Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST

Public Board of Directors Meeting
Thursday 11 January 2024 at 13:00

Lecture Hall, Sandford Education Centre, Cheltenham General Hospital

AGENDA

REF	ITEM	PURPOSE	REPORT	TIME
1	**Chair's welcome and introduction**			13:00
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of previous meeting**	Approval	Yes	13:05
5	**Matters arising**	Assurance		
6	**Public questions**	Information		
7	**Staff story –** *Claire Radley, Director for People and Organisational Development*	Information		13:10
8	**Chief Executive's report,** *Kevin McNamara, Chief Executive*	Information	Yes	13:25
9	**Board Assurance Framework** *Sim Foreman, Trust Secretary*	Assurance	Yes	13:40
10	**Trust Risk Register** *Mark Pietroni, Medical Director and Director of Safety*	Assurance	Yes	13:45
	QUALITY AND PERFORMANCE			
11	**Quality and Performance Committee (QPC) Report** *John Cappock, Non-Executive Director*	Assurance	Yes	13:55
12	**Quality Performance Report** *Matt Holdaway, Chief Nurse and Director of Quality, and Al Sheward, Chief Operating Officer*	Assurance	Yes	14:05
13	**Winter Plan** *Al Sheward, Chief Operating Officer*	Assurance	Yes	14:15
14	**Maternity update** *Matt Holdaway, Chief Nurse and Director of Quality and Lisa Stephens, Director of Midwifery*	Assurance	Yes	14:25
	Break (14:35-14:45)			
	PEOPLE AND ORGANISATIONAL DEVELOPMENT			
15	**People and Organisational Development Committee (PODC) Report** *Balvinder Heran, Non-Executive Director*	Assurance	Yes	14:45
	FINANCE AND RESOURCES			
16	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director*	Assurance	Yes	14:55
17	**Financial Performance Report (Month 8)** *Karen Johnson, Director of Finance*	Assurance	Yes	15:05

	AUDIT AND ASSURANCE			
18	**Audit and Assurance Committee Report** *John Cappock, Non-Executive Director*	Assurance	Yes	15:15
19	**Any other business**	Information		15:25
20	**Governor observations**	Information		15:35
21	**Date and time of next meeting**			15:40
Close by 15:45				

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST DRAFT Minutes of the Public Board of Directors' Meeting 9 November 2023, 13:00, Sandford Education Centre, Cheltenham General Hospital			
Chair	Deborah Evans	DE	Chair
Present	Helen Ainsbury	HA	Interim Chief Digital Information Officer
	John Cappock	JC	Non-Executive Director
	David Coyle*	DC	Interim Chief Operating Officer (COO)
	Marie-Annick Gournet	MAG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	Karen Johnson	KJ	Director of Finance
	Kaye Law-Fox	KLF	GMS Chair/Associate Non-Executive Director
	Deborah Lee	DL	Chief Executive Officer (CEO)
	Jaki Meekings-Davis	JMD	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Ian Quinnell	IQ	Interim Director of Strategy and Transformation
	Claire Radley	CR	Director for People and Organisational Development
Attending	Shyam Bhakthavalsala	SB	Consultant Paediatrician and Neonatologist
	Craig Bradley	CB	Deputy Chief Nurse
	James Brown	JB	Director of Engagement, Involvement and Communications
	Sophie Dawe	SD	Patient story speaker (Item 4)
	Sim Foreman	SF	Interim Trust Secretary (minutes)
	Kate Hellier	KH	Deputy Medical Director
	Katherine Holland	KH	Head of Patient Experience (Item 4)
	Kevin McNamara	KM	Incoming CEO
	Al Sheward	AS	Incoming COO
Observers	Three governors and a Care Quality Commission (CQC) inspector observed the meeting in person. One member of the public attended for the patient story (item 4).		
Apologies	Vareta Bryan	VB	Non-Executive Director
	Matt Holdaway	MH	Chief Nurse and Director of Quality
	Alison Moon	AM	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Director of Safety/Deputy CEO

REF	ITEM
1	**CHAIR'S WELCOME AND INTRODUCTION**
	The Chair opened the meeting and welcome everyone and in particular those deputising for colleagues who were absent through illness or annual leave. The minutes would reflect the running order of the meeting. The Chair reported it was DL's last board meeting as CEO and wished to formally record the thanks and gratitude of the Board in recognition of her service. DL was a committed public servant and leader who had achieved incredible things over the last seven years. After uncovering and addressing a financial deficit early in her CEO tenure, DL went to deliver the Centres of Excellence strategy (which now formed the foundation for the future development of services) alongside attracting capital funding, driving progress on cancer waits and showing exemplary leadership during the COVID pandemic. The Chair highlighted DL's two defining characteristics as being completely patient centred in all that she did and the tremendous humanity shown to colleagues. All present joined the Board in thanking and congratulating DL for her work.

2	**APOLOGIES FOR ABSENCE**
	Apologies from VB, MH, AM and MP were NOTED.
3	**DECLARATIONS OF INTEREST**
	There were no declarations of interest.
4	**PATIENT STORY**
	KH introduced SD who shared her story of a Hodgkin's Lymphoma relapse. SD talked about her experience of receiving care and treatment at the Trust and how she had used art and painting to help her cope and described seeking to become a volunteer artist. SD commended Maggie's for the peer group support for patients in their 20s and 30s. Board members were encouraged to hear positive feedback on the services SD had used and praised her incredible art. SM highlighted the power and importance of art therapy and agreed to introduce SD to contacts at the University of Worcester. **ACTION (SM).** CB encouraged SD to consider art therapy as a career as there were currently registered art therapists amongst Allied Health Professional (AHP) staff. KH updated on lessons learned from SD's experience which included recognising the importance of health psychology, reviewing when it was appropriate to deliver a cancer diagnosis over the telephone (and the difficulties in getting this balance right and a commitment to repair the bird house in the hospital garden. **RESOLVED:** The Board **NOTED** the patient story and thanked SD for presenting it.
5	**MINUTES OF PREVIOUS MEETING**
	RESOLVED: The minutes of the meetings held on 14 September and 28 September 2023 were **APPROVED**.
6	**MATTERS ARISING**
	There were no matters arising from the 14 September 2023 and actions from the 28 September 2023 would be carried to the next meeting. **ACTION (SF)** **RESOLVED:** The Board **NOTED** the update on matters arising and actions.
7	**CHIEF EXECUTIVE'S BRIEFING**
	The Board was briefed on the following: • Performance deterioration in Category 2 response times and ambulance handovers leading to national focus on the Trust with KM attending a national meeting on behalf of Gloucestershire and Swindon on mandated timeframes for handover. Discussions were ongoing in relation to regulatory tension versus patient safety and quality but recovery plans were in train and performance was expected to improve in a week. • A need to reduce the number of days of stay without any clinical value to reduce bed occupancy noting that discharge was on an upward project trajectory, but was not yet where the Trust wanted it to be. • Industrial action had meant a small number of cancer patients had treatment cancelled which whilst clinically acceptable was poor experience for them and their families. • The 400 plus patients waiting over 62 days for treatment had reduced to 223 at time of writing the report – urology and colorectal accounted for more than 75% of the delays. • Over 65 days and diagnostic performance continued to do well. • Lecture theatres on both sites were being fitted out to support hybrid meetings which would hopefully allow better engagement at the 2024 Annual Member Meeting (AMM) than had been seen this year. • Staff survey responses were 10% higher than the whole of the previous survey with two weeks left for submissions. It was noted that higher response rates generally gave more positive feedback and the team driving this work were thanked. Gloucestershire Managed Services (GMS) was also surveying staff and three weeks behind the Trust and response rates were at 35% compared to 39%in total in 2022.

	• Staff awards were underway with the first event taking place the previous evening and another that day. • Progress by the staff experience task force included a 24/7 food offer which had been well received on DL's back to the floor night shifts. • Ward moves fully underway and DL had visited every ward to check in with staff with feedback received being positive. The Emergency Department (ED) move would go ahead and although more challenging, would follow the same principles as other successful moves. • Fit For The Future - Data on stroke care shows improvement with the Trust moving up to a "B" rating and the Board celebrated KH and her team for this achievement. • Three Counties Medical School (TCMS) had opened earlier in the year and the Trust had been part of the trail blazers to make this happen. JC expressed excitement that TCMS was beginning to thrive, especially in the face of the difficulties in breaking into the sector. • Following publication of board papers, it was confirmed that long awaited reports from the Care Quality Commission (CQC) would be published the following day and were broadly positive. DL would be providing media comments on these. The CQC had reissued a 29A for maternity for failure to comply with safeguarding Level 3 targets, which was disappointing given progress made in this area (Improved from 45% to 73% against 85% target); • Correspondence from the Health and Social Care Secretary Steve Barclay requesting that NHS organisations stop recruiting to equality, diversity and inclusion (EDI) roles was disappointing and prompted a response from Gloucestershire partners that fully supported investment in EDI and which mirrored the response from NHS Providers. **RESOLVED:** The Board **NOTED** the update from the CEO.
8	**BOARD ASSURANCE FRAMEWORK (BAF)**
	The Board received the BAF and noted the ongoing work to further shape and develop the strategic risks within the document. Discussion took place on SR10 related to capital and it was suggested the detailed wording be expanded from it being a risk about capital and more the "estate at risk" to reflect the nature of the "impoverished estate" and this should read across to related risks. Access to capital to address the estate issues then becomes a mitigation. This would be considered as part of the BAF review process. **ACTION: KJ/IQ/SF** **RESOLVED:** The Board **NOTED** the BAF.
9	**TRUST RISK REGISTER (TRR)**
	KH presented and reported there had not been significant change since the last update as the Trust prepared to transition from Datix Web to Datix Cloud, but for assurance confirmed that all risks were still in the Datix system on the Trust accessible via the web and actions could be updated via risk managers. Discussion took place on the following items: • How the new Datix system linked into IT - HA confirmed this had been a local implementation that her team had supported following a "Go / No Go" decision which included meeting with Divisions to agree management of the go live process. The Board heard that the Finance and Resources Committee (FRC) would be looking at "back-office systems" and this should be included in that scope. • The simplicity of the TRR in the appendices was welcomed, particularly in relation to likelihood and consequence scores, but it was requested that the risk arrow score be refined to show changes since last update. **ACTION (KH/Lee Troake).** • Health Technical Memoranda (HTM) compliance relating to water and fire safety and how this applied to authorised persons in GMS, engineers in the Trust, external consultants

	covering staffing gaps or other acceptable alternatives. This would be followed up offline and an update circulated. **ACTION (KH / Lee Troake).** **RESOLVED:** The Board **NOTED** and **RECEIVED** the Trust Risk Register.
10	**QUALITY AND PERFORMANCE COMMITTEE (QPC) REPORT**
	CB presented the Key Issues & Assurance Report (KIAR) and highlighted there were no RED rated items. The Committee had received assurance on the Human Tissue Authority Mortuary Audit, the CQC report due to published the following day, children in the system awaiting onward social care services and maternity staffing (in particular the14% vacancy rate and 99% for one-to-one care. The Committee had also requested a report on boarding at the September 2023 meeting.
10.1	**QUALITY AND PERFORMANCE REPORT** The Business Intelligence (BI) team were working to improve the report and readability as well providing a direct link for the Board to interrogate the data in way that could be shared publicly. It was highlighted that some indicators did not have a target i.e stroke care and it would be helpful for these to be added to provide assurance to the Board. **ACTION (HA/BI Team).** Discussion took place on the 175 patients who had no criteria to reside (NCTR) and awaiting discharge and what was the position of ICS and Gloucestershire County Council partners on this. It was explained that this was all in the remit of the Newton and winter planning work and that the Trust had been an exemplar until 2019 using good processes such as Red to Green and the SAFER Bundle, and the organisational memory on this needed to be revisited and reinvigorated. Discussion was underway with partners about changes to processes linked risk management to mitigate impact of boarding. KH added this linked to the cultural work and discussion led by CR, which is starting to show people can change things in a way they had not felt able to in the past, with the response to industrial action a good example of this. The People and OD Committee (PODC) dashboard would be provided at the next meeting. **ACTION (CR).** **RESOLVED:** The Board **RECEIVED** the update from the Quality and Performance Committee as assurance and **NOTED** the quality and performance report.
11	**LEARNING FROM DEATHS**
	KH presented the report and advised the Trust had a very experienced medical examiner service alongside staff who wanted to learn to do things better to improve things in future i.e. clinical care, communication etc. As a result, it was possible to go back and look at any serious incidents. The report showed feedback from families related to concerns about flow and patients' locations and that there had been slight improvement on recent times. SHMI (Standardised Hospital Mortality Index) data was starting to improve, although there appeared to be greater potential for harm at weekends with work underway to understand the differences to improve flow, visibility and access at weekends. There was also a need to ensure that data captured reflected those patients with dementia, as failure to do so made it appear patients were in better health then they actually were and leads to a potential overstatement of mortality measures. The Board also heard three new projects had been initiated to improve communications related to end-of-life care. Discussion took place on whether the sections within clinical meetings as a reflective space for learning from deaths provided enough time and whether junior doctors' feedback was being captured. Assurance was sought on whether the hip fracture analysis was out of variance and had any implications for mortality rates. It was confirmed that there had been a Neck of Femur (NoF) deep dive which was reported to the QPC and showed timely theatre capacity was confirmed as one of the best indicators of impact on mortality. QPC had received a comprehensive recovery plan and assurance on next steps. Further discussion took place on the Urgent Emergency Care (UEC) Improvement Board providing assurance on the key

	elements (actions taken and when alongside improvements against target, including further analysis on coding changes, via the Hospital Mortality Group first then usual committee route. **RESOLVED:** The Board **NOTED** the Learning from Deaths Quarterly Report.
	Break at 14:26
12	**PEOPLE AND ORGANISATIONAL DEVELOPMENT COMMITTEE (PODC) REPORT**
	BH presented the report from the meeting chaired jointly with VB and provided a summary of the discussion. There had been a deep dive on staff retention with particular focus on admin and clerical staff which had had shown a number of issues: benchmarking NHS versus private sector, competition within the ICS and a lack of career pathways. This was rated RED due to stable workforce priority. There were a number of AMBER items: • Agency controls were reviewed in respect of both finances and sustainable workforce and supported the team dynamic. PODC was keen to see more progress and sought further assurance on key milestones for next time. Discussion took place on the agency controls and the Board noted a £270k reduction as at Month 7 (M7) and that costs had been double that in the previous year. Costs related to surgery had increased but these were related increased activity levels. Agency spend from M6 to M7 had fallen by £470k with £300k related to nursing costs in Medicine and work continued to convert some of the 43 agency staff into bank staff and thanks to MH and CB were recorded for this. • Equality Diversity and Inclusion (EDI) attrition data showed no evidence to prove that a high number of ethnic minority candidates were adversely impacted in the recruitment process in comparison to white applicants, but more work was needed to facilitate managers' ability to drill down and that despite no data, the perception of an issue still existed and needed to be addressed. It was also explained that the data included lots of applicants from "red list" countries not allowed by the NHS. • Staff survey uptake had been strongly encouraged and supported with a voucher for completion. The GMS survey was also underway and PODC would like to see these results reported in concert. In relation to staff retention, it was confirmed that a new retention group has been established to tackle this. Discussion took place on how well the system was starting to look at this and it was confirmed there was lots of collaboration amongst NHS partners, but less so from the local authority, on looking at a collaborative bank and focus on health and wellbeing. It was confirmed that FRC had also highlighted the need for discussions on job bandings to minimise the disruption (money and time related to recruitment) to organisations and that the issue was wider than Gloucestershire and could extend across the region. **RESOLVED:** The Board **RECEIVED** the update from the People and OD Committee.
13	**GUARDIAN OF SAFE WORKING (GOSW)**
	SB presented the report as the new Guardian. The Board was reminded of the requirement since 2016 under the junior doctors' contract to monitor their hours via exception reports, with all of these being reviewed by the Guardian for any safety implications. From April to June 2023 there were 80 exception reports, being a one third increase on the same time in 2022, but a reduction from January and March 2023. The majority of these were from general medicine which had 25 unfilled junior doctor vacancies. There were also about ten in Emergency Department and between one and four in other specialities. Cover on wards was a key theme from the exception report and most had been resolved by additional pay (£517.85). No fines had been levied over the last two quarters but some were carried from previous years. Two immediate safety concerns were investigated, both relating to not enough junior doctor consultant support and both had been resolved to the satisfaction of the juniors. SB was

	looking at communications issues from these as a more senior colleague was available but the junior doctors in question did not know about that this. SB advised the junior doctors' forum had not been meeting due to there being no chair appointed but this had now been addressed and meeting would resume. SB was asked whether any safeguarding concerns, especially in paediatrics, had been identified from the reports and the Board was assured there were no exceptions related to this and this was most likely due to consultant cover in place from 09:00 to 22:00. The Board also heard that MH and MP were talking to the ICS Safeguarding lead about improving the efficacy of communications. **RESOLVED:** The Board **NOTED** the update from the Guardian for Safe Working.
14	**WORKFORCE RACE EQUALITY STANDARD (WRES) AND WORKFORCE DISABILITY EQUALITY STANDARD (WDES) ANNUAL REPORTS,**
	CR presented the reports previously received by PODC and confirmed data had been uploaded to the national system. There have been some improvements on WRES but some issues remained for WDES i.e. 46% staff had disability status unknown. The issues were in part relate to the Electronic Staff Record (ESR) system and the lack of comparisons. It was confirmed that Becky Fell, from the September 2023 staff story, was the newly appointed chair of the Disability Staff Network and every network had been provided with some funding to invest in creating time to build and work as a network. DL was a member of the Disability Network WhatsApp groups and shared that many of the things that concerned people were in the gift of line managers to resolve. Discussion took place on the ways in which staff could access support and the role of the Staff 2020 Hub in helping with this (not doing it). CR also confirmed sign off for a regional bid to fund an advisor in the Hub to drive work on reasonable adjustments. The Board welcomed the update and requested sight of the action plans to get an overview of what changes would happen in what timescale etc. CR agreed this should happen and set out the requirement to publish plans on the internet. **ACTION (CR).** Further discussion took place on the assurance gaps related to staff moving between Band 5 and Band 6 and Band 8A and Band 8B and a stark likelihood of appointment/shortlisting. CR advised an HR graduate was looking at getting behind the data and discussions were taking place with the Associate Chief Nurse in relation to linking into elements of the model employer programme. In relation to the shortlisting drop off, CR explained the biggest factor was that colleagues got another job. The Trust was looking at the establishment of a cultural ambassador role to involve people sooner, but doing this in such a way that it's not felt to be tokenistic. **RESOLVED:** The Board **NOTED** the Trust's WRES and WDES data. *DL left the meeting.*
15	**FINANCE AND RESOURCES COMMITTEE REPORT**
	JMD presented the KIAR covering two meetings, September 2023 (Finance and Digital) and October 2023 (Finance and Estates) and key points highlighted were: • Receipt of national guidelines in September for £28m savings delivery alongside productivity savings being work on by KJ and her team • Progression of the Digital strategy with the achievement of HIMS Level 5 • Continuing to report a financial breakeven position in October noting work underway and that the capital position remained tight • Learning from issues related IUFRS 16 • Risks from staff moving between organisations as previously discussed • Positive report on GMS workforce action plan and recognition that GMS recruitment process needs to be more time sensitive • IQ leading work to install electric vehicle charging across the estate

15.1	• Two business cases agreed with one presented to confidential board earlier KLF updated that the feedback on GMS recruitment had been acted upon as evidenced at a recruitment event the previous weekend where 350 people attended and a number of offers were made on the day. 20 to 25 agency staff were also being converted to permanent staff and work of Richard Giles and his team was commended. **FINANCIAL PERFORMANCE REPORT (MONTH 6)** KJ reported that there had been movement in the position over the past 48 hours and the system position showed both the Trust (£3.8m deficit) and ICB (£3m deficit) as financially challenged, the latter as a result of Continuing Health Care (CHC) and prescribing costs. The Board noted an update on the breakdown of these cost drivers i.e escalation areas for bed and boarding. The ICS was working on a year-end plan for November 's FRC. The October plan had shown likely and best-case scenarios and the aim now was for a breakeven across the system for the January 2024 board meeting as M9 data would be available. KJ updated that 48 hours previously there had been a national conference for CEOs and Directors of Finance to redefine the timescale for this work to within the next two weeks. Tis was as a result of £800m into the NHS from Treasury and government; £200m of this being new money and the remainder £600m from capital to revenue transfers. Some of this was allocated to supporting the cost of industrial action and linked to clinical staffing and could be £8m - £9m. The Board also heard the Elective Recovery Fund Target has been reduced to 103% and over delivery would generate incentive monies. The three priorities for NHS organisations were confirmed as: 1) Financial balance 2) Safety of patients in winter and ambulance handovers 3) Elective care and cancer treatment As the deadline for approval of plans was confirmed as 22 November 2023, the Board AGREED to convene a virtual meeting on a date to be agreed. KJ stressed that that the allocation was not known as yet and that the Trust must continue to progress the good work taking place on the run rate. A question was raised on the risk of the Trust losing any capital underspend back into the national team. IQ would follow up. **ACTION (IQ).** Following approval of the plans the Chair, CEO, COO and DoF of each system partner would be required to explain plans at face-to-face meetings with regional colleagues from 27 November 2023 **RESOLVED:** The Board **RECEIVED** the update from the Finance and Resources Committee and **NOTED** the Financial Performance Report at Month 6. The Board also AGREED to convene an extraordinary meeting before 22 November 2023 to approve the financial plan.
16	**AUDIT AND ASSURANCE COMMITTEE REPORT**
	JC presented the report and confirmed there were no RED rated issues. There were some AMBER related to the year-end audit process and lesson learned for the future, an internal audit into workforce planning and revalidation and work on long overdue follow up actions. The Committee had also been assured on a number of GREEN rated reports that included GMS, Counter Fraud and the audit (internal and external). The Board was also updated on a discussion on KIARs between the NEDs and Trust Secretary which agreed a new approach to preparing these in order to improve consistency of reporting and interpretation. The changes would be introduced from January 2024. **RESOLVED:** The Board **NOTED** the Audit and Assurance Committee report.
17	**ANY OTHER BUSINESS**
	Public Board question from September 2023

