.17	582.02	834.81	799.75	782.28	807.64	794.16	821.21	906.67	122.39	786.04		No target	
Starters FTE	79.76	42.43	59.94	70.65	77.03	69.31	51.46	91.38	85.03	60.58	94.35	86	72.96		No target	
Leavers FTE	68.51	89.94	66.53	81.1	88.76	47.74	84.88	67.55	83.93	67.04	75.62	69.27	64.17		No target	
Workforce Expenditure and Efficiency																
% turnover	11.1%	11.7%	11.7%	12.3%	12.9%	11.8%	13.8%	14.2%	14.4%	14.5%	14.5%	14.7%	14.5%		<=12.6%	>15%
% turnover rate for nursing	9.72%	9.70%	10.52%	10.83%	10.99%	10.69%	12.15%	12.80%	13.03%	13.05%	13.80%	14.58%	12.46%		<=12.6%	>15%
% sickness rate	3.9%	3.8%	3.8%	3.8%	3.9%	4.0%	4.0%	4.1%	4.2%	4.2%	4.2%	4.1%	4.1%		<=4.05%	>4.5%

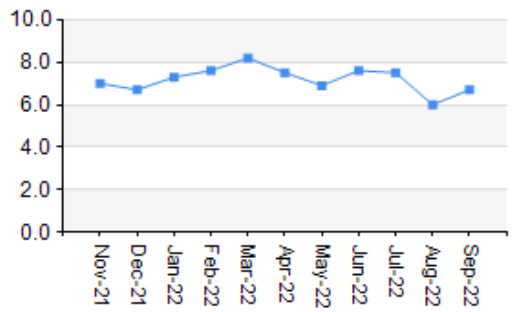
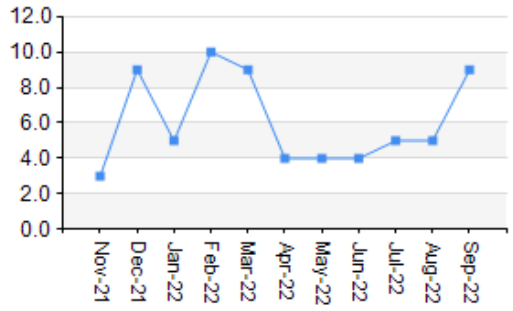
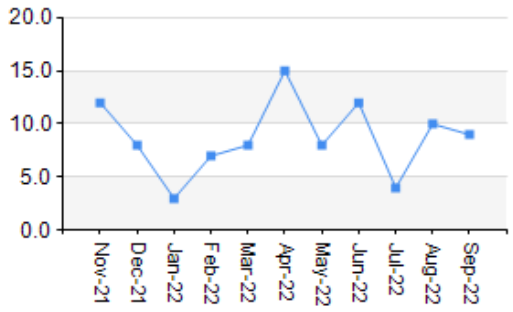
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		The new electronic prescribing system will automatically record the risk assessment for all patients. Results from this will drive any further improvement work, this is likely to be in the new year.	**Quality Improvement & Safety Director**
Clostridium difficile - infection rate per 100,000 bed days **Standard: <30.2**		During September there were a total of 9 C. difficile cases associated with health care (2 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.	**Associate Chief Nurse, Director of Infection Prevention & Control**
MRSA bacteraemia - infection rate per 100,000 bed days **Standard: Zero**		In September 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 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**

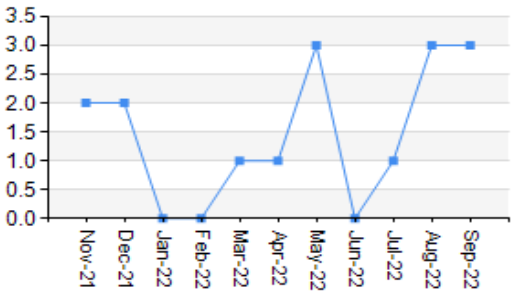
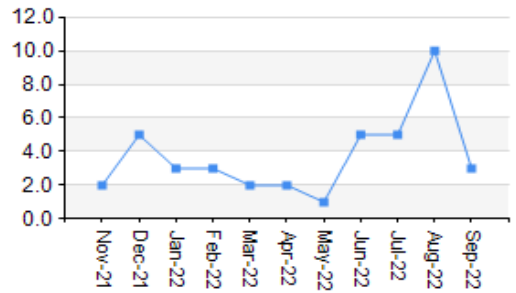
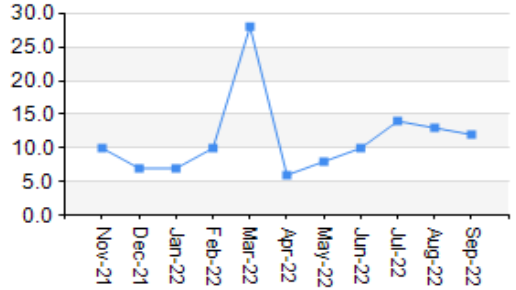
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
MSSA - infection rate per 100,000 bed days **Standard: <=12.7**		During September we had 3 health care associated MSSA blood stream infections; comparred to 10 health care associated cases in August. 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. It is also noted that there has been a regional increase in MSSA BSIs and the trust plans to support a regional reduction collaborative.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of category 3 pressure ulcers acquired as in-patient **Standard: <=5**		There were no category 3 pressure ulcers reported.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of ecoli cases **Standard: No target**		During September we had 11 health care associated cases. Reducing E.coli BSI and all Gram negative bacteraemia continue to be a focus of the IPC strategy specifically related to urinary tract infection prevention, improving patient hydration and improving the management and care of invasive device. All patients with a healthcare associated E.coli BSI have a rapid review to understand contributing factors and a subsequent post infection review is completed if there lapses in care that require action	**Associate Chief Nurse, Director of Infection Prevention & Control**

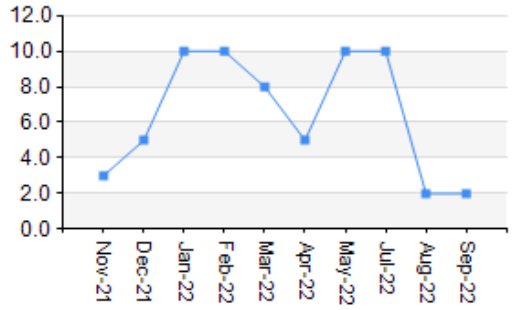
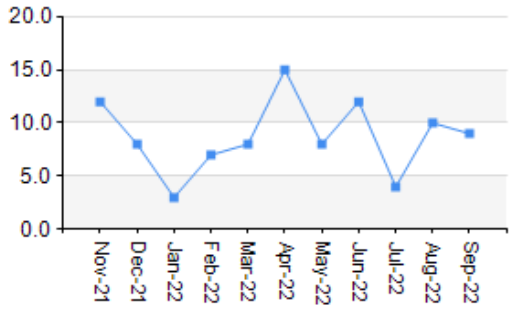
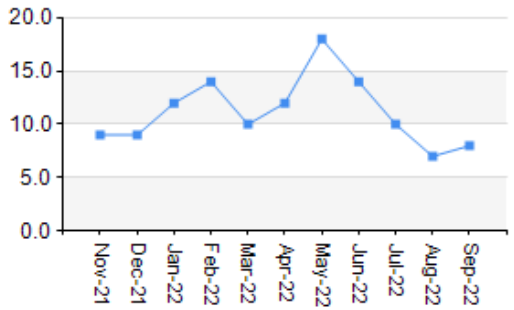
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of falls per 1,000 bed days **Standard: <=6**		The rate of falls per 1,000 bed days is running at 6.6 in July and the 12-month rolling average is 7.1 which is comparable to the previous rolling 12-month average. The Trust Falls Prevention plan is focussed on evidence-based approach to falls risk assessment and interventions. Recently, NHS England carried out an on site peer review at our request, we are awaiting feedback on their recommendations.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		The number of falls resulting in moderate or severe harm is 9 in September and the 12-month rolling average is 6 per month. All of these cases are reviewed in the weekly Preventing Harm Hub and rapid feedback on safety improvements is given. The Trust Falls Prevention plan is focussed on evidence-based approach to falls risk assessment and interventions. Recently, NHS England carried out an onsite peer review at our request, we are awaiting feedback on their recommendations. It is important for this data to be presented as a rate per 1,000 bed days and that change will be made in the new QPR.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month **Standard: <=5**		During September there were a total of 9 C. difficile cases associated with health care (2 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.	**Associate Chief Nurse, Director of Infection Prevention & Control**

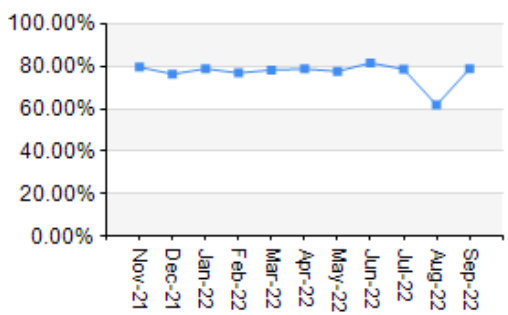
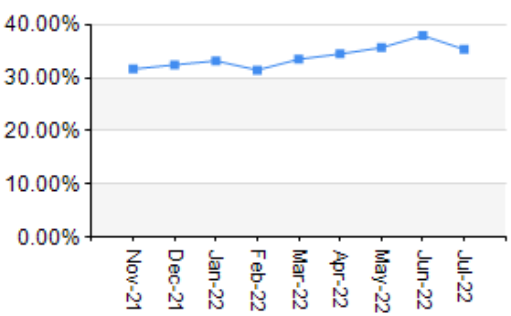
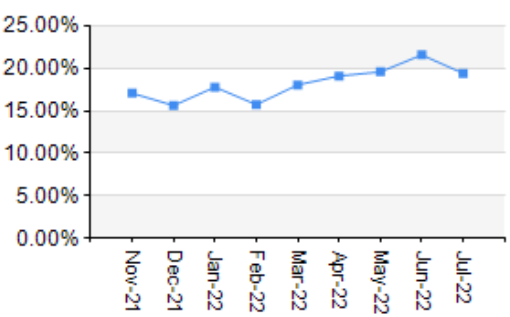
Exception Reports - Safe (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of klebsiella cases **Standard: No target**		During September we had 3 health care associated cases of Klebsiella blood stream infections. Reducing Klebsiella BSI and all Gram negative bacteraemia continue to be a focus of the IPC strategy specifically related to urinary tract infection prevention, improving patient hydration and improving the management and care of invasive device. All patients with a healthcare associated Klebsiella BSI have a rapid review to understand contributing factors and a subsequent post infection review is completed if there lapses in care that require action	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of MSSA bacteraemia cases **Standard: <=8**		During September we had 3 health care associated MSSA blood stream infections; comparred to 10 health care associated cases in August. 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. It is also noted that there has been a regional increase in MSSA BSIs and the trust plans to support a regional reduction collaborative.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of patient safety incidents - severe harm (major/death) **Standard: No target**		All reporting of serious harm when classified as a SI are investigated with action plans and reported to QDG and QPC	**Quality Improvement & Safety Director**

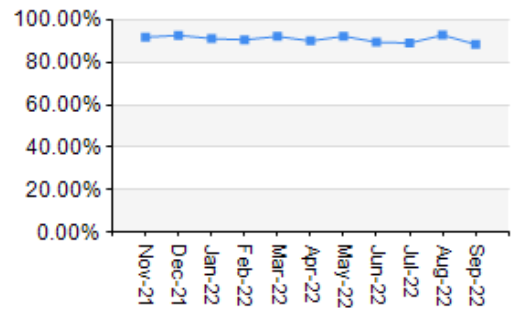
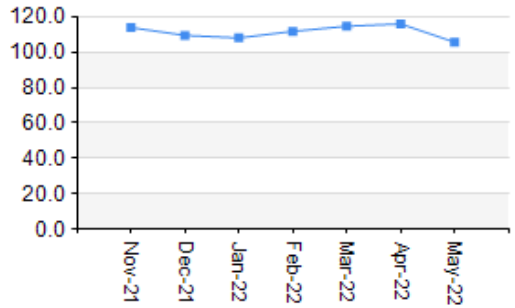
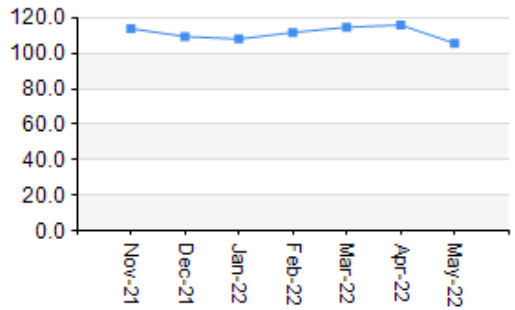
Exception Reports - Safe (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of RIDDOR **Standard: SPC**		Each incident is reviewed individually and local themes are reported to the Divisional and Trust H&S meetings	**Quality Improvement & Safety Director**
Number of trust apportioned Clostridium difficile cases per month **Standard: 2020/21: 75**		During September there were a total of 9 C. difficile cases associated with health care (2 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.	**Associate Chief Nurse, Director of Infection Prevention & Control**
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, we are currently evaluating this initiative however patients are now waiting in an ambulance for much less time. 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.	**Associate Chief Nurse, Director of Infection Prevention & Control**

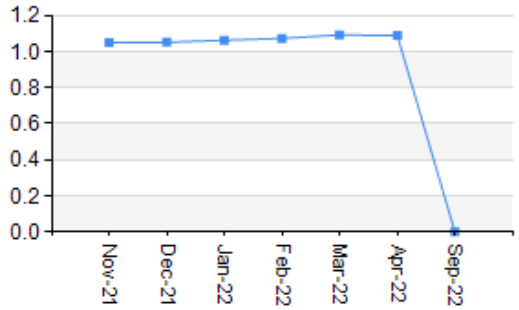
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		The service has 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 feedback 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 Breastfeeding 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**
% C-section rate (planned and emergency) **Standard: No target**		Under Review	**Divisional Director of Quality and Nursing and Chief Midwife**
% emergency C-section rate **Standard: No target**		Under Review	**Divisional Director of Quality and Nursing and Chief Midwife**

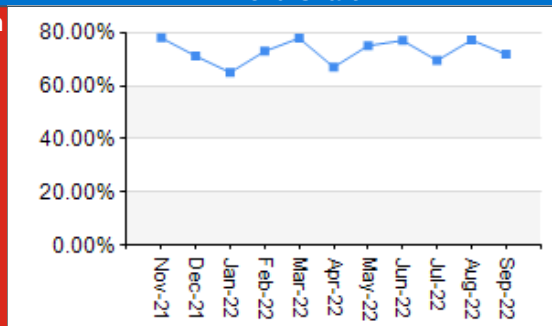
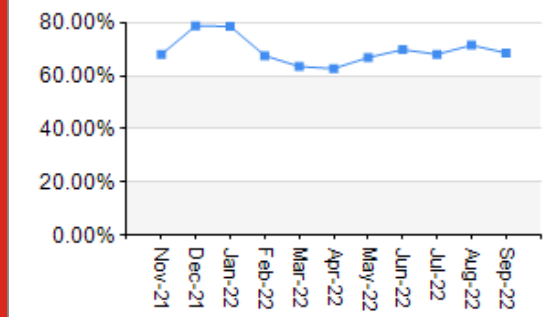
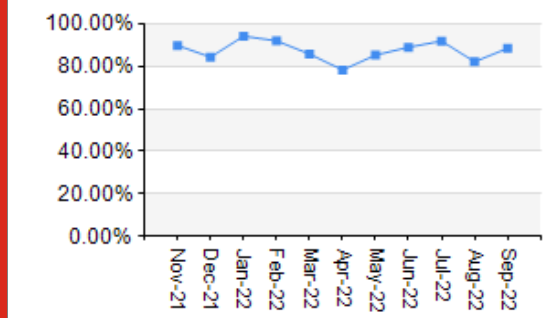
Exception Reports - Effective (2)

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 e.g., 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 has been increasing.	**Divisional Director of Quality and Nursing and Chief Midwife**
Hospital standardised mortality ratio (HSMR) **Standard: Dr Foster**		HSMR has risen over recent months we will be reviewing any areas of concern through HMG. The model behind HSMR compares current outcome vs data from the last ten years. Therefore if there are changes to outcomes nationally over recent months they will not be reflected in the model immediately a good example of that has been in the impact of covid. What we are seeing now may reflect the impact of congestion in all parts of the system. We are also looking at the Charlson scoring of comorbidities which is currently lower than expected and is likely to be impacting the results. A number of acute trusts are seeing a similar rise in HSMR.	**Deputy Medical Director**
Hospital standardised mortality ratio (HSMR) - weekend **Standard: Dr Foster**		HSMR has risen over recent months we will be reviewing any areas of concern through HMG. The model behind HSMR compares current outcome vs data from the last ten years. Therefore if there are changes to outcomes nationally over recent months they will not be reflected in the model immediately a good example of that has been in the impact of covid. What we are seeing now may reflect the impact of congestion in all parts of the system. We are also looking at the Charlson scoring of comorbidities which is currently lower than expected and is likely to be impacting the results. A number of acute trusts are seeing a similar rise in HSMR.	**Deputy Medical Director**

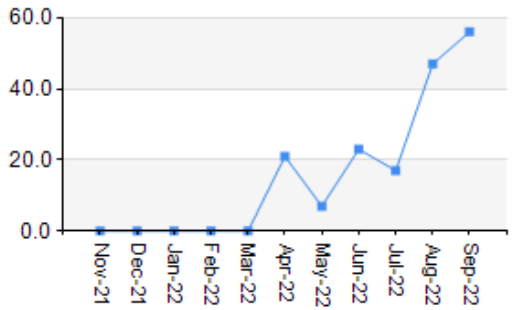
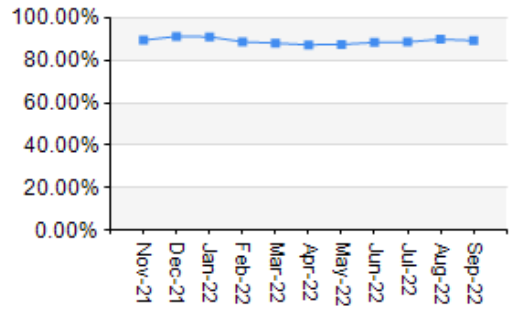
Exception Reports - Effective (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Summary hospital mortality indicator (SHMI) - national data **Standard: NHS Digital**		This metric is stable and remains green, it is monitored in HMG	**Deputy Medical Director**

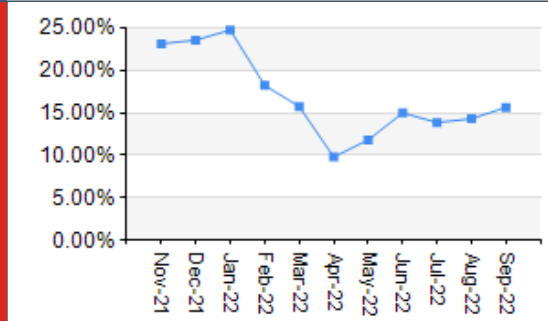
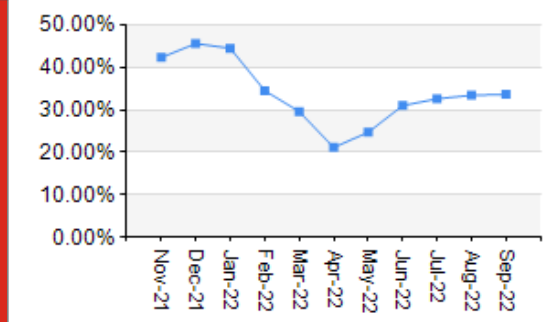
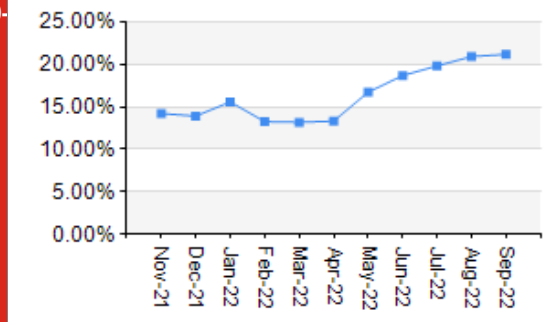
Exception Reports - Caring (1)

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 71.8%, a decrease from 77.2% in August. The number of new concerns received in September was 312, down slightly (-5%) compared to last month. Of these 224 (71.8%) were listed as having been closed within 5 working days.	**Head of Quality**
ED % positive **Standard: >=84%**		The current positive FFT score for ED is at 69% across both sites, a decrease from 71.5% in August with the main theme emerging focussed on wait times, which is reflective of the operational pressures in the department. 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 88%, which is a significant improvement from August 2022 (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 happening in November in partnership with the Maternity Voices Partnership 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**

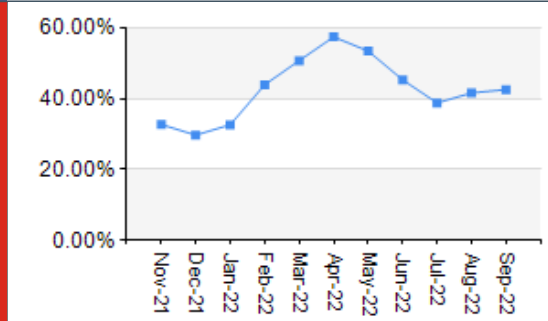
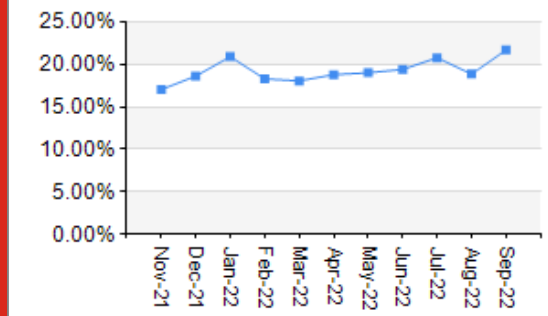
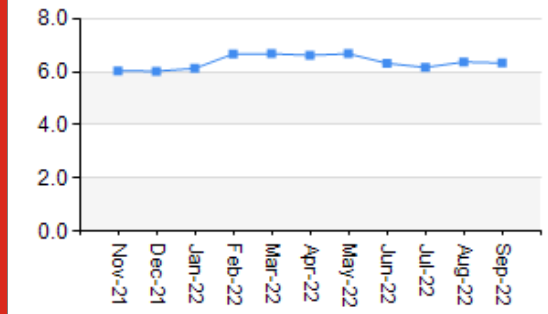
Exception Reports - Caring (2)

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 ICB 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.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Total % positive **Standard: >=93%**		The Trust had 5937 responses to FFT in September 2022, and the overall Trust FFT positive score has seen a slight decrease in positive score this month to 89.2%. This is largely due to decreases in the positive FFT score for unscheduled care. 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**

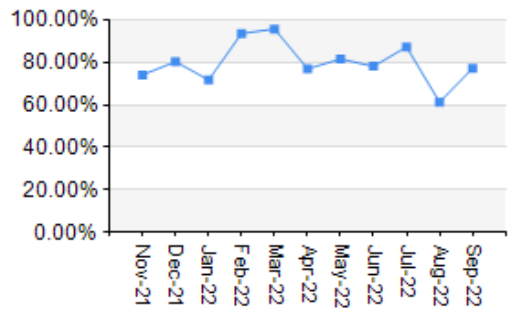
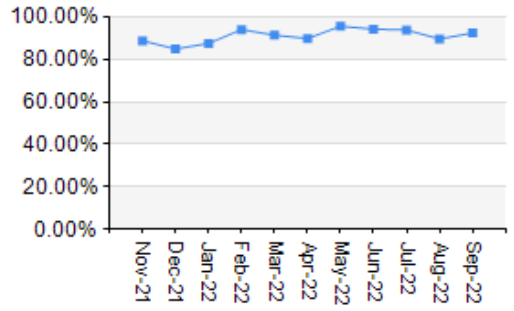
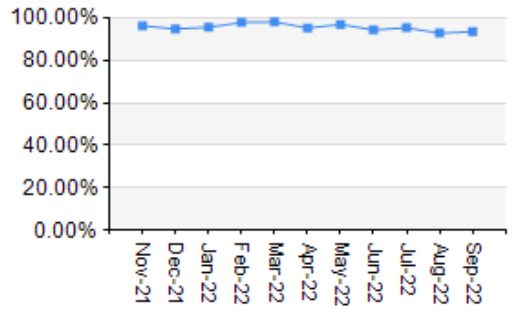
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers < 15 minutes **Standard: >=65%**		% of ambulance handovers < 15 minutes should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**
% of ambulance handovers < 30 minutes **Standard: >=95%**		% of ambulance handovers < 30 minutes should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**
% of ambulance handovers 30-60 minutes **Standard: <=2.96%**		% of ambulance handovers 30-60 minutes should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**

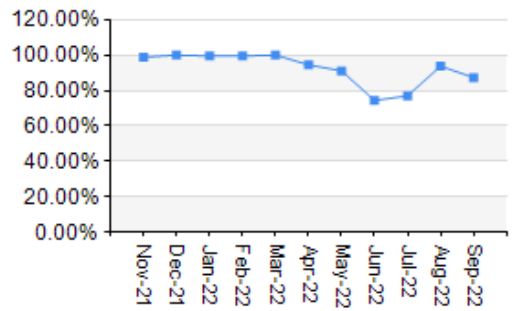
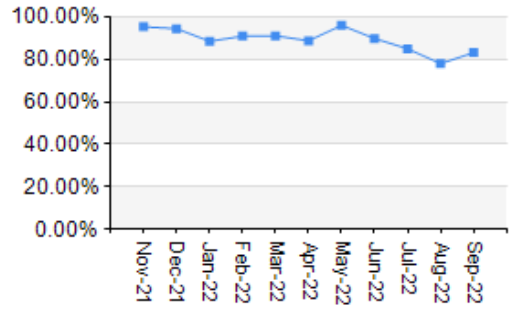
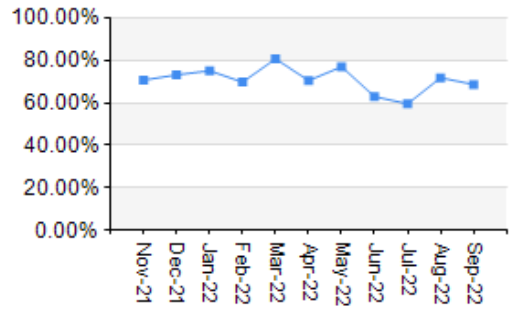
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers over 60 minutes **Standard: <=1%**		% of ambulance handovers over 60 minutes should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		The unconfirmed position for September has deteriorated, dropping to 21.67% compared to 18.8% last month. The key change being a swing in Echo performance, with an additional 275 breaches being recorded in month.	**Associate Director of Elective Care**
Average length of stay (spell) **Standard: <=5.06**		Under Review	**Deputy Chief Operating Officer**

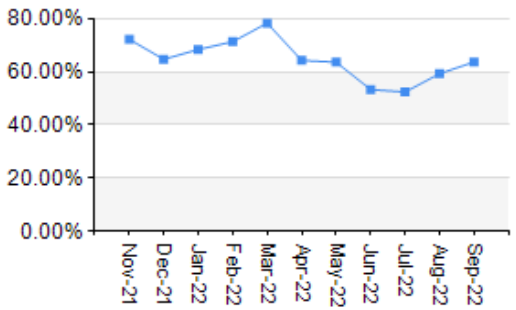
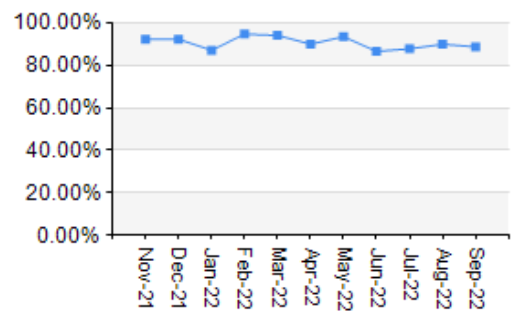
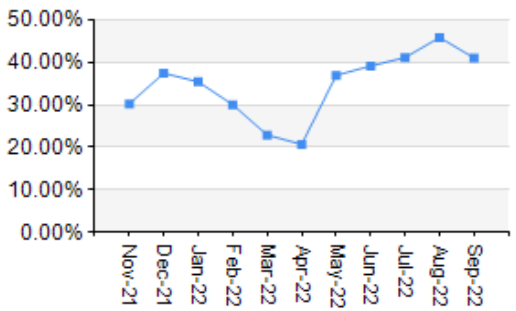
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancelled operations re-admitted within 28 days **Standard: >=95%**		In August there was a total of 20 patients cancelled on the day that could not be rescheduled within 28 days, which is very similar to the previous month. These included 8 T&O; 4 Urology; 4 Ophthalmology; 1 Gynae; 1 Cardiology; 1 Medical Endoscopy and 1 Surgical Endoscopy. The reasons were varied but primarily due to emergency/trauma demand; consultant emergency leave; lack of kit/equipment.	**Associate Director of Elective Care**
Cancer - 2 week wait breast symptomatic referrals **Standard: >=93%**		2ww breast symptoms performance (unvalidated) Standard = 93% National = 70% GHFT = 92.3% DFS = 127 Breaches = 8 7 out of 8 breaches related to patient choice	**General Manager - Cancer**
Cancer - 31 day diagnosis to treatment (first treatments) **Standard: >=96%**		31 day new performance (unvalidated) Standard = 96% National = 92% GHFT = 93.4% 335 treatments 22 breaches Uro 6; Skin 4; Lung 4; Lower GI 3; Gynae 2; Breast 2 All surgical elective capacity breaches aside from skin and lung (SABR)	**General Manager - Cancer**

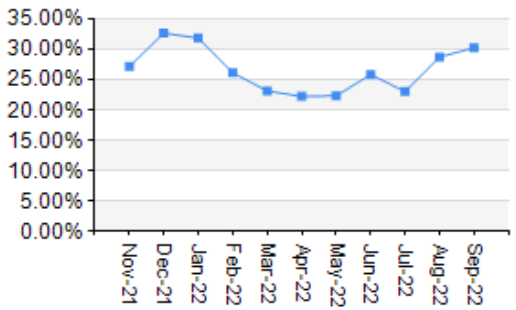
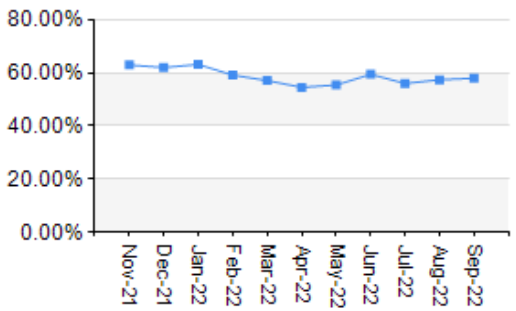
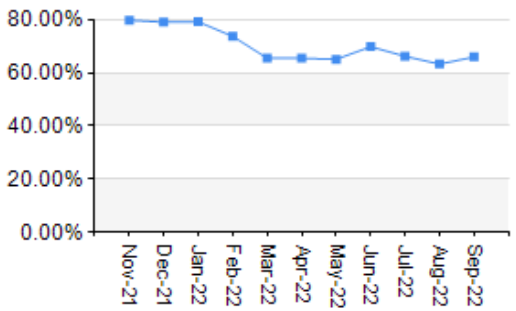
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy) **Standard: >=94%**		31 day subs radiotherapy performance (unvalidated) Standard = 94% National = 90.5% GHFT = 87.1% Treated = 90 Breaches = 23 Performance impacted by known radiographer staffing issues (Trust risk) in spring and summer. Backlog significantly reduced and performance now improving (currently 83% in October)	**General Manager - Cancer**
Cancer - 31 day diagnosis to treatment (subsequent – surgery) **Standard: >=94%**		31 day subs surgery performance (unvalidated) Standard = 94% National = 80% GHFT = 84.5% Treated = 58 Breaches = 9 Breast 1,Gynae 1, Uro 7 All breaches related to theatre capacity	**General Manager - Cancer**
Cancer - 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated) Standard = N/A National = 72% GHFT = 67.3% Treated= 24.5, Breaches=8 Uro= 3 Gynae= 1 Haem = 1 Lower GI = 1 Lung= 1 Skin = 1 4 complex patient pathways. Two elective capacity breaches (1 SABR 1 surgery) and 1 due to patholoy reporting delays	**General Manager - Cancer**

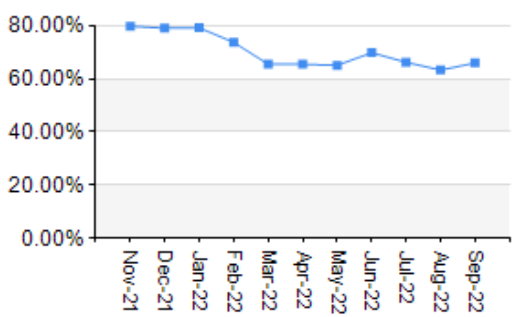
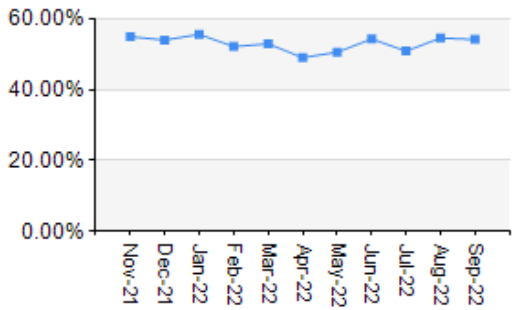
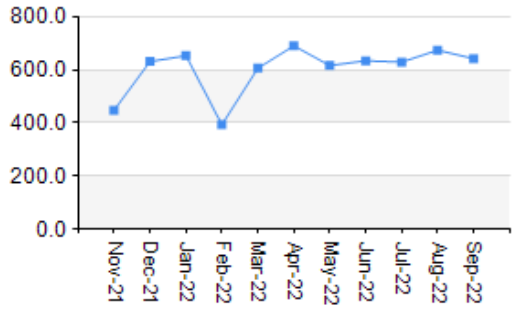
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer - 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) Standard = 85% National = 61.9% GHFT = 63% Treatments =188, Breaches 69.5, LGI=18.5, Urology=16.5 Performance improvements seen in Urology where backlogs are being cleared. Main reason for breaches were elective capacity issues although the number of LATP breaches has significantly reduced to 4 breaches. The majority are relating to surgical or Pre op	**General Manager - Cancer**
Cancer - urgent referrals seen in under 2 weeks from GP **Standard: >=93%**		2ww Performance (unvalidated) Standard = 93% National = 75% GHFT = 88.6% DFS = 2371 Breaches 270, Skin=45, Lower GI=128, Gynae=38 High demand and capacity issues impacting Lower GI (Surgical and Endoscopy). Dermatology now recovered in October.	**General Manager - Cancer**
ED: % of time to initial assessment - under 15 minutes **Standard: >=95%**		% of time to inital assessment under 15 mins should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**

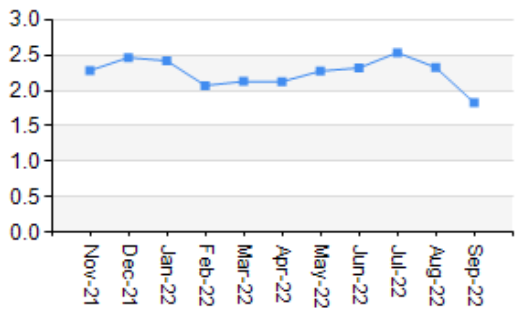
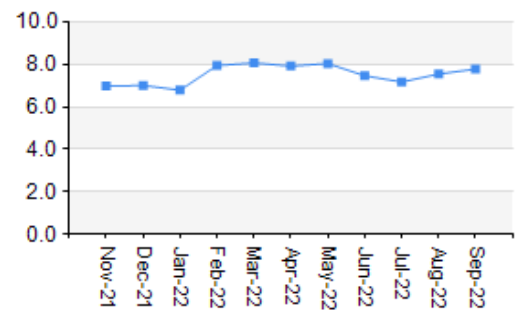
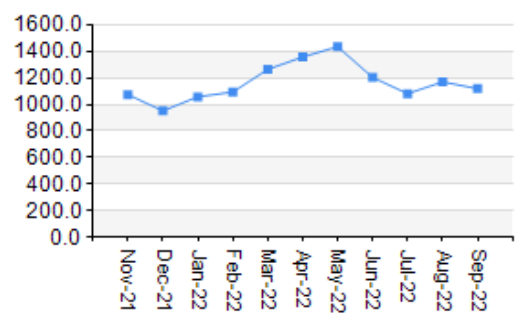
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % of time to start of treatment - under 60 minutes **Standard: >=90%**		% of time to start treatment under 60 minutes should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (type 1) **Standard: >=95%**		% total time in department under 4 hours should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours (types 1 & 3) **Standard: >=95%**		% total time in department under 4 hours should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**

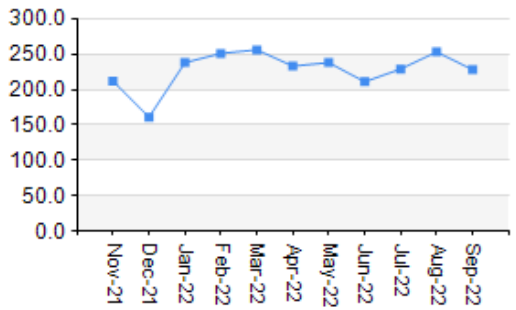
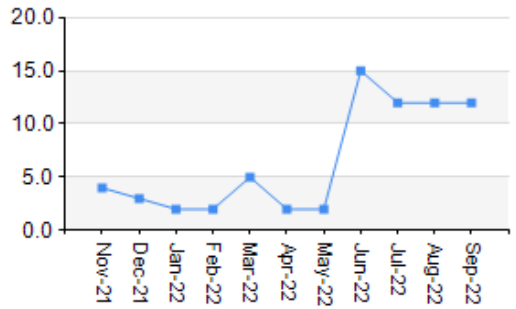
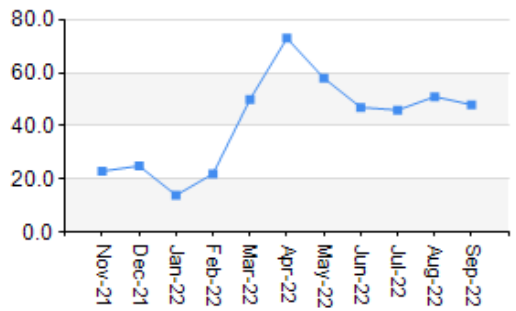
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department - under 4 hours CGH **Standard: >=95%**		% total time in department under 4 hours should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**
ED: % total time in department - under 4 hours GRH **Standard: >=95%**		% total time in department under 4 hours should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		Number of pts experiencing a 12 hour trolley wait should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**