	The Board was reminded of public question from Mr Main that had been submitted too late to be considered at the September 2023 meeting and RECEIVED the response provided with both provided as shown: **Question** - *"Question for the next Board meeting. I would like to share my frustration and that of my sister over the poor and inadequate telephone system going into your AE at the Royal Gloucester. This is no way a criticism of the medical staff who you should be proud off and are first class. My brother-in-law was admitted to your AE department this Wednesday late PM. I drove down from Surrey to support her.* *We tried for over an hour to connect with AE using two phones to no avail. After an hour we gave up and drove to the hospital a round trip of 57 miles to seek information and reassurance on the condition of my brother-in-law. We arrived at AE and were treated with respect and we got the information and location for him.* *My Question to the executive is this why did this happen? Why no Q system to tell the relatives time scale of the waiting times, you display AE waiting times.* *What action are you going to take to improve the situation so as other patients' relatives do no suffer the stress of trying to get through and it was stressful.* *Can I suggest the Board at their next meeting try to contact AE.* *I require an assurance that the system will be reviewed."* **Response from Katherine Holland, Head of Patient Experience** – *"Apologies for the delay in sending this over to you. Please find below the response to your questions that you raised to our Trust Board. As I have previously noted, this was taken to Board in September. Dr Gregson, Director Change and Governance at Gloucestershire Managed Services has been able to support the responses to your questions.* *You raised a concern about being unable to reach the Emergency Department at Gloucestershire Royal Hospital despite trying for a hour. You then took the decision to drive to the department in order to obtain an update on your brother-in-law. In answer to your question about why did this happen,* *"Our Emergency Department have a limited number of lines, calls handled via our switchboard will be passed to these extensions as part of a hunt and return process. This means all extensions will be tried by the system and if not answered will be returned back to the switchboard.* *Calls unanswered in ED only happens when resources in ED are deployed responding to demands placed on the department.* *Responses from the Switchboard can be delayed at peak times, again when resources are deployed to meet urgent demands.* *The direct line to the ED will either be answered, engaged or ring out, again as a result of resources responding to demands placed on it. The line should always connect and if hasn't then this would be classed as a fault and remedial action would be taken to restore the service if we are made aware. We have reviewed our records and no fault has been reported, but we would encourage anybody to report faults to us at the switchboard"* *You also asked why we do not have a queue system to advise relatives of the waiting times. You note that we are able to display the waiting times in the Emergency Department.* *"The switchboard system does not provide the capability to advise queue position or wait times."* *Lastly, you asked what action we are going to take to improve the situation so as other patient's relatives do not have the same experience as you and Pamela did.* *Our Unscheduled Care team are currently in the process of recruiting a Patient Experience lead, this post previously was an important role in ensuring relatives and carers were kept informed of the care of patients. Previous feedback has been very positive from relatives about*

	the difference this post made to their experience we found that this is in part is due to this role being non-clinical. *"Gloucestershire Managed Services also suggests the process for updating patient location is reviewed to identify if more UpToDate ward information can be supplied to switchboard/ED, to assist relatives in contacting patients."* *Thank you, Roger, to both you and Pamela for taking the time to raise this important issue."* Discussion took place on this matter and plans to improve things. It was recognised that there were opportunities to improve communications (as had also noted in the Learning from Deaths report) both via telephone and writing. GMS classed the switchboard operator role as "hard to fill" with ongoing recruitment taking place to ensure all calls (internal and external) as well emergencies continue to be answered and actioned. HA agreed to look at opportunities within the phone system and updated on a project to introduce a Patient Portal accessible via smartphones that would mitigate risk of letters arriving after appointment dates with some governors providing a patient and public perspective into this. There were no other items of any other business.
18	**GOVERNOR OBSERVATIONS**
	The Chair invited observations from governors in attendance. These included commendations for the patient story, broadly positive CQC update, increased staff survey response and reduction in agency costs. One governor felt the Learning from Deaths report was comprehensive and detailed but queried whether it was appropriate to be shared in public. Governors noted the work to improve ambulance handovers and the focus on weekend mortality rates.
Close 15:53	

ACTIONS/DECISIONS (9 NOVEMBER 2023)			
Item	**Action**	**Owner / Due Date**	**Update**
4. Patient story	Introduce SD to colleagues at University of Worcester.	SM Jan 2024	Introductory emails sent. **CLOSED**
6. Matters arising	28 September actions carried to the January 2024 meeting.	SF Jan 2024	See below - **CLOSED**
7. BAF	SR10 - Consider detailed wording be expanded from it being a risk about capital and more the "estate at risk" to reflect the nature of the "impoverished estate" to read across to related risks.	KJ/IQ/SF Mar 2024	Incorporate into January update to committees then onto March Board **OPEN**
9. Trust Risk Register	Risk arrow score be refined to show changes since last update	KH / Lee Troake Jan 2024	Actioned. **CLOSED.**
	Provide update offline on Health Technical Memoranda (HTM) compliance relating to water and fire safety and how this applied to authorised persons in GMS, engineers in the Trust, external consultants covering staffing gaps or other acceptable alternatives.	KH / Lee Troake Jan 2024	Actioned. **CLOSED**
10. QPC Report	It was highlighted that some indicators did not have a target i.e stroke care and it would be helpful for these to be added to provide assurance to the Board.	HA / BI Team Jan 2024	The BI team has started formulating ideas for an Integrated Performance report (IPR). This would include aligning and reporting across all domains of the strategy. The existing Board and sub-Board reports would be replaced with a singular IPR which could be cut or presented in different ways and would allow for linkage of risk across domains. It is proposed new IPR specification is worked up over the coming months as the new Trust and Clinical Strategy is developed and that the IPR would align to this. This will be done with a working group with

			the new Director of Integrated Governance and other members nominated of each Exec lead. **CLOSED**
	The People and OD Committee (PODC) dashboard would be provided at the next meeting.	CR Jan 2024	Provided for information linked to PODC KIAR at 15.2. **CLOSED**
14. WRES and WDES annual reports	Board to receive action plans to get an overview of what changes would happen in what timescale etc.	CR Jan 2024	Action plans provided to Board members. Reports published on Trust website; Workforce Race & Disability Equality Standard (WRES/WDES) Report 2022-2023 (gloshospitals.nhs.uk) **CLOSED**
15. FRC Report	Follow up on the risk of the Trust losing any capital underspend back into the national team.	IQ Jan 2024	No notification received as to a change in capital allocation. We are however in active dialogue with the National team to agree formal slippage to the 5th Orthopaedic Transformation Investment Fund (TIF) bid into 2024/25. **CLOSED**
ACTIONS/DECISIONS (28 SEPTEMBER 2023)			
Item	**Action**	**Owner / Due Date**	**Update**
Scorecard completions	Scorecard completion at 100% but shown as RED. LS to update.	LS Oct 2023	This element of the dashboard has now been developed to provide assurance on the production board compliance and included separately to the PQS dashboard, but within the PQS paper. **CLOSED**
Ockenden	Progress action report to QPC in October 2023 on AMBER rating.	MH/LS Oct 2023	No further update on Ockendon Gap analysis, Due for review again in October 2023, now delayed until November 2023. Proposed to CLOSE rather than hold open until November as **t**his will be monitored via the Maternity Delivery Group (MDG) with progress updated to QPC. **CLOSED?**
Maternity dashboard	Future dashboards reporting to show in-month and target position.	MH/LS Oct 2023	This is still work in progress. No update. **OPEN**

PUBLIC QUESTION TO BOARD

From Mr K Smith

What - if any - changes to treatment, allocatable to patients, were implemented on Woodmancote Care of the Elderly (COTE) Ward, at Cheltenham General, over the winter straddling 2016 and 2017?

Trust response:

There were no changes to the availability of any treatments provided to patients during the time period in question.

Treatment pathways are clinically appropriate for individual patients, and personal to their circumstances

Gloucestershire Hospitals
NHS Foundation Trust

CHIEF EXECUTIVE OFFICER'S REPORT TO THE BOARD OF DIRECTORS

JANUARY 2024

1 Operational Context

1.1 Following a period of sustained improvements in operational performance we are currently facing a number of challenges, most notably in urgent and emergency care where we are once again experiencing significant ambulance handover delays with the consequent impact of ambulance community response times. This picture has been replicated across the South West and driven by a number of factors including an increase in attendances, the acuity of patients and a reduction in acute beds secondary to building works. This deteriorating picture resulted in the Chief Executive attending a meeting, convened by the Secretary of State for Health and Social Care, where the expectations for significantly improved performance were set out. Additional recovery actions are being explored and enacted including the use of a pre-ED cohort area.

1.2 Even with these actions, we have started 2024 in an incredibly challenging position. Despite good levels of discharges over the Christmas period, we have not been able to support timely flow through our ED due to high numbers of admissions and specifically the number of patients conveyed to us by ambulance. Against a typical back drop of c70-80 conveyances a day, over the festive period this has consistently been at 20-30% higher with an unprecedented level on Christmas Day. In the absence of seasonal viruses (and other typical factors that drive up demand), the reasons for this increase are not well understood and are being explored with system partners and SWAST (South West Ambulance Service Trust).

1.3 Inevitably, recent industrial action by medical colleagues has introduced a number of additional operational challenges but our teams and leaders have worked incredibly effectively to maintain safe care. The timing of the latest industrial action has been especially challenging and of particular concern is the period of six days in the New Year – typically one of the busiest times of year. The number of junior doctors working on strike days has seen a significant increase in this latest round of industrial action with an estimated c50% choosing to work in contrast to 5% and 25% respectively in earlier strike periods. Finally, given this context, I am pleased that the BMA has agreed to put forward the latest pay offer from Government to its consultant members and that further industrial action is paused pending the outcome of the ballot, which closes on the 23rd January. However, if the pay offer to consultants is not accepted, the majority have voted to in favour of further strike action.

1.4 Despite this backdrop, the Trust continues to perform well in respect of elective waiting times when compared to the regional and national position. However, the numbers of patients waiting more than 65 weeks has increased from 80 at the start of the year to 690 at the end of December. The biggest impact has been felt in the 52+ cohort where the number of patients waiting more than 52 weeks has risen from 1265 at the start of industrial action in November 2022, to 3000 currently which is broadly comparable to the number waiting at the end of March 2021 when backlogs peaked post pandemic. Positively, the position has not deteriorated since the end of August due to additional activity outside of IA periods. The number of patients cancelled due to IA in December

and January was 725 and 955 respectively – 325 procedures and 1355 outpatient appointments.

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

1.6 Despite very significant focus on cancer, as a consequence of industrial action, we have seen an increase in the number of patients waiting more than 62 days for their treatment although we have recommitted to achieving the end of March trajectory of no more than 150 patients waiting more than 62 days. The number of patients waiting more than 62 days for treatment following GP referral has risen considerably in the last month to 282 at the end of December, compared to 403 at the outset of the year; this is however, a significant deterioration on December's position. This represents c11% of the total cancer waiting list against a target of 6%. Urology remains the speciality of most concern. On a more positive note, at December's Trust Leadership Team (TLT) meeting, two investment business cases were approved. The first to address the shortfall in capacity for the key diagnostic in the prostate cancer pathway known as local anaesthetic trans-perineal prostate (LATP) biopsy which will enable considerable recovery to be affected in the final quarter of the year. The second was investment in additional staff to build a more sustainable service, in response to the c20% increase in activity in the last two years.

1.7 As a Trust overall, at the end of December 63% of patients were treated within 62 days of referral against a standard of 85%; nationally the average stands at 59%.

2 Key Highlights

2.1 The staff survey has now concluded. Last year half of our staff completed the survey and this year we set ourselves the target of 60% but are on track to achieve 68%; this puts us in the top 10% of Trusts nationally and hopefully is a reflection of the growing engagement of staff throughout the organisation. Response rates were variable across Divisions and staff groups ranging from 33.9% to 79.8%. Special thanks to Josh Penston, Culture and Patient Experience Project Coordinator for his fantastic efforts in leading this year's staff survey work. Preliminary results are expected this month from those who use Picker as their survey provider, with full results to follow in the Spring.

2.2 In response to feedback following last year's staff survey, a Staff Experience Taskforce was established in April to respond to the question that we asked of all staff 'what's the one thing you would like to see changed that would enable you to recommend the Trust as a place to work and receive care'. In response, four work streams were set up focused on: 24-hour food; a Just Sort It fund; Staff Recognition; and New Starter Packs. They received input throughout from a Project Manager and the Quality Improvement Academy. Each group made remarkable progress, from identifying the root cause of the issues through to putting solutions in place. The Taskforce was a temporary project as part of the wider Staff Experience Improvement Programme, and work is now underway to identify the actions required to finalise and embed all actions from the four work streams, where necessary. A celebration event was held on 19th December, which several members of the Board were able to attend. This was an opportunity to share the activity of each work stream, reflect on the experience and note the impact. A follow-up session was held the same day to consider in more detail the learning from the Taskforce and to consider whether it's an approach that we continue to take which resulted in a resounding 'yes'!

2.3 The NHS has always benefited from overseas recruitment and there's a long history of people coming from other countries to support the service and live and work in England. Our own Internationally Educated (IENs) and International Medical Graduates (IMGs) are becoming an increasingly valuable resource as we continue to wrestle with high vacancy rates but more than that they bring a welcome diversity to our workforce and the evidence is clear, the more we embrace and work with diversity, the more successful we will be. One of the challenges facing these colleagues is passing their Objective Structured Clinical Examination (OSCE) and I am delighted that following a move away from classroom-based learning to a simulated ward environment, the Trust's pass rate has gone from just 14% passing first time to 69% against a backdrop of a national pass rate of 35.2%. Huge thanks to our practice educators and the wider Learning & Development Team.

2.4 We continue with our programme of ward moves with the latest moves also incorporating the expansion of the trauma bed base through the return of the third ward lost during the pandemic. This additional specialist ward is a key part of the fractured neck of femur recovery plan, which Q&P Committee members heard about at their November meeting. This month we see the culmination of building works which, subject to final checks, will see our new expanded Emergency Department at Gloucestershire coming back together as a single department. Schemes such as these, where we need to continue to run services whilst doing major building works, are some of the most challenging and we are all looking forward to seeing the benefits of a single, expanded department. We will be arranging visits to the new department over the coming months and would welcome the opportunity to show Board members around the new department.

2.5 After more than ten years in the role, this month we say goodbye and thank you to Dr Mark Haslam who has been an exceptional clinical lead for organ donation. This service is a real *jewel in the crown* and has received many regional and local accolades during Mark's tenure. In his communication to me he remarked that "*he had been blessed with motivated and supportive colleagues and engagement from the Board which had been genuinely remarkable and admired across the Region".* Mark will be succeeded by Dr Marcin Pachucki.

2.6 I was delighted to receive a letter from the Severn Major Trauma Network who, following three consecutive years of Peer Review findings of "serious concerns" in relation to the ED management of severely injured trauma patients, commented "*the GRH ED, and in particular Dr Emma Colley, ED Consultant and Trauma Lead have implemented an exceptional range of service improvements measures in response to the 2022 Peer Review findings. Whilst, these improvements cannot, as yet, be statistically confirmed to have changed patient outcomes, this clinical focus is commended by the NHSE Trauma Peer Review Panel"*. The team are hopeful that the 2023 dataset, when published later this year, will demonstrate the anticipated improvement in outcomes.

2.7 Finally, this is my final Chief Executive Report to the Board and one that I will not be present to attend. However, I would like to take a final opportunity to thank my Board colleagues for their support and kindness during my tenure and to welcome my successor, Kevin McNamara. Kevin joins the Trust as a time of significant challenge and great opportunity and I wish him every success for his future at Gloucestershire Hospitals.

Deborah Lee
Chief Executive Officer

2 January 2024

To Trust CEO: Deborah Lee

Cc Chair: Deborah Evans
ICB CEO: Mary Hutton

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

30th November 2023

Dear Deborah,

Gloucestershire Hospitals NHS Foundation Trust: NHS Oversight Framework Quarter 2 – 2023/24 Segmentation Review outcome

You will be aware that the extensive Quarter 1 segmentation review process did not conclude until Mid-September 2023. However, under the NHS Oversight Framework we are required, as a minimum, to undertake quarterly segmentation reviews to identify where organisations may benefit from, or require, support to improve performance and quality of care outcomes for patients.

We therefore decided for Quarter 2 the review would be a 'light touch' risk based approach, with a focus on identifying areas of improvement or deterioration against the Quarter 1 areas of concern, as well as identifying, by exception, any new areas requiring further consideration.

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

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

During October 2023, NHS England and the ICBs undertook the review of all the South West providers, with the findings and recommendations being presented to NHS England Regional Support Group (RSG). Details of this are attached at **Annex A,** for your information.

On the 30th October, RSG agreed that segment 3 for the Trust would remain unchanged for Quarter 2, 2023/24.

The Quarter 3 segmentation review will commence in January 2024; however, it is our intention to adopt a pragmatic approach recognising the need for organisations to focus on Winter therefore we will undertake another 'light touch' risk based approach in both Quarter 3 and Quarter 4.

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

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

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

Yours sincerely

Elizabeth O'Mahony
Regional Director
NHS England – South West

OVERVIEW OF THE QUARTER 2 SEGMENTATION REVIEW FINDINGS

ORGANISATION	Q1 OVERALL SEGMENT 2023/24	Q1 RATIONALE FOR 2023/24SEGMENTATION	Q1 EXIT CRITERIA FOR 2023/24	NHS ENGLAND Q2 NARRATIVE UPDATE	ICB Q2 NARRATIVE UPDATE	Q2 EXCEPTION REPORTING	Q2 RSG DECISION
Gloucestershire Hospitals NHS Foundation Trust	3	Overall segment 3 for: • Maternity – Maternity Safety Support Programme • Quality - CQC Overall RI rating • Quality – Summary Hospital-level Mortality Indicator (New) • Workforce – Engagement, Bullying & Harassment, Leadership Culture and Safety Culture • Agency Spend	**Maternity:** • Sustain two consecutive quarters of improvement in line with outcomes of the MSSP diagnostic and supporting action plan.	**NHSE Maternity Update:** Maternity service continues on the improvement phase of Maternity Safety Support Programme (MSSP). System and Regional input being provided to support increasing pace of change. Further CQC section 29a notice issued. Relates to safeguarding training and processes for serious incidents. MSSP team providing support to undertake thematic analysis of cases relating to massive obstetric haemorrhage.	**ICB Maternity Update:** Diagnostic element completed with recommendations and exit criteria agreed. Shared by MIA/DOM with ICB at Maternity Delivery Group. Following the Diagnostics, a Deep Dive: Governance undertaken with clear recommendations around Governance Structure and processes for the Maternity service which are in the process of being implemented. Currently in implementation phase of the programme. Criteria for exit agreed but not timeline. Next steps include: • Review care pathways against care provided. • Support from Maternity Improvement Advisor at scooping meetings. • Review progress in trust oversight of all moderate harms. • Maternity Improvement Advisor to take part in clinical walk rounds and focus groups. • Maternity Improvement Advisor to have monthly meetings with Triumvirate. • Maternity Improvement Advisor to attend NHSR Trust meeting.	**NHS England - None** **ICB – None**	**No change - remain in Segment 3 overall**
			Quality – CQC Overall Requires Improvement: • Appropriate improvement plan in place and the ICB is assured. **Quality – Summary Hospital Mortality Indicator:** • Six months of downward trend in SHMI. Trust to produce Learning from Deaths report to the public Board on a quarterly basis.	**NHSE Quality Update**: • CQC overall RI, Improvement plan in place, ICB have reported they are assured of progress. Oversight by ICB • SHMI – The Trust and ICB have provided evidence to demonstrate that SHMI exit criteria have been met and is now consider individual segment 2. NHSE Insight visit planned in Q3 with date to be agreed with Trust and ICB.	**ICB Quality Update**: The organisation has an action plan in place for the 7 "Must do" and 1 "should do" actions, and the Executives have oversight. The improvement plan is due to be reported at Oct/Nov Quality and Performance Committee (sub board) for assurance. <u>Must Do's</u> Safety - implementation of PSIRF with the 5 safety priorities will improve safety reporting and governance (incident investigations, action plans and risk escalation in a timely way). Culture, staff concerns and EDI - cultural improvement plan in progress for staff, the Director of People is leading the EDI improvement workstream and there is a new full time "speaking up" Guardian to support culture to enable staff to raise concerns. Governance - Good Governance Institute supporting the Board and sub board		

ORGANISATION	Q1 OVERALL SEGMENT 2023/24	Q1 RATIONALE FOR 2023/24SEGMENTATION	Q1 EXIT CRITERIA FOR 2023/24	NHS ENGLAND Q2 NARRATIVE UPDATE	ICB Q2 NARRATIVE UPDATE	Q2 EXCEPTION REPORTING	Q2 RSG DECISION
					committees review and improve governance structures and processes with a focused deep dive on quality. **SHMI** The Trust's Medical Director reviews this metric and has oversight of the improvement work within the Trust Hospital Mortality Group reporting to Board within the Quality and Performance Report on a monthly basis. The quarterly Learning from Deaths report is submitted to the Quality and Performance Committee (sub board) for assurance and the last report received was for Q3. It was noted in the Q3 report that SHMI on a rolling 12-month basis remains high, a detailed review links this with a change in the diagnosed dementia patients in Gloucestershire, which affects the risk profile.		
			Workforce - Perception of leadership culture: • A workforce plan to be in place by end June 2023 that is agreed with the ICB: • High level workforce plan with clear strategic priorities, outcomes and measures to deliver improvements. **Workforce – Engagement:** • A workforce plan to be in place by end June 2023 that is agreed with the ICB: • High level workforce plan with clear strategic priorities, outcomes and measures to deliver improvements. **Workforce – Bullying and Harassment** • A workforce plan to be in place by end June 2023 that is agreed with the ICB: • High level workforce plan with clear strategic priorities, outcomes and	**NHSE Workforce Update:** Funding was provided by region to the trust to support their response to the staff survey results. Following the 2022 Staff Survey results the Trust established a Staff Experience Improvement Programme, which is underpinned by clear guiding principles that are driving focus and actions. The Programme comprises three main workstreams: team and leadership development; addressing discrimination; and supporting a positive speaking up culture. Knowing cultural change takes time, a temporary work stream – Staff Experience Taskforce – is working on 4 short-term projects, delivered between April and December 2023, that demonstrates that the Trust is listening to staff and acting quickly. The Trust's most recent quarterly pulse survey suggests improvements across some aspects of the Programme, albeit the Trust is cautious about the results.	**ICB Workforce Update:** **No update provided**		

ORGANISATION	Q1 OVERALL SEGMENT 2023/24	Q1 RATIONALE FOR 2023/24SEGMENTATION	Q1 EXIT CRITERIA FOR 2023/24	NHS ENGLAND Q2 NARRATIVE UPDATE	ICB Q2 NARRATIVE UPDATE	Q2 EXCEPTION REPORTING	Q2 RSG DECISION
			measures to deliver improvements.				
			Agency Spend: • Reduction in rate of spend so that forecast outturn for agency is within the ceiling. • Compliance with pay cap.	**Finance:** Agency Spend • M4 HCAT score of 25% Vs 100% target. • Trust's M5 agency spend was above plan and ceiling pro-rated to M5. • Conclusion: maintain '3'			

Gloucestershire Hospitals NHS Foundation Trust

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Committee reviewed	Lead	Assurance Committee	Target Risk Score	Previous Risk Score	Current Risk Score
1.	**We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges**								
SR1	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	Nov 2023	Nov 2023	CNO/MD/COO	QPC	3x3=9	N/A	5x5=25
SR2	Failure to implement the quality governance framework	Dec 2022	Nov 2023	Nov 2023	CNO/MD	QPC	3x4=12	N/A	4x4=16
2.	**We have a compassionate, skilful and sustainable workforce, organised around the patient, that describes us as an outstanding employer who attracts, develops and retains the very best people**								
SR3	Inability to attract and recruit a compassionate, skilful and sustainable workforce	Mar 2022	Oct 2023	Nov 2023	DFP	PODC	3x4=12	N/A	5x4=20
SR4	Failure to retain our workforce and create a positive working culture	Dec 2022	June 2023	Nov 2023	DFP	PODC	3x4=12	N/A	5x4=20
	SR04 appears to have disappeared in early 2023 and Trust Secretary working with DFP to get this rebased. The document in June was a duplication of SR03.								
3.	**Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other**								
SR5	Failure to implement effective improvement approaches as a core part of change management	Dec 2022	Nov 2023	Nov 2023	MD/CNO	QPC	2x3=6	N/A	4x4=16
4.	**We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners**								
SR6	Individual and organisational priorities and resources are not aligned to deliver integrated care	Dec 2022	Oct 2023	Nov 2023	COO/DST	QPC	2x3=6	5x3=15	4x3=12
5.	**Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services**								
SR7	Failure to engage and ensure participation with public, patients and communities	Dec 2022	Sep 2023	Nov 2023	DFP	PODC	1x3=3	3x3=9	3x2=6
SR8	Failure to ensure opportunities and capacity for staff to engage and participate	Jan 2023	April 2023	Nov 2023	DFP	PODC	2x3=6	N/A	4x3=12
7.	**We are a Trust in financial balance, with a sustainable financial footing evidenced by our NHSI Outstanding rating for Use of Resources**								
SR9	Failure to deliver recurrent financial sustainability	July 2019	Nov 2023	Nov 2023	DOF	FRC	4x3=12	N/A	4x4=16

Board Assurance Framework Summary

8.	**We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact**								
SR10	Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.	July 2019	Nov 2023	Nov 2023	DST	FRC	4x3=12	N/A	4x4=16
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Dec 2022	Nov 2023	Nov 2023	DST	FRC	3x3=9	N/A	3x3=9
9.	**We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care**								
SR12	Failure to detect and control risks to cyber security	Dec 2022	Sep 2023	Nov 2023	CDIO	FRC	5x3=15	N/A	5x4=20
SR13	Inability to maximise digital systems functionality	Dec 2022	Sep 2023	Nov 2023	CDIO	FRC	2x3=6	N/A	3x4=12
10.	**We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK**								
SR14	Failure to invest in research active departments that deliver high quality care	Feb 2023	Sep 2023	Oct 2023	MD	CIRG	2x3=6	N/A	3x4=12

Archived Risks (score of 4 and below)

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

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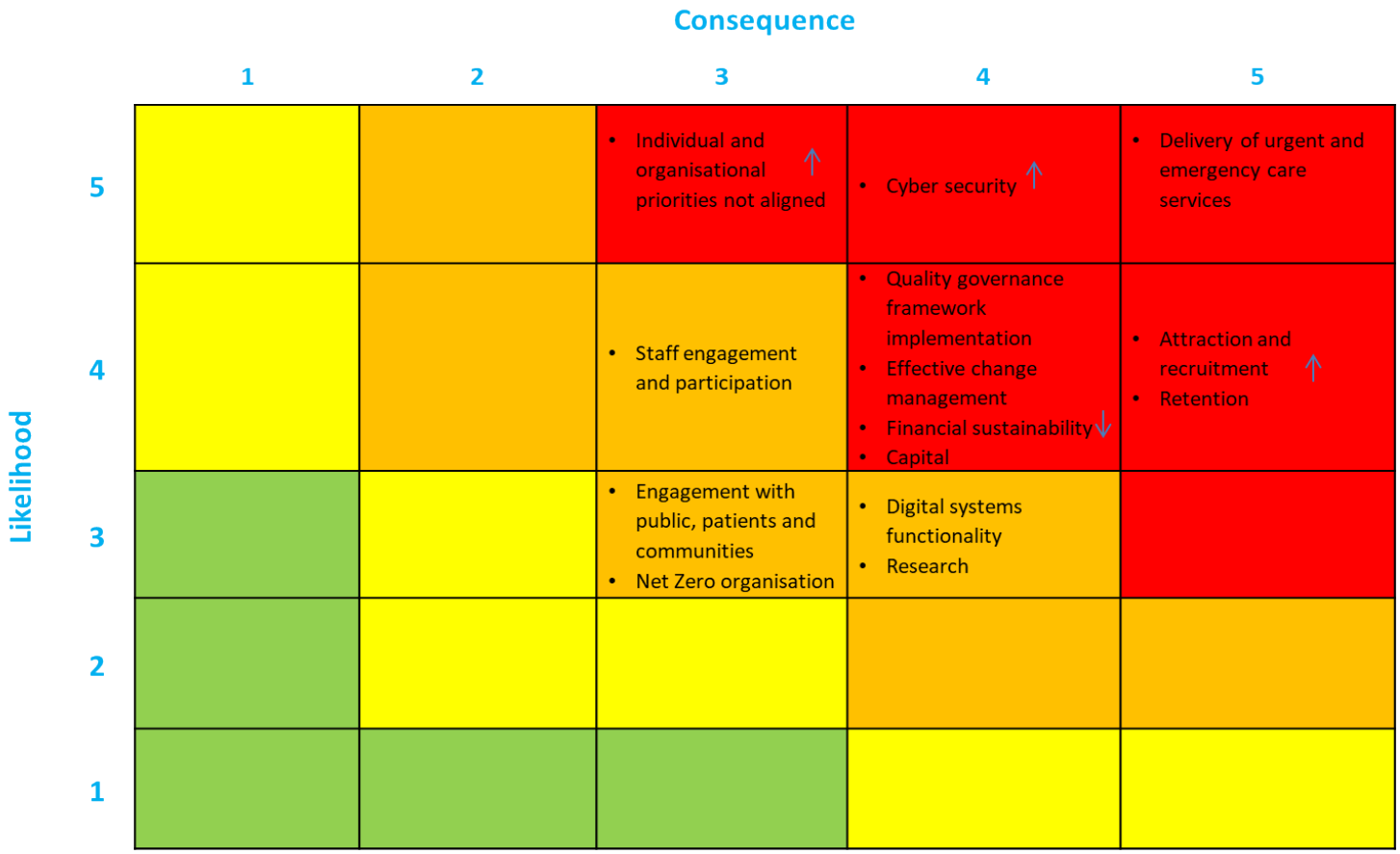
Board Assurance Framework Summary

Heat Map



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

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

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

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

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

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Friends and Family scores continue to be positive • De-escalated from Tier 1 to Tier 3 monitoring with SW Region **KIAR** Stabilised performance was also reported in Urgent and Emergency Care. A patient improvement plan had been established to review further opportunities and achieve the 80% performance target as set out in the Operational Plan. Reduced incidence of Boarding; now pre-empting frequently but excellent controls in place. Trust Risk Register An improvement programme had been established to coordinate all discharge improvement activity, with an aim to support congestion in Emergency Departments. De-escalation from corridor care in ED. • IA – ongoing negotiations and nor further strikes currently planned but possible if negotiations fail	• Delivery of operational standards remains non-compliant (64.2% 4hr; Handover time greater than 15mins) Significant improvements earlier this year not sustained. • Continuation of IA resultant from dispute between BMA and HM Govt requiring significant service changes, loss of capacity and increased time to recover Emergency and Planned care.	Continued monitoring by SW Region at Tier 3 escalation Internal audit reviews 2022-2025

Updated MP – 22 November 2023

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

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR2	Failure to successfully embed the quality governance framework	We are recognised for the excellence of care and treatment we deliver to our patients, **evidenced by our CQC Outstanding rating** and delivery of all NHS Constitution standards and pledges	A range of quality governance issues have been highlighted by internal indicators such as incidents and complaints, and by external reviewers including CQC.	Negative impact on quality of services, patient outcomes, regulatory status and reputation.	Quality and Performance Committee	CNO	SR1 SR3 SR4 SR5 SR8 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x4=12	A refresh of the quality governance framework is being implemented. CCQ inadequate ratings for maternity (2023) and surgery (2022). Well led requires improvement rating for Trust and a MUST DO action to improve governance. The maternity service has second CQC Section 29A warning notice related to same issues identified at previous S29a (clinical incidents and children safeguarding level 3 training). Additional unannounced focused CQC inspection children's services. CQC implement their new inspection framework 24 November 2023 and so new processes will need to be implemented.	**2022/23 end Q3** **3x4=12**	Implementation and embedding of the quality governance framework and CQC Requires improvement rating	Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee Report to Board • Trust Risk Register Report to Board • Quality and Performance Report (QPR) to Board - Key Issues and Assurance Report (KIAR) • Quality and Performance Committee oversees progress of risks, safety, experience, access/performance and outcome improvement plans in areas where significant issues/concern highlighted • Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board • Monitoring of performance, access and quality metrics via Quality & Performance Report • Inspection and review by external bodies (including CQC inspections) reported through the Regulatory Report	Outstanding rating by CQC - New CQC Inspection Framework to be delivered which commences November 2023 after tests in Isle of Wight and Bristol. No control of when CQC inspections will happen.

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

• Quality Strategy (insight, involve, improve) • Risk Management processes • Quality priorities and reporting through Quality Account • Improvement programmes • Executive Review process • Implementation of Operational and Winter Plans • Annual Reports for key programmes (complaints, FTSU, equality, safeguarding, infection prevention and control)	

ACTIONS PLANNED

Action	Lead	Due date	Update for end Q2
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	CNO	End Q2 2023/24 New date end of Q4 2023/24	Delivery of the Quality Plan has been paused whilst meetings take place with Good Governance Institute (GGI). Workshop held with GGI and Executive Leads for Quality/Safety in early October. Presentation of new structures to take at Board development session (Dec/Jan 2023/4)
Work in progress to deliver all the actions against the CQC S29A warning notices	CNO	End Q2 2023/24 New date as continuing S29a end Q1 2024/5	**2nd continuing section 29a warning notice received** for maternity service on 8 September 2023 with rapid improvement required by 10 November 2023. Meeting held with CQC to present current position and trajectories (clinical incidents only 17 did not meet 30 day KPI and children's level 3 safeguarding training will be compliant for all professionals by March 2024). We are mapping the 2 issues across the Trust to see if an issue in other Divisions. Final report from CQC for Surgery and Maternity services published 10 November 2023. CQC have carried out an **unannounced focused inspection in children's services** and we are awaiting report.
Work to improve the ratings of the core services rated as inadequate to improve governance	CNO	End Q2 2023/24 New date end of Q4 2023/24	MDG and QDG have oversight of the CQC improvement plan for the S29a, Must do and Should do improvement action plans for Surgery and Maternity. Final CQC report published (CQC took 29 weeks from inspection to publication). Maternity rated inadequate for a 2nd time and surgery were unrated. Must do's and should do's being mapped into new action plans.
Formal governance review, focusing on quality ward to Board processes	CNO	August 2023 New date end of Q4 2023/24	Workshop held in October with GGI. Director for integrated governance advertised with interviews early November 2023. Reporting structures to be agreed by Board and then implemented.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

Cancer Annual Report Safeguarding Adults and Children's Report	Regulatory Report - Human Tissue Authority inspection 'red' actions progressed and escalated, but plan remained incomplete. - DBS checks and rechecks for mortuary staff (particularly GMS staff) escalated to the Deputy Director for People. Quality and Performance Report - RTT performance for July was 66.9%, with 2855 two week waits; August had 3052. - Zero 78-week breaches at the end of July and two for August. - Follow-up waiting list showed that 46% of the total list was overdue. - Long waiters had reduced. Maternity - NHSE Maternity Safety Support Improvement Programme is still in place and will continue until the service is re-rated to good. - Maternity Governance Review being implemented. - Thematic review of maternal deaths undertaken and there were EDI/health inequalities raised within the analysis of the data. Emergency Care - Patterns of late evening congestion in ED noted. - Further control of boarding required due to the profound effect on quality. - Early discharge and discharge planning challenges continue. - BCI very challenging with significant impact to workflow. CQC Awaiting the report from the Children's unannounced inspection.	• Reporting to Q&P as per schedule • Internal audit reviews 2022-2025

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR3: Workforce - Culture, Experience and Retention Sept 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR3 Culture, Experience and Retention	**Inability to attract and retain a skilful, compassionate workforce that is representative of the communities we serve.**	**To transform the Trust as a place to work and receive care by building a fair and compassionate culture that allows everyone to thrive.**	Staffing issues across multiple professions on national scale. Lack of resilience in staff teams. Increased pressure leading to high sickness and turnover levels.	Reduced capacity to deliver key strategies, operational plan and high-quality services. Increased staff pressure. Increased reliance on temporary staffing. Reduced ability to recruit the best people due to deterioration in reputation.	People and Organisational Development Committee	Director for People & OD	See Risk update Sept 2023

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
▪ Staff Experience Improvement Programme: - Leadership and Team Working - Discrimination - Raising Concerns and Speaking Up - Taskforce - Colleague Communications and Engagement - Restorative Just principles and practice, 4 steps approach and people polices and processes ▪ Divisional colleague engagement plans ▪ Proactive Health and Wellbeing interventions ▪ Addressing HCSW remuneration T&Cs	▪ Increased staff sickness absence including the impact of Long Covid related illness ▪ Pace of operational performance recovery leading to staff burnout ▪ Deteriorating staff experience leading to increased absence, turnover, lower productivity and ultimately poor patient experience ▪ Lack of time for staff to complete e-learning training

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

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
Teamwork and leadership development Develop Specification for external OD support to deliver a Leadership and Teamwork development programme.	Head of L&OD	September 2023 to September 2026	The procurement process has completed with The Wellbeing Collective Ltd (TWBC) selected as preferred supplier. Contract has been awarded from 1st September. September will see the co-design the programme with roll out to the agreed service lines from October as reflected: ▪ Women & Children – Gynaecology ▪ Surgery – Ophthalmology ▪ D&S – Radiology ▪ Corporate – likely a combination of cost centres in the COO and Information service lines (tbc) ▪ Medicine – undecided as yet. Agreed to take a slightly different approach to agreeing which parts of the division will go first, in partnership with TWBC
Teamwork and leadership development Develop organisation map to support Divisions in determining priority teams to work through the Leadership and Teamwork development programme	Head of L&OD	September 2023	Work is underway with the selected service lines to understand team structures and the logistics in releasing those teams to attend the training and interventions with TWBC. Discussions with Finance are also taking place to establish costs for backfill where required.
Discrimination Develop full plan for the new workstream as identified by the 2022 Staff Survey results, including aim, deliverables, benefits and milestones in relation to Anti-racism campaign and "looking after our international nurses"	AD of EL&C	September 2023	Two priorities have been agreed by the EDI Steering Group for the Discrimination workstream: ▪ Improving the experience of our international recruits (not just limited to nursing) ▪ Improving our anti-racist practices The first Task and Finish Group session ran in August, with positive engagement, but recognition that further stakeholder engagement is required. There also needs to be a greater understanding of current practices and concerns in relation to the two priorities in order to agree actions and deliverables which will address the issues. Additional Project Manager resource has been assigned to this workstream and a project plan is under development. Deliverables, milestones, KPIs and benefits will be presented at the October People and OD Committee.
Raising Concerns and Speaking Up Delivery of 12-month workstream plan	Lead FTSU Guardian	December 2023	Delivery of this workstream continues to progress well, with positive feedback of the service refresh across the organisation. Caseload numbers are increasing, demonstrating some improved feelings of safety to speak up. However, it is recognised there is still significant work to do, with the next focus to reduce the number of anonymous cases. by ensuring staff feel open and safe in speaking up. Engagement sessions are planned throughout September and October to inform the narrative of a Freedom to Speak Up Strategy. Work continues to align the Freedom to Speak Up team practices with the National Guardians Office

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

Taskforce Group Establish a taskforce to respond to the question posed to staff "*what is the one thing you would like to change*"	Staff Experience Programme Manager	April - December 2023	Taskforce projects have been agreed and are progressing with support from QI facilitated monthly sessions: **<u>24 Access to Staff Food</u>** ▪ Created the investment case for getting food to overnight staff in GRH and CGH ▪ Investment case finances reviewed ▪ Launched vending machine survey with 500 responses so far **<u>Thank You / Recognition</u>** ▪ Pilot sites have been identified in Pathology ▪ Range of "Tools" have been expanded e.g. new tools from Tivoli, Maternity ▪ More info from ED on how FERF tool could be disseminated ▪ Design & development of Thank You cards **<u>New Starter Packs</u>** ▪ Meetings held with OD and Recruitment with support and focus on welcome packs and manager checklist ▪ Process Map with onboarding/recruitment and managers to be scheduled for 10.10.23 ▪ Questionnaire launch 04.09.23 for 4 weeks ▪ Costing requested from multiple companies for welcome packs **<u>Just Sort It Fund</u>** ▪ Discussions with IT to understand viability of putting the small works form onto the maintenance portal ▪ Developed 'to-be' work flows to improve small works process ▪ Identifying audit areas ▪ Small works survey developed for colleagues to scope out areas of improvement in user experience
Restorative & Just Culture Review of the Trust's people policies, establish procedures and tools which utilise the four-step model within people processes and investigations and establish resources, advice and guidance to support line management practice	AD of HR&R	Timeframes to be scoped and agreed	Full scoping of this workstream will commence in September with the new Associate Director of HR & Resourcing now in post. Initial communications have been included in the monthly Cultural Journey to begin to socialise the concept with the organisation. The Staff Experience Improvement Programme has recognised that this enabling workstream needs to pick up pace and as such further Programme Manager resource has been assigned to support the AD of HR&R.