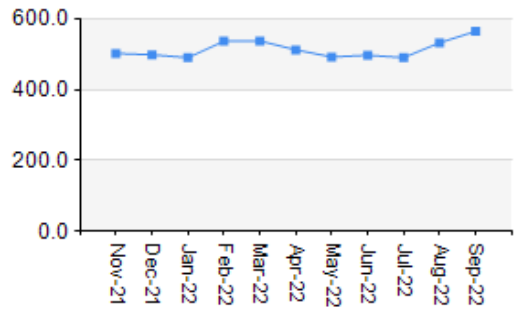
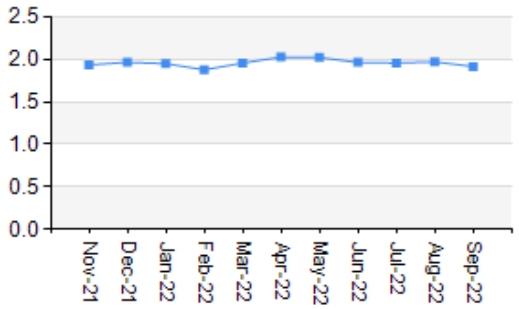
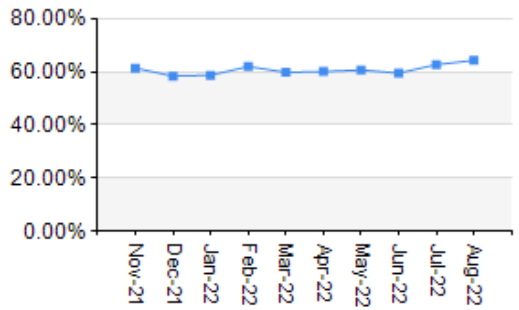
Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Length of stay for general and acute elective spells (occupied bed days) **Standard: <=3.4**		Under Review	**Deputy Chief Operating Officer**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		Under Review	**Deputy Chief Operating Officer**
Number of ambulance handovers over 60 minutes **Standard: Zero**		Number of ambulance handovers over 60 minutes should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.	**General Manager of Unscheduled Care**

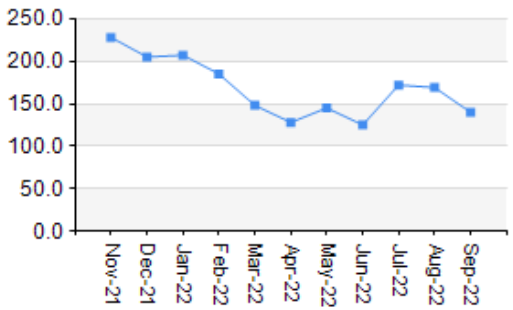
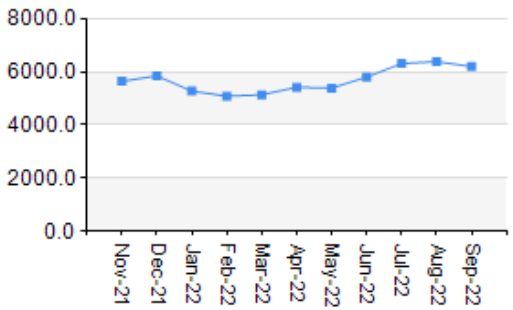
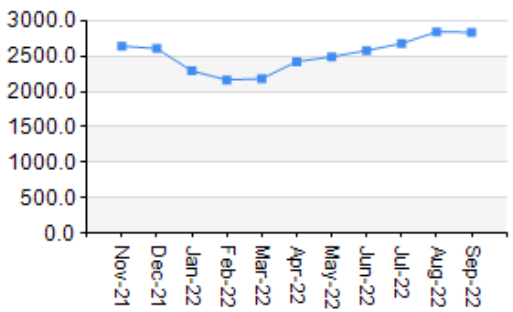
Exception Reports - Responsive (9)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients stable for discharge **Standard: <=70**		Under Review	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		Number of patients with TCI date = 13 Number of patients without TCI date = 42 Total number of >104 day patients = 55 Cancer category No TCI TCI Grand Total Breast 1 1 Breast symptomatic 1 1 Gynaecological 1 1 Haematological 4 4 Head & neck 1 1	**General Manager - Cancer**
Number of patients waiting over 104 days without a TCI date **Standard: <=24**		Number of patients with TCI date = 13 Number of patients without TCI date = 42 Total number of >104 day patients = 55 Has TCI Cancer category No TCI TCI Grand Total Breast 1 1 Breast symptomatic 1 1 Gynaecological 1 1 Haematological 4 4 Head & neck 1 1	**General Manager - Cancer**

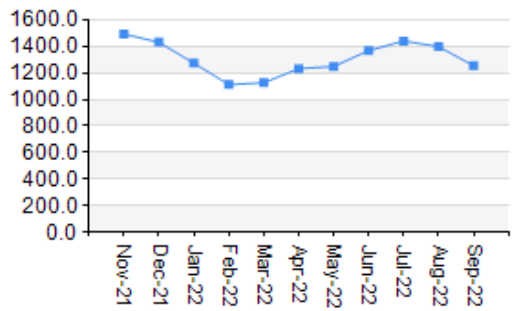
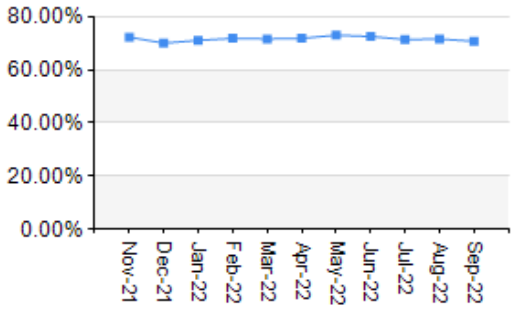
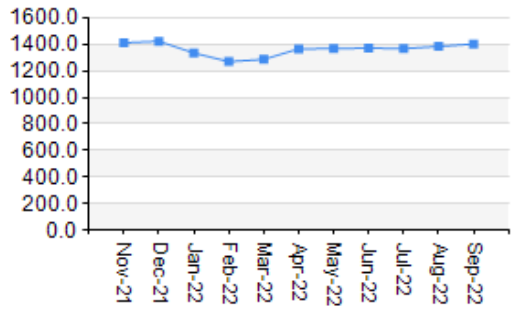
Exception Reports - Responsive (10)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		Under Review	**Deputy Chief Operating Officer**
Outpatient new to follow up ratio's **Standard: <=1.9**		Largely unchanged and remains marginally above target at 1.91 (a reduction of 0.08 on last month)	**Associate Director of Elective Care**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		The number remains around 60% for last few months. It is not expected to change significantly till after the roll out of EPMA and discharge summaries being done on Sunrise instead of trakcare.	**Medical Director**

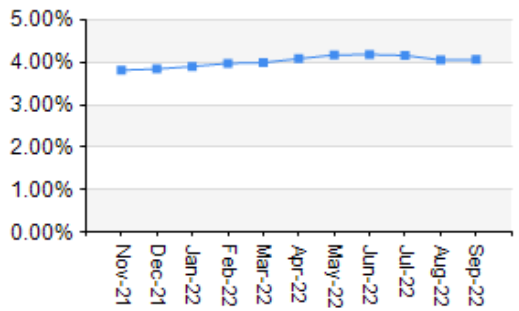
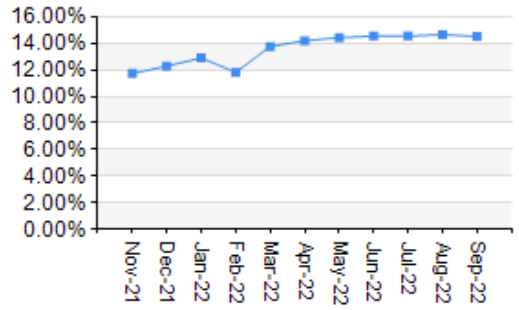
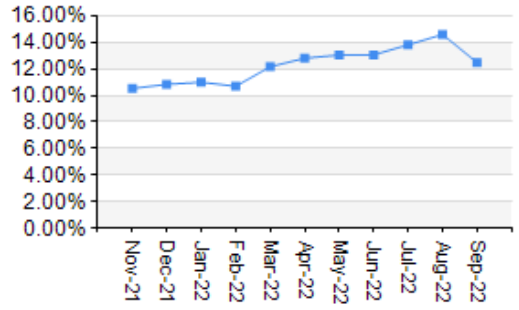
Exception Reports - Responsive (10)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Referral to treatment ongoing pathway over 70 Weeks (number) **Standard: 0**		This cohort has similarly made reductions in month with approximately 30 less patients. These gains are predominantly related to Clinical Haematology.	**Associate Director of Elective Care**
Referral to treatment ongoing pathways 35+ Weeks (number) **Standard: No target**		The number of patients over 35 weeks has reduced in month, by approximately 170 patients.	**Associate Director of Elective Care**
Referral to treatment ongoing pathways 45+ Weeks (number) **Standard: No target**		This cohort remains unchanged in month.	**Associate Director of Elective Care**

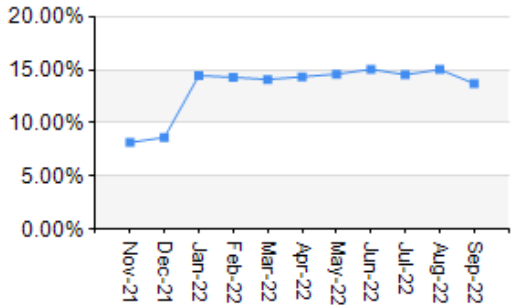
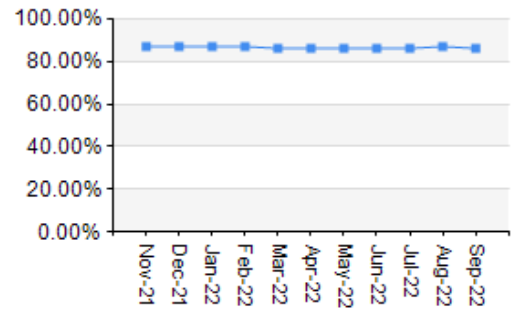
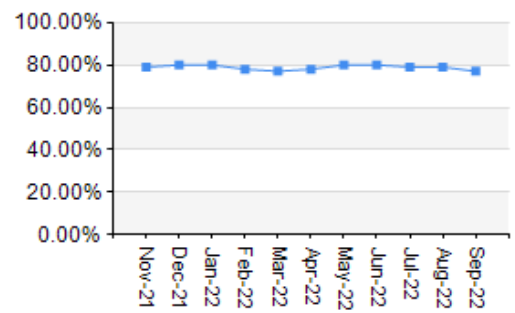
Exception Reports - Responsive (10)

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 September has seen a good reduction of 52 week breaches, with a reduction of approximately 150 on last month. The three specialties that have made most gains are Oral Surgery (-70), Ophthalmology (-41) & Clinical Haematology (-31).	**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 70.66% and is only likely to change by a small amount – potentially to 70.8%. Although a slight decrease on last month performance is considered stable and significantly above the national average.	**Associate Director of Elective Care**
The number of planned/surveillance endoscopy patients waiting at month end **Standard: <=600**		The number of surveillance patients has increase due admin validation capacity. A funding request for a B3 Admin Validator for 1 year, has been submitted to NHSE which will provide focus on significantly reducing the number of these patient.	**Deputy General Manager of Endoscopy**

Exception Reports - Well Led (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% sickness rate **Standard: <=4.05%**		A Financial wellbeing plan is in development with ongoing wellbeing support from the 2020 Hub and interventions from the Staff Psychology team An increase in the number of HR sickness 'surgeries' is planned to support management with the highest sickness rates across the divisions.	**Director for People and OD**
% 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. Establishing a Trust Retention Group is a priority, creating a single oversight of the wide ranging initiatives being undertaken and setting a clear focus on a range of specific initiatives	**Director for People and OD**
% turnover rate for nursing **Standard: <=12.6%**		Career conversations through virtual clinics take place each month for both Registered Nurses and HCSWs. Late Career support is in place for staff over 50 encouraging them to stay in the NHS. Rotational programmes are being developed by the Practice Development team together with pop up career and development stands for staff to informally chat about opportunities in the Trust	**Director for People and OD**

Exception Reports - Well Led (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for registered nurses **Standard: <=5%**		The International Nurse recruitment plan remains on track with a further financial bid for 42 registered nurses submitted to NHSEI this month. If successful, these nurses will arrive between January and March 2023. A successful Nurses, Midwives & ODP Open Day was held at the Trust this month, seeing a number of interviews taking place on the day itself.	**Director for People and OD**
Trust total % mandatory training compliance **Standard: >=90%**		Under Review	**Deputy Director of People and Organisational Development**
Trust total % overall appraisal completion **Standard: >=90%**		Under Review	**Deputy Director of People and Organisational Development**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period September 2022

Presented at October 2022 Q&P and November 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.

September continued to be a challenging month for the Emergency Department (ED) and saw a decrease in performance from 72.59% to 70.52% compared to the previous month. Ambulance handover delays decreased for 30-60 minutes handovers delays however increased 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.

During September the overall diagnostic performance has deteriorated by between 2-3% dropping to an unconfirmed 21.67% compared to 18.8% last month. The key change being a swing in Echo performance, with an additional 275 breaches being recorded in month.

For cancer, performance data showed the Trust met 2 out of 9 standards with 6 out of 9 standards above national average clearly showing a challenging month. The Trust did not meet 28 day Faster Diagnosis Standard performance in August on provisional submission but final submission should see it meeting the standard. 2ww performance continued to be impacted by skin and lower GI. 62 day standard performance for August was 59.3% which will rise following final submission to above 60% 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. >62 day and >104 day numbers continue to reduce slowly.

For elective care, the RTT performance did not meet the national standard, demonstrating a slight dip in performance in month. The month-end submission is anticipated to be 70.8%, which remains considerably higher than the national average of approx 60%. The total incompletes has increased slightly in month and the unconfirmed September position is expected to be around 65,500 (compared to 65,035 last month). The number of patients waiting over 52 weeks has decreased, reducing from 1,397 in August to approximately 1,250 in September. Focus continues to be placed on patients on long waiting patients with the recovery plans of Oral Surgery and Clinical Haematology now starting to make a difference. The number of patients waiting 70+ weeks has reduced by approximately 30. The number of patients over 78 weeks has halved, and as of 13 October there are 26 patients in total. The Trusts continues to have zero 104w breaches.

The Elective Care Hub continues to conclude contact with patients >18 weeks on an open pathway, which has been delayed of late due to staff turnover and vacancies. Postal responses are still being received from patients, later than anticipated and potentially due to the number of postal strikes of late. Work ins ongoing with Ophthalmology to support the review of their FU backlog and this specific project will continue for several months. To dovetail this, the intention is to expand this to other services with FU backlogs, and feedback/comment is awaited from specialties before this can proceed.

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

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

Variation

- 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%	Sep-22	80.7%
Cancer	Cancer - urgent referrals seen in under 2 weeks from GP	>=93%	Sep-22	88.6%
Cancer	Cancer - 2 week wait breast symptomatic referrals	>=93%	Sep-22	92.3%
Cancer	Cancer - 31 day diagnosis to treatment (first treatments)	>=96%	Sep-22	93.4%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – drug)	>=98%	Sep-22	100.0%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Sep-22	84.5%
Cancer	Cancer - 31 day diagnosis to treatment (subsequent –	>=94%	Sep-22	87.1%
Cancer	Cancer - 62 day referral to treatment (urgent GP referral)	>=85%	Sep-22	63.0%
Cancer	Cancer - 62 day referral to treatment (screenings)	>=90%	Sep-22	93.7%
Cancer	Cancer - 62 day referral to treatment (upgrades)	>=90%	Sep-22	67.3%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Sep-22	12
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Sep-22	48
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Sep-22	21.67%
Diagnostics	The number of planned/surveillance endoscopy patients waiting at month end	<=600	Sep-22	1,401
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Aug-22	64.30%
Emergency Department	ED: % total time in department - under 4 hours (type 1)	>=95%	Sep-22	57.95%
Emergency Department	ED: % total time in department - under 4 hours (types 1 & 3)	>=95%	Sep-22	72.27%
Emergency Department	ED: % total time in department - under 4 hours CGH	>=95%	Sep-22	65.97%
Emergency Department	ED: % total time in department - under 4 hours GRH	>=95%	Sep-22	54.10%

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	Sep-22	642
Emergency Department	ED: % of time to initial assessment - under 15 minutes	>=95%	Sep-22	41.0%
Emergency Department	ED: % of time to start of treatment - under 60 minutes	>=90%	Sep-22	30.2%
Emergency Department	Number of ambulance handovers over 60 minutes	Zero	Sep-22	1,118
Emergency Department	% of ambulance handovers < 15 minutes	>=65%	Sep-22	15.6%
Emergency Department	% of ambulance handovers < 30 minutes	>=95%	Sep-22	33.6%
Emergency Department	% of ambulance handovers 30-60 minutes	<=2.96%	Sep-22	21.2%
Emergency Department	% of ambulance handovers over 60 minutes	<=1%	Sep-22	42.5%
Maternity	% of women booked by 12 weeks gestation	>90%	Sep-22	88.2%
Operational Efficiency	Number of patients stable for discharge	<=70	Sep-22	227
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Sep-22	564
Operational Efficiency	Average length of stay (spell)	<=5.06	Sep-22	6.3
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Sep-22	7.8
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Sep-22	1.8
Operational Efficiency	% day cases of all electives	>80%	Sep-22	83.3%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Sep-22	88.1%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Sep-22	77.1%
Operational Efficiency	Urgent cancelled operations	No target	Sep-22	0

Access Dashboard

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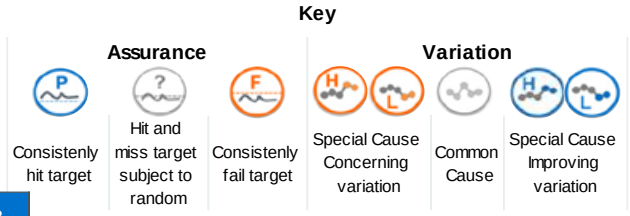
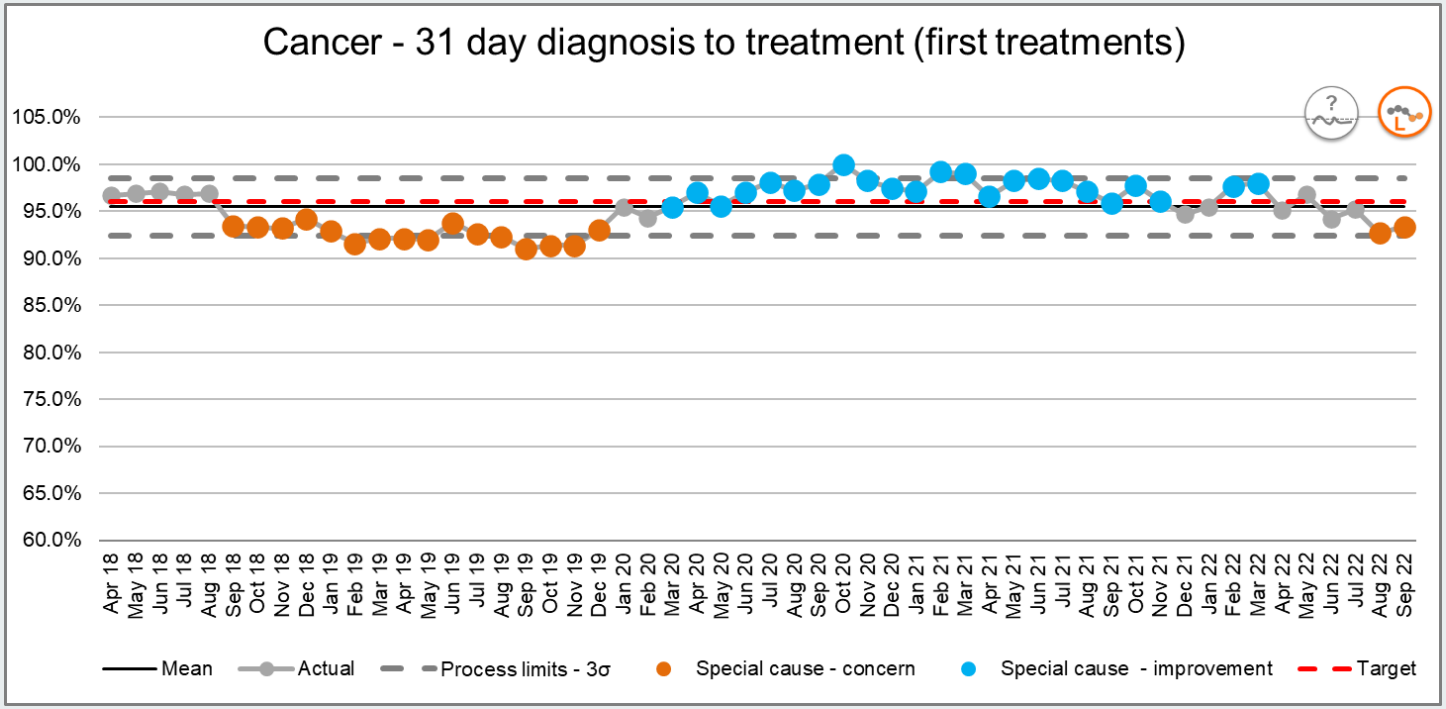


MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Outpatient	Outpatient new to follow up ratio's	<=1.9		Sep-22	1.91	
Outpatient	Did not attend (DNA) rates	<=7.6%		Sep-22	6.8%	
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%		Aug-22	6.9%	
Research	Research accruals	No target		Aug-22	234	
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Sep-22	70.66%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Sep-22	6,210	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Sep-22	2,841	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Sep-22	1,255	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	0		Sep-22	141	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		Sep-22	79.4%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Sep-22	100.0%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		Sep-22	82.4%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		Sep-22	73.50%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Aug-22	43.30%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Aug-22	43.3%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

31 day new performance (unvalidated)
Standard = 96% National = 92% GHFT = 93.4% (335 treatments 22 breaches)
Uro 6; Skin 4; Lung 4; Lower GI 3; Gynae 2; Breast 2

All surgical elective capacity breaches aside from skin and lung (SABR)
5 breaches within 1 day of breach

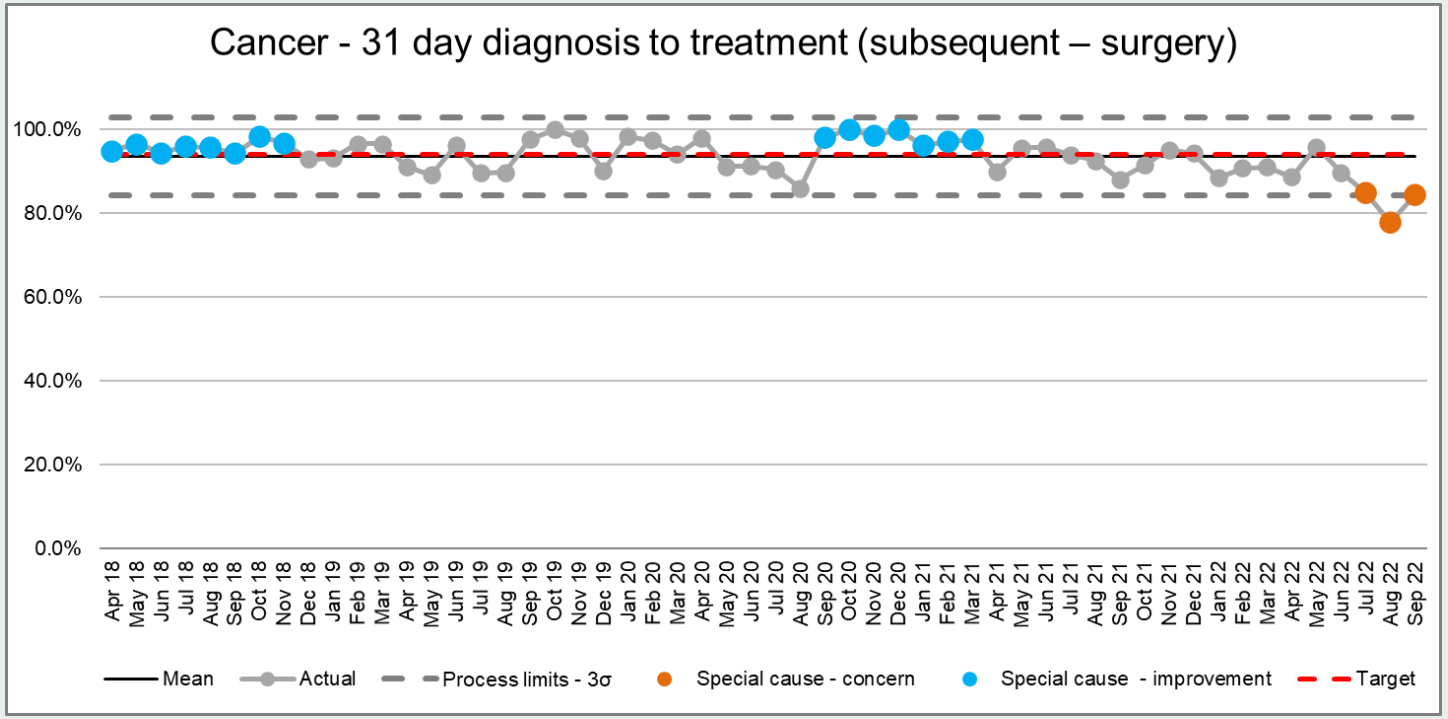
- General Manager - Cancer

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 3 points above the line and 8 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 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 surgery performance (unvalidated)
Standard = 94% National = 80% GHFT = 84.5% (Treated = 58 Breaches = 9)

Breast 1,Gynae 1, Uro 7
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 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 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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SPC – Special Cause Variation

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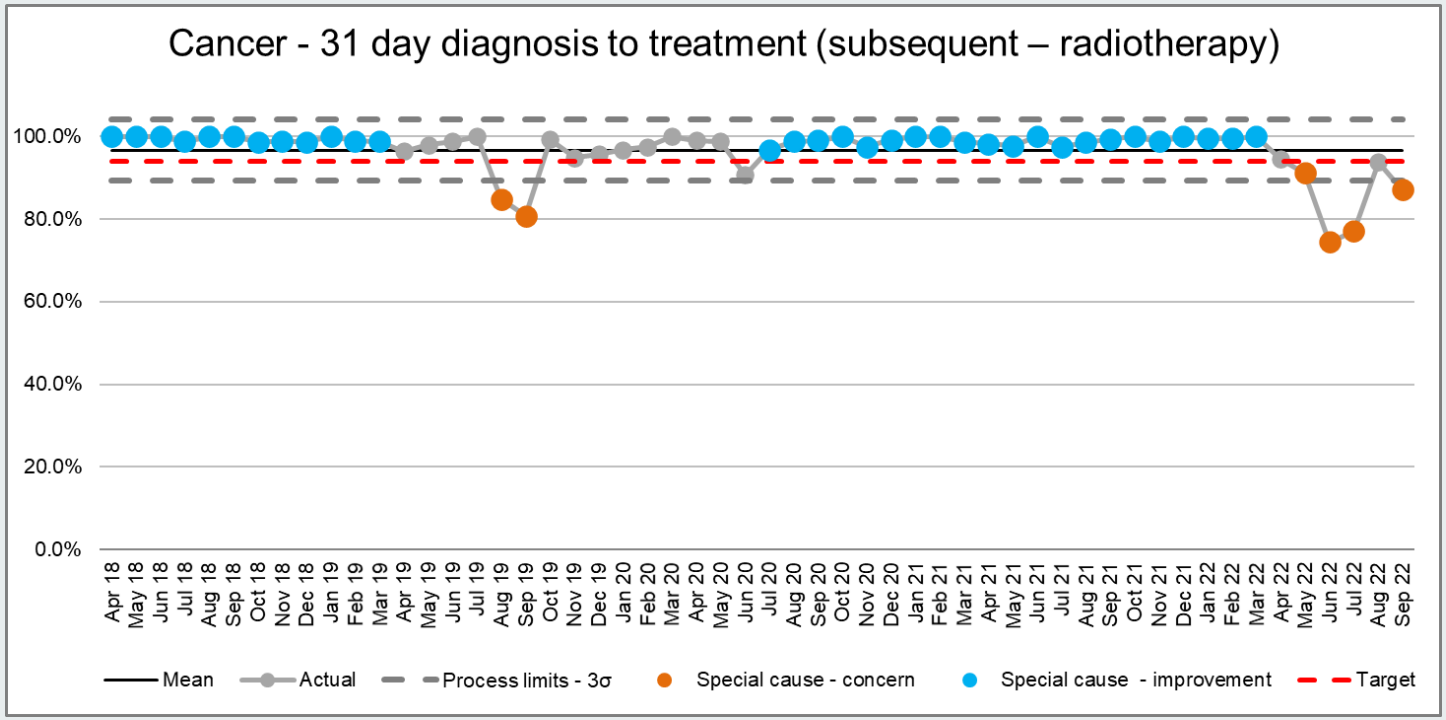


Commentary

31 day subs radiotherapy performance (unvalidated)
Standard = 94% National = 90.5% GHFT = 87.1%

Treated = 90 Breaches = 23

Performance impacted by known radiographer staffing issues (Trust risk) in spring and summer. Backlog significantly reduced and performance now improving (currently 83% in October)

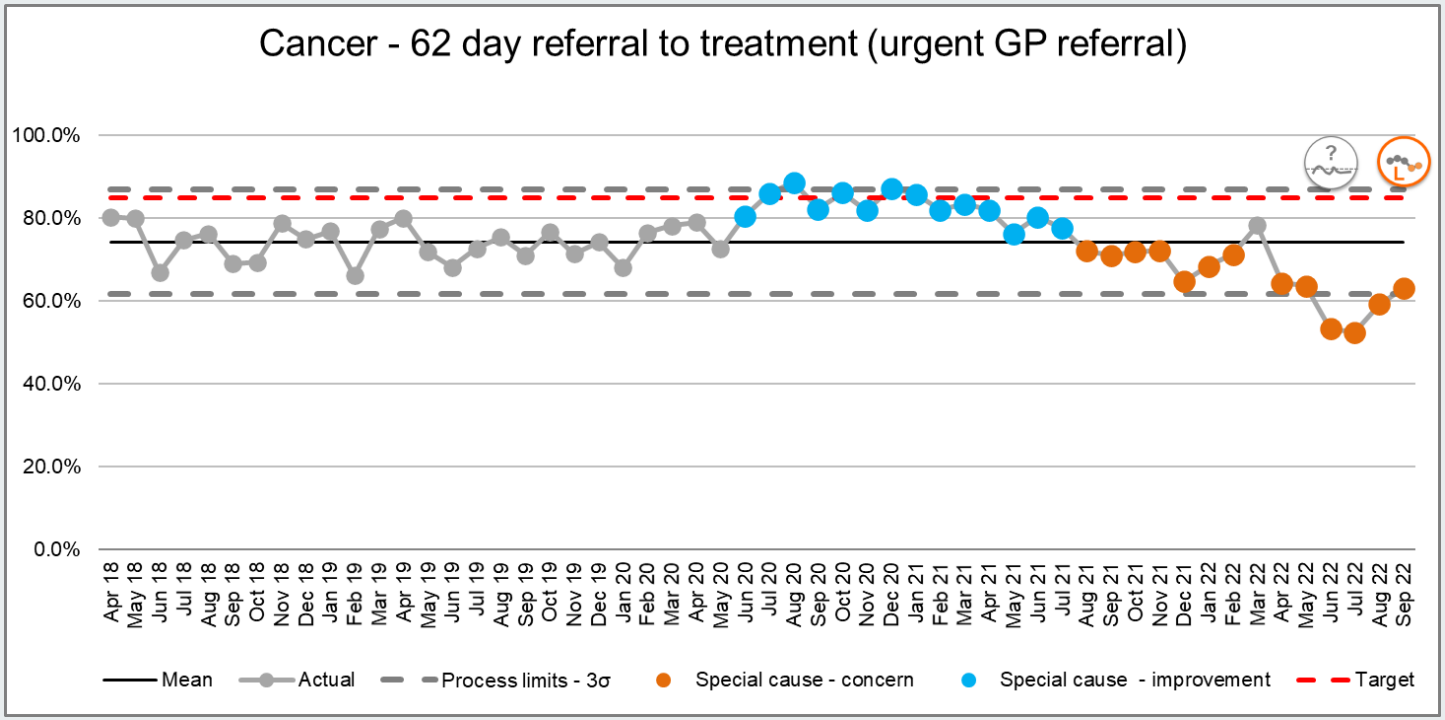
- General Manager - Cancer

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 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.
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

62 day GP performance (unvalidated)
Standard = 85% National = 61.9% GHFT = 63% (Treatments =188, Breaches 69.5, LGI=18.5, Urology=16.5)

Performance improvements seen in Urology where backlogs are being cleared. Main reason for breaches were elective capacity issues although the number of LATP breaches has significantly reduced to 4 breaches. The majority are relating to surgical or Pre op assessment capacity or biopsy capacity (exc LATP). Complex patients constituted 16 breaches with 6 relating to tertiary referral into the trust. 7 breaches were patient-initiated delay. 6 breaches were related to pathology reporting delays with 5 breaches related to radiology event or report.

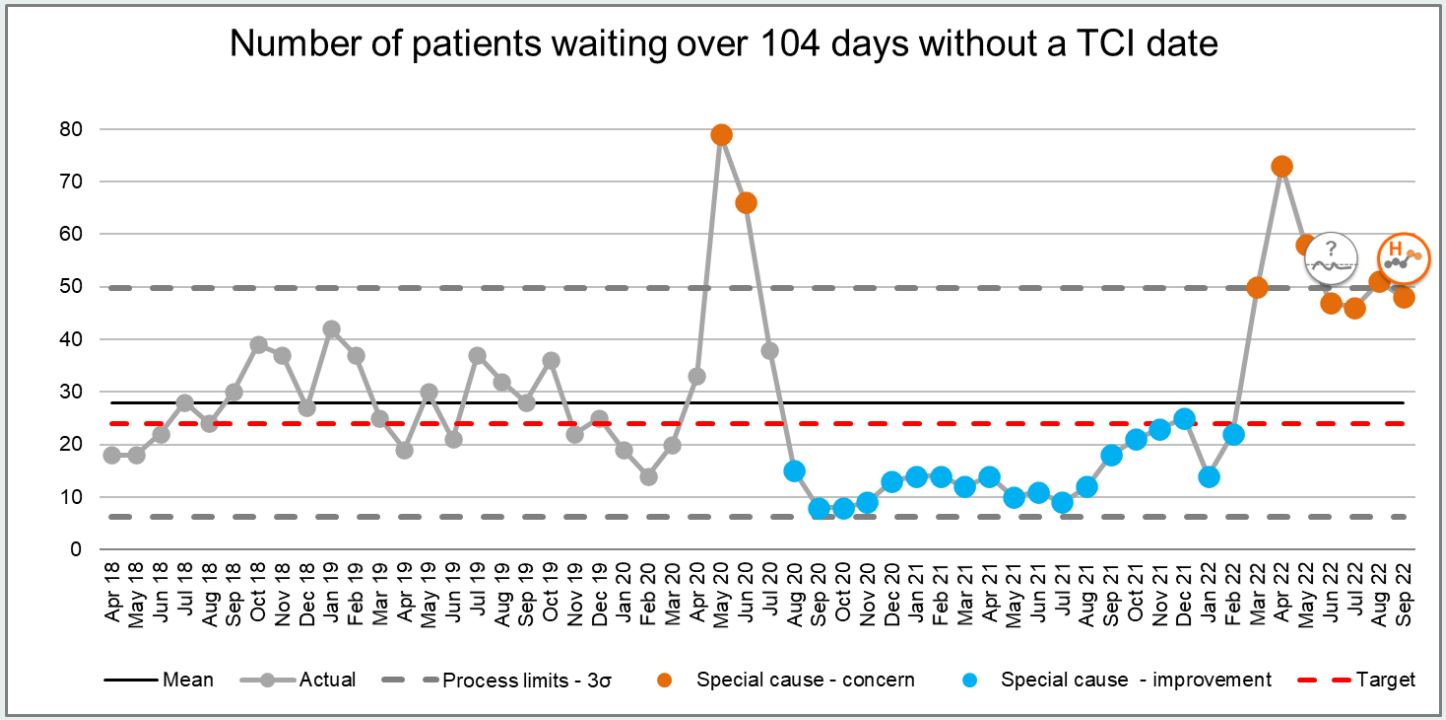
- General Manager - Cancer

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 2 data points which are above the line and 3 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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Number of patients with TCI date = 13 /Number of patients without TCI date = 42/Total number of >104 day patients = 55
Numbers slowly reducing from highs in the 70's. Reduction mainly seen in Urology where prostate pathway issues relieving. 9 patients referred in late to the Trust. 10 awaiting TCI. 20 not yet diagnosed.

104 day patients reviewed daily and validated weekly.