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

Establish a Trust wide Retention Group focussing on 2-3 core initiatives at a time, informed by expert exit data analysis	DDfPOD	Commenced	First Retention Group held in July 2023 to discuss specific initiatives for focus. A deep dive analysis of metrics for the A&C staff group was reported to the PODC by way of an interim report in August 2023. Further triangulation of analysis and a response to the findings will continue through this group, ensuring initiatives are data driven.
Financial Wellbeing Support	AD of EL&C	Time frame to appoint by Nov/Dev 2023, Charity panel commencement Nov 2023	Half-price food and free tea/coffee (when bringing own mug) from GHT food outlets offer extended for all staff for 2023-24. Wellbeing conversations taking place with Charity as to the assistance that could be provided. Wellbeing panel being set up by the Director for the Charity to provide focus on the Wellbeing agenda. Financial Wellbeing is being taken to the ICS Health and Wellbeing Group for system wide discussions
Mental Health Wellbeing Support	Staff Psychology Lead	September 2023	The Staff Psychology team, which currently sits within P&OD, are transferring back to sit under the wider umbrella of the Clinical Psychology team from the middle of September 2023. This is against the backdrop of various drivers: achieving a better aligned professional structure for the team, professional development of the service within the wider Clinical Psychology context, the changes within the P&OD Wellbeing structure, and the need to evolve and mature our health and wellbeing offering across GHFT and indeed the wider ICS.
National Programme for B2-B3 HCSW Job profiles and pay drift. To include addressing GHT's legacy of varying pay and sick pay T&Cs for this staff group	DDfPOD	Ongoing and on track Programme to be delivered by 31 March 2024	Significant focus continues on the roll out of this programme. Principles shared with Staff-side Colleagues. Endorsed with the exception of UNISON. Trust side, approval received by PODG and DOAG in Sept 2023. Onto TLT later in the month. Full launch and comms programme being planned for October with a wide-reaching programme of engagement.
Becoming a Real Living Wage Employer (ICS collaboration)	DDfPOD	Timescales in line with HCSW programme above	A review of the Trust's apprenticeship rates and those pay bands where staff are on the National Living Wage, in partnership with the ICS is to commence, however the System wide HCSW Programme highlighted above offers the opportunity to address these pay issues.
Establish baseline and parameters for achieving Model Employer targets for parity of Ethnic Minority colleagues in band 8a+ roles by 2028	Head of Leadership & OD	Delayed until mid-late Sept 2023	A report has been produced by the P&OD NHS Graduate Trainee. A presentation of report findings and recommendations was scheduled for end August however this has now been delayed to mid-late September.
Cultural Awareness Pilot site for National Programme	AD of EL&C	Ongoing July- October 2023	Train the Trainer course identified for GHFT. OSCE Lead and 2 other trainers are being identified to become first cohort of pilot trainers. 20 Line Managers to be identified/selected within the Trust to go through the 6-8 weeks online Cultural Competence training and through the in-house workshop. First Train the Trainer end of July 2023. First Cultural Competence training expected to commence September/October.

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

Colleague communications and Engagement ▪ Review and audit all internal communication channels ▪ Service engagement with Staff Survey results ▪ Ongoing promotion of NQPS in Q1 and Q2 ▪ Review Electronic Staff Record (ESR) to segment staff groups, improving the tailoring of messages ▪ Involve leaders to identify the most effective methods of communicating (i.e Team Briefs, Cascades etc) ▪ Support NHS Staff Survey to increase awareness and uptake ▪ Support annual Staff Awards - celebrating staff through recognition and reward ▪ Successful staff engagement as part of NHS75 and Windrush75	DofComms	May - December 2023	Delivery of all actions are underway: ▪ Staff Awards 2023 - nominations now open with Staff Awards event to take place in November ▪ NQPS July completed and feedback to staff – highest response rate seen ▪ Preparation of Staff Survey 2023 is underway ▪ Review of Brilliant Basics approaches for Comms Team ▪ Review of Community Engagement team structure ▪ Planning for AMM underway (28 Sept)

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
▪ Ability to offer flexible working arrangements ▪ Inclusion Network with three sub-groups (ethnic minority; LGBTQ+, and disability). ▪ Compassionate Behaviours Framework ▪ Technology Enhanced Learning and Simulation Based Education ▪ Divisional colleague engagement plans ▪ Proactive Health and Wellbeing interventions covering physical, mental and financial wellbeing	▪ Below average staff survey results ▪ Diversity gaps in senior positions ▪ Gender pay gap ▪ WRES and WDES indicators ▪ EDS22 ratings ▪ Cost of living increases ▪ Exit interview trends ▪ Inconsistent Pay T&Cs for HCSWs	▪ Staff Experience Improvement Programme ▪ Internal audit reviews 2022-25: - Cultural Maturity - Cross health economy reviews - Equalities, Diversity and Inclusion - Health and Wellbeing - Staff Engagement

Key:

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

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

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x4=16	Staff and CQC feedback – too many initiatives - reduce Staff engagement scores Need to build a systematic improvement function at all levels Lack of capacity to support improvement	**Dec 2023** **2x3=6**	Implementation of Quality Governance arrangements Implementation of PSIRF Implementation of a prioritisation process for improvement activity from Ward to Board	Newly developed BAF risk

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	CN	Q1 2023/24 - Overdue	Progress delayed because of Trust wide governance review. In progress, revised Divisional focus QDG piloted in August 2023, September QDG to pilot corporate agenda and October to pilot QDG agenda for specialty committees. Further developmental workshops planned for November 2023
Introduction of PSIRF	MD	Q4 2023/24	In progress. Business case and VCP approved, to introduce additional resource to support the introduction of PSIRF. Role now advertised. Aiming for January 2024 for Board approval of PSIRF, prior to ICB approval in February 2024. The PSIRF programme is under considerable pressure due to resources for initial implementation. This is detailed in the Safety Report submitted to Q&P Committee.
Establish A3 thinking approach to establish a recognised planning and monitoring approach for improvement	CN\ MD\I Q	Q3 2023/24	Meeting scheduled 18 September 2023 VC/IQ to review progress and next steps.

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

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

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR6: Individual and organisational priorities not aligned NOV 2023

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR6	Individual and organisational priorities and resources are not aligned to deliver effective integrated care	We put patients, families and carers first to ensure that care is delivered and experienced in an integrated way in partnership with our health and social care partners	Individual organisations have their own strategy and priorities Budget allocation to organisations rather than priorities	• Lack of integration and system working • Inconsistent priorities and lack of single strategy for Gloucestershire • restriction of the movement of resources (including financial and workforce) leading to an impact upon the scope of integration	Quality and Performance	COO/D ST	SR1 SR7

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• System wide development and agreement of Operational Plan (2023/24) • Systemwide STRATEGIC and TACTICAL escalation Groups (SEG, TEG) established as BAU • Quality and Performance Committee oversees progress of improvement plans in areas of significant concern. • Delivery Group exception reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board as BAU • Monitoring of key performance metrics via Quality and Performance Report (QPR) • Quality Strategy, Risk Management and Executive Review processes in place as BAU • Efficiency Board in place • Key issues and assurance reporting (KIAR) • ICB attendance at Q&P Committee • Triumvirates in place for the Operational/Clinical Divisions • Continued delivery of Estate Strategy on both GRH and CGH	• Operational Plan 2023/24 not fully compliant in every domain (Activity agreed to delivery ~~105~~103%; Financial gap identified and not fully mitigated). • Operational Performance Delivery but with system ownership and buy in. • Ambulance conveyance reductions identified as urgently necessary – system-wide action plan requested by D Coyle. • Both organisational and whole-system risks acknowledgement to patient safety associated with long LOS and inappropriate conveyance required.

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR6: Individual and organisational priorities not aligned NOV 2023

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
~~BAF planned to assure Trust Board of Elective Priorities 2023/24~~	~~COO~~	~~Jul 2023~~	~~Paper to Q&P on 28/06/2023 recommending Monthly Assurance Paper~~
~~Winter Planning schedule in place following reflection and prioritisation workshop (ICB, GHC and Trust)~~	~~COO~~	~~Sep 2023~~	~~Reflection and System wide workshops already taken place and key schemes being developed and delivered via the Operational Plan 2023/24~~
Continuation of Operational Plan (2023/24) delivery monitoring at system level	COO	Jun 2023	BAU
Recovery and Reset plan developed and being delivered in response to CAT2 performance and SWAST Offload times	COO	Oct 2023	BAU with assurance offered to Exec Tri, ICB and NHS SW

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

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

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

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

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

CONTROLS/MITIGATIONS

- Board approved Engagement and Involvement Strategy
- Annual Review of Engagement and Involvement published
- Annual Members' Meeting
- Engagement Tracker – mapping activity/impact – 8700 contacts over 58 community events / projects
- Quarterly patient experience report to Quality and Performance Committee
- One Gloucestershire approach to public involvement – codesign of 'Working with People & Communities' Strategy
- Community Outreach Worker in post (funded by NHS Charities Together) to support seldom heard groups and identify gaps in engagement.
- Successful completion of Fit for the Future programme
- Programme to develop a 1000 strong ICS 'Citizens Panel' to support local community engagement

GAPS IN CONTROL

- Objective measurement of impact of public and patient engagement and involvement
- Resource gap for engaging, involving and growing Trust Membership.
- Review of Engagement Team structure
- Engagement Toolkit – joint with ICS partners – to improve the quality and consistency of public/patient involvement.
- Revised CQC and NHS England approach in assessing community engagement

ACTIONS PLANNED

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

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

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Codesign of One Gloucestershire 'Working with People & Communities' Strategy • Completion of Fit for the Future engagement and consultation programme • Progress demonstrated in publication of Engagement & Involvement Annual Reviews • Level of engagement and involvement from Governors • Inclusion of patient and staff stories at Trust Board including bi-annual learning report • One Gloucestershire involvement group established – ensuring joined up priorities and work.	• Trust membership has reduced to below 2,000 with limited diversity • Opportunity to actively elect more divers Governors and grow membership • Friends and Family Test Scores have dipped, in particular ED and PALS calls have tripled in last 18 months from around 200+ per month to over 600.	Internal audit reviews 2022-25: • Patient Safety: Learning from Complaints/Incidents • Equalities, Diversity and Inclusion • ICS Citizens Panel

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR8: Staff engagement and participation — April 2023

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

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

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

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

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR9: Financial sustainability NOVEMBER 2023

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY
4x4=16	• The plan for 23/24 shows a balanced position. However, there is a level of risk in the plan that is yet to be mitigated, £6.6m gap on the transformational FSP target, £4m on the system led transformational initiatives and £1.4m additional target which was agreed as part of balancing the plan – total risk £12m. • Increase cost of temporary staffing due to workforce challenges including those arising from industrial action. • The lack of flow in the hospital causing restrictions on elective recovery impacting on the ability to earn ERF. • Additional staffing demands above funded levels	**Dec 2022**	**5x3=15**	• Everyone in the Trust (from Board to ward) understands and owns their element of responsibility around good stewardship of public money. • On line financial training to raise awareness of the importance of good financial control. • Full review of all revenue investments made during the pandemic to determine whether they are still to be supported or if financial commitment should be removed. • Continued monthly monitoring to understand the drivers of the deficit. • Drive the financial sustainability programme, chaired by the CEO, to start to see the recurrent benefits of financial improvement. • Full review of all non-clinical agency spend showing clear exit plans for those posts that can be recruited to permanently.	Aug 21
		April 2023	**3x4=12**		April 21
		June 2023	**3x4=12**		Sept 20
		Dec 2023	**3x4=12**		July 19
		Jan 2024	**3x4=12**		
		Feb 2024	**3x4=12**		
		Mar 2024	**3x4=12**		

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

	• Pressure on operational capacity, limiting the focus on how to drive out efficiencies whilst improving patient outcomes. • Productivity information is showing a reduction in activity but not a corresponding reduction in costs to match.		• Full review of all vacant posts with a view to removing those that have been vacant for 12 months or more • Development of system transformation programmes to support longer term financial health included Newton • Development and acceptance of a financial recovery plan if applicable – showing clear executive leads. • Review and implementation of divisional governance related to financial controls and forecasting Target risk shifted out to 16 in December, which is aligned with the CURRENT risk. The focus linked to Financial Recovery Plan is for the reduction of the target risk in the final quarter through improved performance and minimising the deficit, although breakeven not anticipated. March target based on receipt of non-recurrent funding. November 2023 - December target risk reduced due to progress on financial recovery progress and anticipated non-recurrent funding announcement on 9 November 2023, however March target March raised to 12 as non-recurrent funding amount not yet confirmed	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• PMO proactively supporting operational and corporate colleagues to generate and deliver future sustainable schemes using tools such as model hospital etc • Programme Delivery Group for financial sustainability chaired by the CEO to raise importance of financial balance • Pay Assurance Group (PAG) • ICS one savings programme to share ideas, resources and drive consistency • Monthly monitoring of the financial position • Controls around temporary staffing • Driving productivity through transformation programmes i.e., theatres and OP • Weekly financial recovery meetings in place with those adversely deviating from plan • Final draft of an accountability framework has been developed and is being rolled out by the Executive. This is focused on the Executives holding divisions to account, with escalation of issues up to Trust Leadership Team (TLT) for escalation, as appropriate to relevant Board committees. An update will be provided to Audit and Assurance for information linked to internal controls. • Medicine division have been put into enhanced oversight to provide additional support to improve their position. There are weekly meetings chaired by the COO. • Established a recovery plan for each division. This will be overseen by the COO via the monthly efficiency Board.	• Robust benefits identification, delivery and tracking across major projects • Inability to generate ideas - Looking to get some expert support into the organisation – going through the triple lock process. • Capacity issues to generate and implement ideas at pace i.e., RMN decision making thresholds • No central medical rostering system in place - TLT approved e-Roster procurement on 17 October 2023 with implementation target date of Spring 2024 • Reporting mechanism for tracking productivity in theatres and Outpatients (Target to introduce from January 2024) • Reporting to FRC from January 2024 every other month, with deep dive to areas of concerns, progress and successes in the intervening months

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

• Review of the National Check and Challenge oversight list to identify further opportunities, or gaps in controls. • Review of ward nursing establishments • Controls on high-cost medical temporary staffing are being reviewed • Systemwide review of RMN pressures and solutions. • Relaunch business planning for 23-24 • System implementation of triple lock to be implemented effective week commencing 9 October 2023 (accepting that formal documentation is still in progress) • Developed recovery plan (in place) with key programs of work with named EXEC and SRO • Rostering rules prior approval to over roster where applicable in place with templates on ESR and Chief Nurse sign off on any over roster requests. • The approval process for ad-hoc additional medical shifts needs review; Increased controls in Locums Nest to stop ad hoc shifts being approved retrospectively implemented from 1 November 2023. • Controls on the approval of WLIs/overtime payments strengthened. Additional paid activities (APA) panel in place. Monitoring via divisions and controls through FSP. Bi-weekly Medical Grip & Control meeting reviews all aspects of medical workforce spend.	

ACTIONS PLANNED

Action	Lead	Due date	Update
Robust benefits identification, delivery and tracking across major projects	DOS	Oct 23	The business planning process needs to be re-launched to bring business, workforce and money together in a sustainable plan. Guidance to be produced along with timeframes for development. *Appointment of new Programme Manager for Operational Planning has been completed and has been tasked to undertake the new business planning process. Benefits realisation is now part of all new business cases and tracked by Finance BPs (and FSP PMO for saving schemes)* *CLOSED – Operational Planning lead / DCOO now working on this years Operational Plan. Benefits realisation now being embedded as part of BAU processes*
Drivers of the pressures understood and communicated to system and regulator partners – Based on RUN RATE	DOF	Monthly	Forms part of the regular monthly monitoring, if the RUN RATE starts to move into a deficit, then more formal plans will be developed. Implemented on 6 November 2023. **CLOSED.**
WTE growth from 19/20 actuals to 22/23 establishment understood and challenged	DOP	~~Jul 23~~ Nov 23	WTE growth was presented to F&D in Sept 22 but further work needed to understand whether WTE growth is still required. Updated in Sept 23 reflect 22/23 WTE growth impact which continues to show WTE increase since 19/20. Exec team peer review and discussion to challenge this. Scheduled for Exec Team review on 13 November 2023.
Relaunch of business planning for 23/24	DOS	Oct 23	The business planning process needs to be re-launched to bring business, workforce and money together in a sustainable plan. Guidance to be produced along with timeframes for development. Appointment of new Programme Manager for Operational Planning has been completed and has been tasked to undertake the new business planning process.

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

			CLOSED – Operational Planning lead / DCOO now working on this years Operational Plan
Implementation of divisional governance	DOF/COO	Nov 23	The efficiency Board, chaired by the COO, now includes a session on financial recovery and oversight. The initial meeting of this refreshed format is in September. A draft accountability framework has been developed and will provide a structure to move divisions into increased oversight as applicable. This is being rolled out by the Executive. This is focused on the Executives holding divisions to account, with escalation of issues up to Trust Leadership Team (TLT) for escalation, as appropriate to relevant Board committees. An update will be provided to Audit and Assurance Committee (AAC) for information linked to internal controls. On agenda for AAC in November.
Greater focus on productivity opportunities within theatres and OPD	DOF	Dec 23	Clear governance and reporting in place to focus on greatest opportunities with input from system colleagues. DOF preparing "plan on a page" in November and this will link to FRC reporting schedule being introduced from January 2024.
Determine and assess output from Recovery Action Plan	DOF	Nov 23	Initial reporting to FRC in October 2023. Completed and now forms part of month end report from Nov 23 - **CLOSED**
Generate long term transformational plan for the Trust to support Medium Term Financial Plan (MTFP) delivery	DOS	Jan 23	FSP PMO are now developing Transformational plans & pipeline of schemes to support the MTFP plan. External specialist support is still be explored to support this piece of work and convert ideas into schemes and delivery plans

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Achieved key annual financial targets in 2020-21. • Achieved key annual financial targets in 2021-22. • Achieved key annual financial targets in 2022-23. • Continued the monitoring of financial sustainability with a greater focus on recurrent savings • ERF performance to secure monies for the system • Improved and co-ordinated system working. • Development of productivity analysis at divisional level • Robust financial reporting highlighting key pressures in a timely manner	• Temporary staff spend consistently above target. • Workforce spend is significantly above plan with productivity significantly below plan • Planned Trust and System underlying deficit moving into 23/24 a significant concern. • Continuing under-delivery of recurring efficiency programme. • ERF achievement for 2023/24 is a cause for concern • Lack of benefit realisation on schemes that should be delivering financial improvement • No real consequences of financial deviation • No review on whether to continue to stop a project if overspending	• Internal Audits planned 2022-25: • Cross health economy reviews • Shared Services reviews • Risk Maturity • Data Quality • Budgetary Control • Charitable Funds • Payroll Overpayments • NHSE/I scrutiny of Trust/system finances. • ICS accountability and assurance on system wide transformational changes.

UPDATE

November 2023: Overall active progress continues on gaps in control with progression as shown above) – key focus is now on reducing the run rate to give best chance of balanced plan for 204/25 and development of a transformational plan to support long term financial sustainability.

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

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

REF.	STRATEGIC RISK	GOAL / ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR10	**Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.**	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact.	• National Capital Department Expenditure Limits (CDEL) • Age, condition and inefficiency of GHFT buildings & infrastructure • Previous equipment purchase profile resulting in peaks in end-of-life equipment • Scale of backlog maintenance: £83M (2022 ERIC submission) of which £41M is Critical Infrastructure Risk (2021 6 facet survey)	• Unable to address backlog and critical infrastructure risks resulting in service interruptions impact on patient access, safety and quality • Poor quality theatre and ward environment impacting on patient outcomes & patient & colleague experience • Equipment failures leading to service interruptions impacting on patient access and diagnosis timescales	Finance and Resources Committee	DST	SR9 SR11

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		Jan 2023	Jan 2024			
4x4=16	One Gloucestershire CDEL results in an annual capital budget of c£24M per year for GHFT. This is split across estates, digital and equipment. This allocation is insufficient to address the scale of backlog maintenance (£83M) risk within an appropriate timescale as well as a refurbishment, equipment replacement & digital programme.	**4x4=16**	**4x4=16**	• CDEL limits constrain the level of capital investment One Gloucestershire can commit to • Estate backlog maintenance schemes compete with other strategic and operational priorities, including strategic estate schemes, digital and equipment replacement • Equipment Managed Equipment Service (MES) procurement on hold as business case did not demonstrate value for money and impact of IFRS16 was unknown in 21/22. • ICS Partners have greater awareness of risk GHFT is carrying across estates in particular, which could lead to a change in CDEL allocation from 2023/24. • GHFT have a good track record of securing capital from NHSE schemes (UEC, TIF, CDC etc) and these schemes include backlog maintenance element.	Sept 2023 Apr 2023 Feb 2023 Sept 2022 July 2022 April 2022 April 2021 Oct 2020	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Trust Board and ICB sighted on the scale of GHFT estates backlog and Critical Infrastructure Risk	• Lack of alternative routes to capital other than NHSE/I.