- 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.
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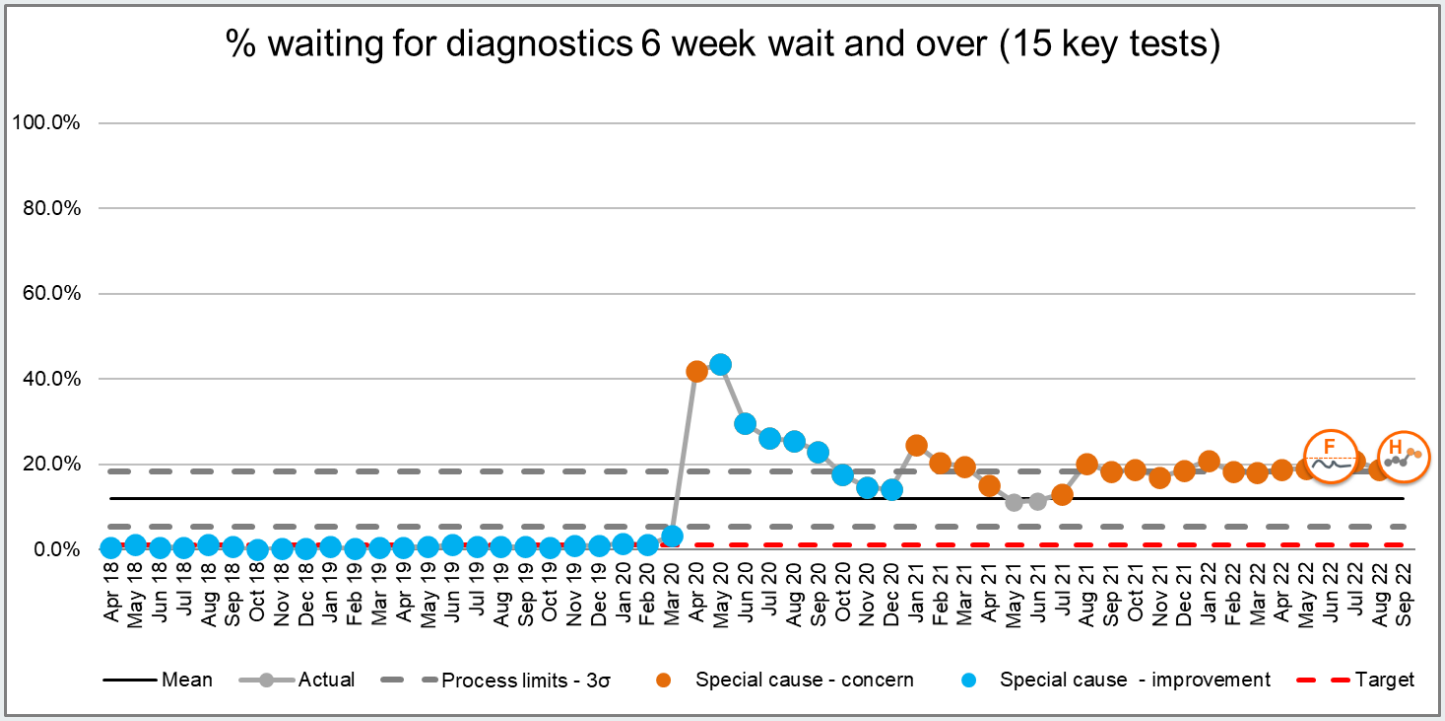

Commentary

The unconfirmed position for September has deteriorated, dropping to 21.67% compared to 18.8% last month. The key change being a swing in Echo performance, with an additional 275 breaches being recorded in month.

- 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 19 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

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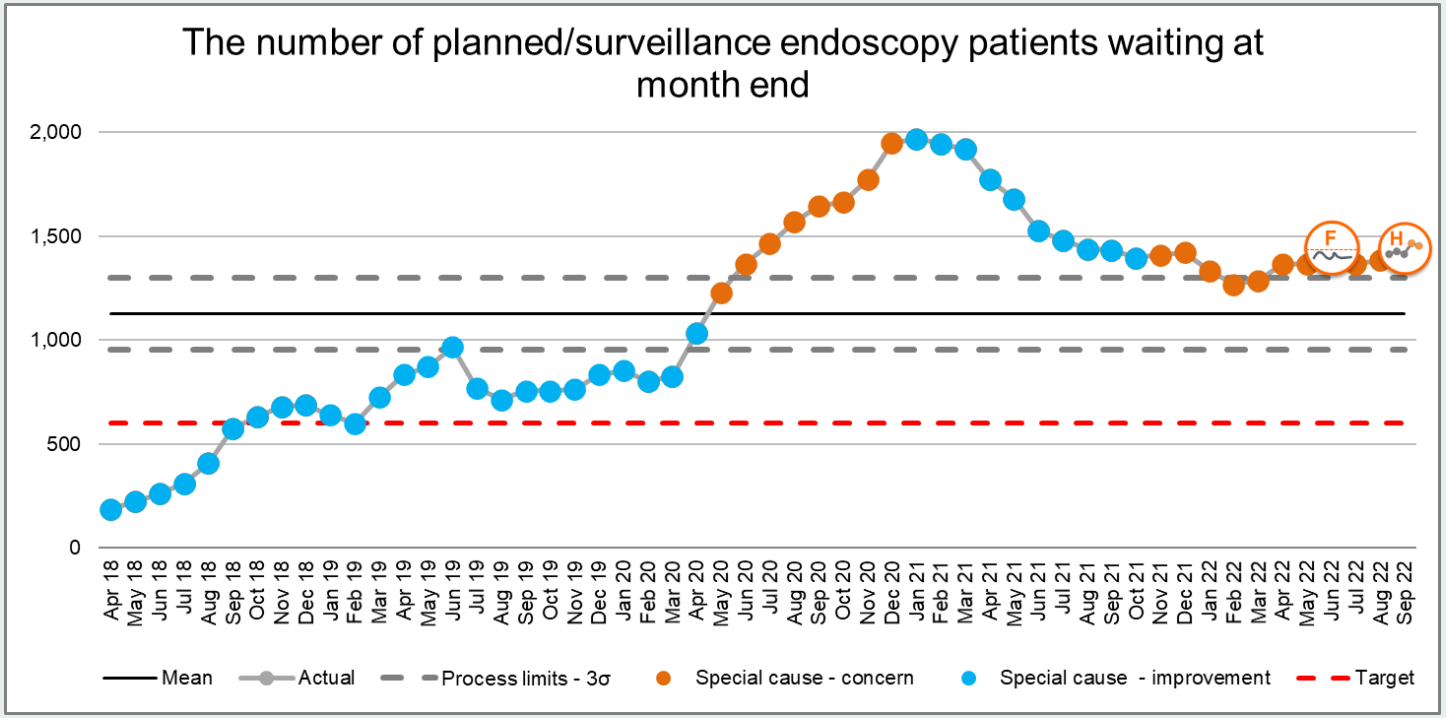

Commentary

The number of surveillance patients has increase due admin validation capacity. A funding request for a B3 Admin Validator for 1 year, has been submitted to NHSE which will provide focus on significantly reducing the number of these patient.

- 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 26 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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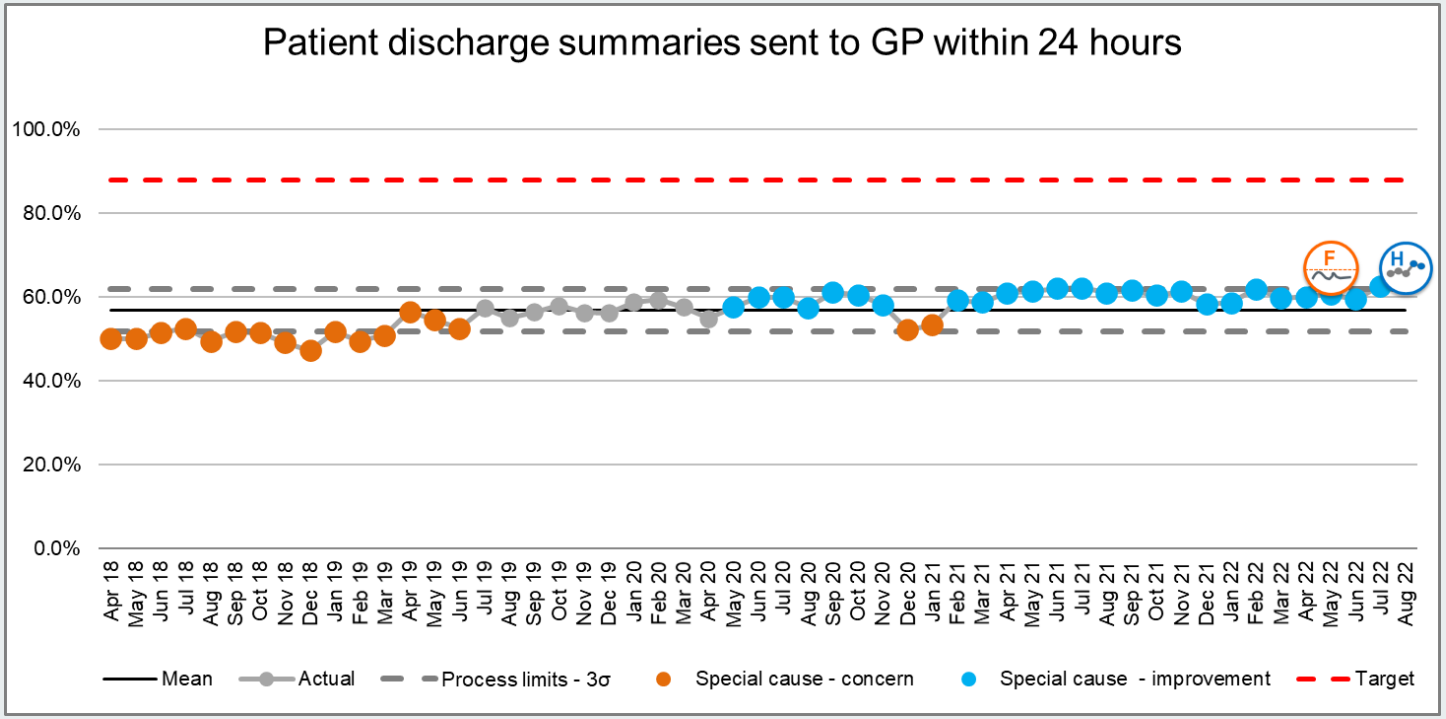

Commentary

The number remains around 60% for last few months. It is not expected to change significantly till after the roll out of EPMA and discharge summaries being done on Sunrise instead of trakcare.

- 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 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.
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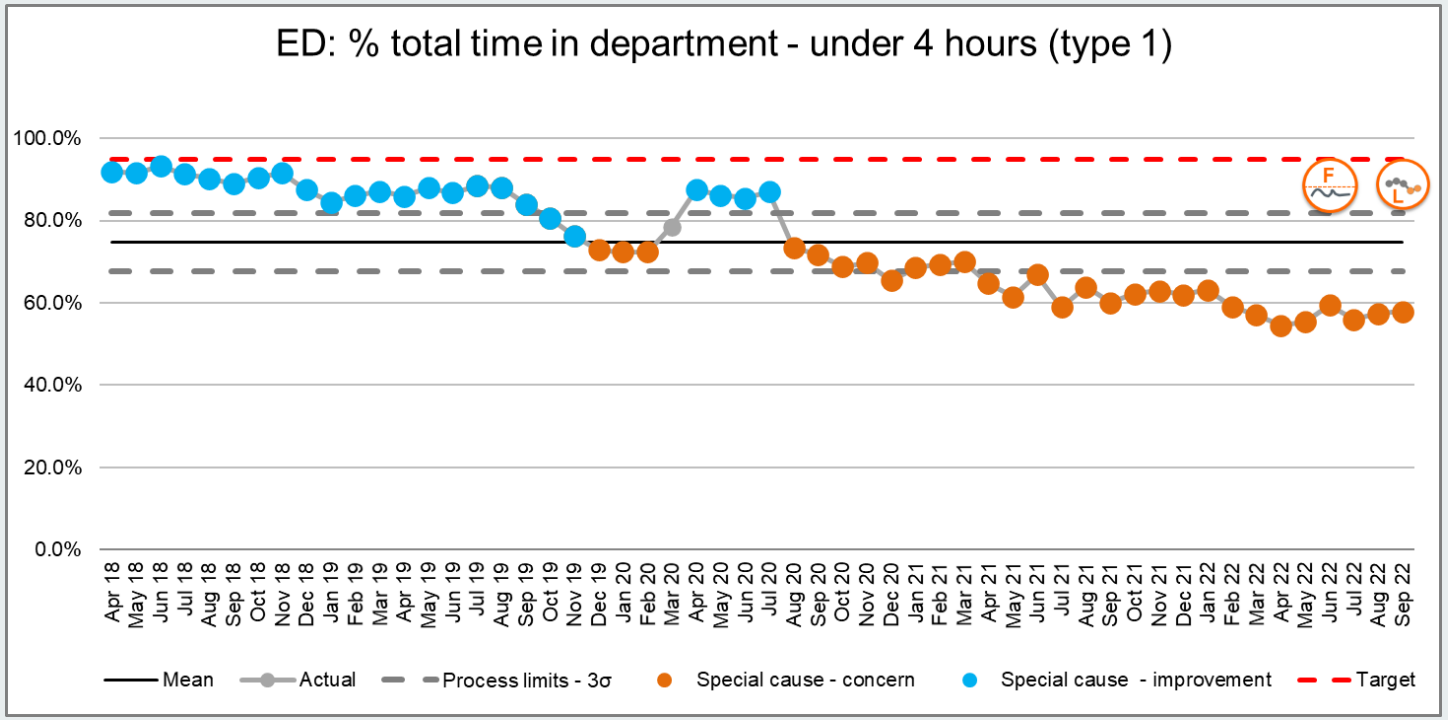

Commentary

% total time in department under 4 hours should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

- 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 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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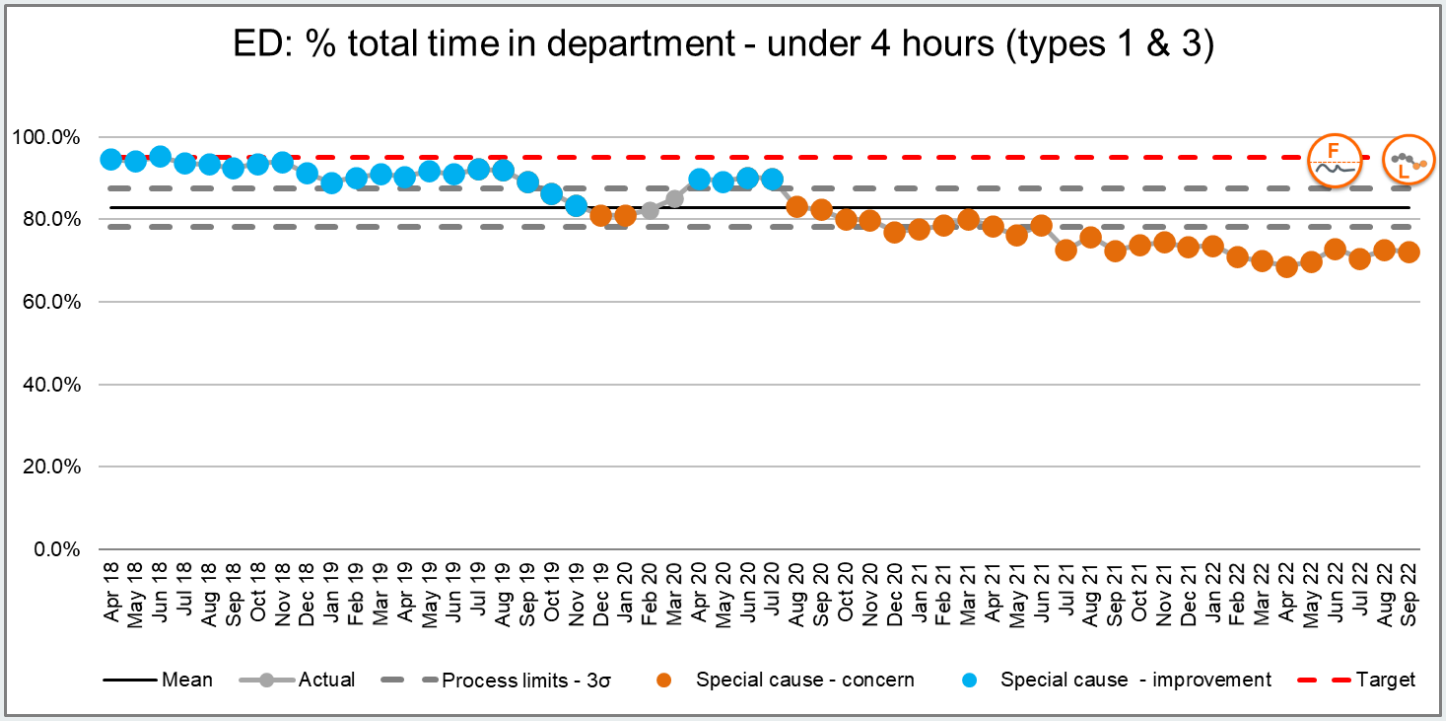


Commentary

% total time in department under 4 hours should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

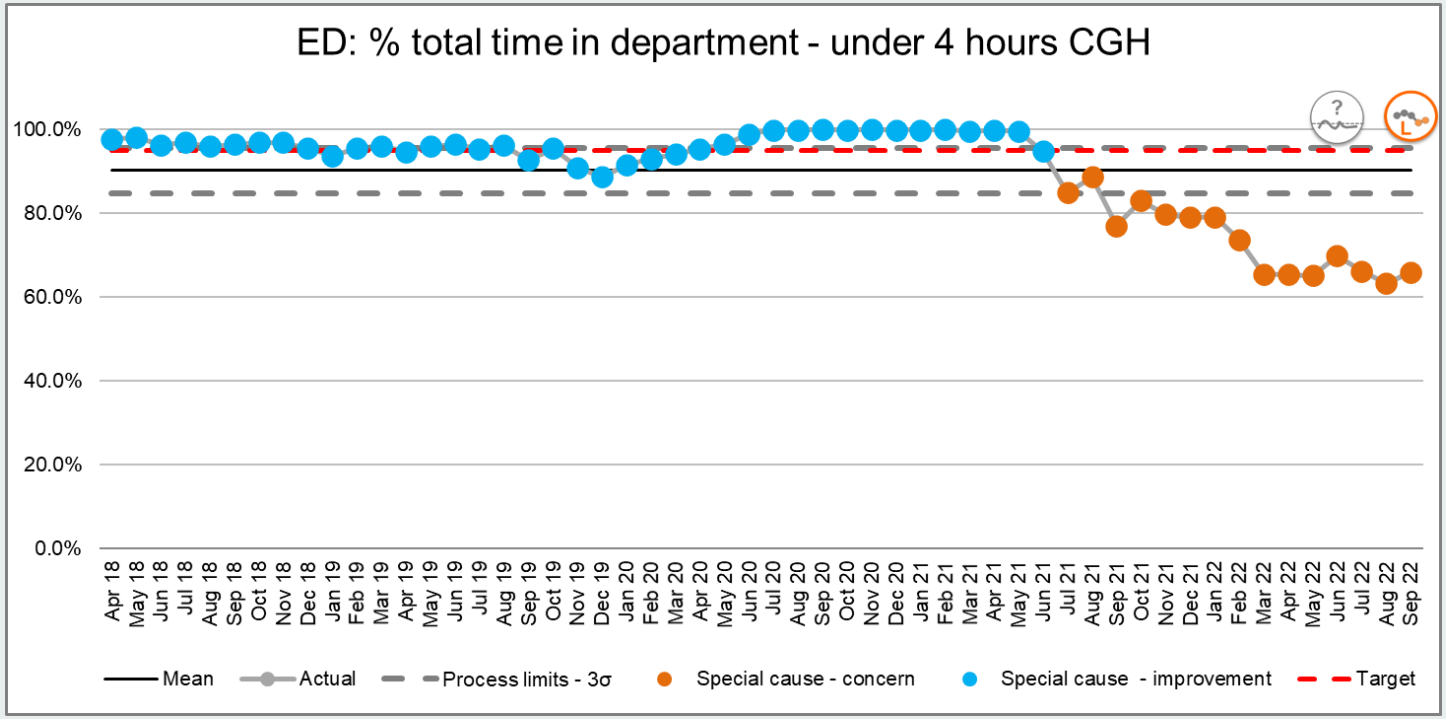
- General Manager of Unscheduled Care

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
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 time in department under 4 hours should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

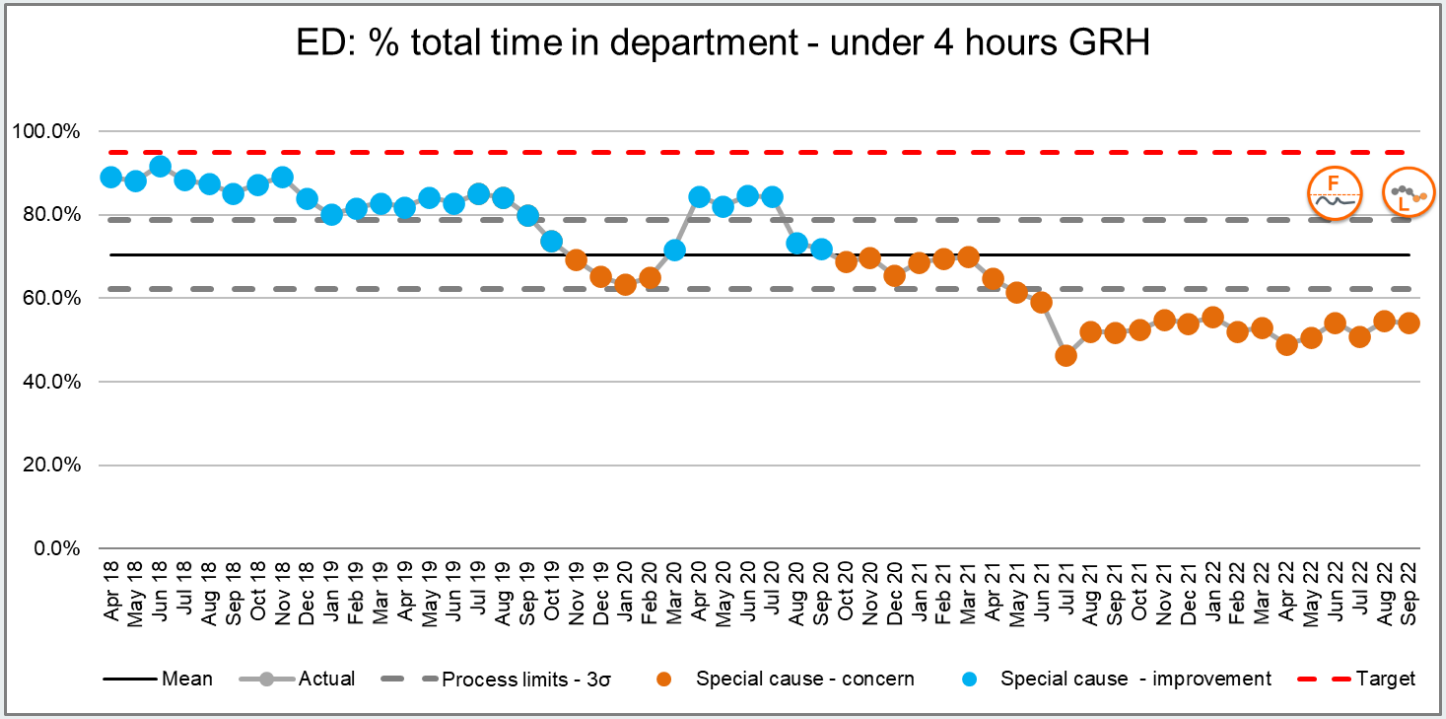
- General Manager of Unscheduled Care

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 25 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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

% total time in department under 4 hours should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

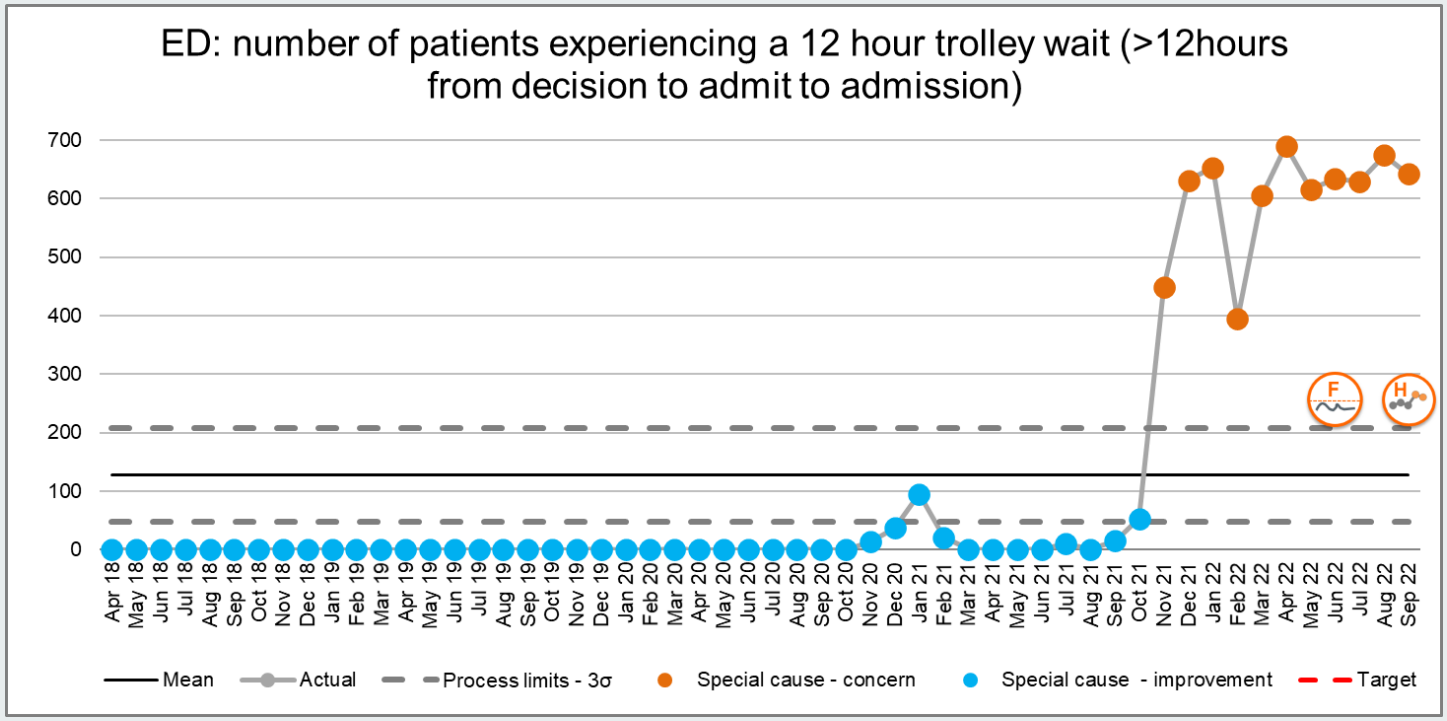
- General Manager of Unscheduled Care

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 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

Number of pts experiencing a 12 hour trolley wait should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

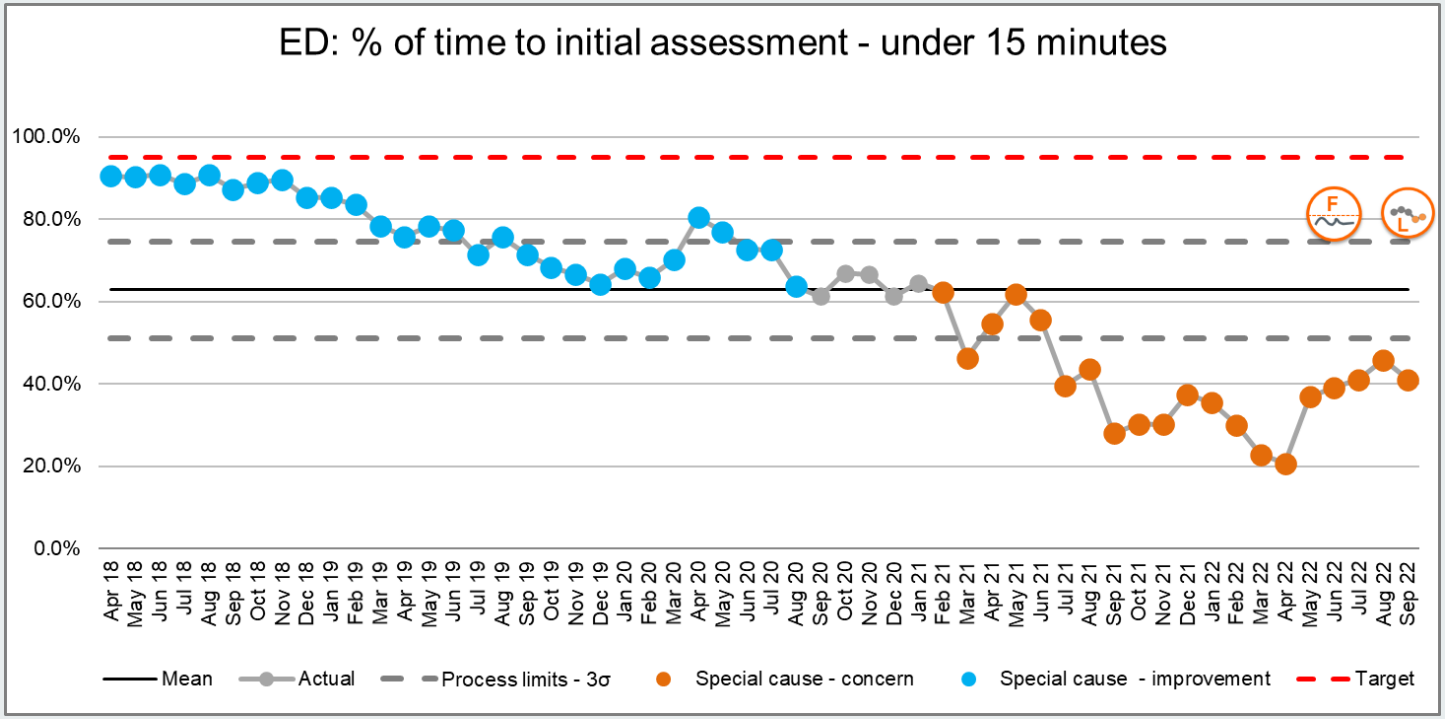
- General Manager of Unscheduled Care

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 11 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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

% of time to initial assessment under 15 mins should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

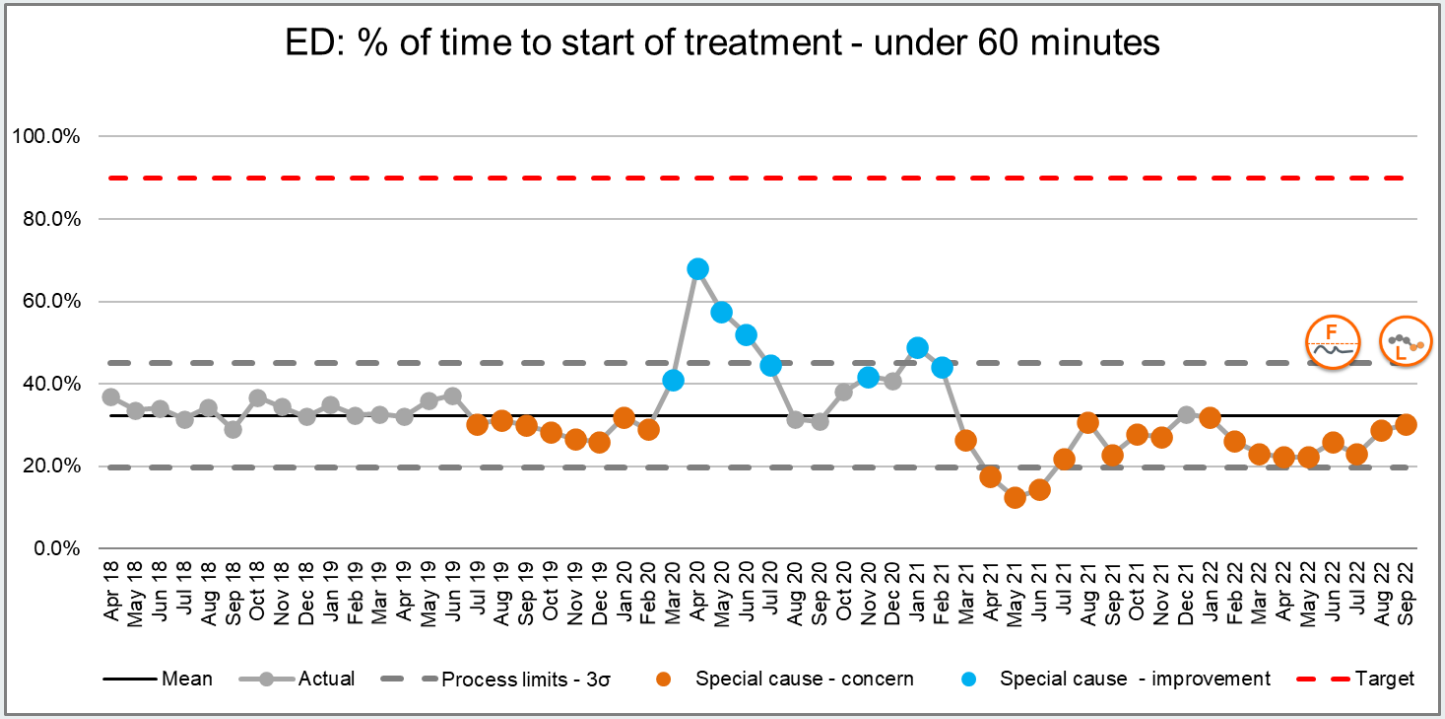
- General Manager of Unscheduled Care

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 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 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

% of time to start initial treatment should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

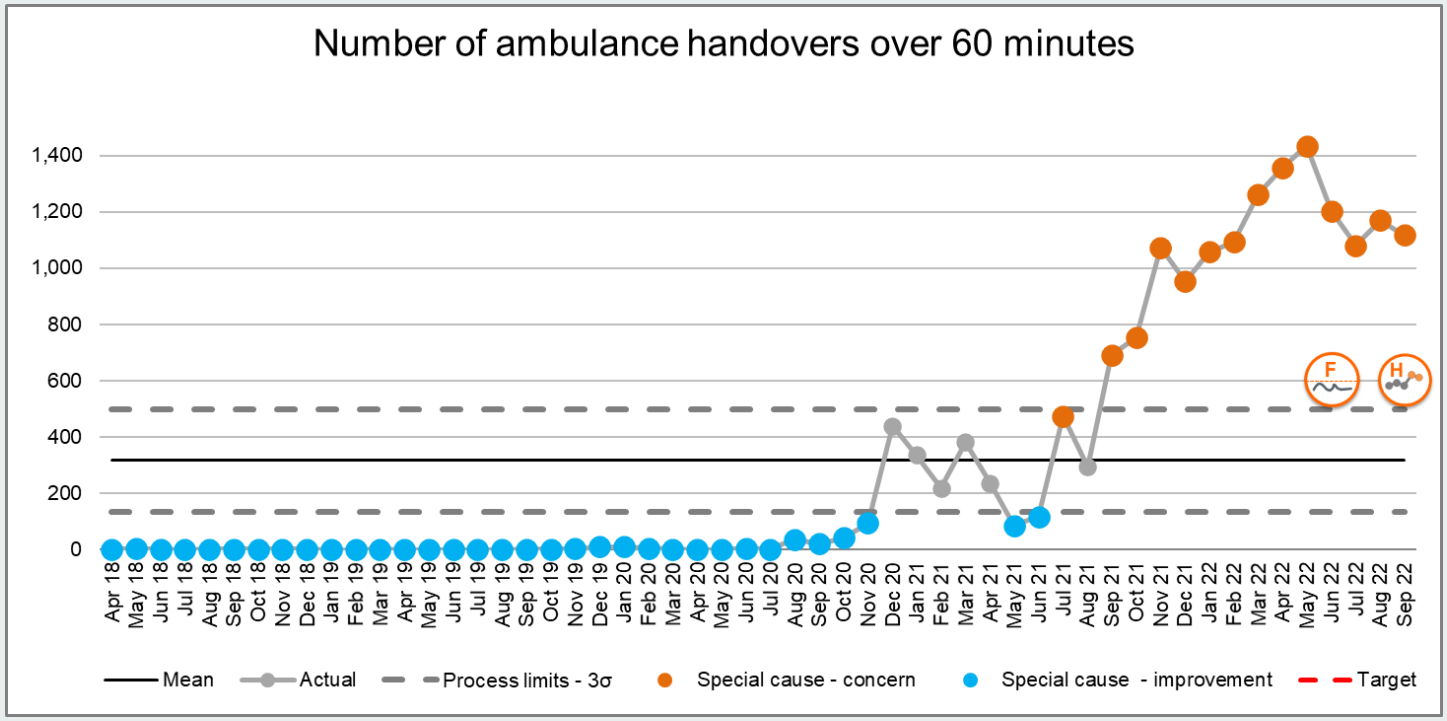
- General Manager of Unscheduled Care

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

% of ambulance handovers over 60 minutes should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