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

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Review equipment MES business case learning from how other Trusts/ ICSs have managed IFRS16	DoF/ DST	Q3 23/24	Project to be re-launched in 2023/24. Will require project resource. Pathology MES business case underway, LINAC and Imaging MES being considered.
Improve awareness across ICS partners of level of risk GHFT is carrying across estate and equipment	DoF/ DST	From Q3 22/23	ICS capital group established with DoF and DST. Improved awareness of risk is already influencing CDEL prioritisation decision making Movement to a 5 year capital Programme from 24/25 **COMPLETE** - Monthly meetings in place and ICS fully aware and sighted on level of risk
Review scope, function, priorities and resourcing of ICS Estates Strategy Group	DST	Q1 23/24	Raise via ICS Strategic Executive **COMPLETE** - Monthly meetings in place and ICS fully aware and sighted on level of risk
Explore partnership opportunities to develop GHFT estate and/or adjacent sites	DST/ GMS	Ongoing	Opportunities in progress/ being explored with GCC and other potential partners.
Ongoing development of feasibility studies to respond to national/regional calls for business cases.	DST	Ongoing	Latest feasibility study being undertaken for GRH Theatre estate
Regular dialogue with National and Regional NHSE teams to explore funding opportunities and pipeline of bids	DST	Ongoing	Monthly meeting with Regional NHSE Estate leads

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Trust ability to respond to and secure ad-hoc capital funding in-year from NHSE&I. Schemes include backlog maintenance element • PFI is being maintained to 'Condition B' in line with contract	• Level of estate risk is increasing as reflected through risk scores • Unable to fund a ward refurbishment programme until 2024/25	Internal audit reviews 2023-25: • Environmental Sustainability • Estates Management

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

• New estate comes on line in 2023 (GSSD) providing good quality estate with reduced maintenance requirement. GSSD has addressed areas carrying backlog e.g., Gallery Wing, DSU at CGH. • Estate capital investment has been prioritised in 2023/24 at £14/£24M CDEL. • Recent investment in Radiology has reduced equipment risks (but resulting in lumpy replacement profile) • Board development session in September 2023 to highlight the risks and options being considered		
UPDATE		
Sept 2023: actions updated to reflect progression and new actions for 2023-24 November 2023 – revision to causes, rationale and Target risk score for Jan 2024.		

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR12: Cyber security — Sep 2023

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
5x4=20	The National Cyber Security Centre (NCSC) is clear that there are groups and individuals who want to target the NHS; and these are no longer carried out by isolated individuals, but are mounted by large and sophisticated criminal groups. Several high-profile public-sector organisations and NHS trusts have experienced breaches in the last two years and suffered cost and data losses – directly impacting patients/residents.	**Dec 2023** **5x3=15**		Newly developed BAF risk

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

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

• Monthly reports to Digital Care Delivery Group, Finance & Resources cttee, ICS Digital Execs • NHS national monitoring (alerts) and NCSC alerts • Communications and engagement with users on prevention	

ACTIONS PLANNED

Action	Lead	Due date	Update
- Rationalisation of detection and prevention tooling. Introduction of targeted monitoring and alerting across key systems and entry points. - Establishment of comprehensive asset register for devices including medical devices and internet of things. - Review and robust management of third-party suppliers to prevent downstream implications - Removal of all end-of-life software and hardware.	CDIO	Dec 23	Since the last F&R actions have progressed to mitigate the recently raised cyber risk. An interim CISO (Chief Information Security Officer) has been appointed and started In August. There has been progress in bringing historic disparate actions plans together so there is one view of the cyber-programme. A review of tooling, monitoring and alerting has also been performed and it has been identified the tooling suite being used needs to be rationalised. In addition, the monitoring and alerting mechanisms in place at the Trust are not adequate to identify invasive attempts and these are being rewritten and implemented. An asset register for end-point user devices has been established but is yet to being fully completed site-wide. It is being expanded to contain medical devices and IoT. The Trust is working with the wider ICS on developing a cyber-security strategy in line with the new National Cyber-Security Strategy.

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

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

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

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

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

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

• ICS Sustainability Group established to oversee delivery of ICS Green Plan (Statutory requirement)	

ACTIONS PLANNED

Action	Lead	Due date	Update
Progress on delivery against GHFT Green Plan reported through F&R Committee	DST	Ongoing	Process established. Last update in July 2022
Continue to research and respond to external grant applications	GMS (THu)	Ongoing	GHFT secured £13M from latest PSDS scheme or the Tower Block façade & window replacement
Establish EV Task & Finish Group	DST	Q3 2023/24	Term of Reference produced. Group to mobilise in Q3 & link in with ICS
Engage in ICS/ Gloucestershire County Sustainability groups to make linkages and pursue joint initiatives	GMS (JC)	Ongoing	GHFT/ GMS involved in EV strategy group to explore multi-partner options to support transition to EV across public sector organisations and shared use of infrastructure
Explore options within PFI contract to improve EPC ratings of PFI estate ahead of transfer to GHFT in 2035	DST	Ongoing	Will form part of PFI contract review

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

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

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR13	**Inability to optimise digital systems functionality and progress as a digital hospital**	We use our electronic patient record system and other technology to drive safe, reliable and responsive care, and link to our partners in the health and social care system to ensure joined-up care	• Inconsistency of approach and not following digital strategy • Implementing new systems without digital approval – that don't integrate with clinical record (EPR) • Lack of required investment in digital skills, resources and infrastructure • ICS wide strategy not operationalised and/or financial gap to deliver. Poor clinical and operational engagement in what is new developments or optimisations	• Reduced ability to innovate, use clinical intelligence and data effectively and plan. • Unable to reach Govt requirements to become a HIMSS level 6 organisation; impacting reputation as well as safety. • Inability to work effectively across the care system, providing poor joined-up care. • Inefficient operational practice and planning/flow. • Inefficient systems/poor data can contribute to clinical errors and poor safety • Unable to meet expectations of patients, commissioners and regulators.	Finance and Resources Committee	CDIO	SR9 SR12

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Electronic Patient Record (Sunrise EPR) becomes single source of clinical information, implemented to HIMSS level 6- and five-year plan by 2024. • Joining Up Your Information (JUYI) implemented in partnership with external partners and available to access through EPR • Data Warehouse providing one version of the truth supporting clinical and operational dashboards used for planning across the ICS.	• ICS strategy implementation and plan not embedded/complete • Use of different systems across the ICS • Inability to integrate systems bought outside of digital remit (divisional) • Funding stability & competing Trust priorities for capital.

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

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

ACTIONS PLANNED

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

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

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

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR14	**Failure to enable research active departments that deliver high quality care**	We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK	• Lack of capacity within R&D department • Lack of willingness of departmental management to support research activities within their department • Financial approval of VCPs delayed by misunderstanding of research funding processes	• Disengagement of staff in research activities • Departure of research active staff to other more research active organisations • Unable to support staff to design, set up or deliver their research studies (own account & portfolio) • Lack of opportunity to secure additional funding for research and generate surplus for Trust • Higher turnover of staff leading to increased locum and bank staff → increased financial burden • Negative impact on reputation • Inability to secure university hospital status	People and Organisational Development	MD	SR5 SR8 SR9

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

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

ACTIONS PLANNED

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

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

Report to Board of Directors

Date	11 January 2024		
Title	Trust Risk Register		
Author / Sponsoring Director/ Presenter	Lee Troake, Head of Risk and Safety Mark Pietroni, Medical Director and Director of Safety		
Purpose of Report (Tick all that apply ✓)			
To provide assurance	✓	To obtain approval	
Regulatory requirement		To highlight an emerging risk or issue	✓
To canvas opinion		For information	
To provide advice		To highlight patient or staff experience	

Summary of Report

Purpose

The Trust Risk Register (TRR) enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation. Following Risk Management Group on 1 November and 6 December 2023 the following changes were made to the Trust Risk Register.

Key issues to note

TRR updates:

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

For further details see enclosed Trust Risk Report and Trust Risk Register Summary.

DATIX Web

DATIX Web remains in view only mode. A proportion of risks have surpassed their review date as a result of staff being unable edit their risks due to the suspension of the risk module. Overdue risk reviews dates will be extended in DCIQ as part of the transition to the new system. This will provide a reasonable period during which owners can review their risks once DCIQ opens to staff.

In November, DATIX Web developed issues with the search function which has significantly affected the accurate reporting on risks and incidents. This has been raised with DATIX and a technical fix is awaited.

DATIX Cloud (DCIQ)

DCIQ remains unstable, causing slowness and buffering within the system. RL DATIX (supplier) initially advised a software update was scheduled for the end of October 2023 to resolve this. However, this did not taken place.

Following further discussion with RL Datix, the Trust had been advised that DCIQ will be moved to a new infrastructure, with the Trust system proposed to move in January 2024. There was no

fixed date provided by RL DATIX. The functionality issues on the DCIQ risk module will remain an issue longer term as RL DATIX do not intend to resolve these through essential product development.

The issues with DCIQ are a commercial matter and have been consistently escalated through the RL DATIX Project Manager, Account Manager and the Product Owner. These were also escalated to the Chief Digital Officer in the Trust who, along with the Head of Risk, H&S met with the DATIX Account Manager and Product Developer.

Nationally, the only requirement is for DCIQ is to be LFPSE (Learn From Patient Safety Events) compliant to enable patient safety incidents to be uploaded to the national database. NHSE are moving from the current National Reporting and Learning System (NRLS) as it is considered to be unstable, to LFPSE. NHSE are being kept informed of issues with RL Datix across multiple Trusts and these are discussed very visibly on the NHS Futures Platform. As a result, the original deadline of March 2023 for Trusts to move to LFPSE has been extended several times and is now 'as soon as possible' rather than a specific date. NHSE's involvement in pressuring RL DATX to improve functionality however is limited to the aspects that relate to LFPSE and so other issues relating to the instability and functionality of the risk module in DCIQ are not being taken forward by NHSE.

NHSE confirmed that DCIQ was compliant with LFPSE prior to our purchase of the product whilst at the time Datix Web was not. Although there were multiple products available on the market when DCIQ was purchased, a decision was made that the Trust should stay with our current provider RL Datix and, as a result, a review of the suitability of other providers was not explored before purchasing DCIQ.

At Risk Management Group (RMG) in December 2023, a decision was made to continue with the launch of the DCIQ risk and incident modules as, on balance, this was preferable to the risks associated with remaining on DATIX web and having the risk and incident modules on two different platforms; which would prevent critical interoperability between modules. It was also noted that other Trusts have gone live with manual work-arounds for the risk module, which while not ideal from a productivity and efficiency perspective, offer a route to Go-live.

In late December the Chief Digital Officer in the Trust and the Head of Risk, H&S agreed that the go-live date for the risk module on DCIQ would be the week beginning 15 January 2024. Divisions were required to confirm their local preferences for manual permissions on the system.

In preparation for go-live, the newly appointed DCIQ project manager will complete the following by 5 January 2024:

- Input manual permissions onto each risk in the risk modules (approx. 630 risks)
- Extend the review date of all overdue risks to ensure owners have a minimum of 4 weeks to review their risk in the new system (review dates that are already set beyond this timeframe will remain on their scheduled date)
- Cross-check that actions on each risk are accurate (as some may have been closed or updated in Web since the risk transfer date)
- Close any open actions related to risks on web. Owners will then only need to update risk actions on DCIQ rather than closing them out on both systems going forward

Revised Risk Management Framework

The new Risk Management Strategy has been finalised following consultation. The final documents have been be forwarded to Trust Policy Approval Group for publication when DATIX Cloud (DCIQ) comes online.

Water Safety Risk & Fire Safety Risk

GMS reported to RMG that a new Head of Compliance has been appointed to support GMS in compliance with all Healthcare Technical Memorandums (HTM). GMS reported that despite work to fill the prerequisites of the eight HTMs, it still remained a challenge to meet the requirements within the estates team. GMS highlighted a continued difficulty in providing reactive services and fulfilling proactive Planned Preventative Maintenance (PPM) Schedules across the Trust. HTM 05 Fire safety and HTM 04 Water systems were still a concern, although GMS reported they were confident that the risks had been reduced and the premises were safe for patient care.

Risks or Concerns	
See Trust Risk Register	
Financial Implications	
Approved by: Director of Finance / Director of Operational Finance	**Date:**
Recommendation	
The Board is asked to NOTE the report	
Enclosures	
Trust Risk Register Summary and RMG Trust Risk Report	

RISK MANAGEMENT GROUP

TRUST RISK REGISTER - DECEMBER 2023

1.0 RISKS PROPOSED FOR ESCALATION TO TRR

C4007POD / Cloud Ref 141
Risk Lead: AH
Executive Lead: CR

Inherent Risk
The risk that substantive non-medical staff are not fully compliant with their appraisal requirements and they receive a low-quality appraisal experience
Cause
• Appraisals are a mandatory requirement for all substantive non-medical staff and must be completed on an annual basis (with a new starter needing to have their appraisal 10 months into post). • A well conducted appraisal meeting should take anything from 45 minutes-2 hours to undertake and requires the input of both the appraiser (line manager/supervisor) and the appraisee (staff member). Additional time is needed by both parties to prepare for the appraisal, and complete the appraisal paperwork after the meeting. • The time and skills required to complete the appraisal process can mean that appraisals are delayed, not completed, and/or done in such a way which fulfils the administrative/compliance requirements whilst neglecting the aspects of the appraisal process which have the potential to bring benefits to the individual, team and patient care.
Impact & Effect
Effect: • Delayed or incomplete appraisals adversely impact one of the Trust's Key Performance Indicators, which is to achieve 90% appraisal compliance rate. • Appraisal experience is measured through the annual staff survey and results contribute to one of the People Promise element scores: "we are always learning". • Colleagues who do not receive a timely appraisal, and/or have a poor appraisal, may feel less valued and supported. There is increased risk they will not receive constructive feedback on their performance. They may not have access to training and development opportunities. Overall individual and team performance may suffer • The Trust is held to account by the Care Quality Commission on the delivery of appraisals and management of People key performance indicators, as these are indicators associated with the Safety and Well-Led domains.
Scoring
Workforce C3 x L4 = 12
Evidence of scoring
2 linked risks
Key Controls
• Monthly compliance reports distributed to leaders. • Regular appraisal skills training available to managers (online and face-to-face).

• Appraisal refresher content available on the intranet for managers to refresh their skills
Gaps in Controls
• Assurance that managers who do appraisals have completed requisite training. • Review of existing policy, processes and paperwork to ensure these are fit for purpose • Review of training effectiveness • Deep-dive into staff survey results to understand areas of best practice and poor experience, to identify and inform priorities
Actions
• Identification of barriers to a) staff having an appraisal; b) managers recording the appraisal and c) staff reporting a good quality appraisal experience • Update policy, processes and paperwork in light of stakeholder engagement • Review and relaunch appraisal training to meet the needs of managers and staff • Launch and rollout new policy, procedures, paperwork and training to support effective appraisals • Undertake full review of current policy, practice and paperwork to ensure the process is efficient and effective

D&S3834 / Cloud Ref 281
Risk Lead: MP
Executive Lead: CR

Note: Pharmacy leadership group revised the score in October 2023 in light of the upcoming Section 10 inspection in December. Staff sickness and a critical skills gap has previously been identified as having impacted on services, leading to standards and wait times well below what is expected. Identified as an intolerable risk in March 2023.

Inherent Risk
The risk of not being able to provide a pharmacy manufacturing service and losing MHRA Specials License due to staff shortage
Cause
• Insufficient staff in key areas e.g., Manufacturing, pre-packing, nutrition team, radiopharmacy, QA combined with an increasing workload e.g. in the wake of the successful oncology business case approx. 3 years ago. • Increasing complexity of both workload and regulatory requirements. • Imminent retirement of some key staff
Impact & Effect
Staff shortages lead to compromises on: • quality of training, • maintaining quality standards, • maintaining competencies, • ability to drive forward improvements • sustainability of some specialist services e.g. Intrathecal.

• inappropriate staff undertaking tasks e.g. highly qualified staff undertaking portering duties • Current staff overworked This leads to: • Increase risk rating on inspection by Regional Quality Assurance • A greater demand on service than can be provided safely and longer waiting times • Patients having to travel to different centres for treatment • Procedures cancelled • Low morale of staff, poor mental and physical health of staff • Staff (especially management) accruing excessive TOIL and unable to claim back in a timely fashion • The risk of staff leaving and being unable to recruit • The risk of increased sickness
Scoring
Workforce C4 x L4 = 16, Quality C3 x L3 = 9, Safety C3 x L3 = 9
Evidence of scoring
No linked records
Key Controls
• VPCs for Pharmacy manufacturing have now been agreed and signed off • Careful management of rotas • Paid & unpaid overtime & TOIL • Appropriate prioritisation of tasks • Annual stress risk assessment • Working to improve staff engagement
Gaps in Controls
• More staff to release management time for quality management and driving improvements forward • Move prepacking to same site as manufacturing (i.e., CGH) to mitigate the risk by making better use of staffing • Inadequate Contingency arrangements • Capacity plan needs to be improved to reflect impact of staff absences & vacancies
Actions
• Active recruitment of new staff against the approved VCPs • Implementation of a funded Quality Management System

2.0 RISKS WITH AGREED TRR SCORE FOR HOLDING AT DIVISIONAL LEVEL

None

3.0 DOWNGRADE OF TRR RISK TO DIVISIONAL / SPECIALTY RISK REGISTER

None

4.0 PROPOSED CLOSURE OF RISKS ON TRR

None

5.0 OVERDUE REVIEWS OF TRR RISK

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

6.0 OVERDUE ACTIONS ON TRR RISKS

Actions can still be viewed and updated in DATIX web. Actions can be accessed in several ways:

1. Accessing your personal 'to-do' list on datix web
2. Search for any action within the action module assigned to you or a specific person
3. Searching via the speciality or division
4. Searching overdue actions and filtering as required
5. Searching using a key word

The following actions are associated with risks on the TRR and are overdue.

Risk action linked to:	Action Owner	Action Description	Due Date
M2815Stroke	KHr	Enhanced training for ED staff (nurses and doctors) re the stroke pathway and timelines to work to	27/11/23
	KHr	To work with ICB to improve patient awareness of stroke services not going to GRH	30/11/23
	AR	Stroke awareness training of ED triage nurses	20/11/23
	DC	Reducing ED pressures to allow staff to work safely and prioritise patients appropriately	20/11/23
M2613Card	IQ	Ensure catheter labs open in December	30/11/23
C3941EFD	DP	Purchase of water safety system	30/11/23
	KH	Complete evaluation of waterless bathing trial	30/11/23
	DP	Review water tanks	30/11/23
	AO	Review of birthing pool	30/11/23
	DP	Agree and implement solutions for water temperature control D block	30/11/23
S3968Oph	CB	GIRT actions	30/11/23

D&S2404CHaem	AJ	Bespoke recruitment incentive	04/10/23
C3876EOL	JS	Solution for the digital storage and completion of national documents for application for CHC funding	28/11/23
	SW	Monthly rapid discharge home to die meeting established	31/10/23
	SW	Job description review	30/09/23
S3481Th	MK	2nd Obstetric theatre paper Gateway to TLT by 18 April	07/11/23
S3337	TH	1–3-year strategy plan for SAU and 5th floor	30/11/23
C3898POD	RG	Establish responsibilities and method of joint working between stakeholders in the contract	30/11/23
IT3755Cyber	TT	weekly Cyber risk review	21/11/23
D&S3743CHaem	AJ	Bespoke recruitment incentive	09/11/23

Appendix A Trust Risk Register

Risk Ref	Risk Description	Risk Category	Sub Category	Previous score	Current Score (Date changed to current score)	Risk Score Change (Since last reporting period)	Target Score	Review Date
WC3845 Obs	Risk of first trimester screening offer being missed (if dating scan occurs after 14+1 weeks gestational window for screening), affecting patient pregnancy options and care pathway.	Quality	Recruitment & retention	**8**	**16** **(June 2022)**	⇔	6	29.2.24
D&S2404 Haem	Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of medical capacity and increased workload.	Workforce	Recruitment & retention	**9**	**16** **(Aug 2021)**	⇔	6	29.2.24
C1437 POD	The risk of being unable to recruit and retain sufficient suitably qualified clinical staff including Medical & Dental, Registered Nurses & Midwives and Allied Health Professionals, thereby impacting on the delivery of the Trust's strategic objectives.	Workforce	Recruitment & retention	**8**	**20** **(June 2022)**	⇔	12	29.2.24
S2976 BIMA	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	Quality	Recruitment & retention	**15**	**16** **(Nov 21)**	⇔	4	29.2.24
S3968 Oph	Risk of a delay to follow-up appointments leading to significant reduction of vision due to insufficient resources to correctly prioritise patients on the waiting list.	Safety	Staffing & Competency	**9**	**12** **(June 2023)**	⇔	6	29.2.24
C3963	Risk of increased harm, breach in regulations, distress and poor-quality experience to patients, staff and visitors when boarding patients in wards.	Quality	High patient demand	**15**	**15**	⇔	4	29.2.24

Appendix A Trust Risk Register

C3941 EFD	The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal hospitals	Statutory	Breach of legislation	**15**	**12** **(Feb 2023)**	⇔	2	29.2.24
C3930 EFD	The risk of fires caused by lithium battery chargers affecting the safety of all users, but particularly affecting ward environments. Risk of statutory breach of duty leading to enforcement notices from Fire Service/HSE/CQC	Safety	Estates	**10**	**15** **(Jan 2023)**	⇔	5	29.2.24
C3876 EOL	The risk of reduced quality of care for dying patients due being unable to discharge to a place of their choice and dying within hospital.	Quality	Integrated Care Board	**16**	**16**	⇔	2	29.2.24
C3767 COO	The risk of harm to patients and staff due to being unable to discharge patients from the Trust.	Quality	Integrated Care Board	**16**	**16**	⇔	6	29.2.24
D&S3743 Haem	The risk of failing to deliver the necessary support to the Laboratory due to insufficient staffing levels and lack of appropriate skill sets, leading to a delay to diagnosis or treatment within the clinical service and harm to the patient.	Quality	Recruitment & retention	**12**	**15** **(Feb 2022)**	⇔	4	29.2.24
M3682 Emer	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Statutory	Integrated Care Board	**15**	**16** **(April 2022)**	⇔	6	29.2.24
WC3536 Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Workforce	Recruitment & retention	**15**	**20** **(July 2022)**	⇔	6	29.2.24
S3481 Obs	The risk of severe harm to patients requiring emergency obstetric surgery caused by an inability to meet a minimum staffing requirement when opening a second obstetric theatre. The risk of harm to the wellbeing of staff when working outside minimum staffing requirements.	Workforce	Staffing & competency	**9**	**16** **(Dec 2022)**	⇔	4	29.2.24

Appendix A Trust Risk Register

S3337	The risk to quality of continued poor patient experience on SAU for patients requiring admission to a ward	Quality	Integrated Care Board	**15**	**16** **(Dec 2022)**		10	29.2.24
D&S3103 Path	The risk of total shutdown of the Clinical Chemistry Pathology laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Statutory	Breach of legislation	**12**	**16** **(May 2021)**		4	29.2.24
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Quality	Digital risk	**20**	**15** **(Dec 2019)**		6	29.2.24
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability) and reduced patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	Workforce	Recruitment & retention	**15**	**20** **(May 2022)**		9	29.2.24
F2895	There is a risk the Integrated Care Board (ICS)/ Trust has insufficient capital due to the Capital departmental expenditure limit (CDEL) and/or is unable to secure additional borrowing to address critical digital, estate or equipment risks and/or deliver key strategic schemes, resulting in interruption in clinical services impacting on patient care and outcomes and overall, Trust performance.	Environment	Breach of legislation	**8**	**16** **(April 2023)**		6	29.2.24
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in a failure to recognise, plan and deliver appropriate urgent care needs.	Safety	Delayed diagnosis and treatment	**8**	**12** **(Aug 2019)**		6	29.2.24

Appendix A Trust Risk Register

M2815 Stroke	The risk to patient safety due to delays in the acute stroke pathway for patients attending Gloucestershire Royal Hospital (GRH) Emergency Department.	Safety	Delayed diagnosis and treatment	**16**	**12** **(March 2023)**		6	29.2.24
C2803 POD	The risk that staff morale, productivity and team cohesion are eroded by adverse workplace experiences and/or significant external events, which in turn adversely impacts patient safety, job satisfaction, colleague wellbeing, and staff retention.	Workforce	Equality, Diversity and Inclusion	**4**	**16** **(July 2022)**		6	29.2.24
C2669 N	The risk of harm to patients as a result of inpatient falls	Safety	Clinical Assessment	**15**	**12** **(April 2018)**		6	29.2.24
C2667 IC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C. difficile infection.	Safety	Infection Control	**16**	**12** **(Aug 2020)**		6	29.2.24
M2613 Card	The risk to patient safety as a result of laboratory failure due to ageing imaging equipment within the Cardiac Laboratories.	Safety	Equipment	**16**	**12** **(Feb 2020)**		4	29.2.24
D&S25 17 Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Quality	Facilities	**8**	**10** **(Oct 2022)**		4	29.2.24
S2424T h	The risk to business interruption in theatres due to the failure of the ventilation to meet the statutory required number of air changes.	Business	Facilities	**4**	**16** **(May 2020)**		6	29.2.24
M2268 Emer	The risk of patient deterioration, harm and poor patient experience when care is provided in the corridor during times of overcrowding in ED	Statutory	Integrated Care Board	**16**	**16**		4	29.2.24

Appendix A Trust Risk Register

C1945 TV	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	Safety	Infection Control	**9**	**12** **(Feb 2021)**		6	29.2.24
C1850 N Safe	The risk of ineffective care, prolonged stay and harm of a child or young person (12-18yrs) with significant emotional dysregulation or mental health needs at Children's Inpatients Gloucestershire Royal Hospital. This risk of harm to other patients, staff and visitors caused by abusive or violent behaviour of a child or young person whilst on the ward.	Safety	Abuse and Violence	**9**	**12** **(Oct 2019)**		4	29.2.24
C3826 POD	Risk of delays in managing formal employee relations cases due to limited investigating officer capacity resulting in poor staff experience, poor quality investigations and increased employment tribunals.	Workforce	Staffing and competency	**12**	**9** **(June 2022)**		2	29.2.24
C3898 PO	The risk of delayed arrivals, poor candidate experience and withdrawals of overseas nurses due to a lack of available Trust accommodation.	Workforce	Recruitment and retention	**12**	**16** **(Nov 2022)**		4	29.2.24
IT3755 Cyber	The risk of significant disruption to service delivery, patient safety and financial position in the event of a successful cyber attack	Business	Digital Risk	**20**	**12** **(July 2023)**		4	29.2.24
C4007 POD	The risk that substantive non-medical staff are not fully compliant with their appraisal requirements and they receive a low-quality appraisal experience	Workforce	Staffing and competency	**16**	**12** **(Nov 203)**		8	29.2.24
D&S3834	The risk of not being able to provide a pharmacy manufacturing service and losing MHRA Specials License due to staff shortage	Workforce	Staffing and competency	**12**	**16** **(Oct 23)**		3	29.2.24

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 29 November 2023		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Water safety report **Could be amber/red**	Numerous actions remain open (red) on action plan and several rated green have only partial evidence to support. Known capacity issues and risks being mitigated? to what extent and with what impact on other areas. Executive reporting that water safety group well chaired, holding to account and several meetings lined up.	Committee need to see evidence of achievement of outstanding areas to be actioned and assurance of mitigations to risks of capacity issues.
Maternity report	Comprehensive suite of data and performance metrics showing a challenged and pressurised service, although an improvement in the perinatal vacancy rate was noted. Maternity Incentive Scheme (MIS) progress noted and residual risks to compliance. Results of CQC unannounced inspection in April confirms as inadequate and a further section 29A report issued.	MIS scheme to be presented to January extraordinary committee prior to Board sign off in January. Regular reporting to continue into Committee ensuing key areas of concern are highlighted within the reporting.
Quality and Performance	Incident reporting – Trust seems to have lower % for reporting patient safety concerns when compared to others, also levels of overdue action plans for serious incidents noted. A concern and an area of executive focus.	Evidence needed to committee of plans to improve reporting and cultural environment, linked with Trust plan to introduce the national patient safety strategy and ensure links to existing cultural work and F2SU. New executive led safety huddles now in place.
	Fractured Neck of femur – detailed briefing on current position and improvement work. Divisional leadership presented and gave assurance that the issues were known and being worked on, with some improvement in latest reporting.	Further update to committee bi-monthly until stable.
	Discharges- Newton work on discharges noted involving both ‘simple’ and complex discharges.	Deep dive into Discharges requested by committee (linked to winter plan actions)
	Gynae-Oncology update – progress noted with improvement plan and reassurance that divisional leadership was into the detail and working with the speciality team. Review of patients and any impact	Committee to receive further briefing on gynae-oncology and any wider tumour site work.

	underway. Question of other tumour site processes in place is being reviewed.	
	Wider cancer and planned care performance noted with challenges in key areas of urology, colorectal and head and neck respectively.	Deep dive into head and neck improvement plan to come to committee.
	'Results Reporting and Acknowledgement' findings within radiology briefed as high executive safety priority	Exception reporting through Quality Delivery Group to Committee.
Winter Plan	Detailed account of winter resilience plan presented to committee. Outstanding query on accurateness of bed deficit plan to be resolved prior to Board. Consideration to be given on what assurance committee can receive on actions which are in the gift of the Trust to resolve	Further iteration of the plan to go to Board and executive to review what comes to committee for ongoing assurance.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Regulatory Update	The process/ system of receiving updates on all regulatory activity is positive. Questions and challenge on specific aspects undertaken.	
Items not Rated		
System feedback – system wide update on falls prevention work will be welcomed.		
Impact on Board Assurance Framework (BAF)		
Board Assurance Framework strategic risks SR1, 2, 5 and 6 - Discussion and current updated given by respective executive leads.		

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period October 2023

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

URGENT & EMERGENCY CARE
ED was particularly busy in October. Volume of attendances increased by 2.5% compared with September and were running just over 4% higher than the average run-rate for the year-to-date. This higher level of footfall in the department has undoubtedly had a negative impact on performance with both four-hour performance having deteriorated to 57.1% in October (from 58.5% in September) and twelve-hour performance having deteriorated to 85.6% (from 86.8% in September). This has also manifested itself in an increase in ambulance handover times during the course of the month – although we believe that this data [from SWAST] may be over-stating the extent of these delays. This latter point will be largely addressed when the X-CAD system is implemented – hopefully prior to the end of November.

SDEC attendances have fallen – very marginally – by 3.7% in October (compared with September). Nonetheless, this represents a level of activity which is just over 9% higher than the current monthly average. Of those referred into SDEC in October, a third of these came into the department via ED. Only 9% of those coming through SDEC ended up being admitted to the hospital.

ELECTIVE CARE
The October data is still undergoing validation prior to submission on 17 November, but based on current figures can confirm that the 78 week standard will not be met. The final position is anticipated to be around 22 breaches which is slightly higher than Septembers submission. These relate to ENT (14), Oral Surgery (6), Cardiology (1) and Neurology (1). A handful of these patients are categorised as P6 meaning they have chosen to delay treatment during part of their pathway. The part-validated RTT position demonstrates an improvement, with performance moving from 64.8% in September to around 65.5% in October. The number of 52 week breaches is anticipated to remain similar to the previous month with an estimate of just under 3,000, however those waiting over 65 weeks has slightly increased (710 in September to around 775 in October). With 3 days of Industrial Action at the start of October this is a relatively stable position, partly mitigated by ENT Glanso clinics.
Based on current bookings, the November position is expected to be similar to October.

DIAGNOSTICS
DM01 performance for October has been validated and the breach performance is confirmed as 15.74%. This is an improvement on last months position of 17.86%. The number of breaches having reduced in most modalities, with a total reduction of 140 in month – the 2 modalities with a breach rate in excess of 50% remain Colonoscopy and Flexi sigmoidoscopy. Slight improvements have been noted in Neurophysiology.

CANCER
Unvalidated Oct-23 performance shows overall delivery of 3 against the 10 national operational standards. The Trust WILL NOT meet the 2WW Standard with performance of 74.8% in Oct. This has been due to staffing issues and capacity with the Breast service. A recovery plan is being generated with additional support provided The Trust CONTINUED TO MEET 28d FDS standard in Oct with a performance of 75.4% and continues to be one of the highest performing Trusts in the SW ICS against the FDS standard. The Trust DID NOT meet the 31d FDT standard in Oct with data showing performance of 86.2%. The Trust DID NOT meet the 62d Standard at 59.4% with 83 breaches for 204.5 treatments. 19.5 of the patients treated were historic patients. The Trust back-log has seen a slight increase with an end of Oct reportable position of 209; Of the GHFT backlog, Colorectal and Urology due to complex pathways and diagnostic capacity. Industrial impact is continuing to have an impact on performance and patients' pathways and this is being monitored and recorded for understanding and analysis

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

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23	Oct-23
All electives (including day cases)	6,197	6,237	5,099	5,933	5,785	6,558	5,086	6,174	6,179	5,896	6,293	5,834	6,239
Day cases	5,179	5,318	4,286	5,133	4,938	5,655	4,347	5,277	5,269	5,008	5,432	5,002	5,134
ED attendances	12,630	12,290	12,726	10,947	10,706	12,511	11,616	12,993	13,176	12,764	12,300	12,813	13,111
FUP outpatient attendances	35,637	38,349	30,805	37,384	33,596	38,507	30,822	34,946	36,689	34,744	35,282	34,691	37,266
GP referrals	10,825	10,742	8,565	10,487	9,771	11,923	9,355	10,646	11,183	10,491	10,761	10,462	11,205
New outpatient attendances	16,991	19,245	15,099	18,394	16,976	18,869	14,916	17,277	18,320	17,677	17,505	17,808	19,255
Non elective (Incl. Assessment)	5,657	5,663	5,284	5,269	5,033	5,725	5,316	5,608	5,703	5,389	5,278	5,547	5,862
Outpatient attendances	52,628	57,594	45,904	55,778	50,572	57,376	45,738	52,223	55,009	52,421	52,787	52,499	56,521

Guidance

Gloucestershire Hospitals NHS Foundation Trust

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

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Cancer	Cancer - 2 week wait breast symptomatic referrals	≥ 93.0%	?	Oct-23	20.7%	L
	Cancer - 28 day FDS (all routes)	≥ 75.0%	?	Oct-23	75.1%	
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%	?	Oct-23	85.3%	L
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%	P	Oct-23	100.0%	
	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	≥ 94.0%	?	Oct-23	97.0%	
	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	≥ 94.0%	?	Oct-23	74.2%	L
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%	?	Oct-23	61.8%	L
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%	?	Oct-23	74.3%	
	Cancer - 62 day referral to treatment (urgent GP referral)	≥ 85.0%	F	Oct-23	60.3%	L
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%	?	Oct-23	78.6%	L
	Number of patients waiting over 104 days with a TCI date	No Target		Oct-23	9	
	Number of patients waiting over 104 days without a TCI date	No Target		Oct-23	39	L
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%	F	Oct-23	15.74%	
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600	F	Oct-23	912	L
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%	F	Oct-23	94.3%	H
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%	F	Oct-23	20.38%	
	% of ambulance handovers < 15 minutes	No Target		Oct-23	8.19%	L
	% of ambulance handovers < 30 minutes	No Target		Oct-23	24.73%	
	% of ambulance handovers over 60 minutes	≤ 1.00%	F	Oct-23	56.03%	
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%	F	Oct-23	43.5%	H
Emergency Department	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%	F	Oct-23	33.4%	H
	ED: % total time in department - under 4 hours (type 1)	≥ 95.00%	F	Oct-23	56.95%	
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0	F	Oct-23	917	
	Number of ambulance handovers 30-60 minutes	↓ Lower		Oct-23	590	
	Number of ambulance handovers over 60 minutes	= 0	F	Oct-23	1,622	
Maternity	% of women booked by 12 weeks gestation	> 90.0%	?	Oct-23	89.8%	
Operational Efficiency	% day cases of all electives	> 80.00%	?	Oct-23	82.29%	
	Average length of stay (spell)	≤ 5.06	F	Oct-23	9.93	H
	Cancelled operations re-admitted within 28 days	No Target		Oct-23	50.00%	L
	Intra-session theatre utilisation rate	> 85.00%	?	Oct-23	91.57%	H
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40	P	Oct-23	3.06	H
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65	F	Oct-23	11.78	H
	Number of patients stable for discharge	≤ 70	F	Oct-23	198	L
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380	F	Oct-23	759	H
	Urgent cancelled operations	↓ Lower		Oct-23	0	L
Outpatient	Did not attend (DNA) rates	≤ 7.60%	P	Oct-23	6.12%	L
	Outpatient new to follow up ratio's	≤ 1.90	?	Oct-23	1.85	L
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%	?	Sept-23	8.59%	
Research	Research accruals	No Target		Feb-23	141	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower	F	Oct-23	311	L

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No Target		Oct-23	10,163	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target		Oct-23	5,335	
	Referral to treatment ongoing pathways over 52 weeks (number)	= 0		Oct-23	2,989	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%		Oct-23	66.24%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	No Target		Oct-23	59.40%	
	% patients receiving a swallow screen within 4 hours of arrival	No Target		Oct-23	77.40%	
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target		Oct-23	61.2%	
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%		Sept-23	100.0%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	≥ 65.00%		Oct-23	100.00%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%		Oct-23	100.0%	

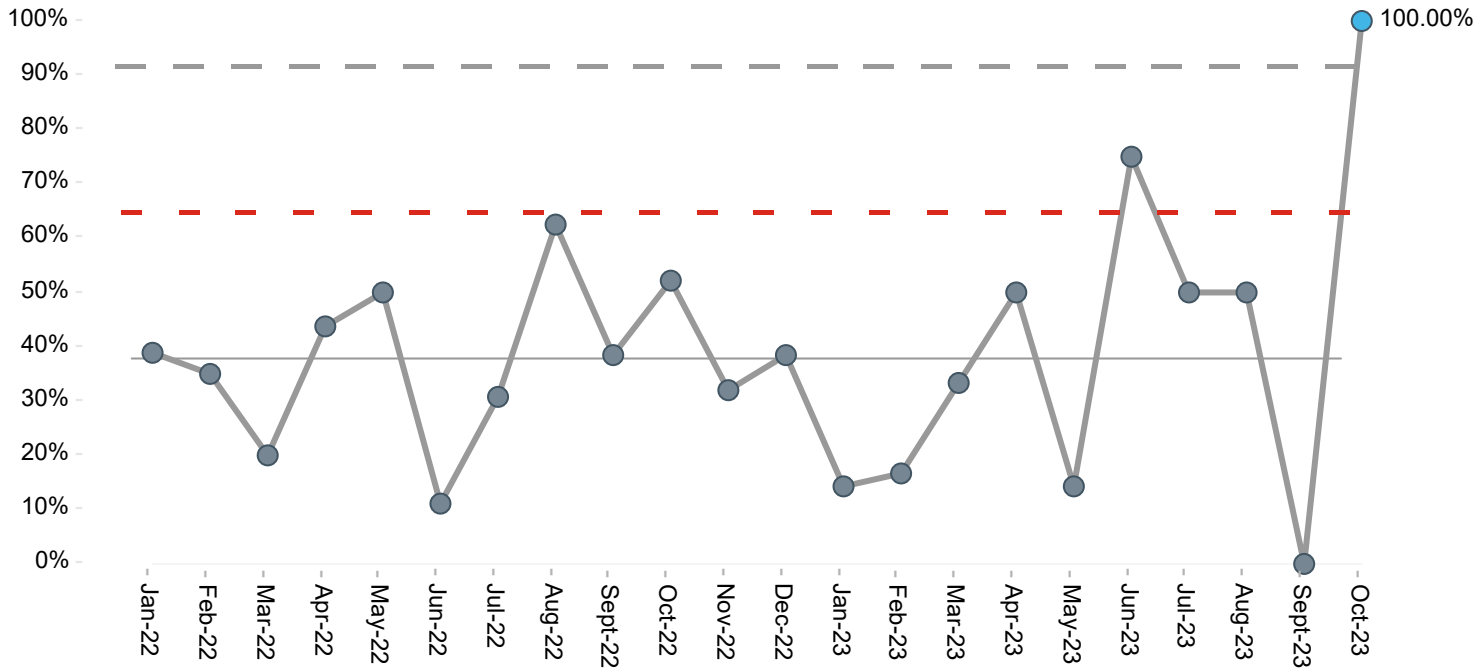
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[471] % fractured neck of femur patients meeting best practice criteria

Target: ≥ 65.00%



Data Observations

[1] SINGLE POINT

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

Commentary

Best practice tariff achievement for #NOFs remains low. The service is taking improvements such as the additional funded Physician Associate role on 3A to provide further orthogeriatric care. Furthermore, there remains a high proportion of #NOFs being admitted to alternative wards than 3A, which with the expansion of the trauma bed base in November 2023 will assist with ensuring patients are on the right ward receiving the right care. The service is also investigating how capital works could be completed on 3B in order to create a #NOF receiving bay, a quote has been recieved for submission to create 4 additional beds on the 3rd floor. The provision of orthogeriatric consultant cover continues to be a problem for patients which will require a business case for future investment to deliver BPT

General Manager – Trauma & Orthopaedics

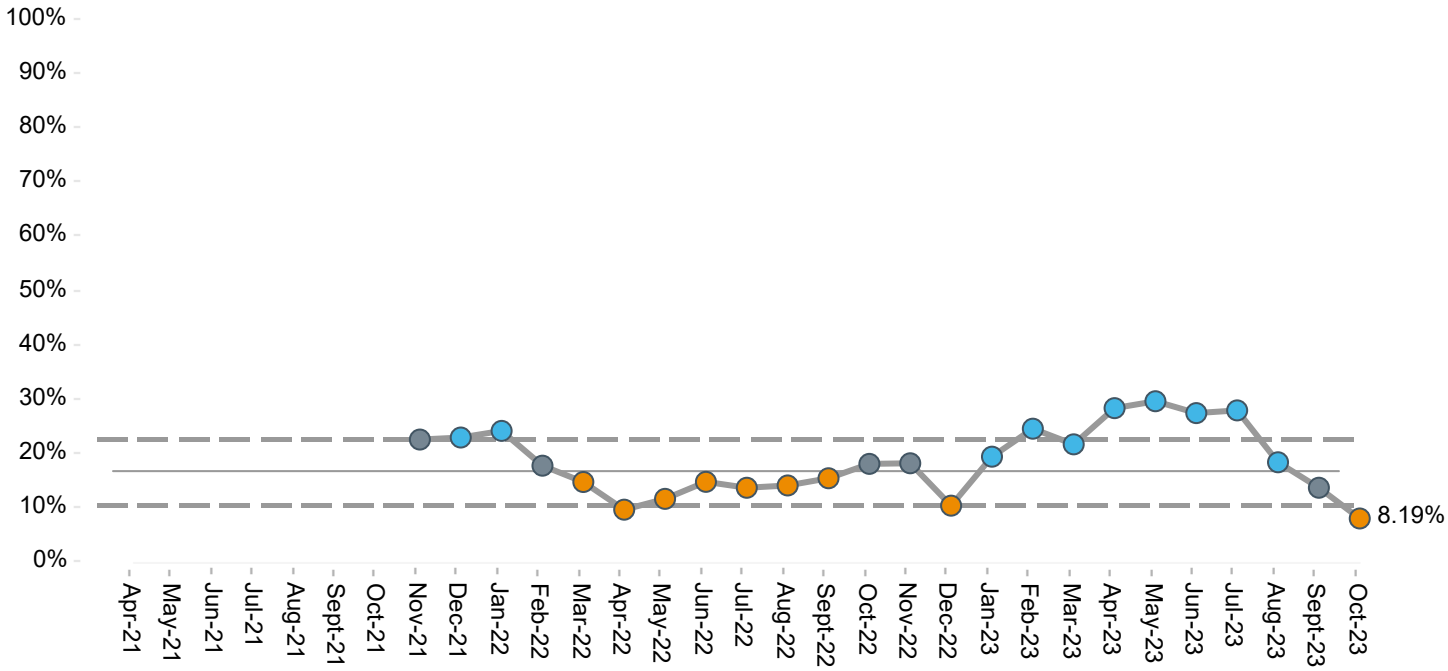
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[594] % of ambulance handovers < 15 minutes

- - - Target: No Target



Data Observations

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[2] SHIFT

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

Commentary

Proportion of ambulance handovers below 15 minutes in the month is low, and this is also reflected in an inflated total ambulance hours lost to handovers.