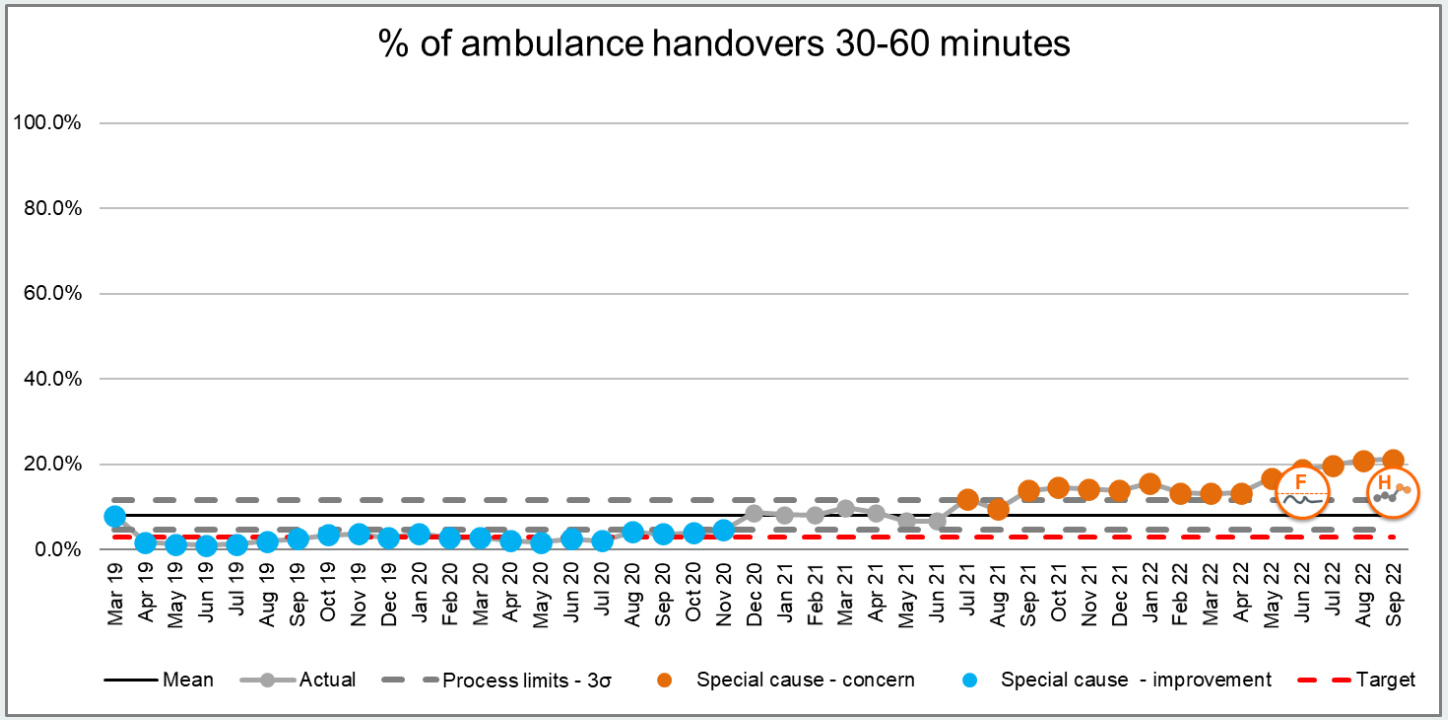
- General Manager of Unscheduled Care

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 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.
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

% of ambulance handovers 30-60 minutes should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

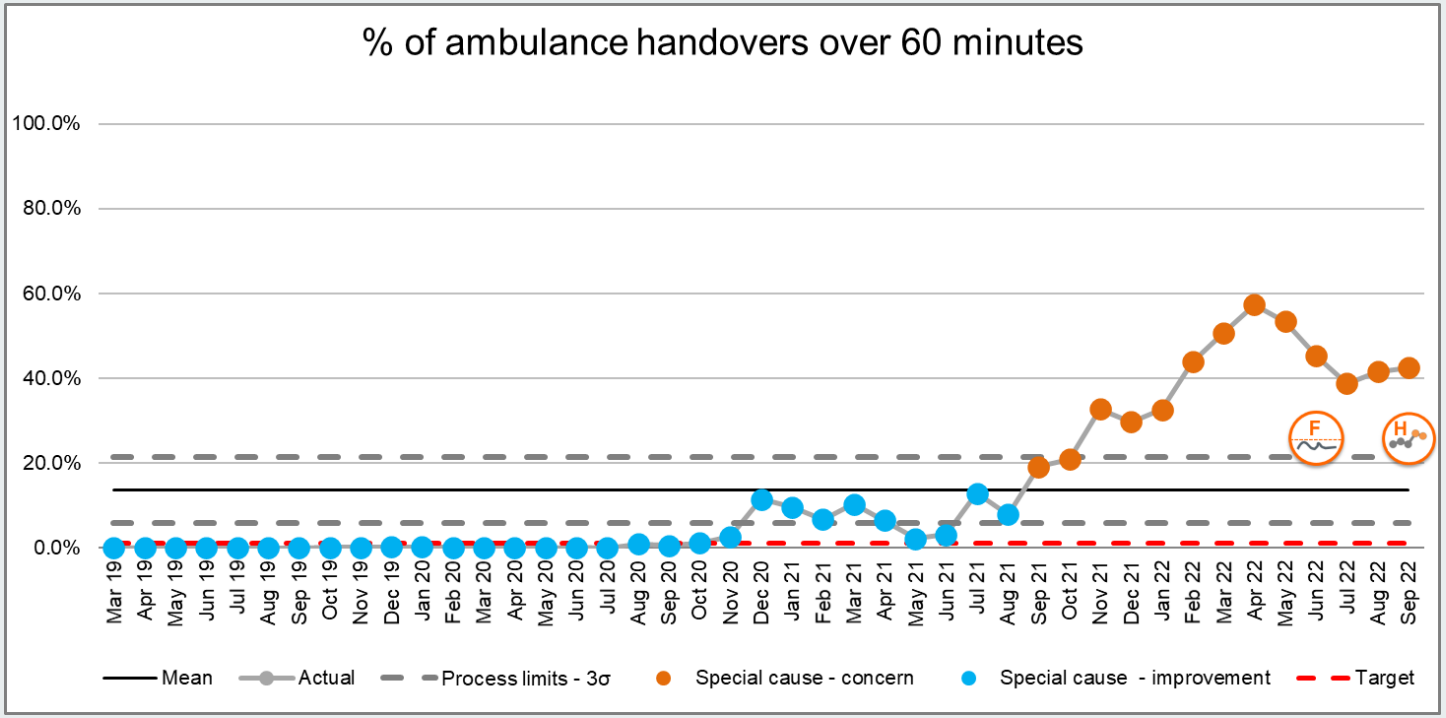
- General Manager of Unscheduled Care

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 14 data points which are above the line. There are 20 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

% of ambulance handovers over 60 minutes should improve for next month's data as a consequence of increased focus from the beginning of October on a 're-set' process initiated by execs.

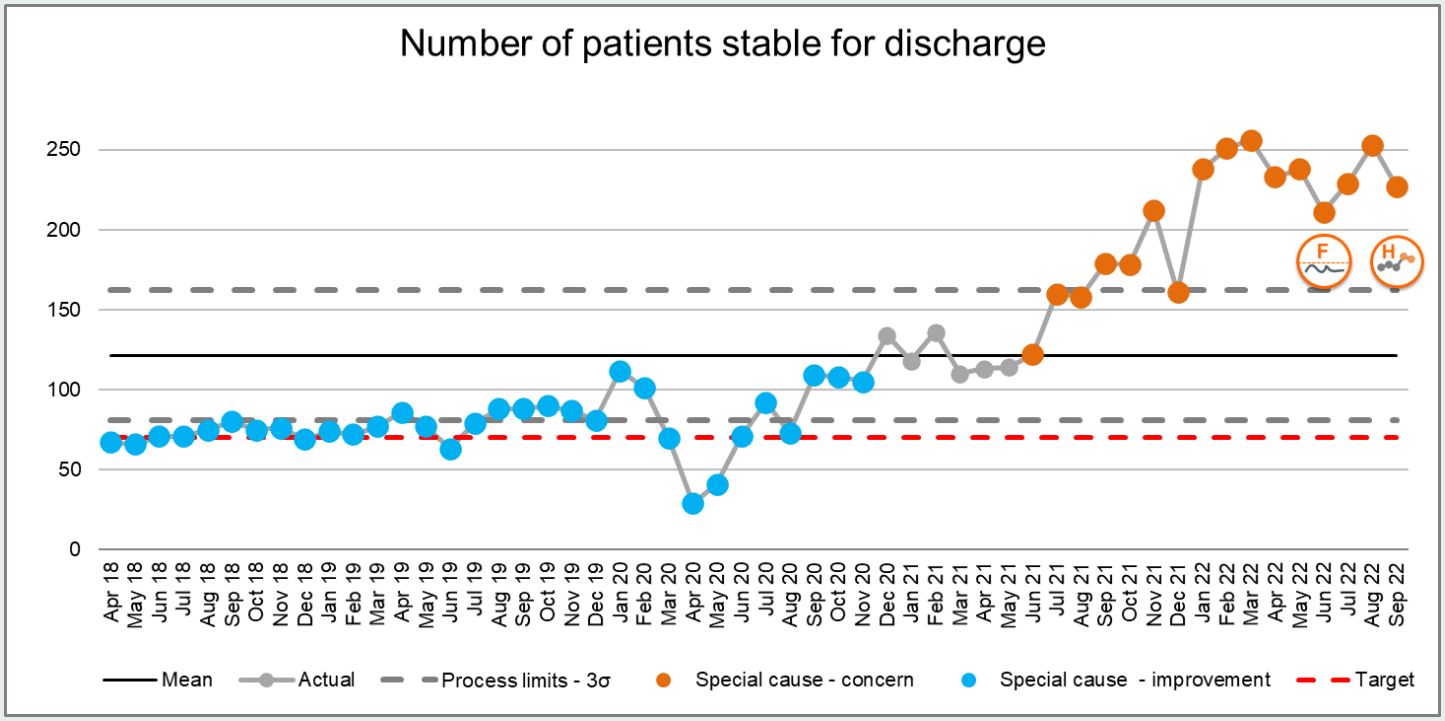
- General Manager of Unscheduled Care

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 11 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 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

Under Review

- 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 12 data points which are above the line. There are 20 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

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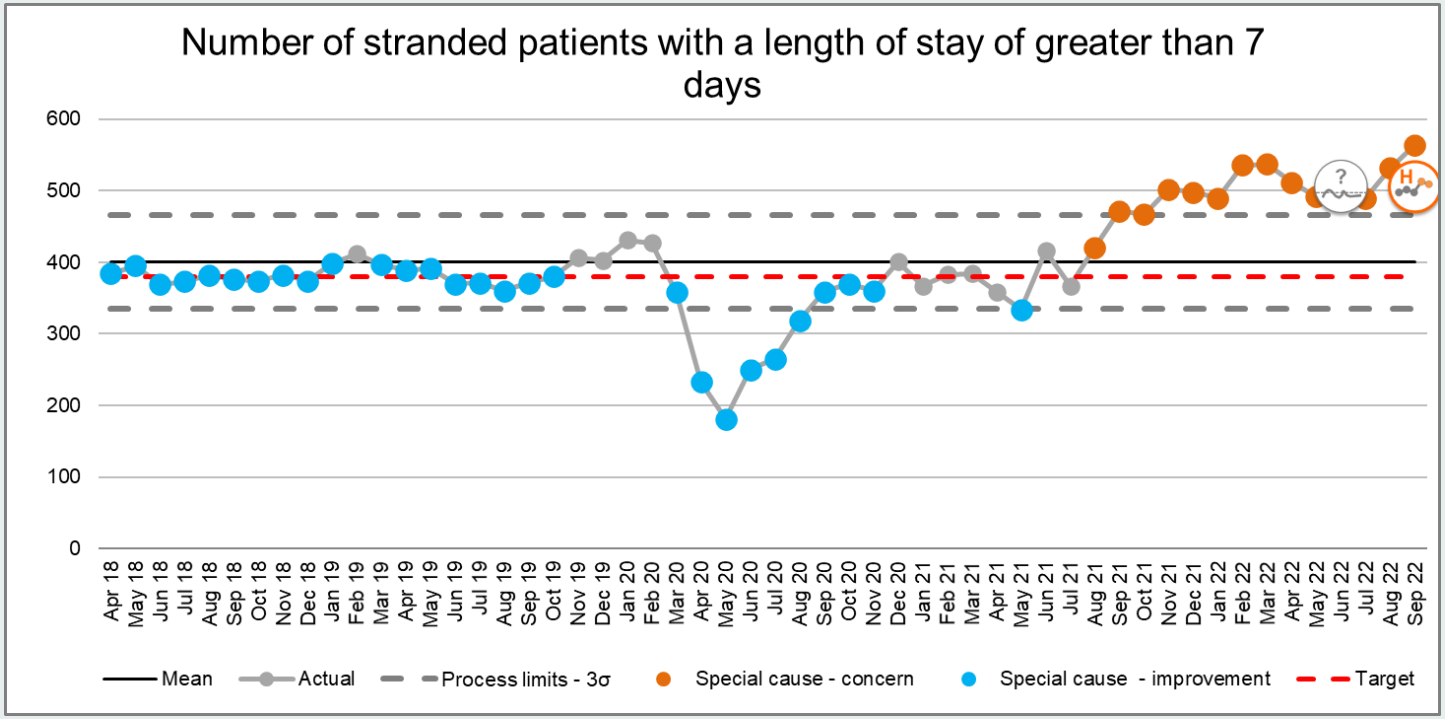
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review

- 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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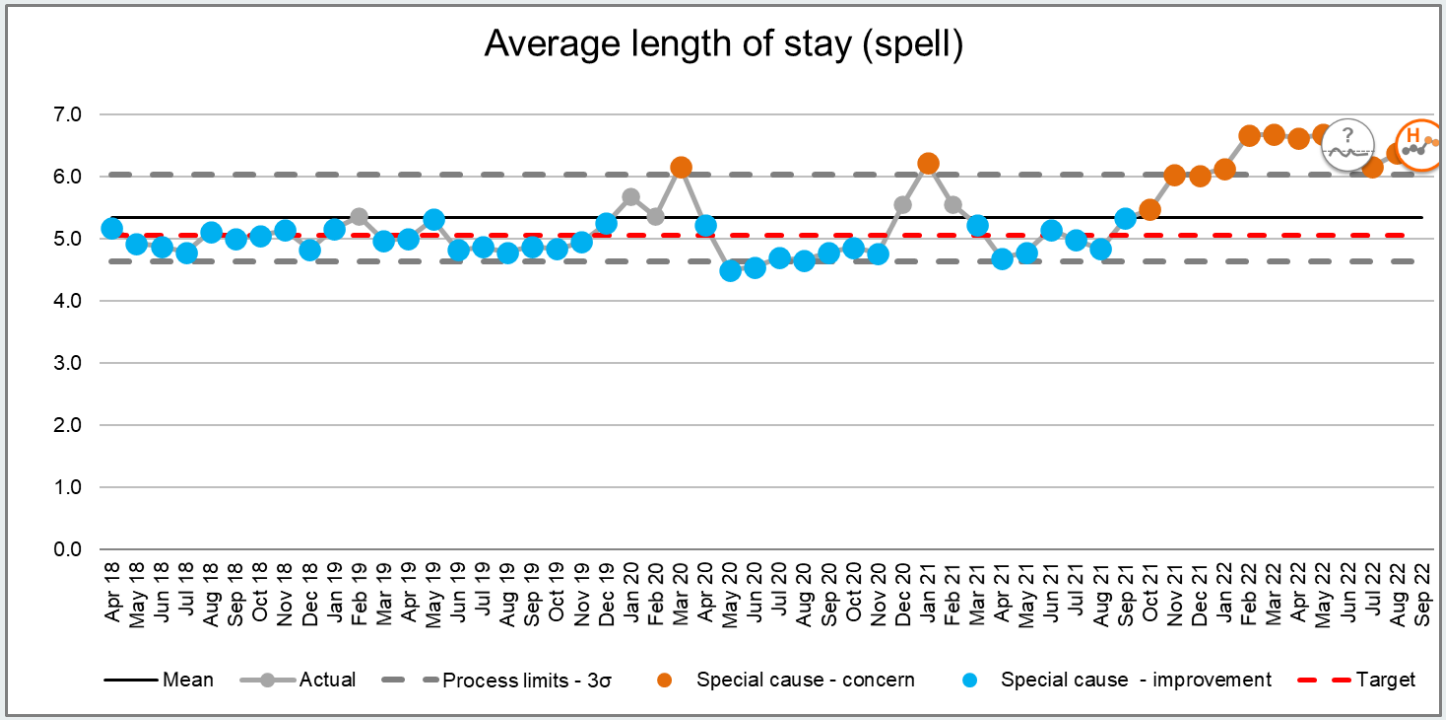
Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

- 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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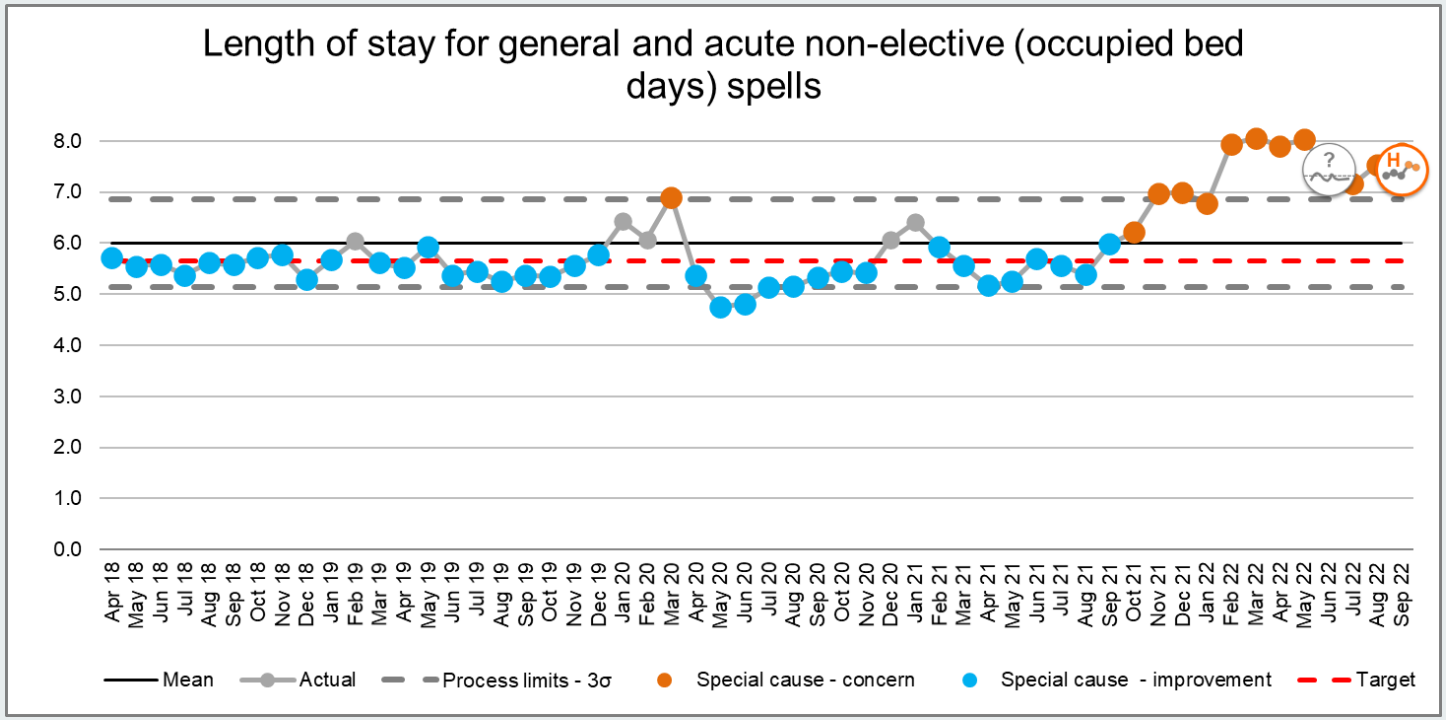

Commentary

Under Review

- 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 is 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 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:
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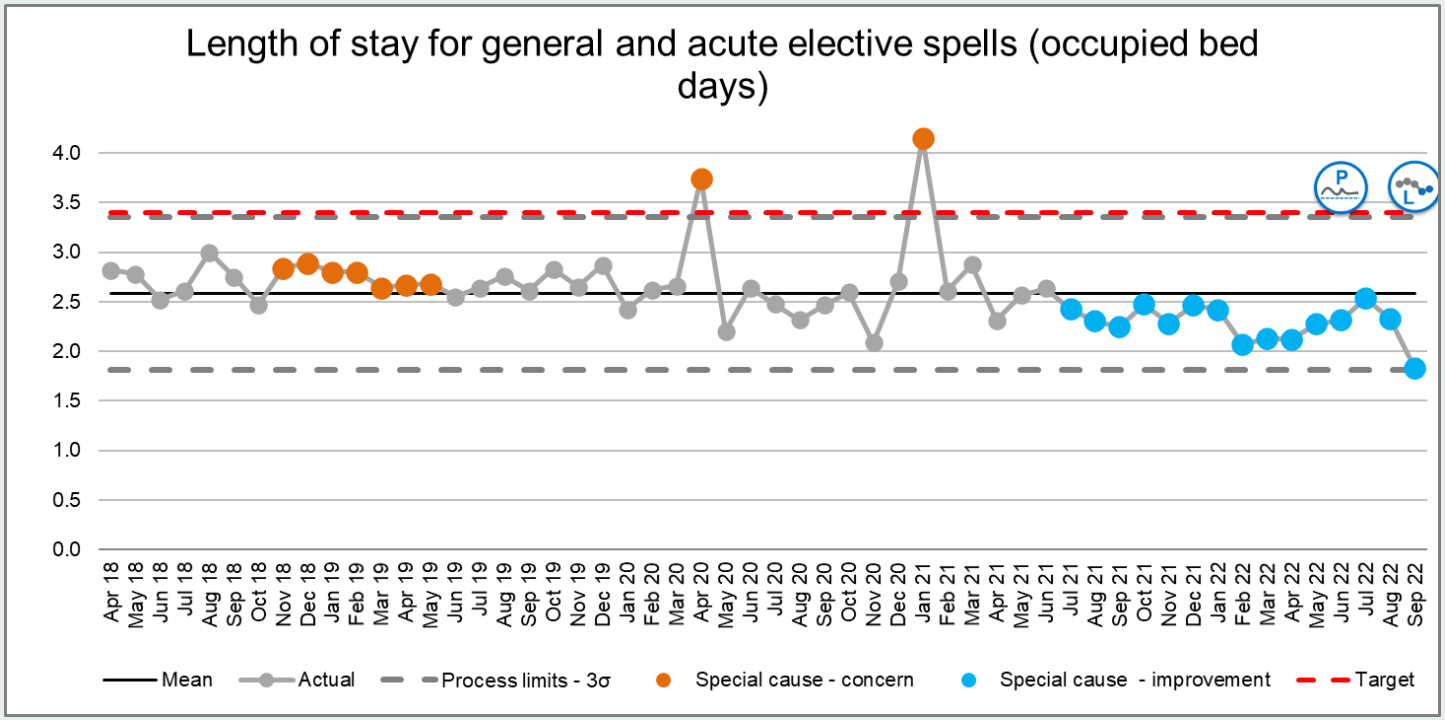
Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

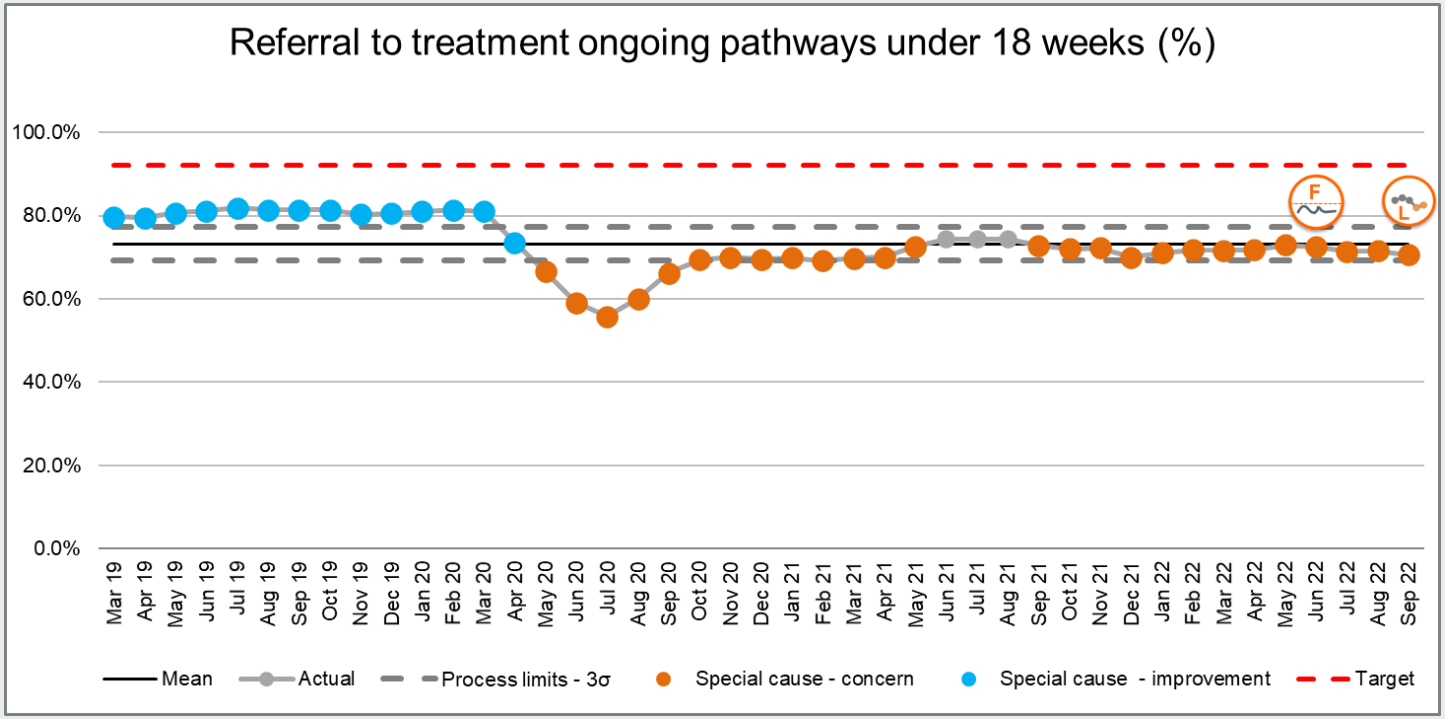
- Deputy Chief Operating Officer

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.

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

See Planned Care Exception report for full details. RTT performance is currently reported as 70.66% and is only likely to change by a small amount – potentially to 70.8%. Although a slight decrease on last month performance is considered stable and 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.
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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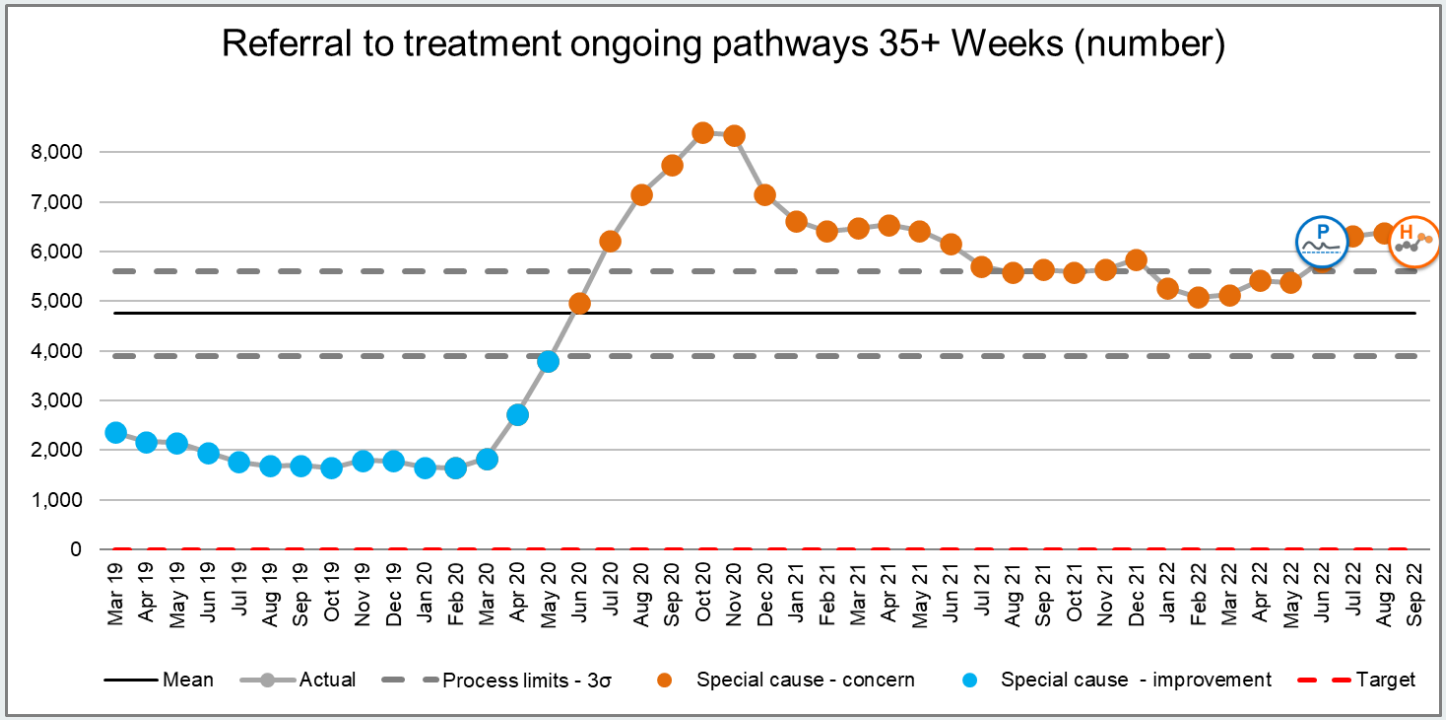
Gloucestershire Hospitals NHS Foundation Trust



Commentary

The number of patients over 35 weeks has reduced in month, by approximately 170 patients.

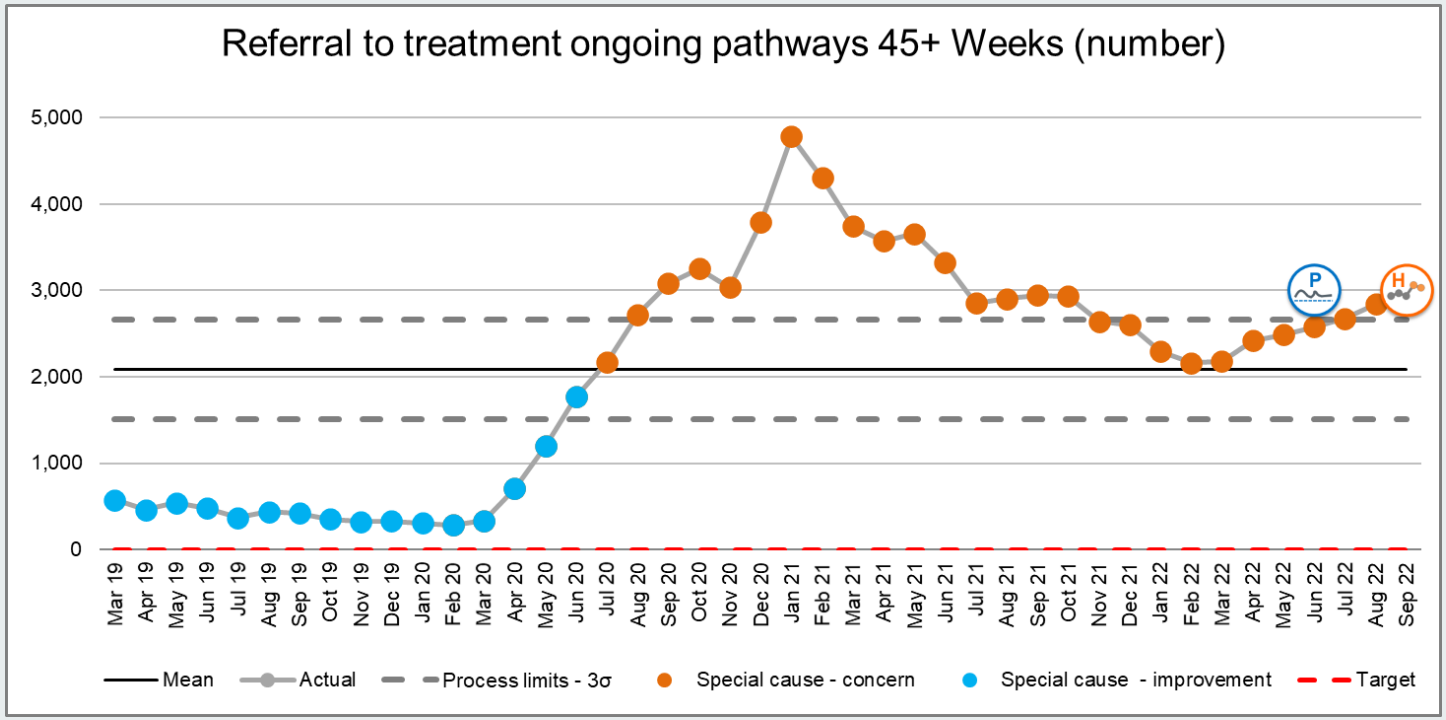
- Associate Director of Elective Care

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 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
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

This cohort remains unchanged in month.

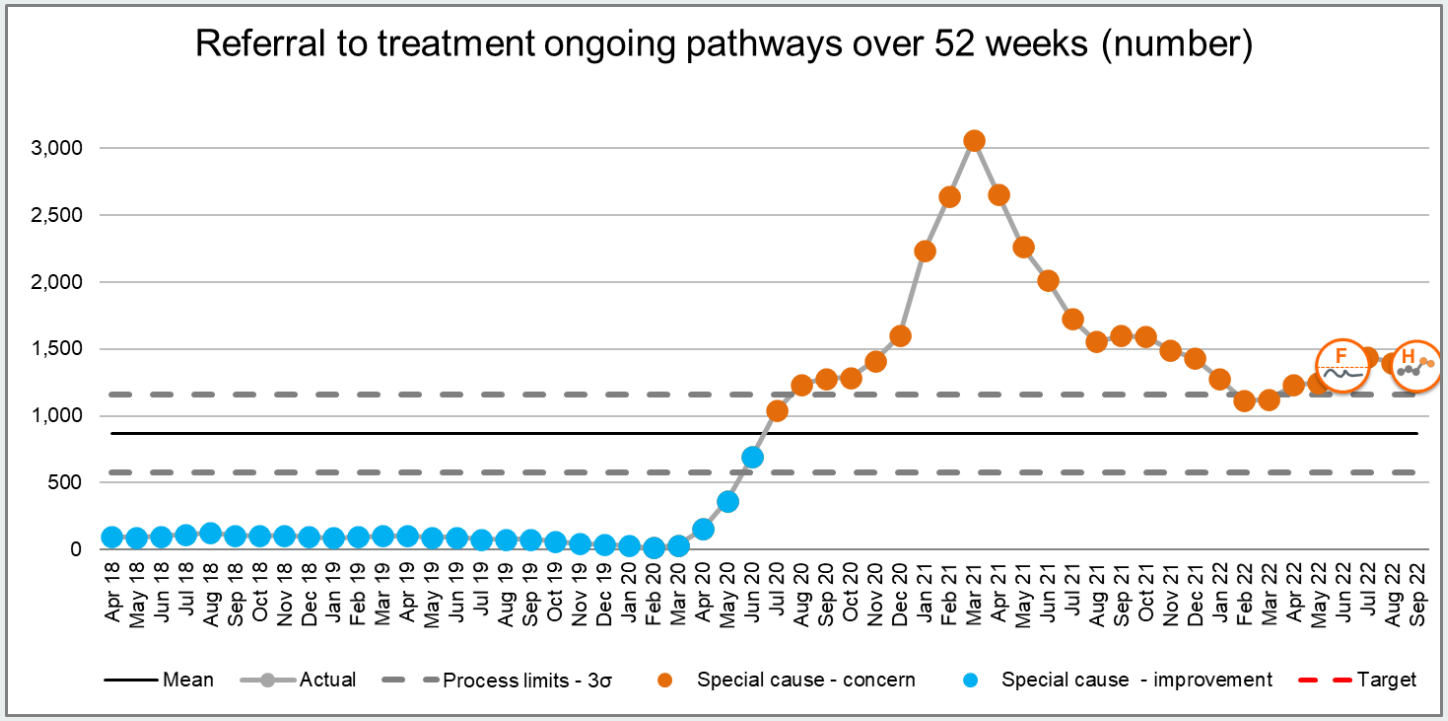
- Associate Director of Elective Care

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 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.
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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

See Planned Care Exception report for a full breakdown. Performance in September has seen a good reduction of 52 week breaches, with a reduction of approximately 150 on last month. The three specialties that have made most gains are Oral Surgery (-70), Ophthalmology (-41) & Clinical Haematology (-31).