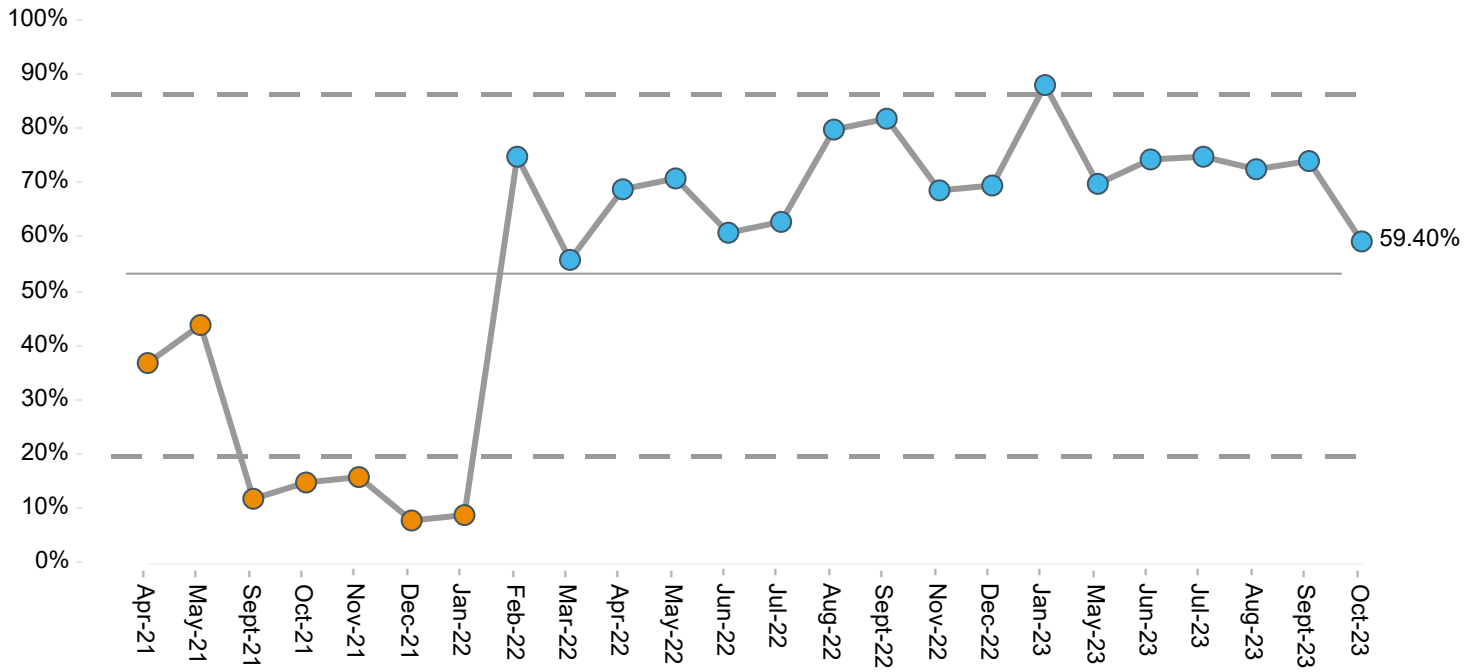
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



Data Observations

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[4] 2 OF 3

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

Commentary

Low admissions to CGH during October and walk-ins/atypical presentations went to GRH
General Manager - COTE, Neuro and Stroke

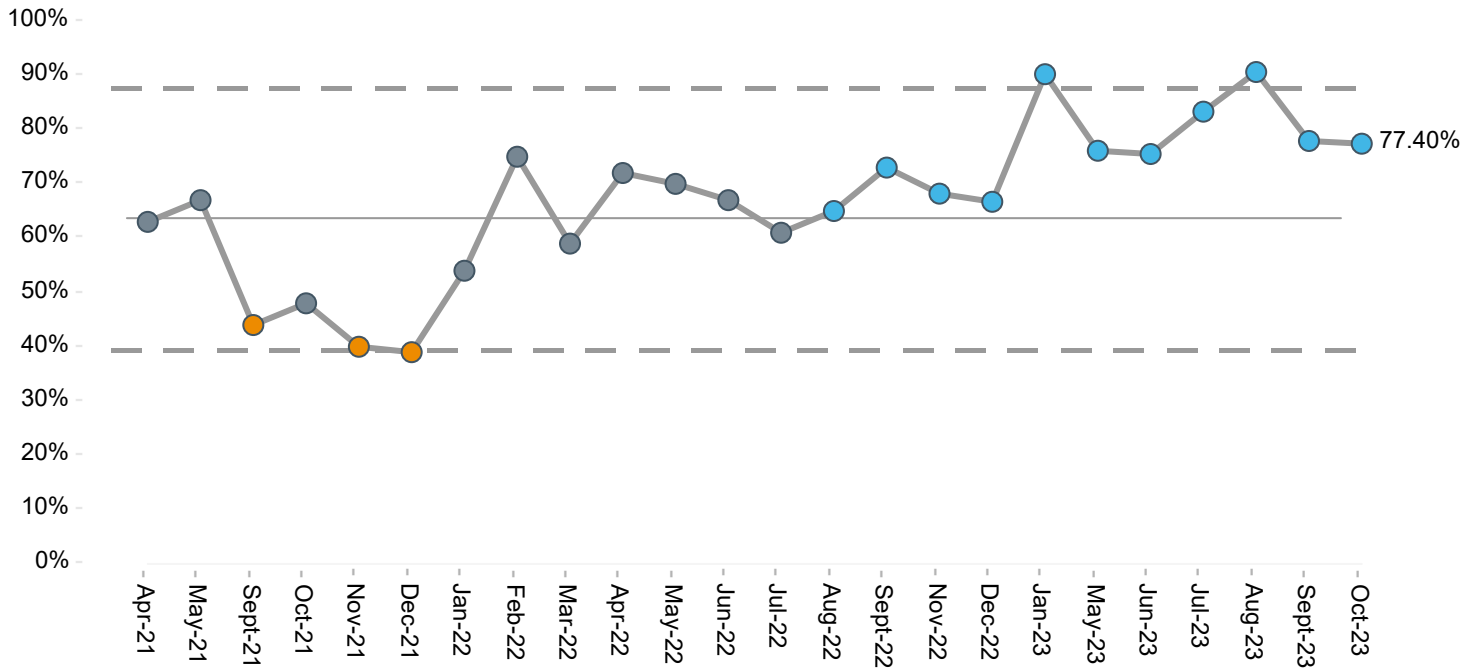
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



Data Observations

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Commentary

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

General Manager - COTE, Neuro and Stroke

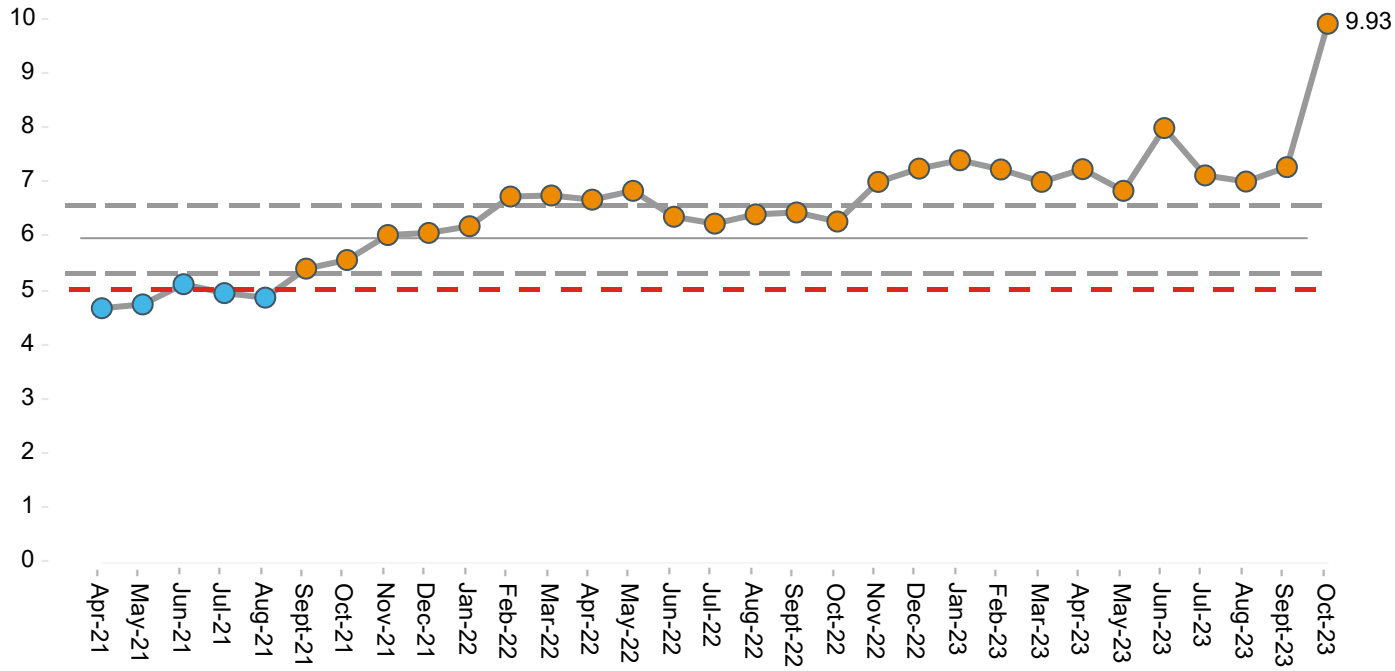
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[188] Average length of stay (spell)

Target: ≤ 5.06



Commentary

Significant increase in month average LOS directly related to reduction in complex discharges and increased long length of stay 21+ day nCTR patients. SBAR+ process initiated to drive flow across system pathways.

Deputy Chief Operating Officer

Data Observations

[1] SINGLE POINT

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[2] SHIFT

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

[3] RUN

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

[4] 2 OF 3

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

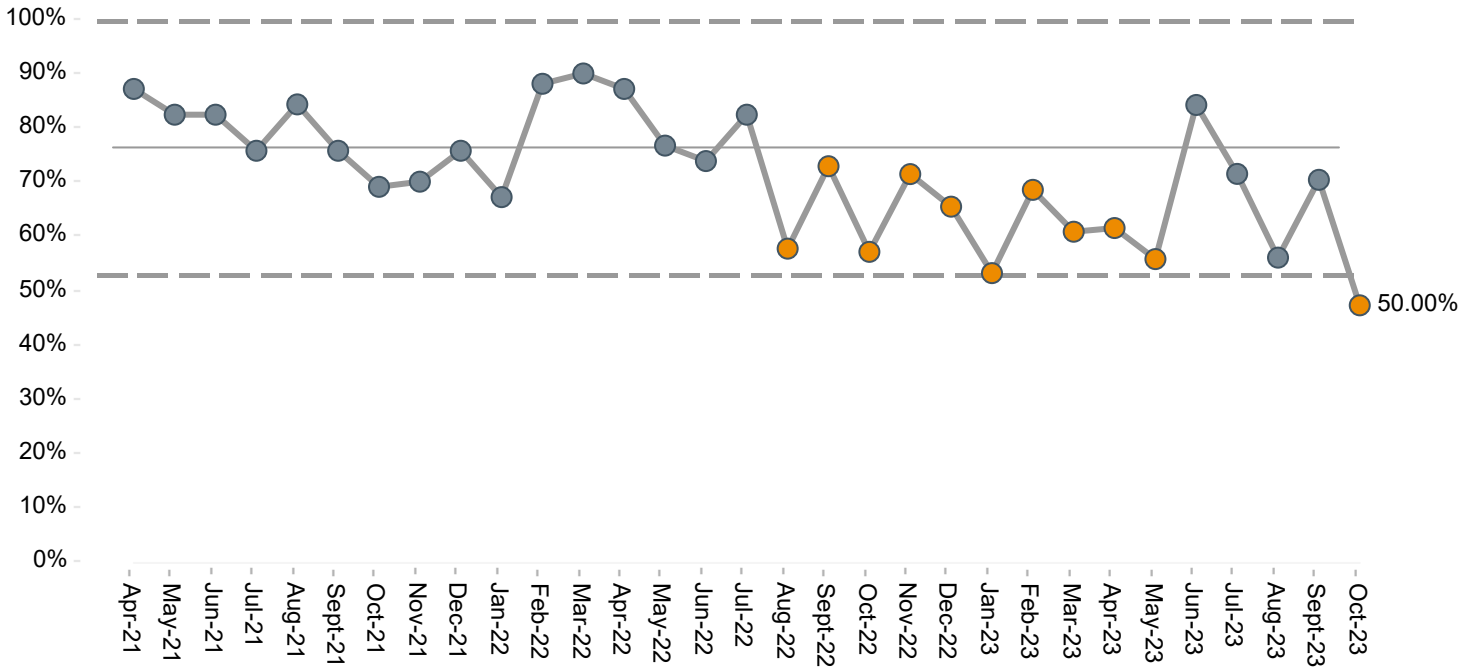
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[180] Cancelled operations re-admitted within 28 days

- - - Target: No Target



Commentary

In September there were a total of 26 patients cancelled on the day that could not be rescheduled within 28 days, which is an increase on the previous month. The two main contributing specialties being Ophthalmology and T&O which accounted for 21 breaches between them. Ophthalmology had an equipment failure which accounted for most, and T&O cancelled for urgent cases with no ability to reschedule within 28 days.

Associate Director of Elective Care

Data Observations

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[2] SHIFT

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[4] 2 OF 3

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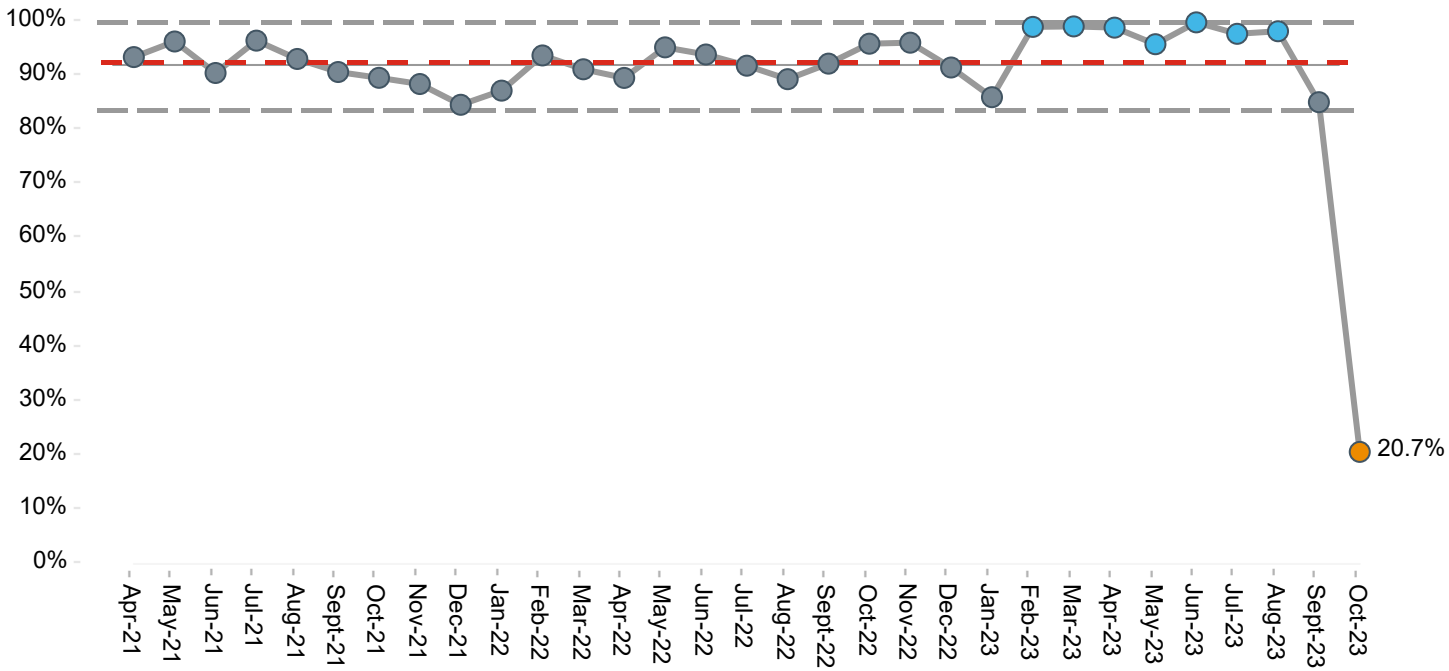
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[170] Cancer - 2 week wait breast symptomatic referrals

- - - Target: ≥ 93.0%



Data Observations

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[4] 2 OF 3

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

Commentary

Unvalidated Oct performance of 20.7% - Decline in performance due to staffing issues within Breast Service. Recovery plan for Breast has been generated and supported by ICB

Divisional Director of Operations

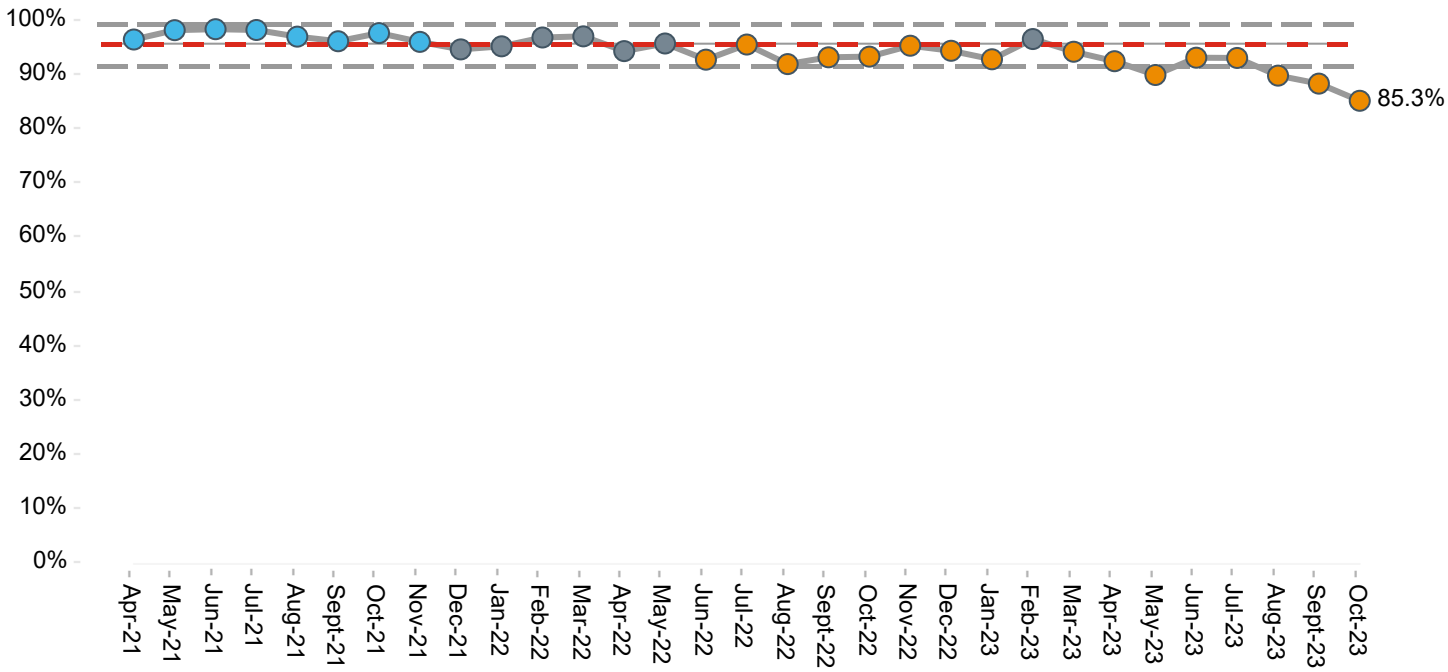
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 96.0%