- 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 24 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
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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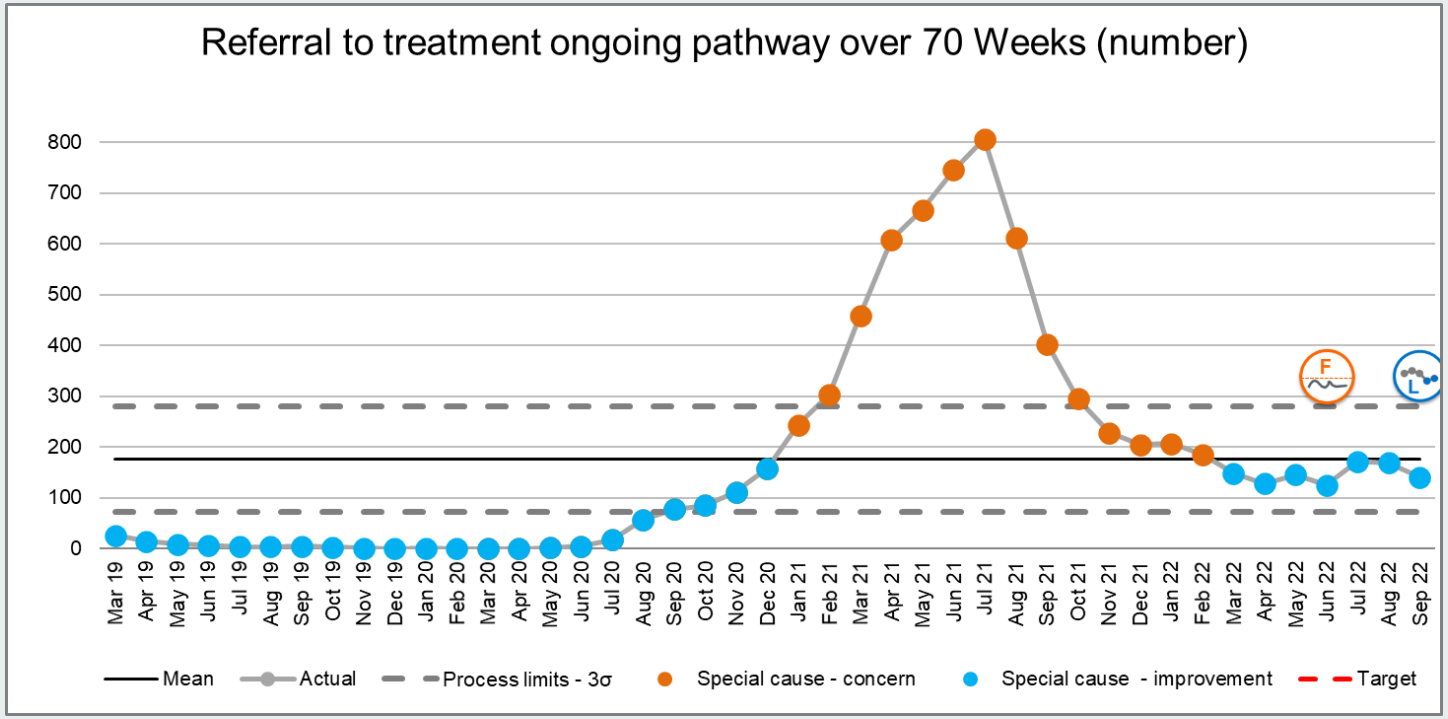
Gloucestershire Hospitals NHS Foundation Trust



Commentary

This cohort has similarly made reductions in month with approximately 30 less patients. These gains are predominantly related to Clinical Haematology.

- 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 9 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 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

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.

Key

Assurance

- Consistently hit target
- Hit and miss target subject to
- Consistently fail target

Variation

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

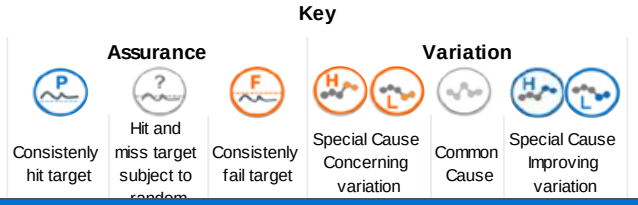
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Friends & Family Test	Inpatients % positive	>=90%	Sep-22	89.5%
Friends & Family Test	ED % positive	>=84%	Sep-22	68.6%
Friends & Family Test	Maternity % positive	>=97%	Sep-22	88.4%
Friends & Family Test	Outpatients % positive	>=94.5%	Sep-22	94.1%
Friends & Family Test	Total % positive	>=93%	Sep-22	89.2%
Friends & Family Test	Number of PALS concerns logged	No Target	Sep-22	312
Friends & Family Test	% of PALS concerns closed in 5 days	>=95%	Sep-22	71.8%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Sep-22	0
Infection Control	MRSA bacteraemia - infection rate per 100,000 bed days	Zero	Sep-22	0
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Sep-22	9
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Sep-22	2
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Sep-22	7
Infection Control	Clostridium difficile - infection rate per 100,000 bed days	<30.2	Sep-22	25.9
Infection Control	Number of MSSA bacteraemia cases	<=8	Sep-22	3
Infection Control	MSSA - infection rate per 100,000 bed days	<=12.7	Sep-22	11.1
Infection Control	Number of ecoli cases	No target	Sep-22	11
Infection Control	Number of pseudomona cases	No target	Sep-22	1
Infection Control	Number of klebsiella cases	No target	Sep-22	3
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Sep-22	81
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No target	Sep-22	38

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Maternity	% C-section rate (planned and emergency)	No target	Sep-22	0
Maternity	% emergency C-section rate	No target	Sep-22	20.0%
Maternity	% of women smoking at delivery	<=8.0%	Sep-22	0
Maternity	% of women that have an induced labour	<=33%	Sep-22	26.9%
Maternity	% stillbirths as percentage of all pregnancies	<0.52%	Sep-22	0.40%
Maternity	% of women on a Continuity of Carer pathway	No target	Sep-22	10.40%
Maternity	% breastfeeding (initiation)	>=81%	Sep-22	78.8%
Maternity	% PPH >1.5 litres	<=4%	Sep-22	3.5%
Mortality	Summary hospital mortality indicator (SHMI) - national data	NHS Digital	Sep-22	0.0
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	May-22	113.4
Mortality	Hospital standardised mortality ratio (HSMR) - weekend	Dr Foster	May-22	105.6

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.

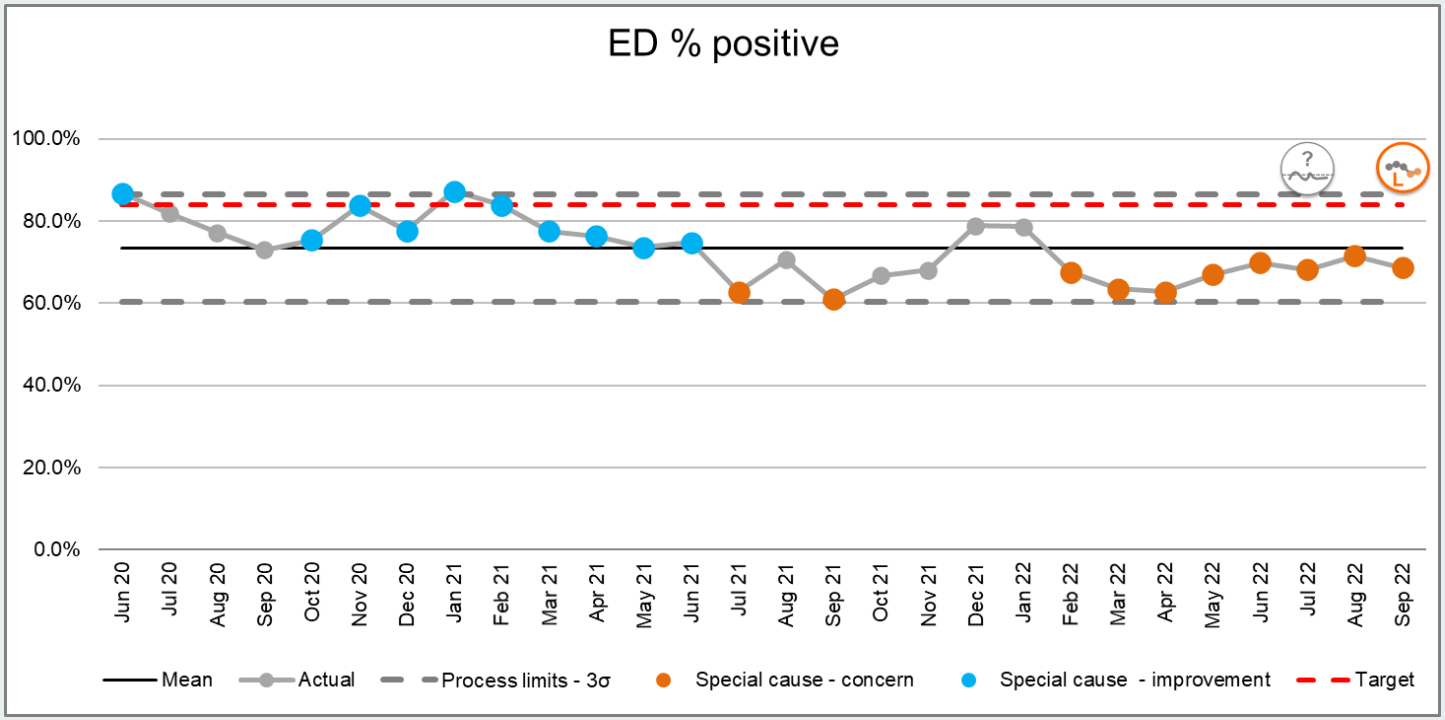


MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	Sep-22	167	
Mortality	Number of deaths of patients with a learning disability	No target	Sep-22	5	
MSA	Number of breaches of mixed sex accommodation	<=10	Sep-22	56	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Dec-21	1	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Sep-22	6.7	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Sep-22	9	
Patient Safety Incidents	Number of patient safety incidents - severe harm (major/death)	No target	Sep-22	12	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Sep-22	26	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Sep-22	0	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Sep-22	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Sep-22	8	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Sep-22	7	
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Apr-21	70%	
RIDDOR	Number of RIDDOR	SPC	Sep-22	2	
Safety Thermometer	Safety thermometer - % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Sep-22	0	
Serious Incidents	Number of serious incidents reported	No target	Sep-22	4	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Serious Incidents	Serious incidents - 72 hour report completed within contract timescale	>90%	Sep-22	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Sep-22	100%	
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Sep-22	82.3%	
Safeguarding	Level 2 safeguarding adult training - e-learning package	TBC	Nov-19	95%	
Safeguarding	Number of DoLs applied for	TBC	Sep-22	76	
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	TBC	Sep-22	3	
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	TBC	Aug-22	2	
Safeguarding	Total admissions aged 0-17 with DSH	TBC	Sep-22	31	
Safeguarding	Total ED attendances aged 0-17 with DSH	TBC	Sep-22	92	
Safeguarding	Total admissions aged 0-17 with an eating disorder	TBC	Aug-22	10	
Safeguarding	Total number of maternity social concerns forms completed	TBC	Sep-22	46	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The current positive FFT score for ED is at 69% across both sites, a decrease from 71.5% in August with the main theme emerging focussed on wait times, which is reflective of the operational pressures in the department. 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.

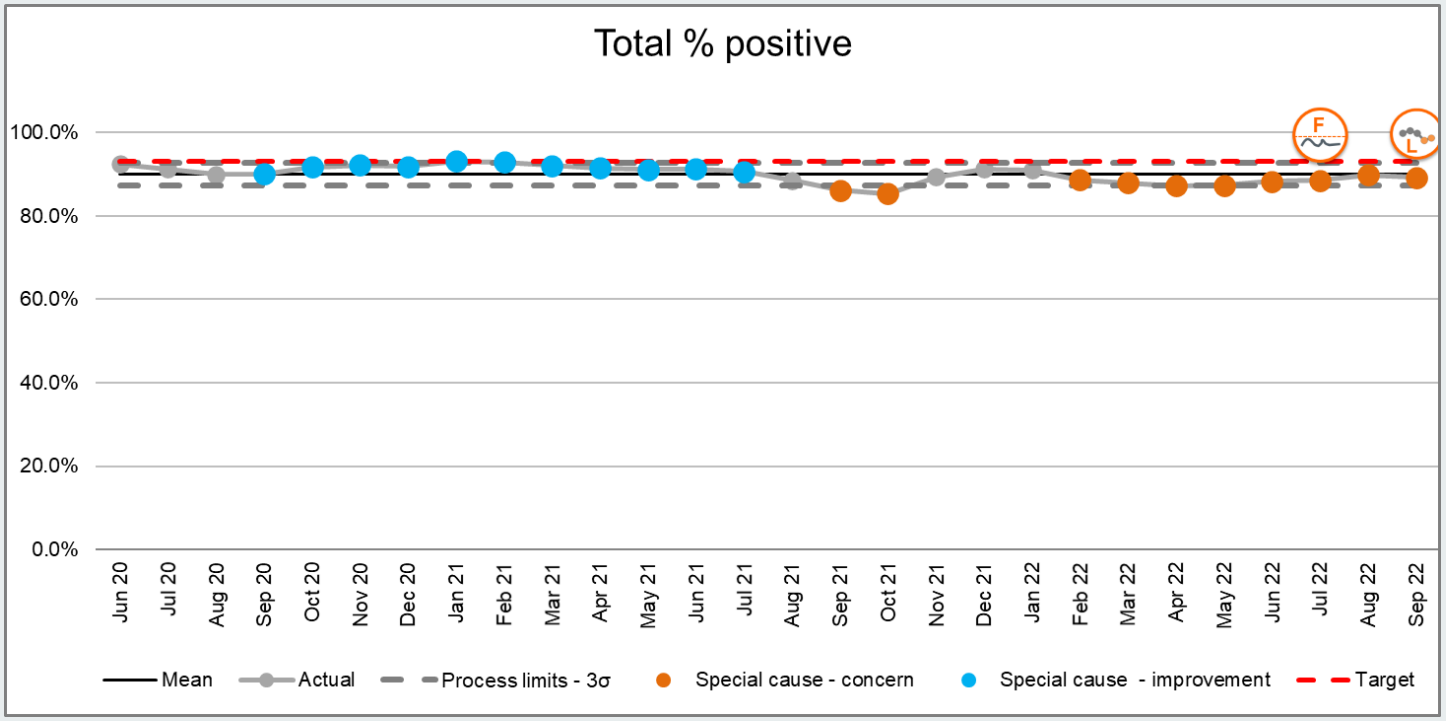
-Head of Quality

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.
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

The Trust had 5937 responses to FFT in September 2022, and the overall Trust FFT positive score has seen a slight decrease in positive score this month to 89.2%. This is largely due to decreases in the positive FFT score for unscheduled care. 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.

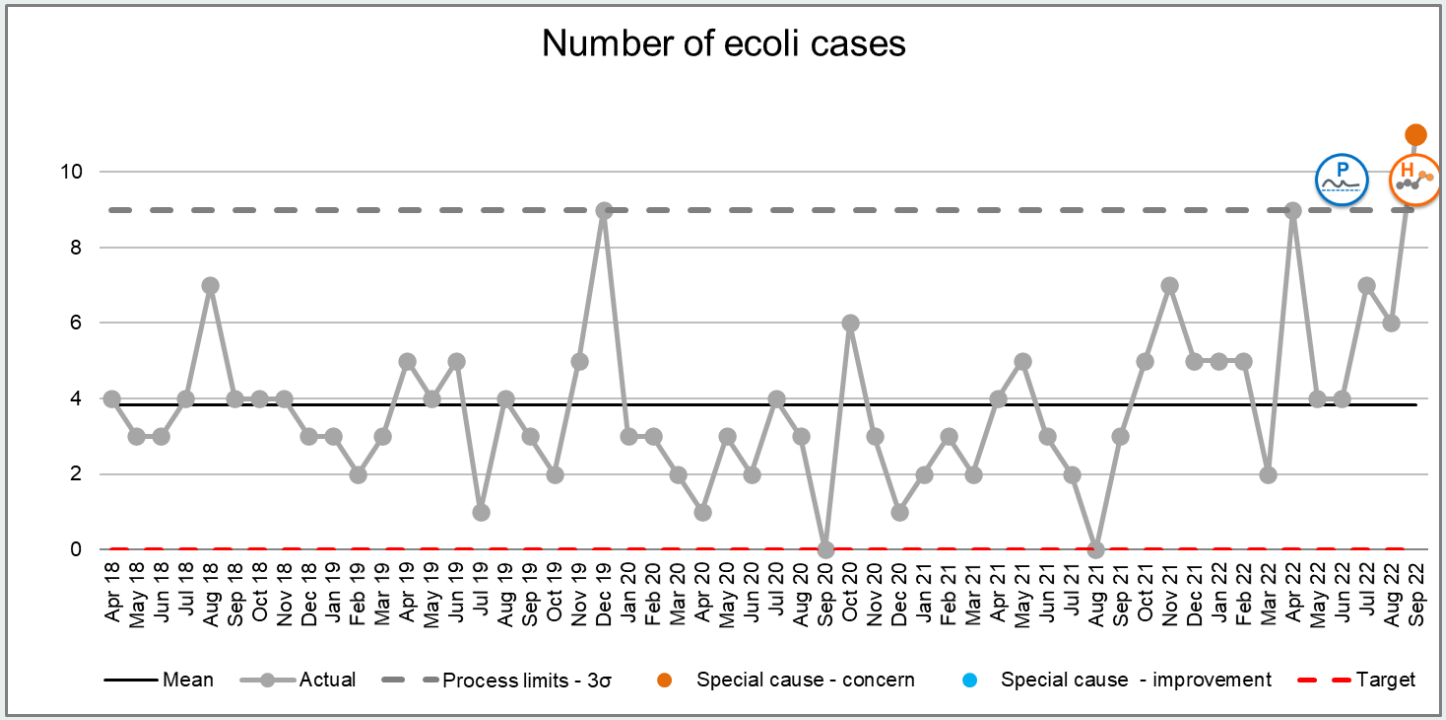
-Head of Quality

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 and 3 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 September we had 11 health care associated cases. Reducing E.coli BSI and all Gram negative bacteraemia continue to be a focus of the IPC strategy specifically related to urinary tract infection prevention, improving patient hydration and improving the management and care of invasive device. All patients with a healthcare associated E.coli BSI have a rapid review to understand contributing factors and a subsequent post infection review is completed if there lapses in care that require action

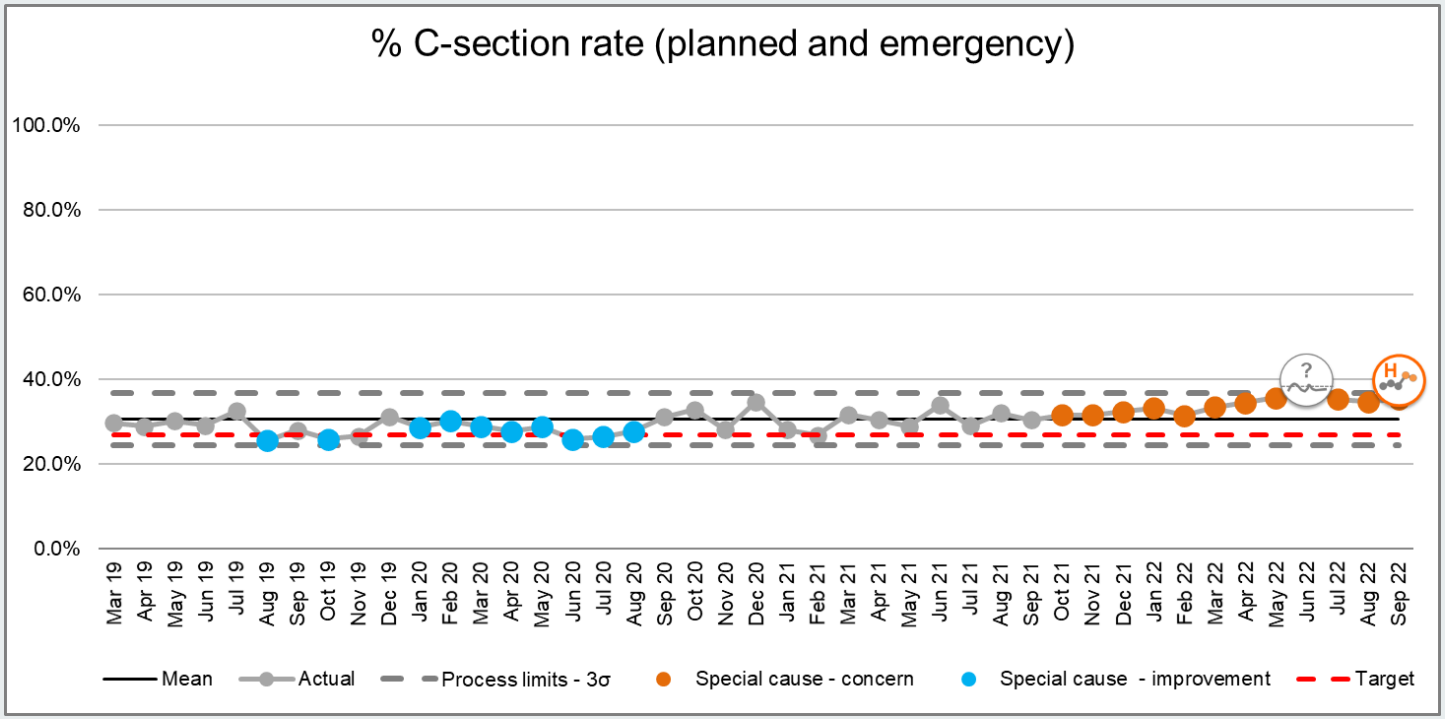
- Associate Chief Nurse, Director of Infection Prevention & Control

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 1 data points which are above the line

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review

- 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.
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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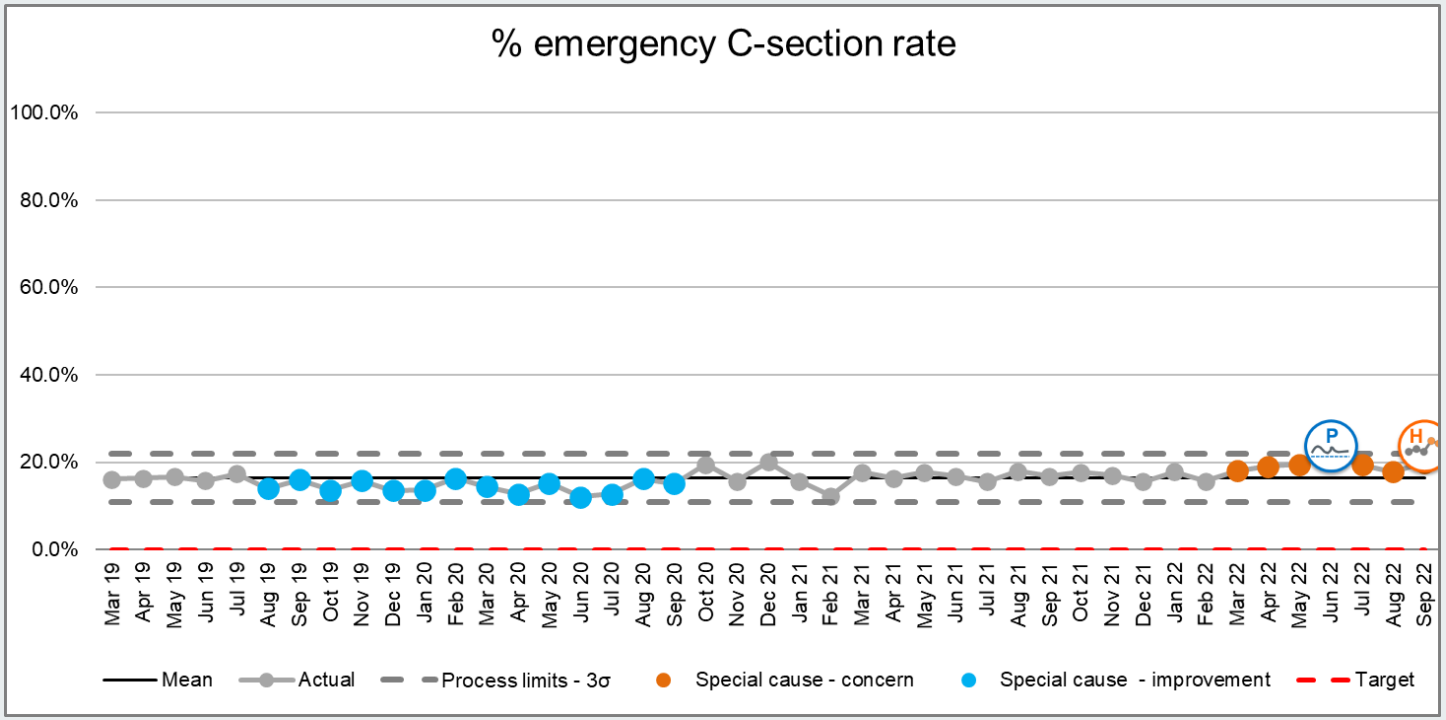
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

- Divisional Director of Quality & Nursing and Chief Midwife

Data Observations

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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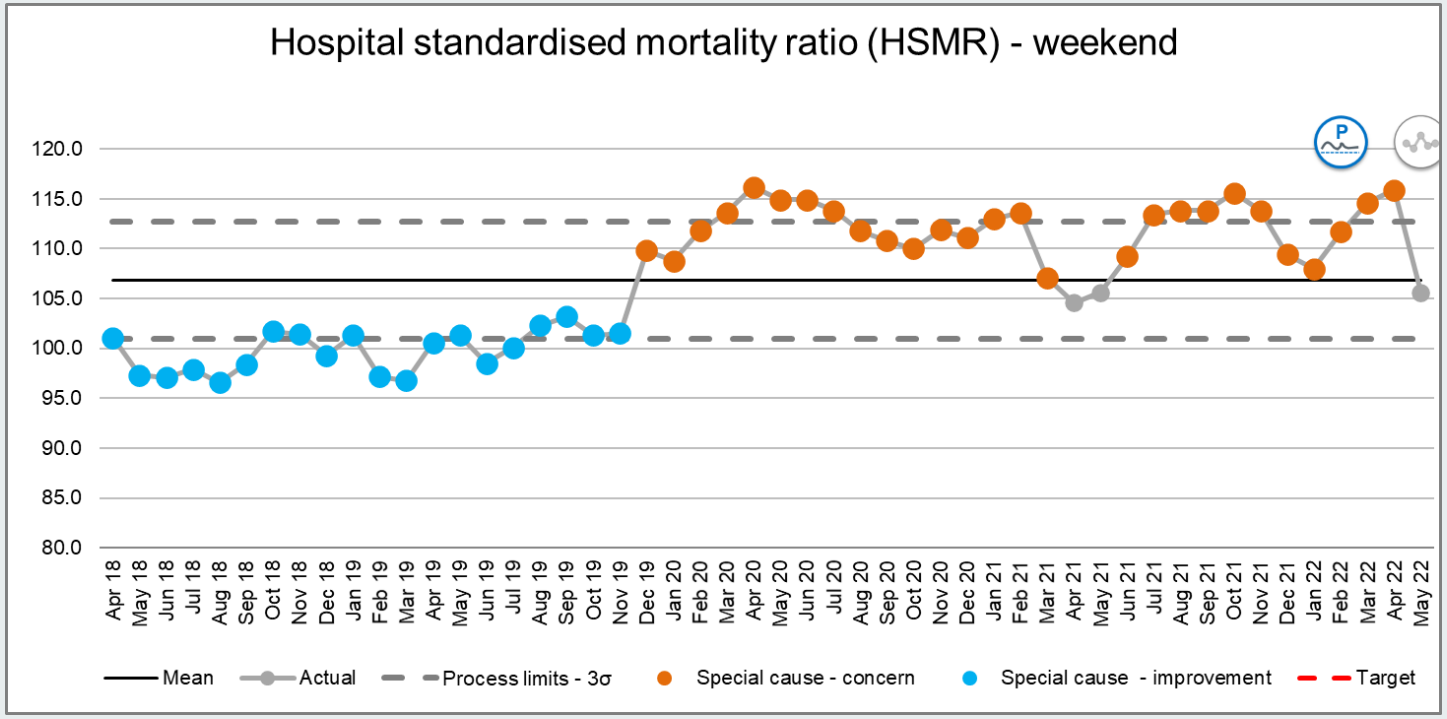
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

HSMR has risen over recent months we will be reviewing any areas of concern through HMG. The model behind HSMR compares current outcome vs data from the last ten years. Therefore if there are changes to outcomes nationally over recent months they will not be reflected in the model immediately a good example of that has been in the impact of covid. What we are seeing now may reflect the impact of congestion in all parts of the system. We are also looking at the Charlson scoring of comorbidities which is currently lower than expected and is likely to be impacting the results. A number of acute trusts are seeing a similar rise in HSMR.

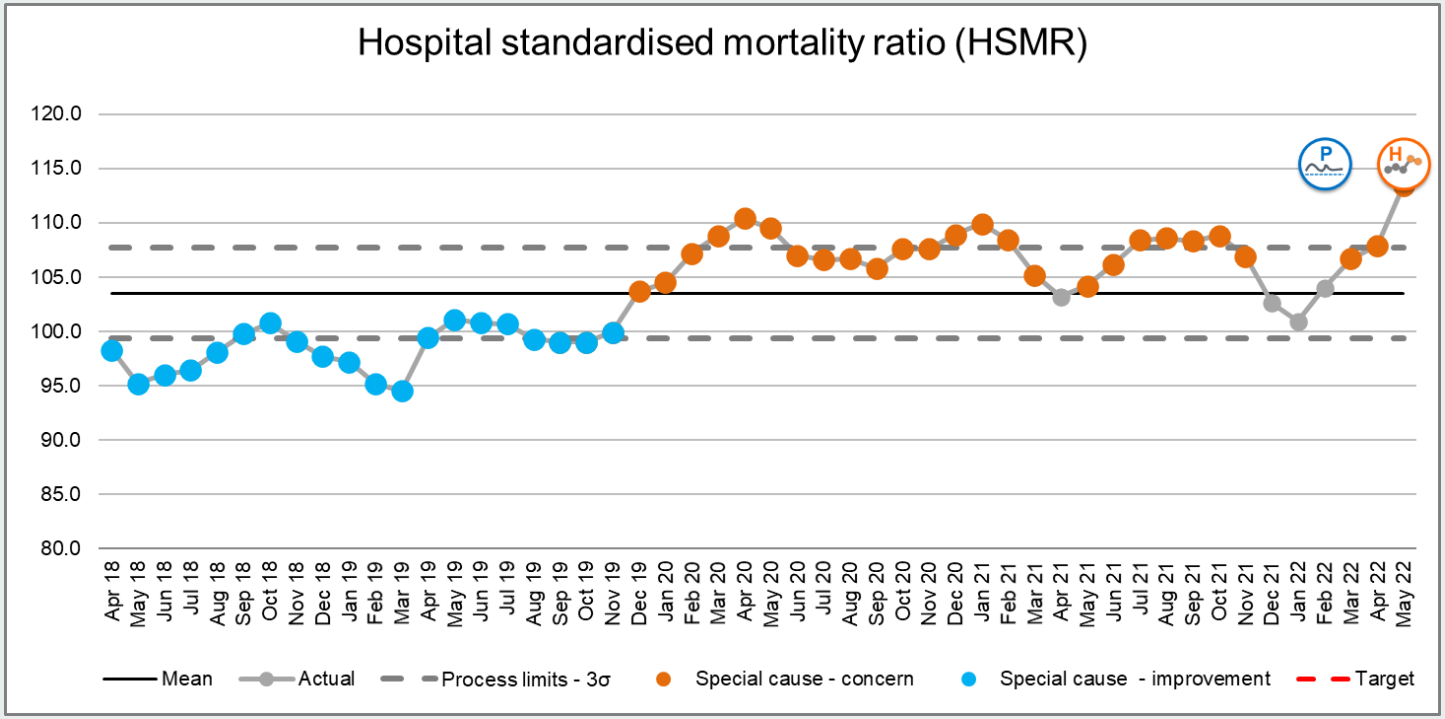
- Deputy Medical Director

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



Commentary

HSMR has risen over recent months we will be reviewing any areas of concern through HMG. The model behind HSMR compares current outcome vs data from the last ten years. Therefore if there are changes to outcomes nationally over recent months they will not be reflected in the model immediately a good example of that has been in the impact of covid. What we are seeing now may reflect the impact of congestion in all parts of the system. We are also looking at the Charlson scoring of comorbidities which is currently lower than expected and is likely to be impacting the results. A number of acute trusts are seeing a similar rise in HSMR.

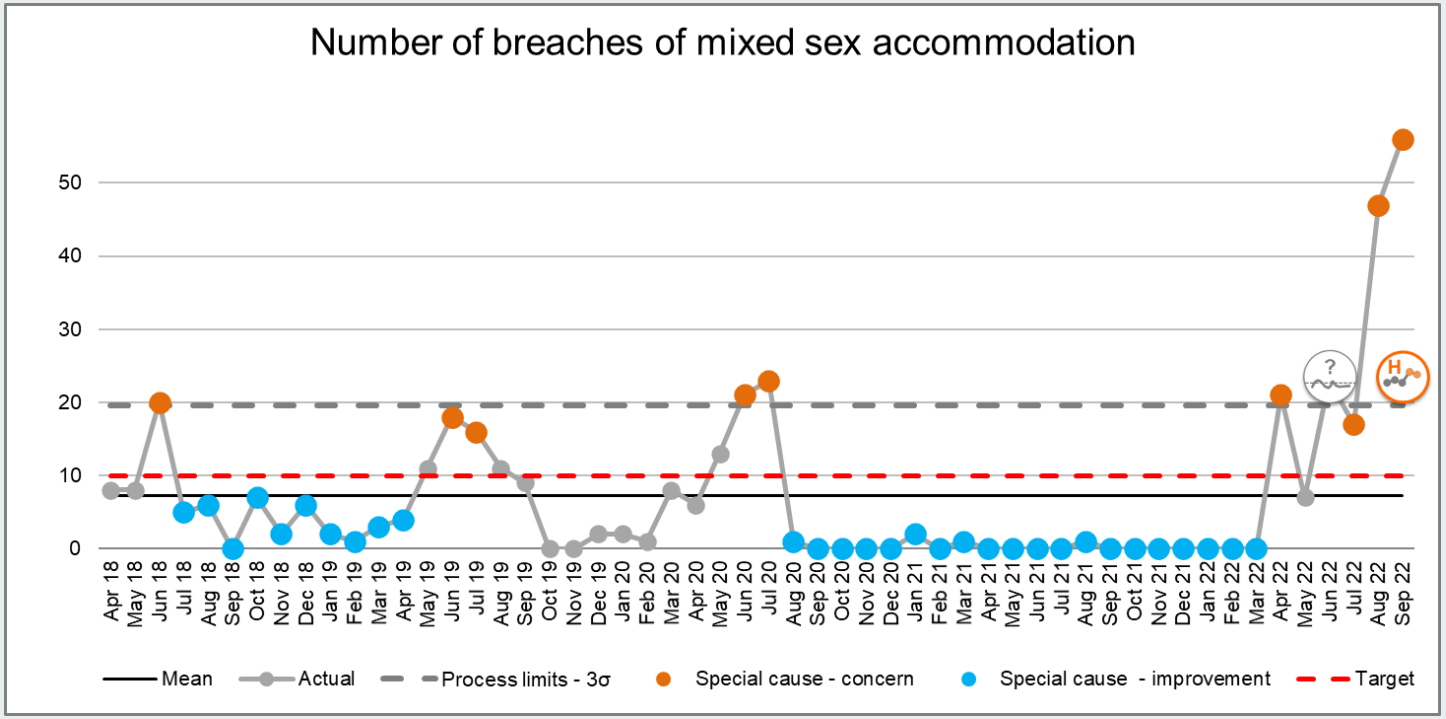
- Deputy Medical Director

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.
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



Commentary

The Trust is reporting mixed-sex accommodation breaches in line with national policy following a period of local agreement with the ICB 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.

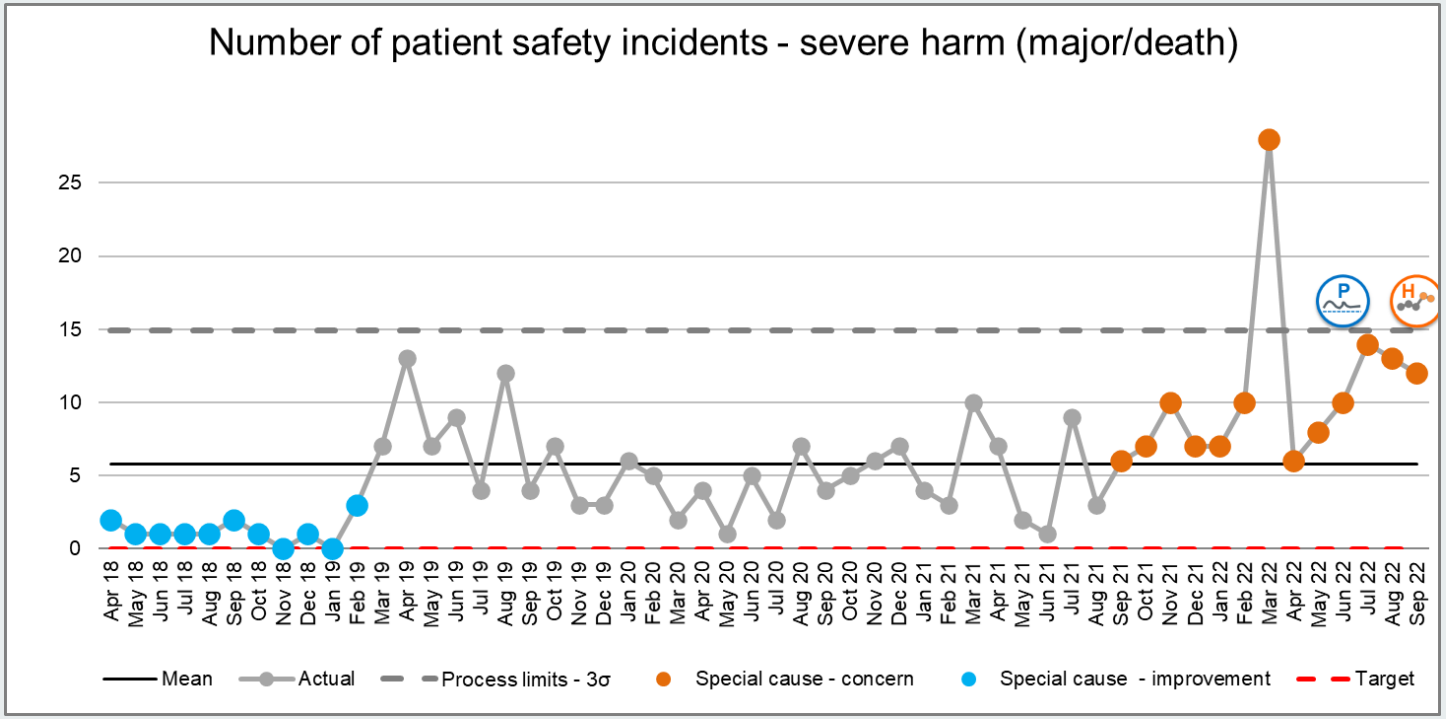
- Associate Chief Nurse, Director of Infection Prevention & Control

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

All reporting of serious harm when classified as a SI are investigated with action plans and reported to QDG and QPC

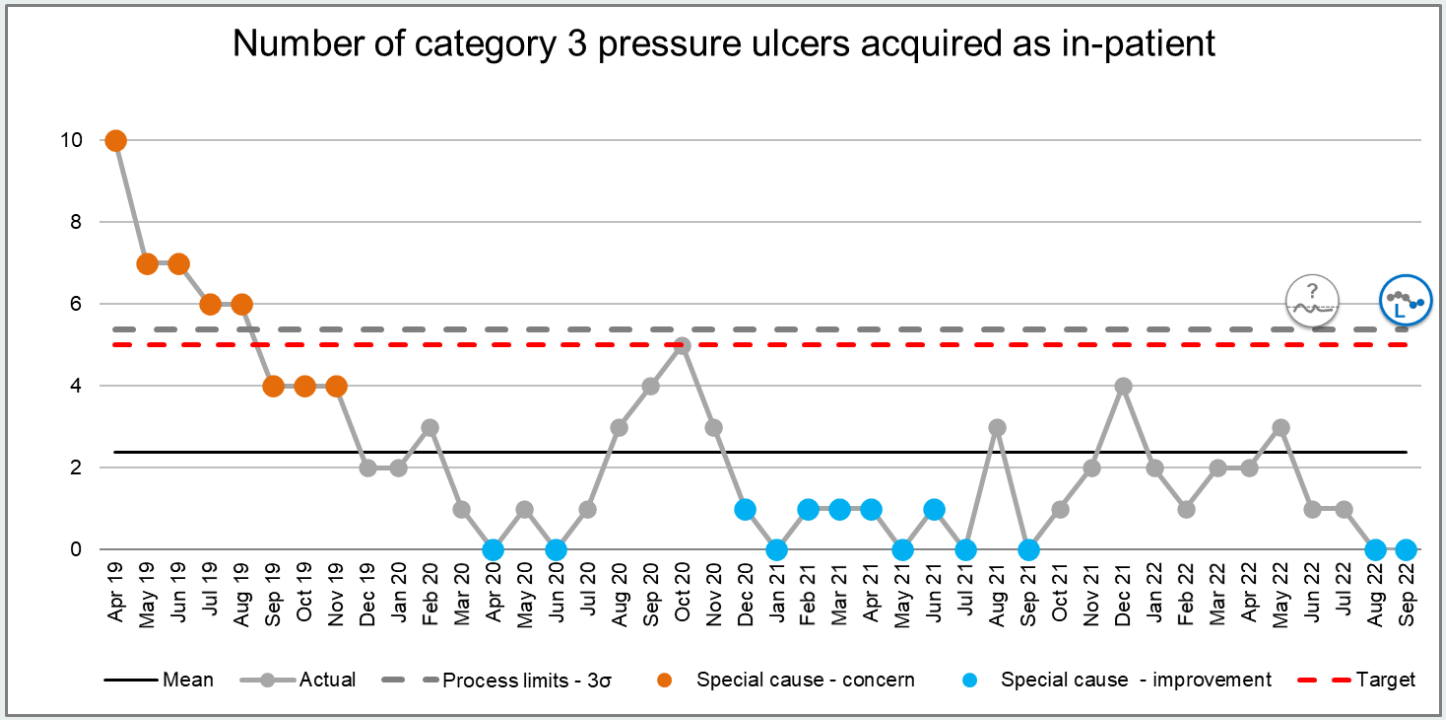
- Quality Improvement & Safety Director

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

There were no category 3 pressure ulcers reported.

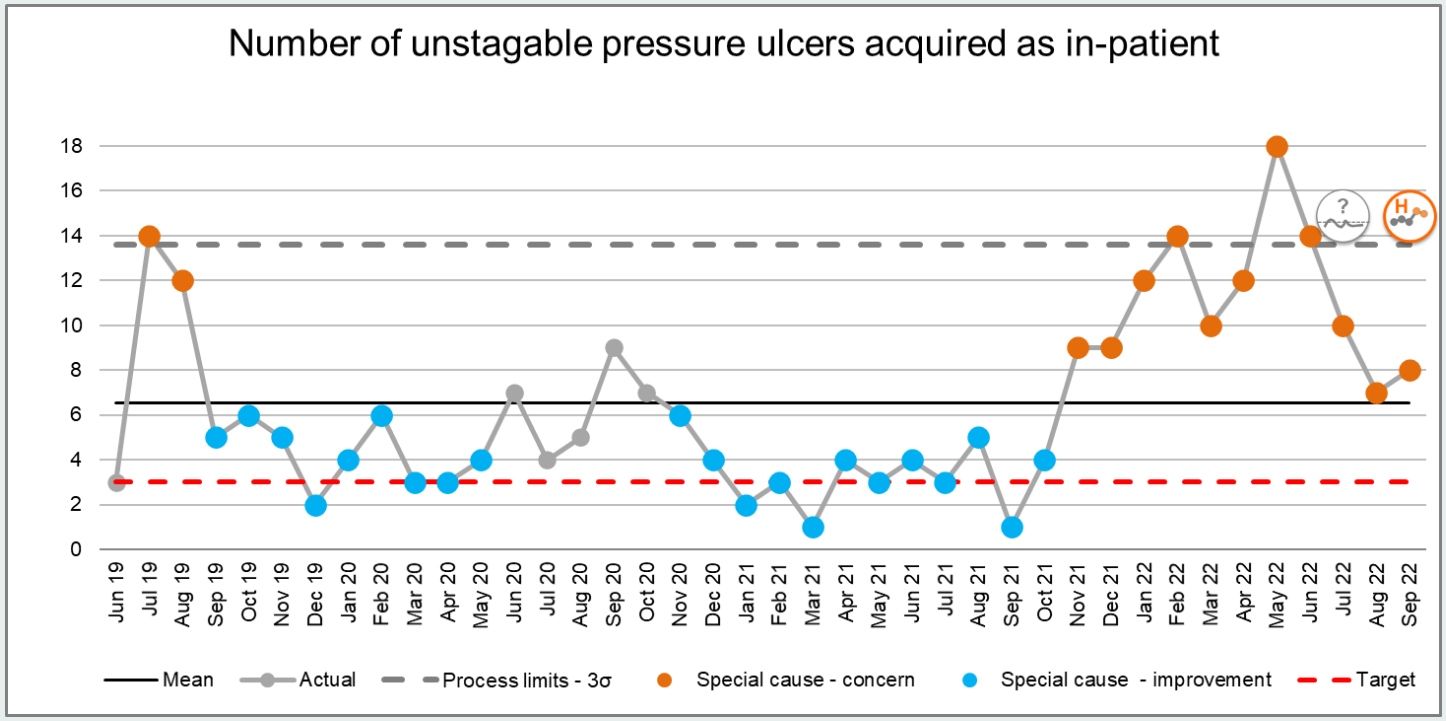
- Associate Chief Nurse, Director of Infection Prevention & Control

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 5 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

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, we are currently evaluating this initiative however patients are now waiting in an ambulance for much less time. 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.

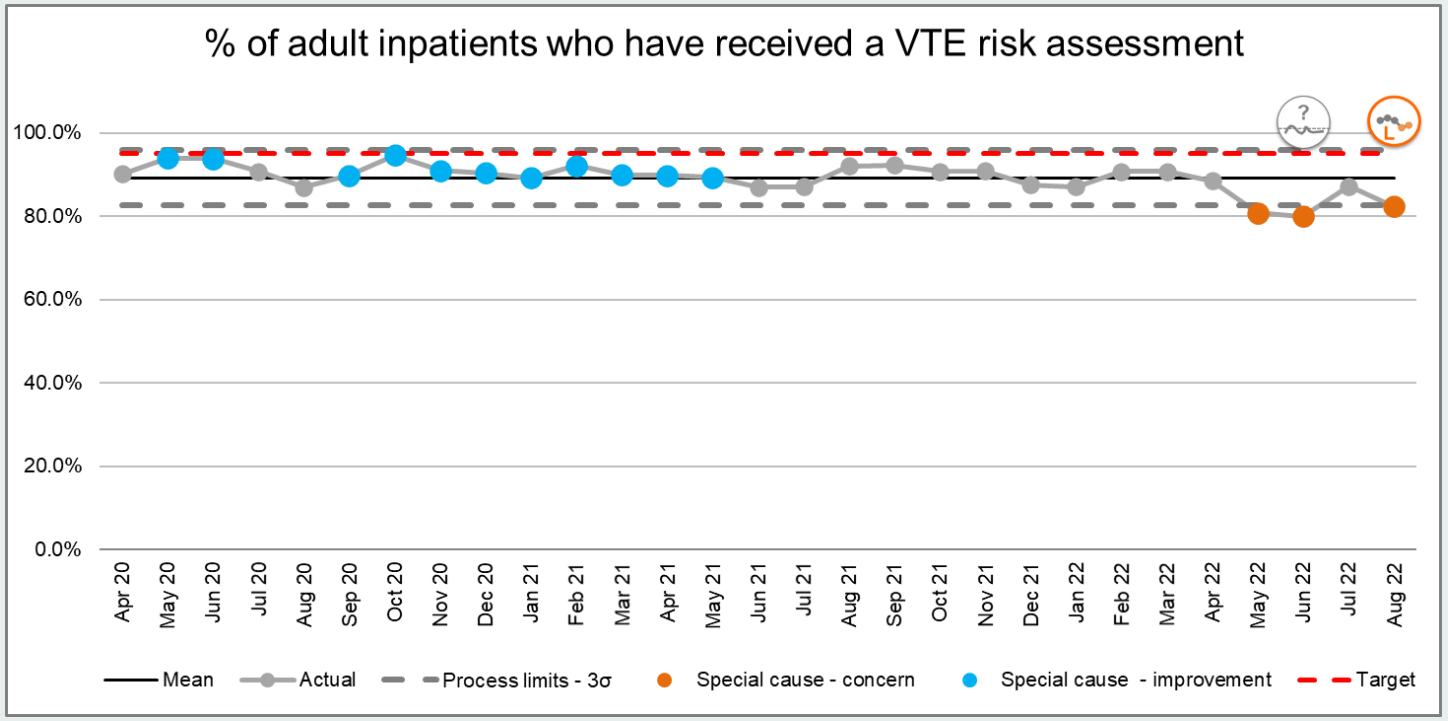
- Associate Chief Nurse, Director of Infection Prevention & Control

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

The new electronic prescribing system will automatically record the risk assessment for all patients. Results from this will drive any further improvement work, this is likely to be in the new year.

- 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 3 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

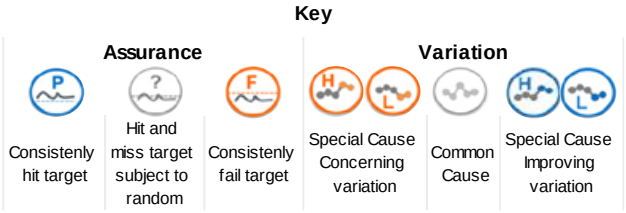
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	
Finance	NHSI Financial Risk Rating		Sep-20	
Finance	Capital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

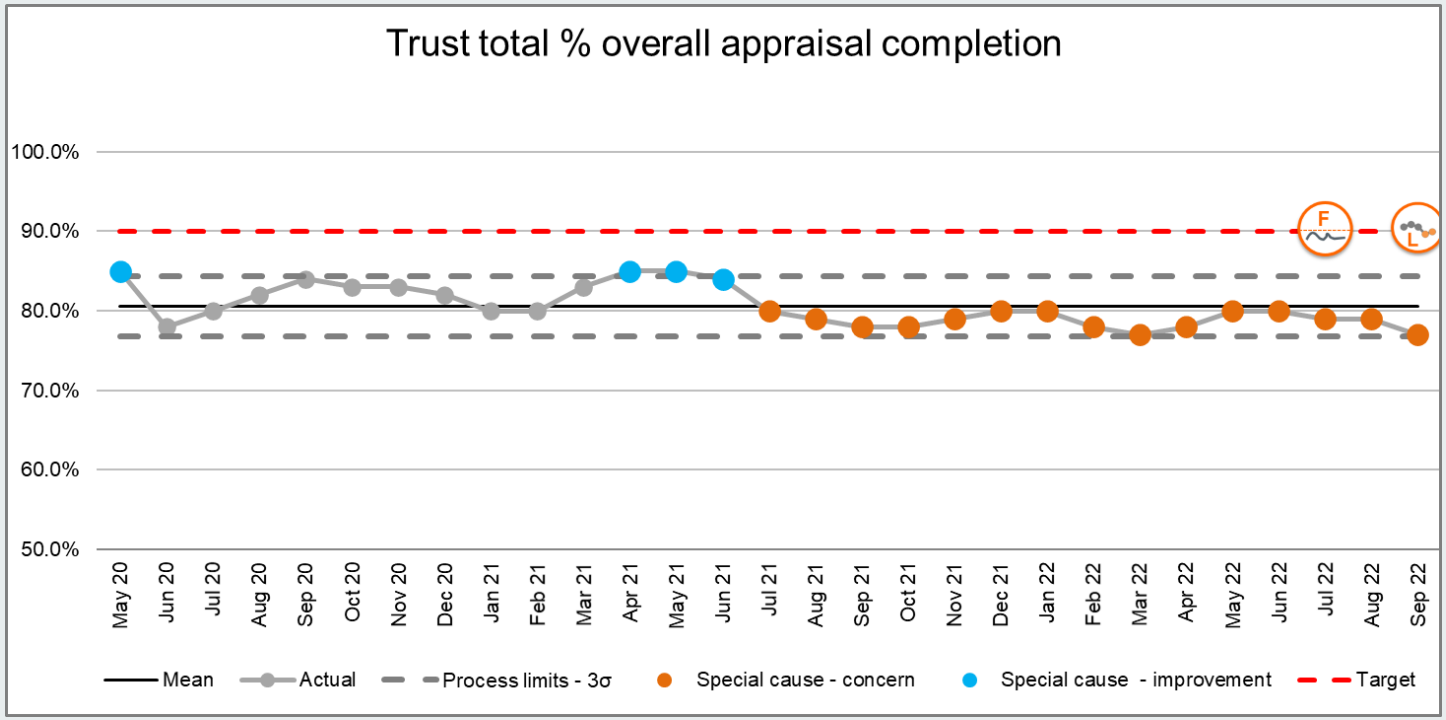
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	Sep-22	77%	L
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	?	Sep-22	86%	L
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	P	Aug-22	86.6%	L
Safe Nurse Staffing	% registered nurse day	>=90%	?	Aug-22	83.6%	L
Safe Nurse Staffing	% unregistered care staff day	>=90%	?	Aug-22	86.1%	L
Safe Nurse Staffing	% registered nurse night	>=90%	?	Aug-22	92.2%	L
Safe Nurse Staffing	% unregistered care staff night	>=90%	P	Aug-22	105.1%	L
Safe Nurse Staffing	Care hours per patient day RN	>=5		Aug-22	5.4	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	?	Aug-22	3.35	L
Safe Nurse Staffing	Care hours per patient day total	>=8		Aug-22	8.7	
Vacancy and WTE	Staff in post FTE	No target		Sep-22	5999.0	
Workforce Expenditure	% turnover	<=12.6%	P	Sep-22	14.5%	H
Workforce Expenditure	% turnover rate for nursing	<=12.6%	P	Sep-22	12.5%	H
Workforce Expenditure	% sickness rate	<=4.05%	P	Sep-22	4.1%	H

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

Under Review

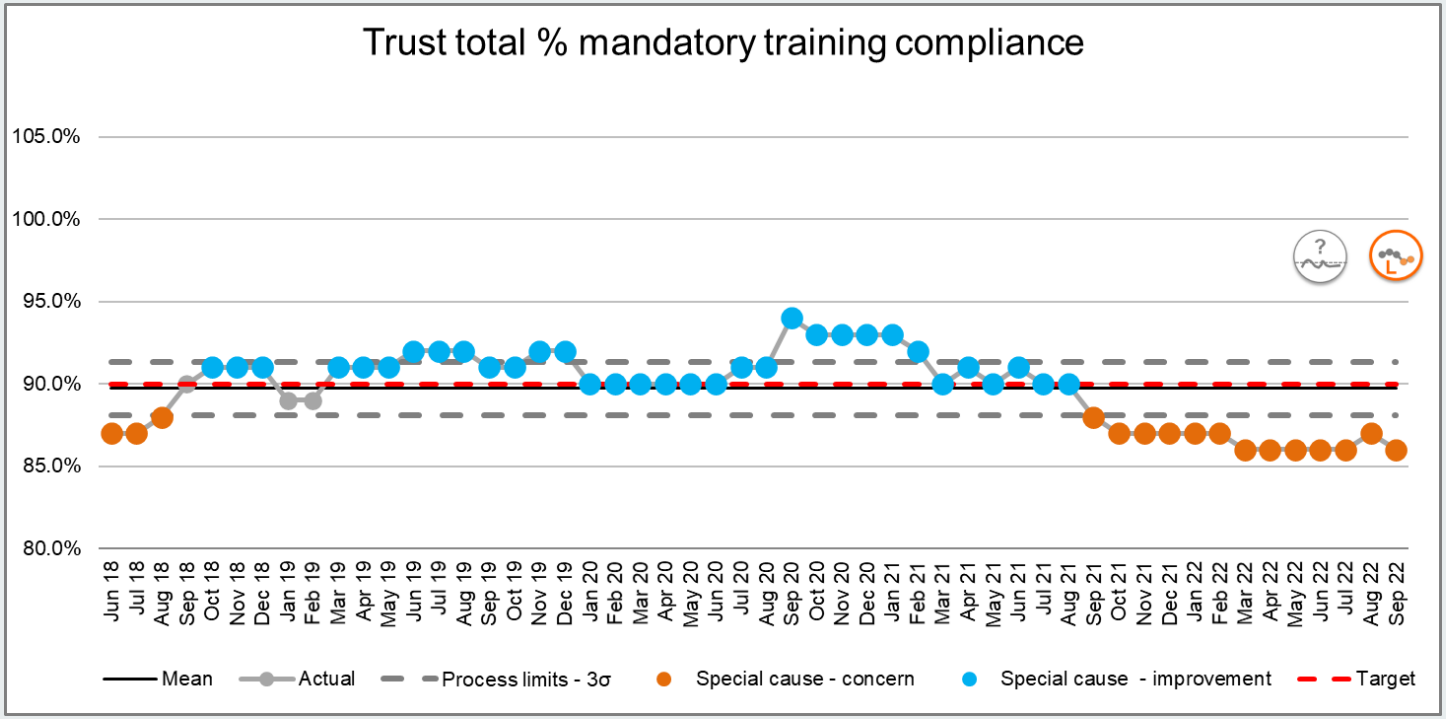
- Associate Director for Education and Development

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

Under Review

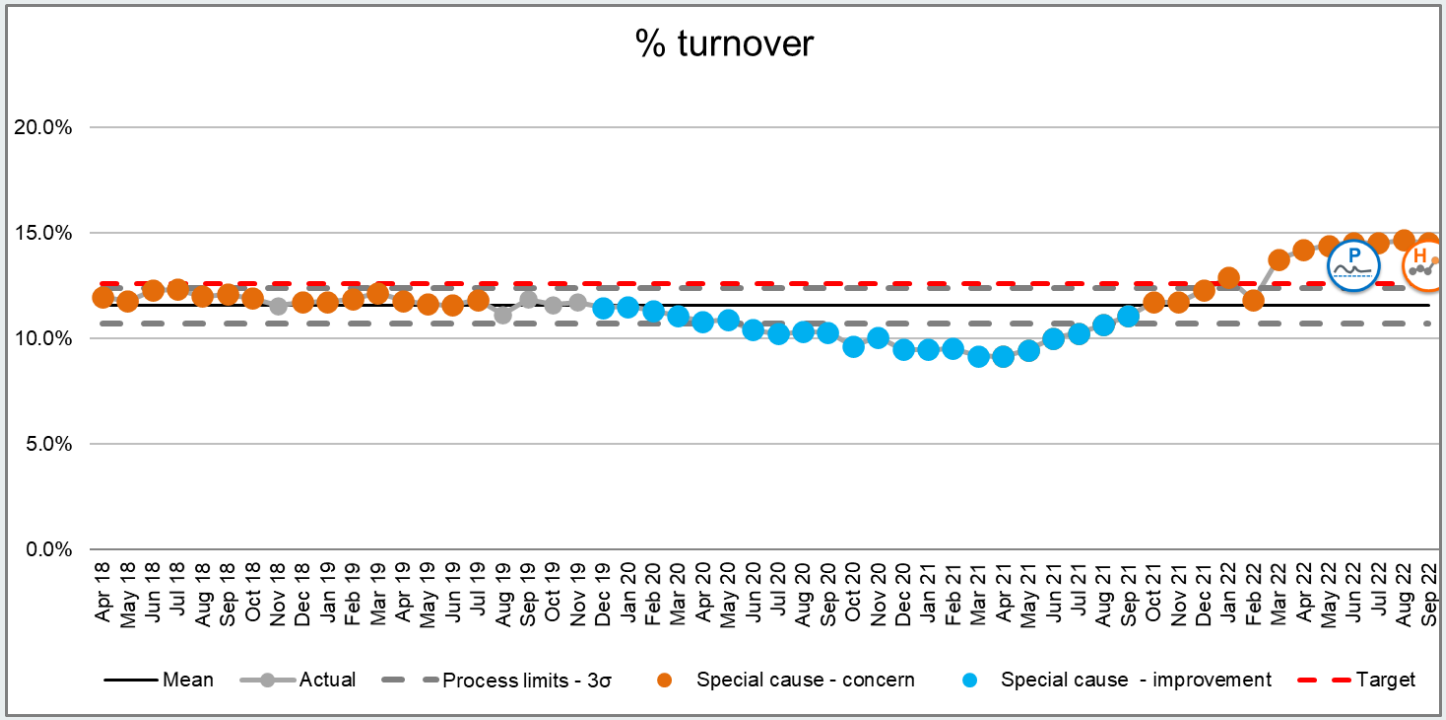
- Associate Director for Education and Development

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 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 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

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. Establishing a Trust Retention Group is a priority, creating a single oversight of the wide ranging initiatives being undertaken and setting a clear focus on a range of specific initiatives

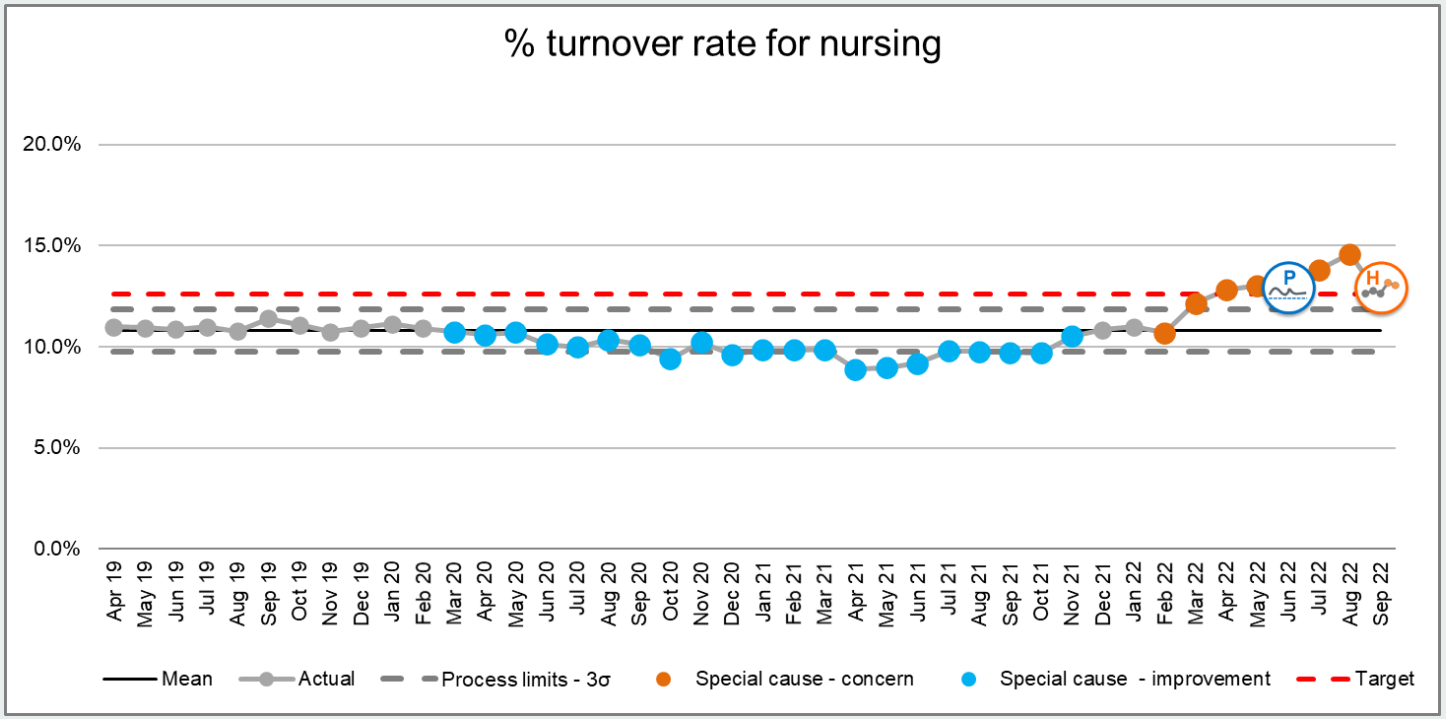
- **Director for People and OD**

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 8 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.
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

Career conversations through virtual clinics take place each month for both Registered Nurses and HCSWs.
Late Career support is in place for staff over 50 encouraging them to stay in the NHS.
Rotational programmes are being developed by the Practice Development team together with pop up career and development stands for staff to informally chat about opportunities in the Trust

- **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 7 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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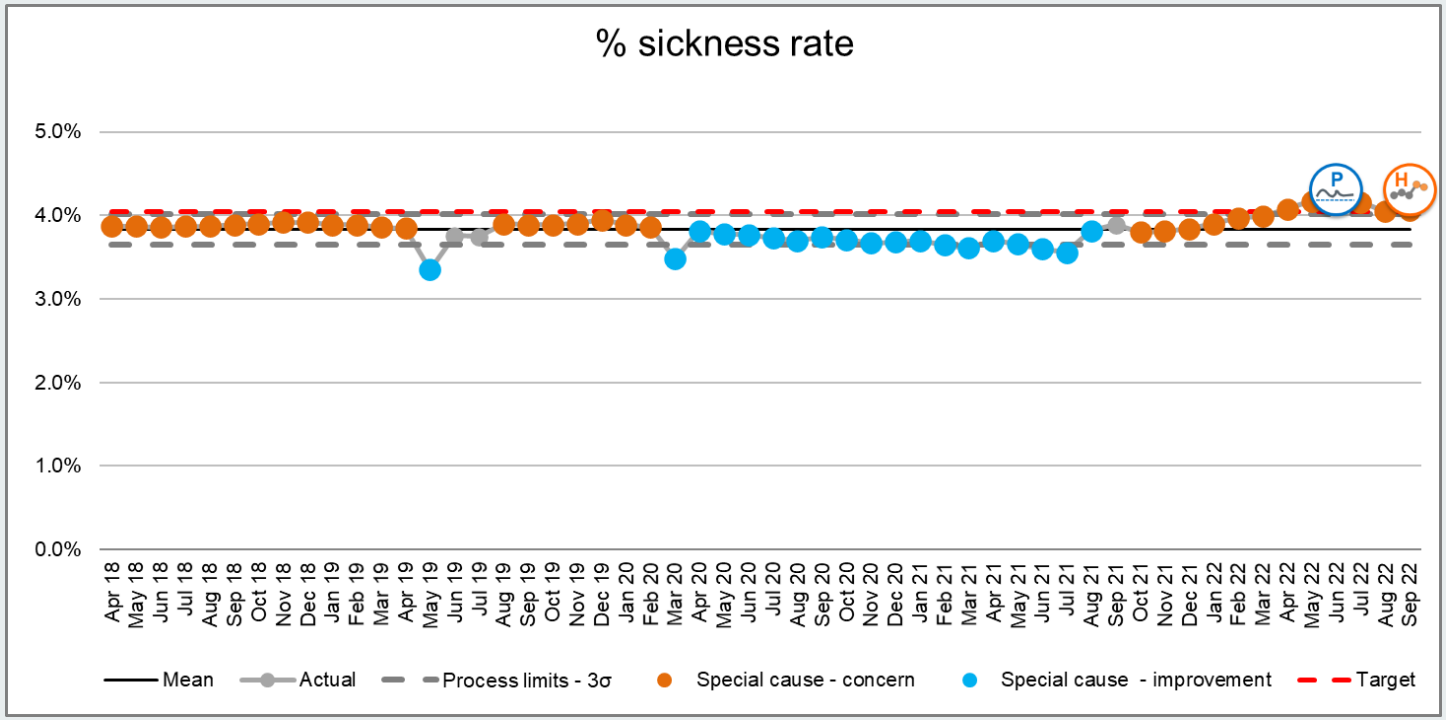
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

A Financial wellbeing plan is in development with ongoing wellbeing support from the 2020 Hub and interventions from the Staff Psychology team. An increase in the number of HR sickness 'surgeries' is planned to support management with the highest sickness rates across the divisions.

- **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 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 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
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Report to Board of Directors

Agenda item:	11	Enclosure Number:	6
Date	10 November 2022		
Title	Maternity Reports		
Sponsoring Directors	Matt Holdaway, Chief Nurse and Director of Quality		

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

Summary of Report

The Board is presented with a set of reports relating to Maternity Services. Each report has been considered in detail by the Maternity Delivery Group, with the LMNS and ICB attending. Presentation to the Board of Directors is required in each case to ensure regulatory and other national requirements are met.

Report	**Findings and our response to the Independent Investigation into East Kent Maternity and Neonatal Services**
Purpose	To provide high level assurance that the report has been reviewed and a gap analysis commenced against the four findings/recommendations.
Recommendation to Board	• The Board to note the next steps for our maternity services as we work with the ICB/LMNS to respond fully to this report • The Board to note that NHS England will be working with the Department of Health and Social Care and partner organisations to review the recommendations and the implications. • The Board to note that in 2023, NHSE will publish a single delivery plan for maternity and neonatal care which will bring together the action required following the East Kent Report, The Shrewsbury and Telford Report (Ockendon 1 and 2).
Quality and Performance Committee	The Committee noted receipt of the letter and acknowledged that the service would provide a high-level review of the gaps prior to Board as required by the NHSE letter. It was noted that this would be done in conjunction with the ICB/LMNS.
Report	**Perinatal Quality Surveillance Report and Maternity Incentive Scheme progress**
Purpose	To provide assurance to the Quality and Performance Committee and 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 July to September 2022 – quarter 2 (Q2).
Recommendation to Board	The Maternity Incentive Scheme requires that the Head of Midwifery and Clinical Director to come to January's Board (before 2 Feb 2023) and present on the position and progress with the safety actions and the Board are asked to support this request.
Maternity Delivery Group	The Maternity Delivery Group was assured by the Perinatal Quality Surveillance

	review process, the learning and the improvement actions.
Report	**Maternity Staffing Report**
Purpose	To meet the Maternity Incentive Scheme's Standard 4, and to demonstrate an effective system of clinical workforce planning and management of staffing/safety issues.
Recommendation to Board	• To accept the report. • To note the Birth Rate Plus funded reassessment report will be provided in Quarter 3. • Bi-annual reports to be received by the Board in line with Maternity Incentive Scheme (October 2022). • Last report March 2022 (delays because of waiting for staffing review BR+.)
Maternity Delivery Group	The Maternity Delivery Group was assured by progress being made, reporting this through to the Quality and Performance Committee by exception. There were continued staffing challenges. No further deployment of Continuity of Carer would be made due to current staffing challenges; however, the two established teams remain and continue to provide care for priority women.

Recommendation

The Board is asked to note the reports and support the improvement plans that are held within the service for key issues.

Enclosures

A reading pack is available to the Board, comprising the following reports:

- Findings and response to the independent investigation into East Kent Maternity and Neonatal Services
- Perinatal Quality Surveillance and Safety Report (Q2)
- Maternity Safer Staffing Report
- Maternity Incentive Scheme table

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Report to Board of Directors			
Agenda item:	**12**	**Enclosure Number:**	**7**
Date	10 November 2022		
Title	Freedom to Speak Up Annual Report		
Author /Sponsoring Director/Presenter	Katie Parker-Roberts, Head of Quality and Lead Freedom to Speak Up Guardian Claire Radley, Director for People and OD		

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

Summary of Report

Purpose

This is the report of the Freedom to Speak up Guardians, providing an annual update on activity for the whole Trust, including reporting for GMS colleagues. Effective speaking up arrangements protect patients and improve the experience of our workers. Having a healthy speaking up culture is an indicator of a well-led organisation.

Key issues to note

At our Trust, there were 120 people who spoke up to the Freedom to Speak Up Guardian between 1 April 2021 through to 31 March 2022. This is an increase of 22% on the number of people who spoke up last year (97). The new Guardian model with multiple Guardians available for people to speak up to has contributed to this increase.

Of the 120 people

- 101 spoke up about issues about staff experience (bullying and harassment behaviours)
- 24 had quality and safety elements within their concerns.
- 26 people raised their concerns anonymously

- The majority of the cases were poor staff experience issues (24 of 120 concerns raised had a quality/safety element, most of which were connected to concerns about staffing levels and the impact this had on patients and colleagues)
- Some of the most prominent staff experience themes shared throughout the year included:
    - Unprofessional and unkind behaviours
    - Breakdown of relationships between colleagues, especially line manager and individual
    - Team culture concerns – behaviours being entrenched within teams
    - People not feeling listened to or supported by managers
    - Concerns about fairness and confidentiality of recruitment processes
    - A feeling that HR is for managers, not for all employees
    - Unfair interview and recruitment processes
    - Poor staff experience – managers having unrealistic expectations and limited support with training in role
    - Concerns about communication between management and teams

The Trust Speaking Up policy has been under review this year, in order to reflect our new Guardian model and the Trust commitment to embedding a Restorative Just and Learning Culture. The policy was finalised and published in August 2022.

Plans for 2022/23

The current Lead Guardian will be stepping back from the role due to maternity leave on 16 November. The Trust are recruiting a full time Lead Freedom to Speak Up Guardian, to increase capacity in the service, not only for reactive case management but to more proactively promote the role, and also to invest time in ensuring learning is connected with other key stakeholders, such as HR, OD and Safety teams.

The Freedom to Speak Up strategy is being reviewed, with a number of actions identified as part of a focus on three key pillars of awareness and visibility; strategic direction and support of wider cultural change programmes, and improved monitoring and metrics. Some key aspects of this work will include:

- Increasing visibility of the Guardians with a programme of walkabouts, which are built into the monthly schedule for Guardians. This will be supported by a comms and engagement plan, promoting the role more widely in the organisation using a variety of routes, and this activity will be reported back quarterly
- Development of a newsletter to share the themes and trends we hear, and to be able to articulate back to the organisation actions that are happening as a result, or how themes feed into programmes of work such as the Restorative Just and Learning work
- A review of the current Guardian model – We still believe as a Trust that having multiple Guardians offers choice to people, to ensure that there is a safe place for all, but we need to review if we have got the current mix of colleagues right and if there are any gaps to fill.
- FTSU Guardians are involved in the Restorative Just and Learning Programme, reviewing our policies and processes for both Safety and HR, to ensure the learning from those who have spoken up feeds in to this wider cultural change programme. The Guardians will continue to play an active role in this work, sharing their insight as part of the diagnostic, as well as sitting in the project teams for improvement, and involvement in review groups
- A number of metrics have been agreed which will be monitored through the National Quarterly Pulse Survey. The following two questions have been taken from the National Survey:
    - % of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation
    - % of staff “agreeing” or “strongly agreeing” that if they spoke up about something that concerned them, they are confident the organisation would address the concern

In addition to these, the Trust will also be asking colleagues:

- If I had a concern, I would feel confident to raise it with a Freedom to Speak Up Guardian

  Strongly Agree/Agree/No Opinion/Disagree/Strongly Disagree/ I do not know who the Freedom to Speak Up Guardians are

These metrics will be reported quarterly through the NQPS, and tracked alongside the core FTSU metrics reported nationally around the number of cases received, themes and trends from these cases and professional groups. The team are working with Business Intelligence to look at how some of this data can be captured in SPC format, to provide trend data over time that can be monitored in committee – this will be for the key headline measures, and also looking at how this can be broken down to look at professional group, staff experience vs patient safety, and other ways of understanding the data to ensure we can maximise learning.

Conclusions

The year-on-year trend for an increase in the number of cases being seen by the Guardians continues, but further work is needed to grow and embed the service. Poor staff experience remains the main reason that most people come and see the Freedom to Speak Up Guardians. The recruitment of a full time Lead Guardian in 2022/23 will support increased visibility and awareness of the service, with more proactive communications and engagement, a review of the service model, greater capacity within the team to support organisation wide cultural programmes, and the development of a robust set of metrics to ensure that we can monitor the effectiveness of the service and the confidence of colleagues in a speaking up service in the Trust.

Recommendation

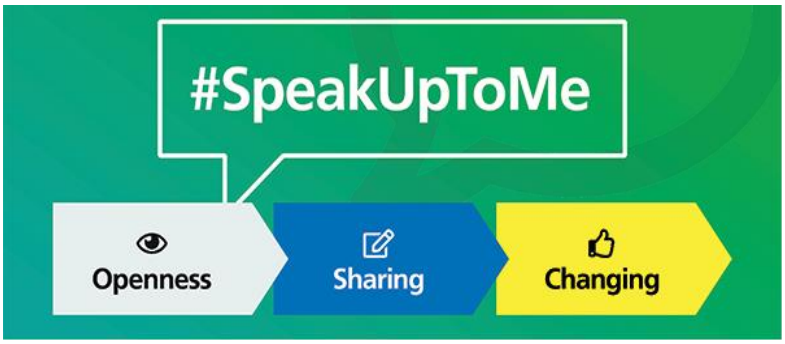
The Board is asked to note the contents of the report and to support the continuing improvement of our speaking up culture within the Trust.

Enclosures

Freedom to Speak Up Annual Report 2021/22

RAISING CONCERNS STEERING GROUP

SPEAKING UP – FREEDOM TO SPEAK UP GUARDIAN REPORT
Annual Report 2021/22



The purpose of this report

Effective speaking up arrangements protect patients and improve the experience of our colleagues. Having a healthy speaking up culture is an indicator of a well-led Trust.

This is the report of the Freedom to Speak up Guardian, Katie Parker-Roberts. Freedom to Speak Up Guardians are appointed and employed by the trust, though their remit requires them to act in an independent capacity.

Guardians are trained, supported and advised by the National Guardian Office. All Guardians are expected to support their trust to become a place where speaking up becomes business as usual. The role, supporting processes, policy and culture are there to meet the needs of workers in this respect, whilst also meeting the expectations of the National Guardian's Office.

Summary

- Only concerns raised with the Freedom to Speak Up Guardian are reported in this document.
- This Trust has returned Q4 data to the National Guardians Office in May 2022

Individual/team change

The following **lessons have been learned and improvements made** for individuals/teams as a result of staff raising concerns over the last twelve months.

- Signposting to HR for advice around organisational change processes
- Advice and support around mediation to resolve issues locally
- OD support put in place for teams
- Signposting to 2020 Hub and Colleague Psychology Wellbeing team where colleagues are needing additional wellbeing support
- Support with entering and navigating HR processes, providing clarity and signposting to wider support available
- Support in managing expectations and having conversations with managers
- Discussions with managers to better support teams and involve teams in discussions and decisions

- Adjustments made to working environment to relieve some work related stress on individual
- Supporting colleagues with redeployment where team environment was not appropriate
- Recommending Coaching and Mentoring for individuals

Organisational change

The following organisational **lessons have been learned and improvements made**

- Themes and trends raised at Team Support Group and Raising Concerns Group to support better triangulation of areas of concern and how we can support teams
- FTSU Guardians supporting Trust work on compassionate culture and behaviours, and part of the Respectful Resolution Programme as well as wider cultural programme work.
- Guardians are also involved in the development of the Restorative Just and Learning Culture programme work which has begun, and the learning and themes from speaking up are key to this programme
- Closer working with managers to identify themes and trends within areas to influence local OD plans
- Divisional HR BPs and OD leads now being provided with themes and trends by division to support triangulation within the division with other data sources
- Data used to support the EDI programme, and protected characteristic data is recorded (with consent) to support this

Trust Data

At our Trust, there were 120 people who spoke up to the Freedom to Speak Up Guardian between 1 April 2021 through to 31 March 2022. This is an increase of 22% on the number of people who spoke up last year (97).

Of the 120 people

- 101 spoke up about issues about staff experience (bullying and harassment behaviours)
- 24 had quality and safety elements within their concerns.
- 26 people raised their concerns anonymously

Table: Annual Freedom to Speak up Guardian data for 2021/22

Concerns	End of Year 2018/19	End of Year 2019/20	End of Year 2020/21	April – June Q 1	July – Sept Q 2	Oct- Dec Q 3	Jan – March Q 4	End of Year 2021/22
Number of people raised directly with the Freedom to Speak Up Guardian	**65**	54	66	11	26	25	32	94
Number of issues raised anonymously	15	19	31	11	6	2	7	26
Nature of issue								
- Patient quality issues	*20	*12	19	3	10	6	5	24
- Staff experience - unacceptable behaviour (bullying / harassment)	*47	*42	78	20	27	19	35	101
Action	All staff provided with support and advice	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Outside referral	0	0	0	0	0	0	0	0
Number of case where people indicate detriment	0	1	15	0	0	0	2	2
Of the people asked in this quarter who would speak up again	Yes 100%	87%	The majority of individuals would speak up again.	The majority of individuals would speak up again.	The majority of individuals would speak up again.	The majority of individuals would speak up again	The majority of individuals would speak up again.	The majority of individuals would speak up again.

*poor staff experience often impacted on quality of care and so some cases count in both categories.

Themes and trends

- The majority of the cases were poor staff experience issues (24 of 120 concerns raised had a quality/safety element, most of which were connected to concerns about staffing levels and the impact this had on patients and colleagues)
- The staff experience themes shared throughout the year included:
    - Unprofessional and unkind behaviours
    - Breakdown of relationships between colleagues
    - Breakdown of relationships between line manager and individual
    - Team culture concerns – behaviours being entrenched within teams
    - Social distancing/PPE compliance concerns
    - Ethnic Minority colleagues experiencing discrimination – behaviours and not being offered the same opportunities as white colleagues
    - People feeling that they have been bullied
    - People not feeling listened to or supported by managers
    - Concerns about fairness and confidentiality of recruitment processes
    - Communication and how to support managing expectations
    - Team dynamics
    - A feeling that HR is for managers, not for all employees
    - Unfair interview and recruitment processes
    - Poor staff experience – managers having unrealistic expectations and limited support with training in role
    - Lack of support from manager regarding reasonable adjustments
    - Concerns about communication between management and teams

- The national reporting template only allows us to log concerns as patient safety or bullying and harassment, which does not give us enough nuance and insight to identify themes and trends across a period of time. The Guardians have introduced sub-categories for internal reporting, to improve our ability to easily identify and monitor trends emerging over time. The categories are:
    - Bullying and Harassment
    - Unprofessional behaviours
    - Discrimination
    - Team culture
    - Poor processes
    - Staffing feeling not valued

- Of the cases that were concluded in the year most would speak up again and use the FTSUG for advice and support. Where some people said maybe or don't know, it was often connected to the outcome of a process rather than an issue with the experience of support from the Guardian. For 2022/23, we aim to re-launch the Guardian role and help manage expectations of colleagues about the support and advice the Guardians can provide. We are also seeking to recruit more Guardians, to support the increased caseload and to better reflect the diversity of our workforce.
- The Guardians are working with our BI teams to review metrics, including the introduction of new measures in the National Quarterly Pulse Survey, to start to

be able to share some of our data in an SPC format so that we can more effectively monitor trends over time. This work is in development.

Case studies/feedback

In addition to the national data set, the team have been gathering case studies and experiences from colleagues who have spoken up, and from those who have received concerns. Below are two examples of the feedback received to date:

- **What made you decide to speak up to a Guardian?**
    - *I was having a lot of issues around working conditions on my ward and due to past complaints not being taken seriously I felt I could not speak to my manager about these issues or that if I had spoken to the manager nothing would get done about it.*

- **What was your experience – how did the Guardian help or support you?**
    - *The guardian I worked with was fantastic and had a great positive attitude. I was very nervous about coming forward but the Guardian reassured and supported me fully. She was very knowledgeable about procedures and things we could do to solve my situation as well as helped me when I struggled to put into words what I was trying to say and couldn't. She arranged a meeting with the matron of my sector as well as accompanied me to the meeting to help support me in person which I was very grateful for.*

- **Did you get the outcome you were looking for in speaking up?**
    - *Yes, soon after things on my ward started to improve and whilst they are not perfect it was absolutely due to the help of the guardians that it improved in the first place as soon as it did.*

- **Is there anything different you would have liked from the Guardians?**
    - *No*

- **Would you recommend the Guardian service to your colleagues if they needed to speak up?**
    - *Yes, in fact I encourage it 100%.*

- **What made you decide to speak up to a Guardian?**

    - *For info, my query was regarding a direct line manager and the way they were interacting and communicating with me. I came forward after the line manager had left, even though I still found this hard and upsetting, so that Senior Managers are aware of the situation, in order to give feedback and to help with any future improvements. I did not feel strong enough to come forward before or by myself, when I was so emotionally drained and anxious and I did not want to cause any confrontation. It is very uncomfortable to raise an issue about a direct line manager and I didn't want to create any more friction within the relationship.*

- **What was your experience – how did the Guardian help or support you?**

    - *The Guardian made me feel more comfortable about speaking up. I wouldn't have had the courage to have spoken up in the same way by myself, if at all. The Guardian was there to listen to my concerns and to give independent advice. They gave me confidence to articulate and say what was on my mind. They were there for me all the way through the process, from start to finish and they have helped me to move forward from what I had experienced with my previous line manager after the process. I really appreciated them being*

there during the meeting with my new line manager to explain what had happened. The support and guidance I received was second to none and was priceless. Thank you very much.

- **Did you get the outcome you were looking for in speaking up?**
    - *Yes, I got the outcome I was looking for by speaking up. The meeting with my new line manager went well. I felt as though I was prepared and was able to say what was on my mind. The Guardian helped me with my thoughts throughout the process and to say them out loud in the right way and at the right time. They helped me ensure that my notes afterwards were truthful and logical. The Guardian followed up with my managers in the correct places. They assured me that my notes were confidential and would be used in the right way for future learning.*

- **Is there anything different you would have liked from the Guardians?**
    - *The Guardian was brilliant, so there is not much different I would have liked from them. To add, that if I had suggestions for training for all types of staff from these scenarios, it would be on, for example, Stress Management, Emotional Intelligence, Communication Skills, Anti-bullying and Assertiveness.*

- **Would you recommend the Guardian service to your colleagues if they needed to speak up**?
    - *Yes, I would recommend the Guardian service to colleagues. The Guardian was there for me during a very dark period, when I needed the help and assistance. I may have not spoken up or I may have even have left the Trust if it wasn't for them. Thank you.*

As part of the work in 2022/23 to look at how we monitor and evaluate the service, this will be reviewed and feedback mechanisms developed to ensure that in addition to the metrics in the NQPS we have both qualitative feedback from individuals who have spoken up and used the service.

Divisional data collection

It was agreed that in addition to the national reporting categories, divisional data would be collected. Across all the divisions, the consistent theme was poor staff experience, behaviours and bullying and harassment. The table below shows the breakdown of concerns received by divisions (where concerns were raised directly with Guardians):

Division	Q1	Q2	Q3	Q4	Total for 2021/22
Surgery	1	2	3	11	17
Medicine	4	9	5	1	19
D&S	2	1	2	7	12
W&C	1	3	2	6	12
Corporate	2	4	13	9	28

In addition to reporting by division, we also report where cases are received from GMS colleagues.

Organisation	Q1	Q2	Q3	Q4	Total for 2021/22
GMS	1	5	0	0	6

This data is shared with HR Business partners, including themes by division, to support data triangulation in divisions, while respecting the anonymity of the concerns shared.

National Guardians Office

NHS Improvement Board Self Review Tool
NHS Improvement issued the Freedom to Speak Up self-review tool with the expectation that Trust carry out an initial review by July/August 2019. The guide aligns with NHSI's well-led framework and offers practical advice and a self-review tool for boards to use. It was agreed that the tool would be used annually by the board to benchmark where we are as an organisation, and the latest review was shared at the January 2022 Trust Board meeting.

FTSU policy review

The Trust Speaking Up policy has been under review this year, in order to reflect our new Guardian model and the Trust commitment to embedding a Restorative Just and Learning Culture. This work has had input from the Guardians, Director for People and OD, colleagues in the Raising Concerns Group and the Quality Improvement and Safety Director. The policy was finalised and published in August 2022.

Guardians

Although there is a national job description for all Guardians to follow, there is no set model for how organisations should structure their Guardian function. We now have 9 FTSU Guardians in the Trust, to offer colleagues more choice, and to increase the visibility and accessibility of our Guardians. The 8 Guardians are:

We have just undertaken further recruitment, and our current Guardians are:

- Katie Parker-Roberts – Head of Quality (Lead FTSU Guardian)
- John Thompson – Lead Chaplain
- Warren Grant, Consultant Oncologist
- Carolyn Warr, Intensivist in DCC
- Lurdes Magalhaes, Procurement Specialist
- Andy Wanstall, Clinical Systems Specialist
- Lawrence Kidd, Anaesthetist
- Karen Wheeldon, Assistant Ward Clerk Manager
- Marc Thom, Portering Co-ordinator, CGH (GMS Guardian)

This year, the following Guardians have stepped down from the role:

- Abbie Bayliss, GMS Guardian – due to wider work pressures
- Sarah Brown, Voluntary Services Manager – retired from the Trust
- Coral Boston, EDI Lead – stepped down due to conflict with EDI role, and being able to provide clarity to individuals about which role she was offering support. We continue to work closely with Coral to ensure we are triangulating data around EDI and discrimination, and that what we hear can feed into our EDI programmes.

During 2021/22, Deborah Lee has been the Executive Lead for Freedom to Speak Up.

Our Trust Freedom to Speak Up Index Score

The Freedom to Speak Up (FTSU) Index is one of the indicators which can help build a picture of what the speaking up culture feels like for workers. It is a metric for NHS Trusts, drawn from four questions in the NHS Annual Staff Survey, asking whether staff feel knowledgeable, encouraged and supported to raise concerns, and if they agree they would be treated fairly if involved in an error, near miss or incident

The survey questions that have been used previously to make up the FTSU index are:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice

In 2020, the Trust had a Freedom to Speak Up Cultural Index Score of 78.4%, which is below the national average (Acute Trust average is currently 79%). The national average had improved overall (from 75% in 2019), and the Trust seen a slight decline in our overall FTSU Index score (down from 79% in 2019).

There was an additional question included in the 2020 NHS Staff Survey which focused on workers feeling safe to speak up more generally:

- % of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation (question 18f)

<u>Changes for 2021</u>

The NHS Staff Survey has undergone significant changes – in line with the People Plan. As a result, some of the questions which comprised the FTSU Index have been dropped, including:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents

- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it

In light of this, the National Guardian's Office will no longer be publishing the FTSU Index.

There was another additional question included in the 2021 NHS Staff Survey which focused on organisational response

- % of staff "agreeing" or "strongly agreeing" that if they spoke up about something that concerned them, they are confident the organisation would address the concern (question 21f)

The table below shows the Trust's score for each of the four Staff Survey questions used to calculate the overall score in 2019 and 2020 and 2021, and the national Acute Trust average for each of these in 2021. The three highlighted questions are the ones we will continue to monitor through the staff survey.

Staff Survey question	Gloucestershire Hospitals score 2019	Gloucestershire Hospitals score 2020	Gloucestershire Hospitals score 2021	National average score 2021
% of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly	60%	63%	No longer used	N/A
% of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents	88%	88%	No longer used	N/A
% of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it	95%	96%	No longer used	N/A
% of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical	69%	69%	71.3%	73.9%

practice				
% of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation	New Question for 2020	62.9%	56.1%	60.7%
% of staff “agreeing” or “strongly agreeing” that if they spoke up about something that concerned them, they are confident the organisation would address the concern	New Question for 2021	New Question for 2021	40.2%	47.9%

The scores above show that people understand the routes for escalating concerns, but still have concerns about how safe they feel in doing so, particularly when thinking not just about safety concerns, but anything that may concern them. For concerns about safety, we have seen an increase in the number of colleagues feeling secure raising a concern, from 69% in 2020 to 71.3% in 2021. The majority of concerns supported by Guardians are focussed on staff experience and wellbeing, and the two questions 18f and 21f highlight that people do not always feel safe in raising their more general concerns, or have confidence that the organisation would address these concerns. The disparity between responses on questions focussed explicitly on safety, and on those which talk about concerns more generally which would incorporate concerns based on staff experience, demonstrates the need for further commitment from the organisation in creating a safe culture where colleagues can not only raise their concerns, but feel and see them being addressed by the organisation.

The data from the Index Score and the Staff Survey is being used to triangulate and inform the wider organisational programmes, including Restorative Just and Learning culture programme, as well as the communication and engagement activity for the FTSU Guardians.

Communications and Engagement Activity

As part of the new Guardian model, we have introduced bi-weekly meetings for the Guardians to meet, providing an opportunity for regular review of areas needing support, and updating and informing our communications and engagement activity. The following communications and engagement activity has taken place in 2021/22:

- Redesign of posters and materials to advertise the Guardians

- Redesign of the intranet area to include photographs and contact details for all Guardians
- Regular reminders about the Guardians through Global emails and promoting the e-learning training
- Inclusion of FTSU Guardians in the Staff Health and Wellbeing materials that were shared Trust-wide
- October was 'Speaking Up' month, which included focussed communications on social media and through internal channels, as well as featuring in one of the Chief Executive vlogs
- The Guardians have been doing more regular walkabouts across the sites, to increase visibility and awareness of the role, including supporting the Trust wellbeing tour delivering tea, coffee and treats to teams. We have a programme planned for this throughout the year, which is updated regularly following insight or data from other colleagues including divisional HR and OD leads about areas which may benefit from additional Guardian presence

In addition to the ongoing programme of engagement, the team have delivered targeted training and engagement, including:

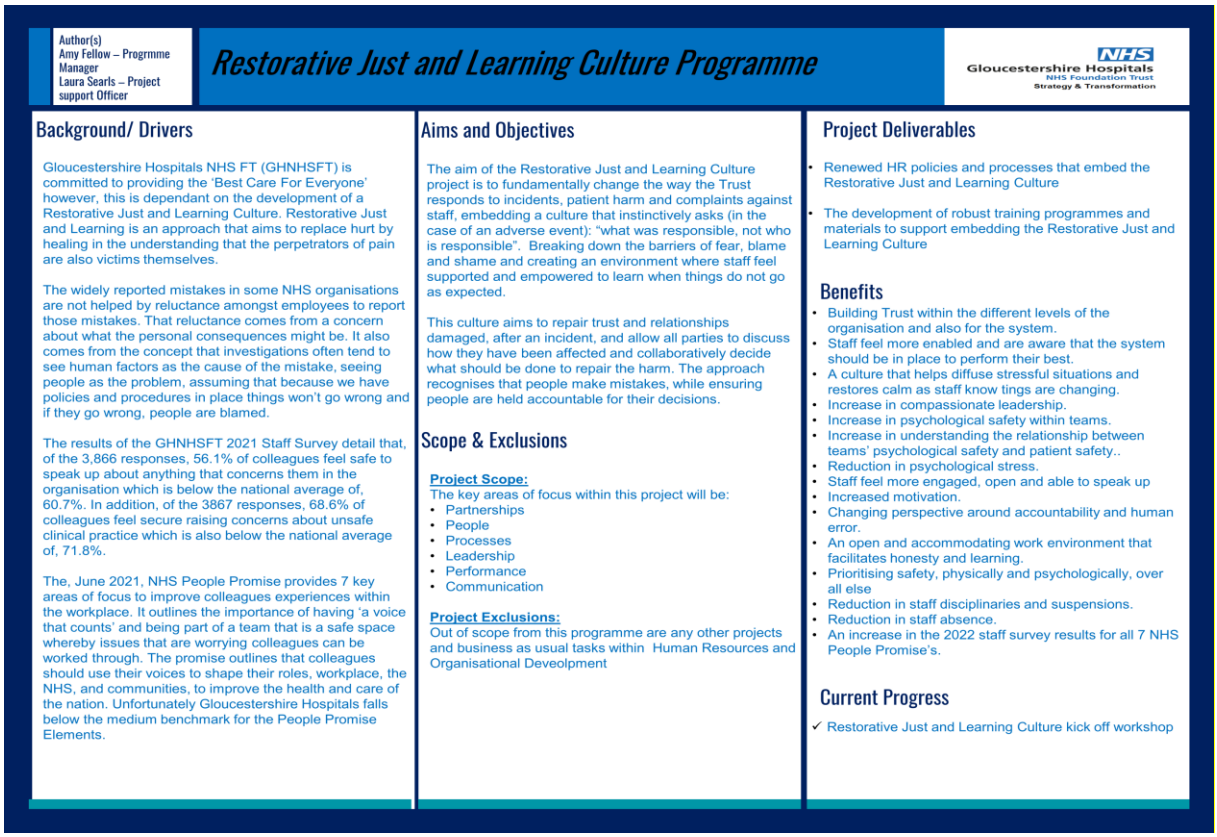
- RCN study day training for nurses across Gloucestershire
- Regular slot as part of the student nursing induction programme
- Training for SAS doctors
- International Medical Graduates [IMG] orientation morning
- Drop-in sessions with colleagues at Victoria Warehouse and Theatre teams
- Promotion of FTSU e-learning for all colleagues and managers through global emails and management distribution lists

As well as increasing engagement and communications activity to increase visibility of the Guardians, there are plans to continue to review and recruit more Guardians. This will be open to all colleagues, but with a focus on recruiting more nurses, ethnic minority colleagues and colleagues who have a lived experience of a physical or mental health long term condition, as we know that we are currently underrepresented in these areas.

Organisational programmes for FTSU

In addition to the work planned in to increase the visibility and accessibility of the Guardians in the Trust, the Guardians are working closely with other teams across the organisation, to ensure that the feedback and experiences heard through Speaking Up are triangulated and the insight used as part of our wider cultural programmes.

A key focus for 2022/23 will be the Restorative Just and Learning Culture Programme, working closely with the Director for People, Quality Improvement and Safety Director and HR and OD colleagues. Below shows an outline brief for this programme:



Looking forward 2022/23

The current Lead Guardian will be stepping back from the role due to maternity leave on 16 November. The Trust are recruiting a full time Lead Freedom to Speak Up Guardian, to increase capacity in the service, not only for reactive case management but to more proactively promote the role, and also to invest time in ensuring learning is connected with other key stakeholders, such as HR, OD and Safety teams.

Our FTSU reports currently are received by both People and OD Delivery Group and Quality Delivery Group, to ensure oversight of both staff and patient safety and experience issues reported through FTSU, with annual reports received at Trust Board.

The Freedom to Speak Up strategy is being reviewed, with a number of actions identified as part of a focus on three key pillars:

<u>Awareness and Visibility</u>

- Increasing visibility of the Guardians with a programme of walkabouts, which are built into the monthly schedule for Guardians. This will be supported by a comms and engagement plan, promoting the role more widely in the organisation using a variety of routes, and this activity will be reported back quarterly
- Review of our training opportunities – how we promote the FTSU e-learning, as well as mapping where Guardians feed into existing training and education offer (such as SAS doctors, student nurses, induction etc) to develop this further
- Development of a newsletter to share the themes and trends we hear, and to be able to articulate back to the organisation actions that are happening as a result, or how themes feed into programmes of work such as the Restorative Just and Learning work
- Promotion of case studies across the Trust, not only from those who have spoken up, but also from those who have received concerns from Guardians, to provide greater understanding of the role and how we can support people to safely raise concerns, and to resolve them

Strategic Direction

- There will be a review of the current Guardian model – We still believe as a Trust that having multiple Guardians offers choice to people, to ensure that there is a safe place for all, but we need to review if we have got the current mix of colleagues right and if there are any gaps to fill.
- FTSU Guardians are involved in the Restorative Just and Learning Programme, reviewing our policies and processes for both Safety and HR, to ensure the learning from those who have spoken up feeds in to this wider cultural change programme. The Guardians will continue to play an active role in this work, sharing their insight as part of the diagnostic, as well as sitting in the project teams for improvement, and involvement in review groups
- The Guardians will also work closely with HR and OD colleagues on the behaviours and incivility work, reviewing and refreshing our Trust values and behaviours and supporting the roll out of Civility Saves Lives

Monitoring

A number of metrics have been agreed which will be monitored through the National Quarterly Pulse Survey. The following two questions have been taken from the National Survey:

- % of staff "agreeing" or "strongly agreeing" that they would feel safe to speak up about anything that concerns them in their organisation

- % of staff “agreeing” or “strongly agreeing” that if they spoke up about something that concerned them, they are confident the organisation would address the concern

In addition to these, the Trust will also be asking colleagues:

- If I had a concern, I would feel confident to raise it with a Freedom to Speak Up Guardian

  Strongly Agree/Agree/No Opinion/Disagree/Strongly Disagree/ I do not know who the Freedom to Speak Up Guardians are

These metrics will be reported quarterly through the NQPS, and tracked alongside the core FTSU metrics reported nationally around the number of cases received, themes and trends from these cases and professional groups.

As well as looking at metrics for the wider organisation, the team are reviewing how we can better understand the experience of colleagues who have used the speaking up service, to include this in reporting. These will include feedback from people who have been through the process (either they have raised a concern or they are stakeholders, line managers etc). This will include confidence measures, to understand their level of confidence in the service when entering the process, and their level of confidence at the end, so we can capture the impact and experience of the Guardian service.

The team are working with Business Intelligence to look at how some of this data can be captured in SPC format, to provide trend data over time that can be monitored in committee – this will be for the key headline measures, and also looking at how this can be broken down to look at professional group, staff experience vs patient safety, and other ways of understanding the data to ensure we can maximise learning.

Recommendation

The Trust Board are asked to note the contents of the report and to support the continuing improvement of our speaking up culture within the Trust.

Author:	Katie Parker-Roberts, Lead Freedom to Speak Up Guardian
Sponsor:	Claire Radley, Interim Executive Lead for Freedom to Speak Up
Date	10 November 2022

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	13	Enclosure Number:	8
Date	10 November 2022		
Title	Fit for the Future Phase 2: Next Steps		
Author **Sponsoring Director**	Micky Griffith, Programme Director, Fit for the Future Simon Lanceley, Director of Strategy and Transformation		

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

Summary of Report

The purpose of this paper is to:

- Provide an update on recent progress, including feedback from the October Gloucestershire Health Overview and Scrutiny Committee (HOSC) review of the Phase 2 Output of Engagement Report, and post-HOSC discussions with NHS England;
- Seek Board approval for the recommended next steps for the Fit for the Future (FFTF) programme.

At September Board it was agreed that a decision regarding any further public involvement would await HOSC feedback.

Recommendation

The FFTF Programme Team and Programme Executive SROs for GHFT and ICB have reviewed all the information and feedback available and propose the following recommendation that Trust Board is asked to approve:

- That, for the reasons stated in the paper, no further FFTF phase 2 public involvement/ public consultation activities are required;
- That a FFTF phase 2 Decision-Making Business Case (DMBC) should be developed based on the 5 services in scope moving to permanent implementation, with the DMBC presented to GHFT and ICB Boards in March 2023 for approval.

Enclosures

- FFTF GHFT Nov22 v1.1

Fit for the Future Phase 2
Update to Trust Public Board
Gloucestershire Hospitals NHS FT

Document Control

Responsible Director:	Simon Lanceley, Director of Strategy & Transformation, GHFT
Status:	V 1.1

Version	Date	Author/ Reviewer	Comments
1.0	01/11/22	Micky Griffith	V 1.0 draft developed for review
1.1	02/11/22	Simon Lanceley	V 1.1 minor changes for GHFT Board

Document Distribution:

Forum/Audience	Date	Doc	Comments
GHFT Board	11/11/22	1.1	
ICB Board	30/11/22		

Contents

1 Purpose of the Document

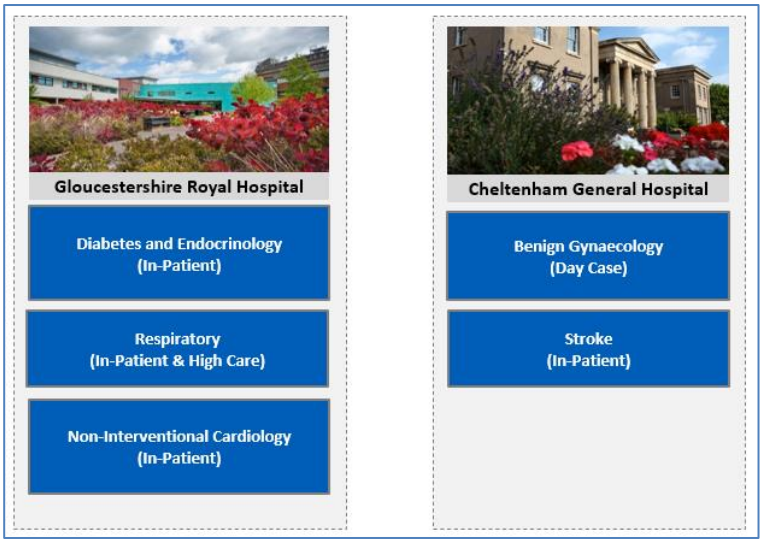
Following the discussion at September Trust Board on the Fit for the Future (FFTF) Phase 2 Outcome of Engagement report, the purpose of this paper is to:

- Provide an update on recent progress, including feedback from the October Gloucestershire Health Overview and Scrutiny Committee (HOSC) review of the phase 2 Output of Engagement Report, and post-HOSC discussions with NHS England;
- Seek Board approval for the recommended next steps for the Fit for the Future (FFTF) programme.

At September Board it was agreed that a decision regarding any further public involvement would await HOSC feedback.

2 Fit for the Future - 2

Fit for the Future is part of the One Gloucestershire vision focusing on the medium to long term future of some of our health services. It's about working together to agree how best to organise these services and helping our dedicated health professionals, working with people and community partners across Gloucestershire; a summary of the FFTF phase 2 in scope services is presented below.



3 Gloucestershire Health Overview and Scrutiny Committee (HOSC)

A FFTF Phase 2 briefing paper and the full Output of Engagement Report was circulated to HOSC members on 27/09/22, to provide members with the opportunity to ask questions in advance, so that responses could be prepared and presented at the October HOSC meeting (18/10/22). Prior to the meeting there were no requests for clarification or further information.

At the October HOSC meeting there were a number of questions and comments raised by HOSC members which were answered by the FFTF team, and the high quality of the output report was noted by the Committee.

Whilst the HOSC minutes have yet to be published, it was evident from the discussion that the HOSC did not raise any concerns with the level of public involvement activities completed to

date, in phase 1 and phase 2, and there were no further requests for public involvement on the proposed changes in scope of phase 2.

4 NHSE South West Regional Team

The FFTF programme has worked closely with the NHS England South West Regional Team throughout phase 1 phase 2. FFTF phase 1 was subject to an NHSE Stage 2 regulatory review process prior to launching public consultation.

To date, FFTF phase 2 has been following the same regulatory process, including the clinical assurance through the South West Clinical Senate Review Panel held in August 2022, public, colleague and stakeholder engagement and production of the Output of Engagement Report. NHSE have been kept fully informed of progress and were provided with copies of the HOSC materials.

A call has taken place at which the outcome of the HOSC discussion was communicated to NHS England, and it was confirmed that, should a decision be taken by the NHS Gloucestershire Integrated Care Board that they are content that the public involvement undertaken has met their duties to involve the public, there would no longer be a requirement to extend the Stage 2 process to include formal public consultation.

5 Issues to Consider

In line with the Stage 2 process, decisions regarding whether the service change ideas in scope of Fit for the Future phase 2 engagement are deemed to be a substantial development of the health service in Gloucestershire, or a substantial variation in the provision of those services, need to be taken by NHS Gloucestershire Integrated Care Board (ICB) in partnership with Gloucestershire Hospitals NHS FT Trust Board and Gloucestershire Health Overview and Scrutiny Committee. This decision needs to consider the Output of Engagement Report, the NHS England Clinical Senate Clinical Review Panel Report and other information deemed necessary to reach such a decision.

The Output of Engagement Report (presented to Trust Board, ICB and HOSC), demonstrated a high degree of consensus in support of the proposals. The Fit for the Future phase 2 programme is grounded in the same centres of excellence strategy that we have had confirmed through previous consultations and has built on the extensive engagement and consultation activities for FFTF phase 1. These consultations identified there is high recognition of the benefits of our centres of excellence approach amongst those responding to our surveys. In addition, many respondents to our FFTF phase 1 Consultation felt that a greater separation of emergency and planned care would optimise care quality, increase staff retention and learning which would result in reduced waiting times and cancellations.

Furthermore, as part of developing our local plans for Gloucestershire over the last few years, we have been asking staff, patients, carers, public and community partners, what matters to them about local health and care services. A significant proportion of respondents agreed we should bring some specialist hospital services together in one place and that getting to the right specialist team first time was more important than distance to travel.

It is our contention that FFTF2 has engaged inclusively, innovatively and constructively with our internal and external stakeholders, most importantly with the residents of Gloucestershire and users of our services. In doing so we believe we have met the requirements of NHSE Guidance:

- Robust public involvement;
- To be proactive to local populations;
- To be accessible and convenient;
- To consider different information and communication needs, and;
- To involve clinicians.

6 Recommendation

When we consider what is required, including whether further public involvement / consultation should be undertaken, the assessment should include:

- What additional information is likely to be forthcoming;
- What additional benefits might be identified;
- If any alternatives will be identified, and;
- A value assessment on the resources applied to further public involvement, set against the other priorities that, we as a system, are working on to improve the health and care of our population.

These questions were asked of the HOSC in October 2022 and from the discussion it was clear that the HOSC did not raise any concerns with the level of public involvement activities completed to date and there were no further requests for public involvement on the proposed changes in scope of phase 2.

The FFTF Programme Team and Programme Executive SROs for GHFT and ICB have reviewed all the information and feedback available and propose the following recommendation that Trust Board is asked to approve:

- That, for the reasons stated in the paper, no further FFTF phase 2 public involvement/ public consultation activities are required;
- That a FFTF phase 2 Decision-Making Business Case (DMBC) should be developed based on the 5 services in scope moving to permanent implementation, with the DMBC presented to GHFT and ICB Boards in March 2023 for approval.

KEY ISSUES AND ASSURANCE REPORT
Finance and Digital Committee, 27 October 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	The Trust reported a deficit of £10.9m, which was £9m adverse to plan. The deficit was driven by a number of factors, including underperformance on out of county contracts, underperformance on pass-through drugs and devices, divisional pay pressures and overspend on temporary staffing, pay award pressure, and GMS inflation. The Financial Sustainability Plan target for the Trust was £19m, of which £5.6m was still unidentified. This meant that the efficiency requirement would become higher as the year progressed. The plan had delivered £8.1m year-to-date against a target of £8m, which was an over-delivery of £0.1m. This was driven by the declaration of the full £1.5m annual corporate savings target in month six. Budget setting methodology had been finalised for divisions and would be shared with the Executive team before discussion at the next Committee meeting.	The financial position continued to highlight a significant challenge to the Trust. Actions proposed by divisions were not generating a reduction in run rates and there was concern about the pace of delivery of divisional action plans. The Committee was very concerned about the deterioration of the forecast position, which is unsustainable. The Financial Recovery Plan set out objectives and actions to further mitigate against the Trust's position. Additional mitigations were being explored, with work taking place to assign an Executive Director to each action to ensure Executive ownership.
Financial Recovery Plan	The Financial Recovery Plan actions to be progressed as a priority included: •Reviewing and challenging divisional recovery plans. •Highlighting the difficult decisions required to improve the financial position. •Progressing the review of temporary staffing controls with a view to reducing spend. •Reviewing all agency spend on non-clinical areas. •Continuing 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. Additional work was being undertaken to gain clarity around run rates and to instil grip and control to stabilise the position. A different model of support for divisions within the Trust, particularly medicine, would be considered.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Financial Sustainability Report	The position at month six, including the forecasted realisation of £7.8m benefits, was an improvement on the month five position. Year-to-date delivery was £5.1m against a plan of £5m, which was an over-delivery of £0.1m, driven by corporate savings. Mitigations to close the savings gap were in place and included reviews of a number of areas within workforce, digital, corporate and divisions.	Work continued to drive forward and stretch identified Divisional and cross-cutting workstreams and to generate new schemes to ensure a successful Financial Sustainability Plan. Plans to generate new ideas would be explored and developed during November.
Capital Programme Report	The Trust had submitted a gross capital expenditure plan of £67.1m for 2022-23. To date, there had been £0.4m of additional capital approved, bringing the total to £67.5m. At month six, the Trust had goods delivered, works done or services received to the value of £17.0m, £6.5m behind plan. There were concerns raised about slippage, deliverability and risk, however increased efforts to obtain a profiled forecast from all project leads had taken place.	The MOU for the Community Diagnostic Centre had been received, but there were some concerns around deliverability. Conversations were ongoing with NHSEI to put mitigations in place. Additional project management was also being explored. A risk-based approach to prioritisation would be utilised around the finance

		ledger, cyber and digital, and electrical infrastructure works. A conversation was required around whether the Trust could take on additional opportunities and how they would be effectively managed.
Procurement Assurance Report	A continued period of pressure for the team was noted; a high number of vacancies was balanced with support for programmes across the Trust. The team had delivered a significant workload, despite the challenges, and had delivered savings in increasingly difficult market conditions.	A case for change for Shared Services would be included in the next report to the Committee; this aimed to address challenges in relation to resourcing and pending legislation changes.
ICS Planning	The Committee was advised of the aim to agree a five-year financial plan across the system.	A report would be received in January.
Digital Transformation Report	Key points were noted as follows: •The ePMA project continued to progress towards a November go-live. •EPR and BI teams had supported the recent Reset Week to improve patient flow. •Maternity services had completed current state process mapping and moved onto future state. Communications had started and would be supported by digital midwives. Hardware requirements and testing was underway. •Clinical and operational representatives were now involved in developing processes for the use of a Long-Stay Risk Score algorithm in Sunrise EPR. •JUYI single sign-on had been completed. •Cyber security remained a serious threat to organisations globally and whilst work on the Trust's own cyber action plan continued at pace, the risk and sophistication of these attacks are growing. ***Back Office IT Systems*** A number of the Trust's back office systems were outdated and required improvement. The current position was unsustainable and a management strategy would be developed to ensure mitigation of risk to the organisation.	Post project implementation reviews were planned to take place. Back office systems recommendations included: •All corporate system owners to be mandated to develop their own systems strategies to ensure future proofing. •System owners to be asked to comply with current cyber security recommendations; ensuring that they make the resources available to manage and support upgrades of both software and operating systems to supported versions. •System owners to be invited to a forum in the future to enable closer working and support with digital teams. •Back-office system governance to be addressed as part of an updated digital strategy in the future, fully exploring the different options to address the risks and issues that currently exist across the organisation.

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Private and Overseas Patients Review	There is a range of next steps in motion to support improved governance and future income streams – laying the foundations for future sustainable growth – as well as ongoing improvements to existing billing practises.	The Committee noted the positive report, and welcomed a future report on governance process assurance.
Commercial Development Oversight	An Oversight Group would be established to ensure appropriate governance arrangements for commercial opportunities. The Group would incorporate the Trust's current Innovation Panel.	The Committee approved the Terms of Reference and agreed that the Oversight Group would formally report into the Committee.

Items not Rated		
Proposed New Ledger	Digital Risk Register	ICS Update

Investments			
Case	**Comments**	**Approval**	**Actions**
Discharge Lounge Procurement	Approved virtually by the Committee.	Ratified	None

The Committee reviewed a GMS contract dispute and agreed revised terms.
Impact on Board Assurance Framework (BAF)
Additional work on IT and Digital BAF risks was underway. Risk rationalisation would be completed this month for assurance.

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	14	Enclosure Number:	9
Date	10 November 2022		
Title	M6 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 6 to the Trust Board.

Month 6 overview

- The Trust is reporting a year-to-date deficit of £10.9m deficit which is £9m 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 6, 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 £9.5m is £7.9m adverse to plan and is the result of a £9m adverse to plan position from GHFT, and a £1.1m YTD surplus position at GHC.

2022/23 Capital

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.5m which includes £0.4m of additional funding awarded in August 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 September (M6), the Trust had goods delivered, works done or services received to the value of £17m, £6.5m behind plan.

Key issues to note

The deficit is driven by:

- Underperformance on out of county contracts of £1.8m
- Divisional pay pressures of £4.3m pay overspend due to use of temporary staff to cover vacancies, provide RMN support and meet unscheduled care demands
- Non pay pressures of £3.8m due to clinical supplies, outsourcing and laboratory reagent costs.
- Financial Sustainability pressure of £2.6m

- Corporate underspends of £0.6m
- 50% of well-being day released in M3 £1.3m

Next Steps

The financial position at month 6 continues to highlight a significant challenge and the pressures are forecast to continue unless mitigating actions are implemented.

The Financial Recovery Plan that was presented to Finance and Digital Committee in September 2022 has been reviewed during October 2022 to assess progress.

The Financial Recovery Plan actions to be progressed as a priority include:

- Reviewing and challenging divisional recovery plans
- Highlighting the difficult decisions required to improve the financial position
- Progressing the review of temporary staffing controls with a view to reducing spend.
- Reviewing all agency spend on non-clinical areas
- Continuing to identify additional schemes to meet the overall financial sustainability programme and income targets.

In addition, work has been undertaken during October 2022 to identify additional mitigations and assign an Executive Director to each action.

Conclusions

The Trust is reporting a year-to-date deficit of £10.9m deficit which is £9m adverse to plan. The Financial Recovery Plan is being implemented and reviewed with updates reported to Finance and Digital Committee.

Recommendation

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

Enclosures

Month 6 Financial Performance Report

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Financial Performance Report
Month Ended 30 September 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 6, 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 £9.5m which is £7.9m adverse to plan. This is the result of a £9m adverse to plan position from GHFT, and a £1.1m YTD surplus position at GHC.

Key risks in the ICS's financial position are:

- Medicines Management pressures Inflation & growth exceeds assumptions
- 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 6

M6 Financial position is reporting a deficit of £10.9m which is £9m adverse to plan. The deficit is driven by :

- Underperformance on out of county contracts of £1.8m
- Underperformance on pass-through drugs & devices overhead income £0.4m
- Divisional pay pressures of £4.3m pay overspend due to use of temporary staff to cover vacancies, provide RMN support and meet unscheduled care demands. Of this, £3m is for RMNs and escalation. Ambulance Cohort Area is now funded so no longer a pressure.
- Pay Award pressure of £0.8m including £0.4m reduction in GMS dividend due to pay award.
- Non pay pressures within divisions of £3.8m net due to clinical supplies, outsourcing and laboratory reagent costs.
- Financial Sustainability pressure of £2.6m
- GMS inflation pressure of £0.8m
- Corporate net underspends of £0.6m, including an accrual of £0.7m for Digital costs that will be incurred in future months.
- Non recurrent benefits of £5m

The Financial Sustainability Plan (FSP) target for the Trust is £19m, of which £5.6m is still unidentified, meaning the efficiency requirement will become higher as the year progresses. The M6 position includes FSP delivery of £8.1m YTD against a target of £8.0m which is an over-delivery of £0.1M, driven by the declaration of the full £1.5M annual corporate savings target in M6. This has offset under-delivery in cross-cutting workstreams that are now supporting the sustainable workforce and productivity agendas, which are contributing to run-rate reduction and cost avoidance.

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 remains under significant pressure despite a slightly improved deficit this month.

Run rate improved in month 6 and the overspend was £152k lower than forecast but this was achieved through technical adjustments and unplanned reductions in run rate.

The recovery plan actions identified by the Trust have not materialised in month 6. A strong focus on grip and control is required for the remainder of the financial year to ensure that recovery actions are progressed and run rates reduced in line with forecast. An update on the Financial Recovery Plan will be provided to the Committee in October 2022 and will include progress of previously identified actions and the responsible executive.

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

Month 6 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £10.9m deficit		M6 Financial position is reporting a deficit of £10.9m which is £9m adverse to plan.
Income is £337.4m YTD which is £6.2m adverse to plan		M6 overall income position is reporting £337.4m income which is £6.2m adverse to plan. The income variance is driven by income plan shortfall of £4.5m (which is offset by provision released against non pay), underperformance of activity on out of ICS contracts c£1.8m and less than expected pass through drugs c£2.2m which sees a corresponding underspend in divisional expenditure budgets. Funding for ESRF schemes has been received in M06 (£0.6m), matched by costs incurred in divisional positions.
Pay costs are £217.1m YTD which is £3m adverse to plan		Pay costs are £176.5m YTD which is £3m adverse to plan. The YTD position includes a one off benefit of c£1.45m. Without this pay would be overspent by £4.45m YTD driven by pay award pressure of £0.8m and the use of temporary staffing in both Medicine and Surgery Divisions for Nursing and Medical staff. The month 6 position (excluding one off benefit) includes Substantive staff underspend of £23.4m offset by overspends in Agency (£8.9m) and Bank/Locum (£17.4m) The total contracted vacancies in month 6 are 745 WTE.
Non Pay costs are £131.3m YTD which is £0.2m favourable to plan		Non Pay costs (including non-operating costs) are £131.3m YTD which is £0.2m favourable to plan. The YTD month position includes a one off benefit of £3.6m. Without this non pay would be overspent by £3.4m YTD. The main drivers of the non pay overspends include inflation £1m, clinical supplies £2.9m and FSP shortfall £2.6m. Drugs costs including pass through are favourable to plan at £0.97m.
Delivery against Financial Sustainability Schemes		Total efficiencies for the Trust are £19m which consist of £4.5m Covid reduction, £1.3m GMS savings and £11.3m Trust wide efficiencies. At month 6, £8.1m efficiencies have been delivered YTD. Forecast delivery is £13.5m which is a shortfall of £5.6m due to unidentified schemes.
The cash balance is £66.6m		Cash has decreased by £0.8m due to a reduction in debtors and creditors and receipt of PDC.

M6 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of September 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 September the Group's consolidated position shows a deficit of £10.9m which is £9m adverse to plan (before donated asset adjustment).

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 6 Financial Position	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	314,608	306,809	(7,799)			0	314,608	306,809	(7,799)
PP, Overseas and RTA Income	3,190	2,317	(873)			0	3,190	2,317	(873)
Other Income from Patient Activities	6,324	6,343	19			0	6,324	6,343	19
Operating Income	18,388	20,209	1,821	32,246	27,483	(4,763)	19,562	21,991	2,428
Total Income	**342,511**	**335,679**	**(6,832)**	**32,246**	**27,483**	**(4,763)**	**343,685**	**337,460**	**(6,225)**
Pay	(203,235)	(205,699)	(2,464)	(10,806)	(11,357)	(550)	(214,042)	(217,056)	(3,014)
Non-Pay	(136,478)	(136,639)	(166)	(20,037)	(15,464)	4,573	(125,444)	(126,402)	(958)
Total Expenditure	**(339,714)**	**(342,338)**	**(2,630)**	**(30,843)**	**(26,820)**	**4,023**	**(339,485)**	**(343,458)**	**(3,972)**
EBITDA	**2,798**	**(6,659)**	**(9,462)**	**1,403**	**662**	**(740)**	**4,200**	**(5,997)**	**(10,197)**
EBITDA %age	**0.8%**	**(2.0%)**	**(2.8%)**	**4.3%**	**2.4%**	**(1.9%)**	**1.2%**	**(1.8%)**	**(3.0%)**
Non-Operating Costs	(4,720)	(4,260)	464	(1,403)	(662)	740	(6,121)	(4,922)	1,199
Surplus / (Deficit)	**(1,921)**	**(10,919)**	**(8,998)**	**0**	**0**	**0**	**(1,921)**	**(10,919)**	**(8,998)**
Dontated Asset Adjustment	221	343	122				221	343	122
Adjusted Surplus / (Deficit)	**(1,700)**	**(10,576)**	**(8,876)**	**0**	**0**	**0**	**(1,700)**	**(10,576)**	**(8,876)**

* Trust position excludes £19.9m of Hosted Services income and costs. This relates to GP Trainees
** Group position excludes £26m of inter-company transactions, including dividends

Balance Sheet

	Group Closing Balance 31st March 2022 £000	GROUP Balance as at M6 £000	B/S movements from 31st March 2022 £000
Non-Current Assests			
Intangible Assets	13,760	12,373	(1,387)
Property, Plant and Equipment	304,585	335,255	30,670
Trade and Other Receivables	4,414	4,349	(65)
Investment in GMS	0	0	0
Total Non-Current Assets	**322,759**	**351,977**	**29,218**
Current Assets			
Inventories	9,370	10,115	745
Trade and Other Receivables	26,360	23,203	(3,157)
Cash and Cash Equivalents	71,530	70,773	(757)
Total Current Assets	**107,260**	**104,091**	**(3,169)**
Current Liabilities			
Trade and Other Payables	(80,104)	(93,227)	(13,123)
Other Liabilities	(14,401)	(7,588)	6,813
Borrowings	(3,626)	(3,612)	14
Provisions	(24,089)	(21,582)	2,507
Total Current Liabilities	**(122,220)**	**(126,009)**	**(3,789)**
Net Current Assets	**(14,960)**	**(21,918)**	**(6,958)**
Non-Current Liabilities			
Other Liabilities	(5,971)	(5,698)	273
Borrowings	(34,064)	(56,931)	(22,867)
Provisions	(3,600)	(3,600)	0
Total Non-Current Liabilities	**(43,635)**	**(66,229)**	**(22,594)**
Total Assets Employed	**264,164**	**263,830**	**(334)**
Financed by Taxpayers Equity			
Public Dividend Capital	361,345	371,930	10,585
Equity	0	0	0
Reserves	19,823	19,823	0
Retained Earnings	(117,004)	(127,923)	(10,919)
Total Taxpayers' Equity	**264,164**	**263,830**	**(334)**

Gloucestershire Hospitals
NHS Foundation Trust

The table shows the M6 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.

YTD Position

As of the end of September (M6), the Trust had goods delivered, works done or services received to the value of £17.0m, £6.5m behind plan.

A breakeven forecast outturn has been reported to NHSI in the M6 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 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 funding awards that are nearing full approval that is not reflected in the month 6 position that will be added to the reported position when full approval is gained. Approvals that are expected to hit in M7, following confirmation of a successful award are;

- Another Salix energy efficiency grant covering 22/23 (£3.2m), 23/24 (£6.7m) and 24/25 (£1.0m)
- PDC funding for the Community Diagnostic Centre scheme 22/23 (£10.8m), 23/24 (£2.2m) and 24/25 (£1.3m)

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 September (M6), the Trust had goods delivered, works done or services received to the value of £17.0m, £6.5m behind plan. The expenditure by programme area is shown below.

		In Month			Year to date			Forecast Outturn		
Programme Area	**Funding**	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**	**Allocation**	**Actual**	**Variance**
Medical Equipment	Operational System Capital	397	89	308	1,386	1,119	266	2,223	2,223	0
Digital	Operational System Capital	615	(430)	1,045	2,888	1,606	1,281	5,634	5,634	0
Estates	Operational System Capital	525	566	(42)	2,134	1,398	736	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	238	(101)	564	1,120	(556)	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	2,767	1,858	909	15,845	11,349	4,495	21,280	21,280	0
Donations Via Charitable Funds	Donations via Charitable Funds	75	0	75	320	0	320	1,281	1,281	0
IFRIC 12	IFRIC 12	68	68	0	409	408	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		**4,585**	**2,390**	**2,195**	**23,544**	**17,001**	**6,543**	**67,458**	**67,458**	**0**
Less Donations and Grants Received	Donations via Charitable Funds	(75)	0	(75)	(320)	0	(320)	(1,281)	(1,281)	0
Less PFI Capital (IFRIC12)	IFRIC 12	(68)	(68)	(0)	(409)	(408)	(0)	(817)	(817)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	Operational System Capital	27	27	0	159	159	0	318	318	0
Total Capital Departmental Expenditure Limit (CDEL)		**4,468**	**2,349**	**2,120**	**22,975**	**16,752**	**6,223**	**65,678**	**65,678**	**0**

The main contributors to being behind plan are;
£4.5m - 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.

£1.3m – the digital project has some credits that have hit due to receipts reversing out and VAT reclaims Finance are working closely with the digital team to understand these in detail and the impact this will have on the forecast. It is the expectation that the forecast will remain unchanged.

A breakeven forecast outturn has been reported to NHSI in the M6 Provider Financial Return. Although there are concerns aboutslippage materialising and further funding awards that will increase the back-ended nature of the programme and concerns about deliverability and risk.

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date deficit of £10.9m which is £9m adverse to plan.
- 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:	**November 2022**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Board of Directors

Agenda item:	**14**	**Enclosure Number:**	**9**
Date	November 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. It brings together the previous 'project update' and 'EPR update' reports into one paper and includes reporting in line with the four main work areas.

Highlights during this last period include:

- ePMA project is progressing towards a November go-live.
- EPR and BI teams supported the recent 'reset' to improve patient flow.
- Maternity has completed the current state process mapping and moved onto future state. Communications are beginning and will be supported by digital midwives, as well as Corporate and Digital Comms teams. Hardware requirements and testing is underway.
- Clinical and operational representatives are now involved in developing a process (and SOPs) for the use of a Long-Stay Risk Score algorithm in Sunrise EPR (not yet live). This will cover its use as a support tool in ED, SDEC and inpatients as required.
- JUYI single sign-on is complete. This means that staff with permission to access JUYI will no longer need to log-in with a Smartcard, but can simply access through Sunrise EPR or TrakCare. Note: *Access to the national Summary Care Record will still require a Smartcard.*
- Cyber security remains a serious threat to organisations globally and whilst work on the Trust's own cyber action plan continues at pace, the risk and sophistication of these attacks are growing.

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 Board is asked to note the report for assurance.

Enclosures

- Digital Transformation Report

PUBLIC BOARD OF DIRECTORS – NOVEMBER 2022

DIGITAL TRANSFORMATION REPORT

1. Executive Summary

This paper provides the Public Main Trust Board with updates on projects being delivered and overseen by the Digital Transformation Office. This now also includes EPR programmes.

The projects are categorised as four digital delivery areas:

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

This work plan continues to deliver 52 projects, as well as all the crucial, ongoing, BAU operations of the Digital and IT shared service departments, against the agreed delivery plan for 2022/23. This delivery is managed despite a high vacancy factor, with 89 vacancies against CIO, and 11 against CITS. Of these vacancies, 95% have VCPs instigated and logged, and 24 have been recruited to in-month, or are awaiting a start date.

1.1 In this report

Highlights during this last period include:

- ePMA project is progressing towards a November go live, a detailed update on is provided in section 2
- A quarterly benefits and strategy update, focussing on quality benefits following the introduction of clinical documentation on EPR is at section 4.
- The latest position on national and regional funding bids for digital is described in section 5.
- Maternity has completed the current state process mapping and moved onto future state. Communications draft strategy and messaging is in place and will be supported by digital midwives; as well as corporate and digital comms teams. Hardware requirements and testing is underway.
- Clinical and operational representatives are now involved in developing a process (and SOPs) for the use of a Long Stay Risk Score algorithm in Sunrise EPR (not yet live). This will cover its use as a support tool in ED, SDEC and inpatients as required.
- JUYI single sign on is complete. This means that staff with permission to access JUYI will no longer need to login with a Smartcard, but can simply access through Sunrise EPR or TrakCare. Note: *access to the national Summary Care Record will still require a Smartcard.*
- Cyber security remains a serious threat to organisations globally and whilst work on the trust's own cyber action plan continues at pace; the risk and sophistication of these attacks are growing.

1.2 JUYI now viewable in EPR without a smartcard

A considerable amount of work has been happening behind the scenes to enable clinicians to view JUYI information directly in Sunrise EPR. Previously they accessed the

JUYI (ICS wide) system through an icon in EPR, which launched a separate system and needed a smartcard.

This new change, launched on 19th October, means that clinicians see the additional patient information directly in an EPR tab – as if the data is in the system itself – providing a quick and seamless view. The access doesn't require a Smartcard, however it is still only available to specific clinical security groups.
This is a small but significant change to make it easier and quicker for clinicians to view all the patient information they need, in one place. Initial feedback has been extremely positive and described as having *"transformed my clinic"* by one consultant.

Clinicians will still use a smartcard to access the Spine (national Summary Care Record).

1.3 Supporting the reset and patient flow

Colleagues from throughout the Trust, primary care and community services came together with the aim of demonstrating the cumulative impact that a number of initiatives could have on ambulance handover delays. The results being a 50% reduction in ambulance hours lost, with no patient waiting more than four hours to be offloaded.

A key part of this effort was the introduction of new functionality on to Sunrise EPR, that provides an instant view of patients ready for discharge. The Site Management Tracking Board is updated daily by clinicians on Board rounds and reviewed in afternoon huddles. It gives clinicians an opportunity to identify patients who can be discharged today and space to add patient flow comments viewable by clinical and operational teams. This was then supported by Business Intelligence teams, who could pull essential data into dashboards for use across the hospital and ICS where needed.

Using this tool on EPR made a significant difference to the way operational and clinical staff in site and across the Trust could work; and the benefits have already been seen.

2. Electronic Prescribing Detailed Update (ePMA)

This section provides an update on the implementation of eletronic prescibring in November (moving the yellow drug chart onto Sunrise EPR). This impacts anyone who prescribes, reviews or administers medication in adult inpatient areas (not maternity), theatres and emergency departments. This is a huge project involving experts from across digital working alongside pharmacy colleagues to scope, prepare and build electronic prescribing into our existing system for Gloucestershire Hospitals.

The dates for moving onto EPR have been confirmed in the following phases:

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

The role of early adopter wards is to safely use the system in a controlled environment with dedicated training and EPR support on hand. This is an approach used before with major EPR go lives and provides an opportunity to deal with issues ahead of the whole hospital implementation.

Go live will be fully supported from 2nd November to 9th December, with floorwalking teams and command centres (GRH and CGH as required) dealing with urgent fixing of issues. These will operate 24 hours a day, seven days a week unless the organisation decides to stand down. They will be staffed by technical and programme teams, as well as EPR suppliers Altera Digital Health (formerly known as Allscripts).

2.1 Clinical engagement and training

Pharmacy and clinical specialists have been involved in the programme since it began, with nursing and medical representation on the project meetings and project board. Digital super users have been involved in system testing. There have also been ward-based demonstrations to check workflows and engage users in the final round of feedback and testing. This will continue as we advance towards go live.

The training programme went live on Thursday 22nd September and is made up of nine (Nurses) or ten Prescribers/Pharmacy e-learning modules including assessments (quiz) to be completed by staff to confirm completion (with a separate quiz for nursing non-prescribers). The *complete* training package takes between 1 and 2 hours to complete, however it is broken down into modules depending on role; each taking between 10 and 40 minutes. Completion statistics will be monitored and reported to PDG and senior clinical leadership teams. Training by role is split into:

- Pharmacy
- Prescribers
- Nurses
- AHPs (AHPs who prescibe will be added to the Prescriber list)

Online training is being supported by videos and user guides, including an overview of ePMA and an introduction for new users of Sunrise EPR. Face to face and guided e-learning will be provided to those who request it. Quick Reference Guides will be available online and in print.

2.2 Business continuity planning

Moving medications from paper forms to Sunrise EPR carries a greater business continuity risk for when IT systems are down. The ePMA programme team is working with the EPRR team to ensure that:

- Business continuity PCs are fully operational.
- EPR business continuity plans are updated to include ePMA.
- Communications with staff on how to locate the PC, the plan and what to do in the event of downtime is prepared and shared ahead of go live.
- A business continuity simulation exercise is completed and actions implemented, ahead of go live.

A representative of the digital team is attending the fortnightly EPRR group in preparating for go live, working closely with departmental leads.

2.3 Safety assurance

Risk assessments are being monitored and reviewed at the Clinical Safety Group. The phased approach to go live was agreed by the group because of the improved safety benefit of having higher volume floorwalking support on each site; this outweighing the disbenefit of transcribing from digital area to paper. Small numbers of patients will be

impacted by this - mostly ED CGH to ED/SAU GRH. The most impacted department is ED and they have been consulted on the proposals, accept the risk and will undertake the transcribing if required, additional resource however is being planned. There will be a 2-week period between Cheltenham Hospital going live with ePMA digital prescribing and Gloucester hospital going live. To prevent any drug errors, during this period a yellow paper drug chart will be completed for all patients being moved, transferred or admitted to Gloucester Hospital from Cheltenham Hospital.

- This paper chart should travel with the patient.
- This drug chart does not have to include all of a patient's normal medications but must include ALL medications given on ePMA with the dose, route and time.
- Write 'ePMA' in the 'given by' signature section to prevent repeat dosing
- Complete a yellow paper drug chart for every patient, even if patients have received no medications in Cheltenham.

2.4 Go-live assurance and criteria

The go live criteria is summarised in the table below and has been reviewed by the Exec Tri, PDG, ePMA Programme Board and IT Senior Leads. All of the criteria will be evidenced and assurance provided as part of the go/no go decision. From Monday 26th September, a member of the digital senior leadership trip will attend the Exec Tri on a weekly basis to provide an update on progress against the criteria agreed. The criteria will also be tabled at Digital Care Delivery Group in both October and November to ensure appropriate governance and progression.

Criteria	Required Metrics (if applicable)	Evidence	Assurance / Sign Off
Technical assurance ready to go	100% of testing scenarios completed. No go-live blocking issues remaining. Technical cutover plan in place.	Testing plan & testing issues list. Technical cutover plan.	PDG Altera Pharmacy
Equipment and devices ready on wards	Medication carts issued and in use on wards. Theatre equipment in place. ED equipment complete (including new build scope).	Site audit report. Ward sign off sheets.	IT Senior Leads Exec Tri SDs & Matrons
Business Continuity & SOPs in place	BCP reports complete. BCP computers online & checked. BCP guides issued. SOPs agreed & published.	Simulation report. BCP audit report. SOPs.	Clinical Safety EPRR Group Director of Pharmacy SDs & Matrons
Formal Governance Complete	OIA and Organisational sign off. Clinical Safety Group approval. Sign off of hazard log.	OIAs returned and approved. CSG report. Hazard report	Exec Tri Pharmacy SDs & Matrons
Training and Communication complete	70% of staff in impacted areas trained before go live (phased approach) Global and ward-based comms issued. QRGs. Video Guides.	E-learning report. Face to Face training report. Ward-based training report .Comms plan executed.	IT Senior Leads PDG Clinical Safety Sign off of SDs & Ward Managers
Pharmacy readiness	Approval to proceed Pharmacy staff briefed & aware of change. Resourcing in place for go live period up until 9th December.	Pharmacy sign off/OIA. Engagement dates/evidence. Go Live Rota.	Pharmacy Leadership D&S Tri MP to be part of Final Go/ No Go
Go Live Support in place	24/7 floorwalking & command centre support from 2nd November – 9th December	Staff Rotas including IT senior leadership cover.	IT Senior Leads
Authority to proceed on day of go live	Exec Tri approval to proceed including MP for CDs sign off. No major technical issues.	Full evidence & assurance Pack presented to Exec Tri.	Exec Tri

3. RAG Status Updates

The reports provide more detail on the status of projects within the Programme of Work categories.

The current status of projects:

EPR	Clinical Systems Optimisation	Infrastructure & Cyber	Business Intelligence
8	15	20	9

Complete or in closure	On Hold	Red Rated	Amber Rated	Green Rated	Discovery Phase
9	2	10	11	12	8

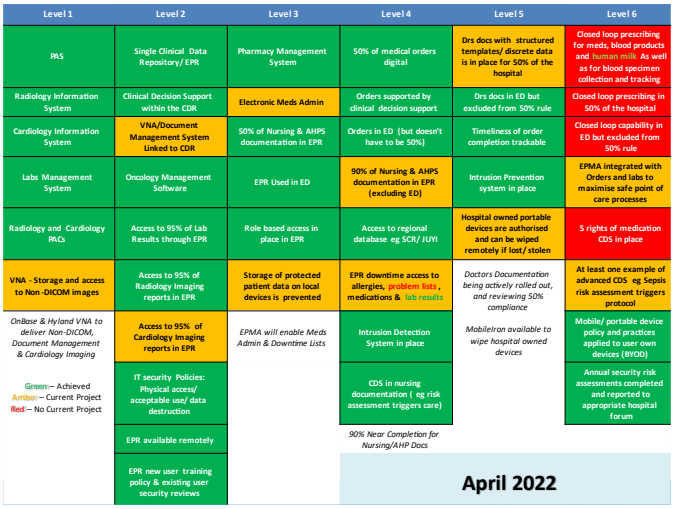
Red	Significant issues with the project – scope, time or budget is beyond tolerance level
Amber	Issue/s having negative impact on the project performance, project is close to tolerance level
Green	Project is on track
Blue	Complete & Closed (or In Closure)

Since the last report two projects have been completed and closed and two projects have gone into closure. Projects closed are:

- Pre-Assessment Digital Workflows
- CGH Data Centre Aircon

4. Digital Strategy and Benefits Update

Everything we deliver must improve patient care and safety; whilst working hard for clinicians. In the next year we have a great opportunity to align our strategy with the new ICB strategy; with a real focus on improving patient outcomes. There are huge benefits achieved already, with a significant step in our journey coming in November when we implement electronic prescribing. This will help us unlock many of the wider safety and care benefits aligned to a digitally advanced hospital. This diagram shows the current status against the 5-year plan to reach the HIMSS Level 6 benchmark by 2024.



4.1 Nursing documents quality update

Reporting on nursing adherence to documentation via the Quality Delivery Group is now fully embedded with divisions submitting a monthly report with regards to their plans to improve documentation completion and providing feedback on common themes and opportunity for quality improvement.

Prior to the introduction of Nursing Documentation in EPR audit and quality reviews of documentation were ad-hoc and used samples. There was very little assurance that nursing teams were able to provide surrounding the standard and quality of documentation but that is very different now. The table below demonstrates the improvement that has been made in this space when comparing data a few months post go live (Jan 20) to August 2022. The difference across the measurements is significant across all fields and it's all credit to the nursing teams changing their approach and using the available data to improve documentation.

Metric	Jan-20	Aug-22	Change
Nursing Admission Document completed within 24 hours	36%	70%	34.65%
Smoking Screening	66%	85%	18.81%
Pain Assessment	77%	91%	14.29%
Manual Handling	73%	90%	16.92%
Delirium Screening	52%	94%	42.20%
Dementia Screening	58%	89%	30.72%
Patient Property Question Completed	66%	82%	16.34%
MRSA Screening	85%	93%	8.10%
CPE Screening	82%	94%	11.32%
Safeguarding Screening	65%	89%	23.32%
MUST	93%	100%	6.53%
Waterlow	77%	87%	9.39%
Falls Assessment Age 65+	21%	76%	55.45%
Alcohol Assessment (Audit C)	61%	81%	20.22%
Assessment and Cares flowsheet to be recorded every 12 hours of an inpatient visit	59%	89%	29.92%
Patients that have had a SSKIN bundle document completed within 8 hours of a Waterlow of 10 being documented	16%	91%	75.31%
Daily Waterlow Score	20%	87%	67.49%
Weekly MUST Score	36%	76%	39.88%
Falls assessment completed at least every 7 days	63%	79%	15.97%
Falls assessment completed within 4 hours of transfer from another ward	11%	49%	37.61%

4.2 Doctors documents benefits update

Since doctors documentation went live in EPR in March 2022 there has been an increase of approximately 200,000 log ins to EPR per month. There have been 68,000 ward round notes and 107,000 clinical review notes completed.

Work has begun to create a dashboard that will provide information and assurance to senior doctors using the documentation now available within EPR. Working alongside the deputy medical director and Chiefs of Service a list of key performance indicators is being created that will allow each area to drill down to understand aspects of care such as time between admission and clerking, time to consultant review, percentage of patients seen daily by a consultant.

This is information that has never been available prior to using EPR and will allow services to really delve into their processes and current performance.

4.3 Pre-assessment patient health questionnaire

The applications team have worked 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. Prior to this change the pre-assessment team were receiving around 100 paper questionnaires a week. Within the first 3 weeks they received 852 back. This project will be reviewed in the next reporting period to look at the impact of on the day cancellations. There are significant patient quality and experience benefits as well.

4.4 Embedding the Digital benefits process

Working alongside the newly formed Strategy, Transformation and Financial Sustainability team we have continue to work through some of the difficulties in realising the benefit opportunities delivered by digital projects. Despite a number of both cash releasing and efficiency benefits being shared as opportunities by the digital programme team over the last year, very little has been converted into bottom line savings by the finance teams. Having asked the Financial Sustainability Programme Managers to investigate with divisions it is fair to say that the cash releasing savings from the stopping of purchasing bespoke paper work from colour connect, order forms and other such paper work are no longer available as the money has either already been spent or the budget has been removed. It is key to highlight that if Digital hadn't provided this saving opportunity budgets would have either been more over spent, or budget wouldn't have been available to remove to contribute to the trust financial sustainability programme.

There is also a re-occurring theme that digital has clearly provided significant efficiency and quality benefits for our patients. As with other large scale transformation programmes there is significant work required from finance to understand and cost efficiency savings appropriately- there are many outcomes in this space that continue to go unrecognised.

The EPMA project had a benefits workshop carried out on 13th July. This workshop was attended by many people from all impacted areas; project team, clinical leads (pharmacy, nursing and doctors), finance business partners, financial sustainability team, operational managers, quality and risk team. Over 50 benefits were identified including four transactional, cash releasing benefits. It is worth highlighting that the workshop flagged a number of issues that make the realisation of cash releasing benefits difficult in the organisation:

- Budget holders felt that they had no control over the spend of money within their budgets (relevant to ward managers owning drug budget) Identifying which budgets money was being spent from due to no central budget (for both drugs and stationery spend) was deemed difficult by finance colleagues and clinical budget holders.

- This has repercussions and means that money saved is not identified and removed from budgets prior to being spent elsewhere, or removed from budgets as it appears surplus and isn't linked back to digital.

The financial sustainability team have expressed how challenging identifying budgets, budget owners and being able to ring fence money is on a day-to-day basis.

5. Funding Update

Both GHT and the wider ICS aspire to deliver long-term strategies that are reliant on digital technology. The NHS has opened up a number of digital funding streams and in consultation with ICS partners and operational and finance staff within GHT, we have successfully bid for funding of projects that will deliver significant clinical, patient and safety benefits - as well as contributing to our journey to HIMSS level 6.

Summary:

- Internal Digital funding of £5,633k is budgeted for capital projects across the four Digital workstreams in 22/23; EPR, Clinical Systems, Infrastructure and Cyber, and Business Intelligence. There are nine individual capital projects that this funding covers within those four workstreams.

- As a Digital Aspirant Trust, GHFT was awarded £6m over 3 years to accelerate our HIMMS journey. £2.7m was received in 20/21 and 21/22, and a further £3.3m is awarded for 22/23.

The following additional external funding streams have had updates during this month:

PEP Funding
£300k capital funding became available to implement a Patient Portal, improving patient experience and workflows. benefitting patients across the ICS. An MOU was sent to GHFT for signature and return during early October. Due to the very tight timescales, an extension was granted of a week. The MOU has not been signed, as Finance decided the cost of capital (depreciation) implications of receiving this capital funding was too onerous.

CDC Funding
The initial CDC revenue funding pot for 22/23 of £410m has been reduced by £105m as a result of the staff pay award. The Digital element of the revenue funding is therefore also reduced, with the values to be confirmed. This has put some pressure on the plan to prioritise the essential work, with focus being on getting Quayside House CDC operational. The capital elements remain unchanged, and therefore funding of £173k digital equipment for Quayside House, £100k is confirmed for Radiology workstations, and £113k of transformation support is confirmed for 22/23. The MOU has been issued for signature.

SW Diagnostics
SW2 Imaging Network & West of England Pathology Network (S3) have submitted LOA's at the end of September. This funding covers Digital Pathology, Image Sharing, Home reporting and iRefer. GHFT's submission is for £1.4m of capital funding and £1.2m of revenue funding over the next 3 years. GHFT are yet to hear when the funding will be confirmed, and through which route.

Frontline Digitisation
As a Digital Aspirant trust, we are eligible to express an interest (EOI) in additional capacity available in this scheme. GHFT have submitted an EOI of £2,200k. This is for further acceleration of HIMMS journey works, including enabling works. The only revenue impact is cost of capital.

Cyber PDC
£100k Expression of interest submitted for network firewalls, and network switches. MOU is expected to be received in next week or two. The only revenue impact is cost

of capital.

Cyber Funding as part of Digital Diagnostics Capability Programme
GHFT have submitted £150k expression of interest for hardware resilience. This will be added to a LOA as part of the network's submission. The only revenue impact is cost of capital.

5.1 Funding-related contracts

No contracts need approval from TLT and/or F&D currently.

6. CITS 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 August 2022. Highlights this month:

- Reports shows a good month with most targets achieved.
- August significantly busier month than July with just under 11,000 contacts with the service desk from all organisations.
- CITS staff continue to support internal moves, GP surgery moves and the distribution of devices for the ePMA project. The period September to November is going to be particularly challenging with building works across both the GHT and GP estate.

7. Information Governance and Cyber Security

Reports as submitted to Digital Care Delivery Group on 4th October.

Key cyber highlights this month:

- A communications campaign is underway to highlight to staff the growing risk of cyber-attack; through phishing, weak passwords and data breaches. This will continue in October and November.
- The team continues to work to the agreed cyber audit action plan, reducing risk and updating systems.
- August High severity alert CC-4140 Critical Update for VMware Products residual risk assessed and mitigated. SIRO approval sought to close.
- SIEM will be discussed at the 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.

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KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 25 October 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
Performance Dashboard	The report was in development, but reflected the Trust's performance against a range of metrics related to the People and Organisational Development Strategy. The Strategy was reflective of the NHS People Plan, which focused on supporting transformation across the following areas: Looking after our People; Belonging in the NHS; New ways of working; Growing for the future. The Committee noted the SPORT analysis within the report which detailed Successes, Priorities, Opportunities, and Risks/Threats to the organisation over the last two months. The Committee noted particularly that mandatory training and appraisal completion rates were below target, and was advised that there was a continued focus on improving Information Governance compliance across the Trust, and plans in place to simplify appraisal paperwork which would be available on the intranet. An appraisal improvement plan was also in place across Maternity Services, which had been highlighted by the recent CQC report.	The Committee welcomed the new format of the report, noting the modern, accessible, clear approach. The Committee was assured by the initiatives being explored to improve mandatory training and appraisal completion rates.
Human Resources Change Programme	An initial approach to developing the HR department was described to the Committee; a departmental improvement plan would be implemented, along with the utilisation of a case assessment tool and review of records of decisions and rationale to identify further process improvements. There were three key priorities: the introduction of the Selenity platform; ensuring the investigation process was fit or purpose, including terms of reference, the establishment of a pool of investigators, and mentoring and support in place; the development of a Mutual Respect, Grievance and Disciplinary Policy.	The Committee was assured by the plans in place.
Workforce Sustainability Programme	The Committee was apprised of progress made on the Transactional Recruitment workstream. Three key areas for process review included: Vacancy Control Panel approval to job offer; Onboarding; Use of digital platforms. Continued delivery of the improvement plan included divisional communications and engagement, a refresh of the TRAC recruitment platform, review of onboarding and IT processes, and increased focus on the 'customer' to implement any new and more efficient ways of working.	The Committee noted the good progress made.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
ICS Update	A recruitment event at Cheltenham Racecourse had been held in partnership with Indeed. Over 200 people were offered jobs on the day, with 125 still on track to join the Trust. This was a very positive example of system working, and an additional three areas were being worked through with system partners: International recruitment; agency reduction; health and wellbeing.	The Committee noted the good work happening across the system, and was keen to ensure ownership of agency spend by all partners.

Items not Rated

Risk Register	CPD Funding

Impact on Board Assurance Framework (BAF)

The BAF continued to be reviewed on a regular basis; culture would be considered as a separate risk.

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.