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[4] 2 OF 3

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

Commentary

Unvalidated Sept performance of 86.2% with 40 out of 289 patients breaching. An analysis is underway of each breach to look at themes which caused delay, and actions plans to be created with specialties to mitigate this and increase performance. While Cancer capacity was continued where possible, recent IA has had an impact on planning treatments

Divisional Director of Operations

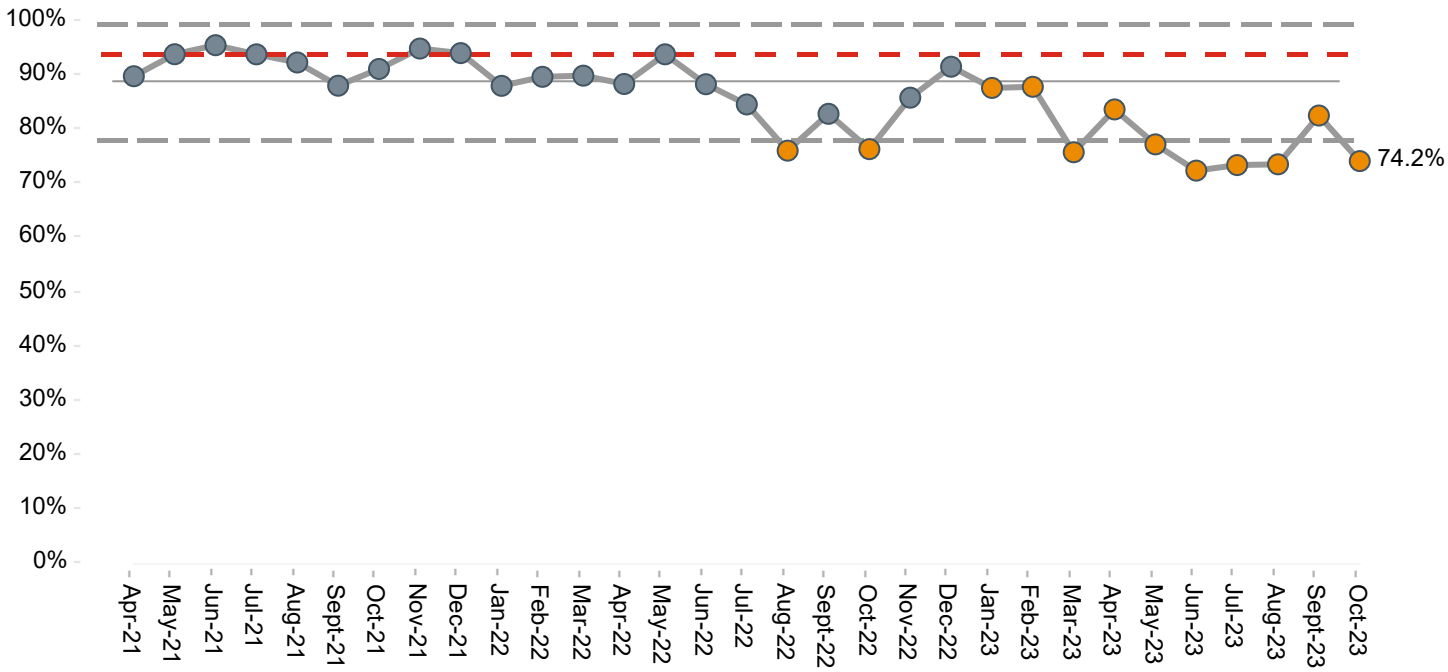
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 94.0%



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[2] SHIFT

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Commentary

Unvalidated performance of 73.9%. While Cancer capacity was continued where possible, recent IA has had an impact on planning surgical treatments

Divisional Director of Operations

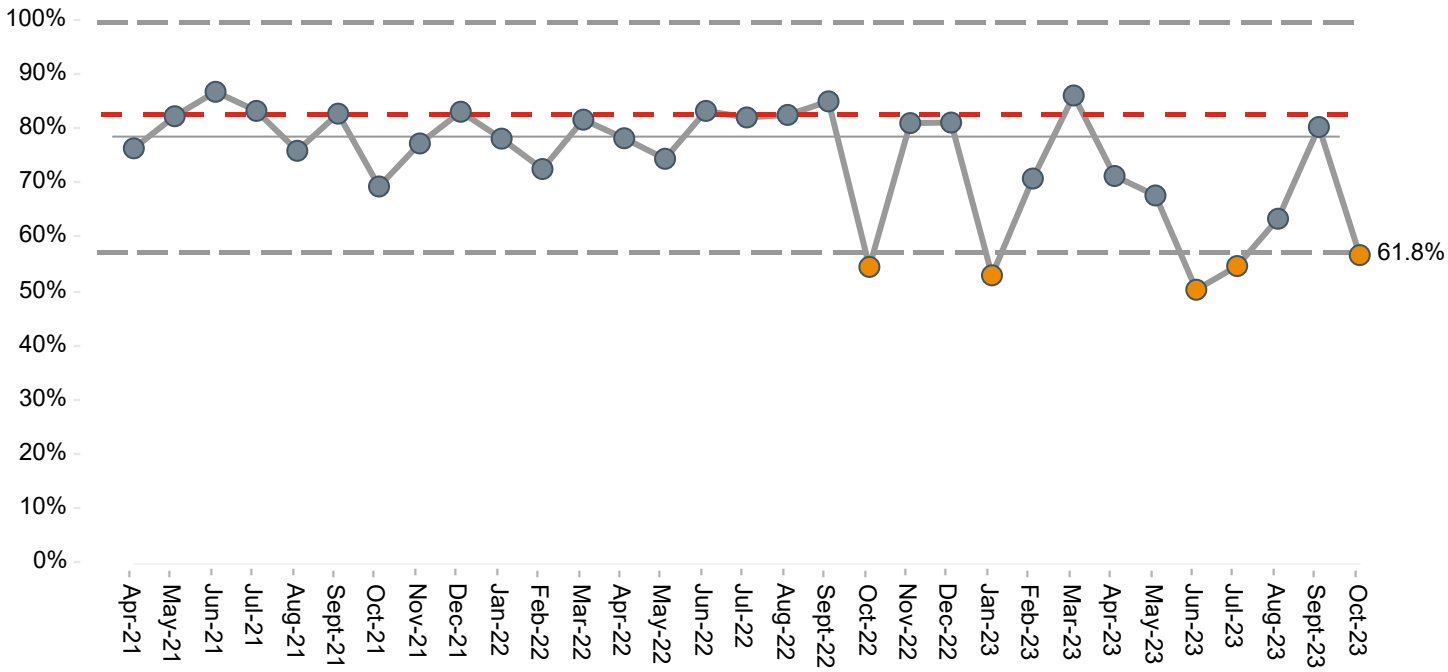
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 90.0%



Data Observations

[1] SINGLE POINT

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Commentary

Unvalidated Oct performance of 63.3% with 5.5 out of 15 patients breaching 62 days. Concerns raised in local performance meetings on delays with referrals into the system and cancer services to review data and issues raised

Divisional Director of Operations

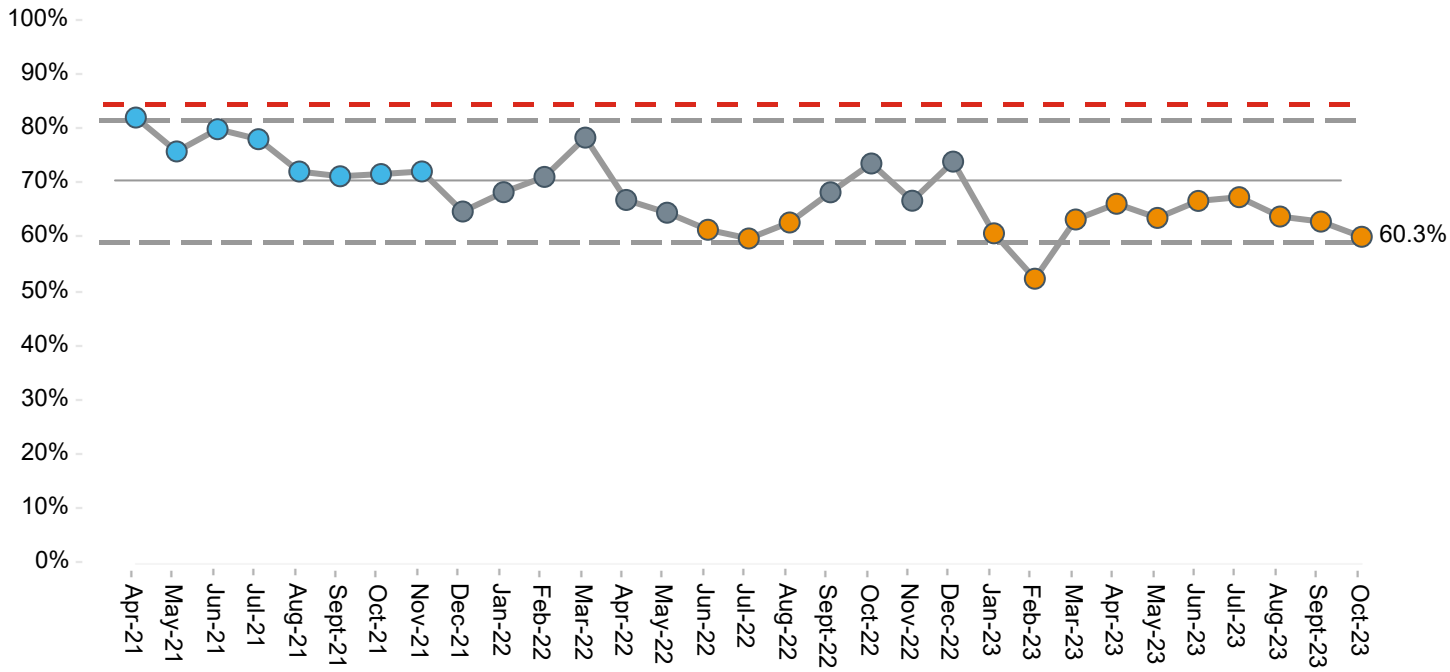
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 85.0%



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[4] 2 OF 3

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

Commentary

Unvalidated Oct position of 59.4% with 83 breaches for 204.5 treatments. 19.5 of the treatments were for patients waiting over 104 days. patients. Daily validation of future 62-day breaches is now firmly in place within Cancer Services and mitigating impact of industrial Action where possible

Divisional Director of Operations

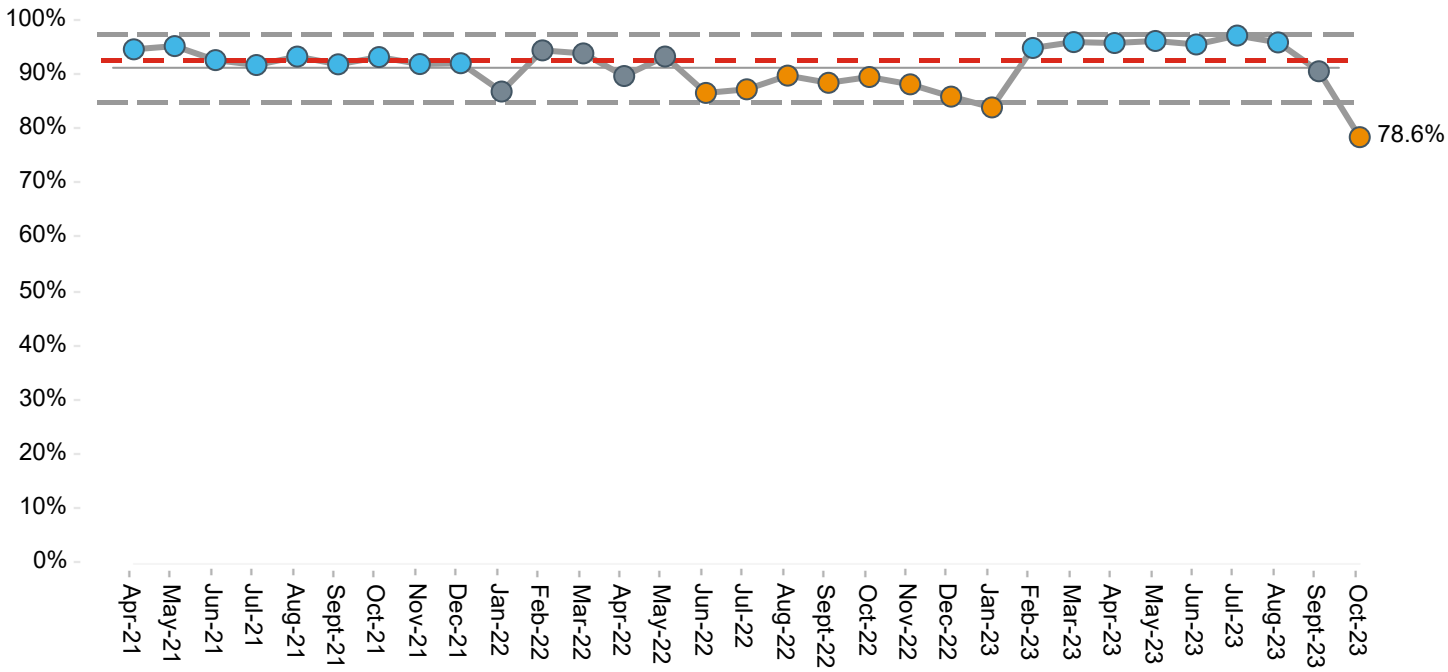
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 93.0%



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[4] 2 OF 3

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

Commentary

October has seen a decline in 2WW Performance, achieving 74.8% in Oct. This has been due to staffing issues and capacity within the Breast service. A recovery plan has been agreed with additional support provided

Divisional Director of Operations

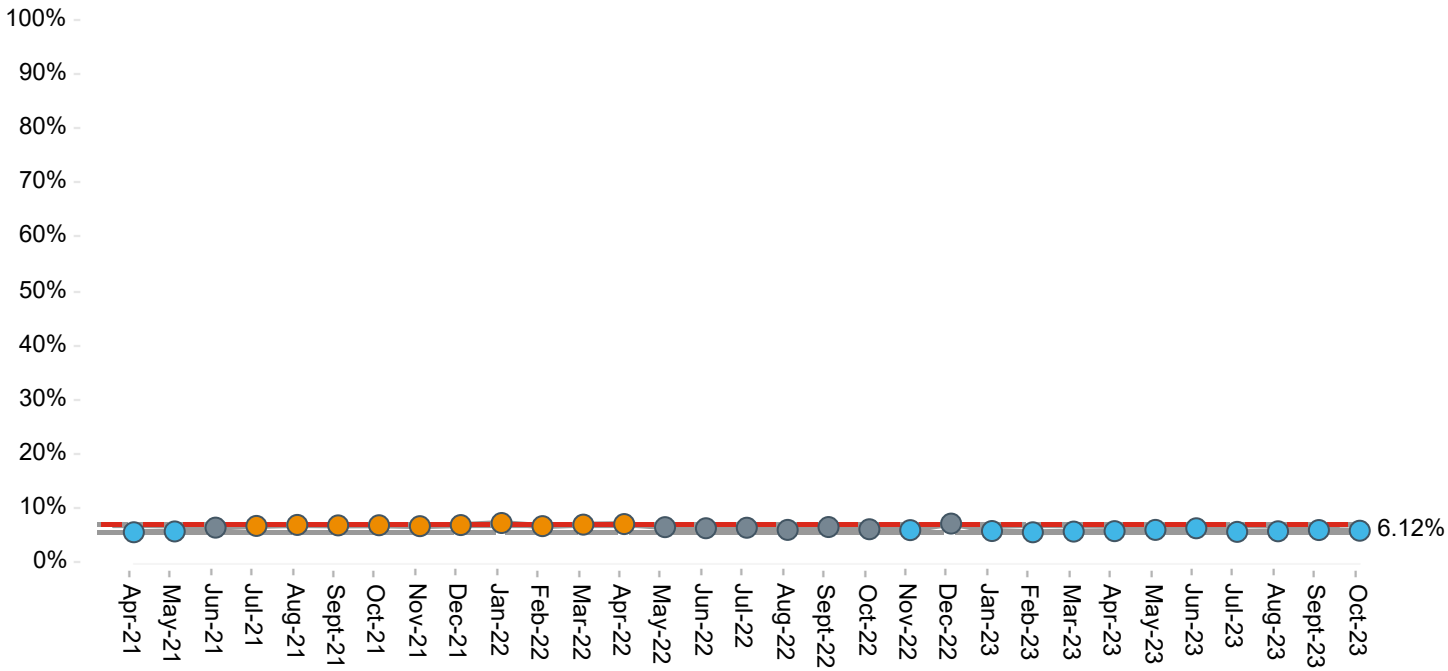
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[491] Did not attend (DNA) rates

Target: ≤ 7.60%



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Commentary

The DNA rate still remains fairly static over the past quarter fluctuating around 6-6.5%, with Octobers position improving slightly and being reported as 6.14%

Associate Director of Elective Care

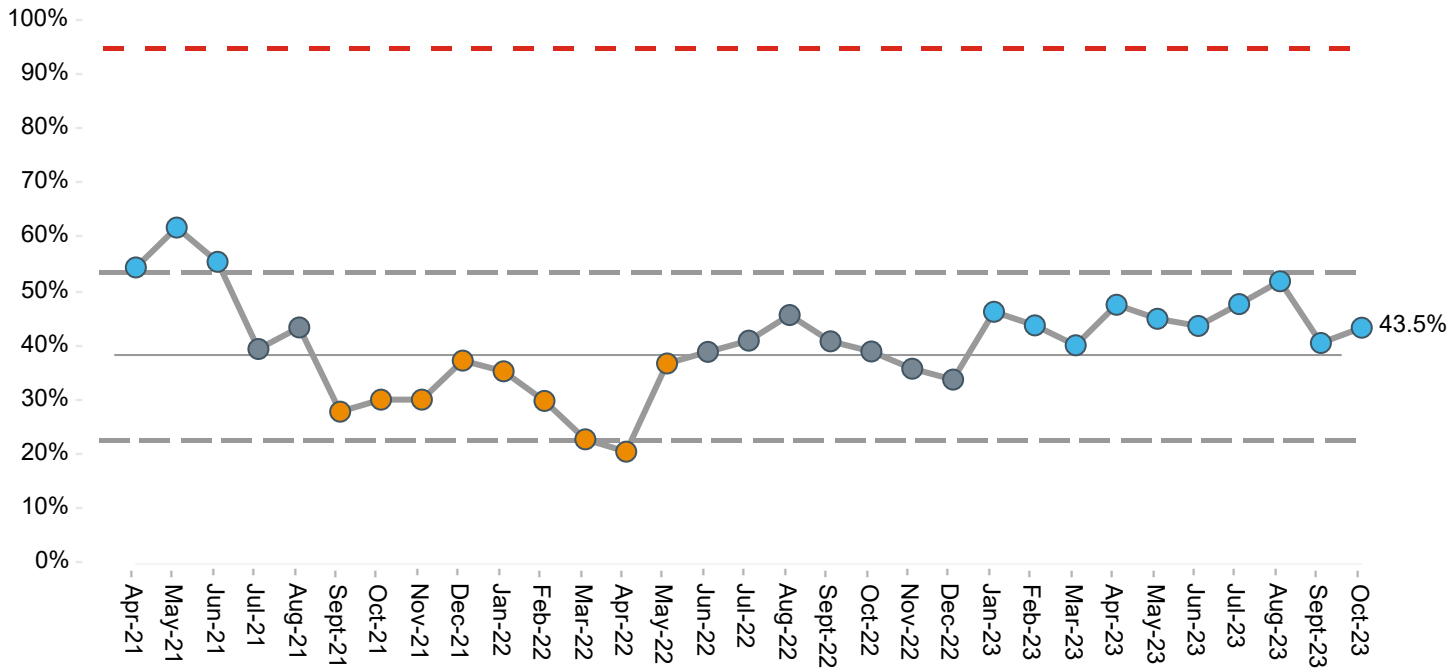
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 95.0%



Data Observations

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[2] SHIFT

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Commentary

Time to triage in our ED has remained constant from September to October at 30 minutes. The average time to triage has remained pretty constant throughout the current year in the range 25 - 30 minutes.

General Manager of Unscheduled Care

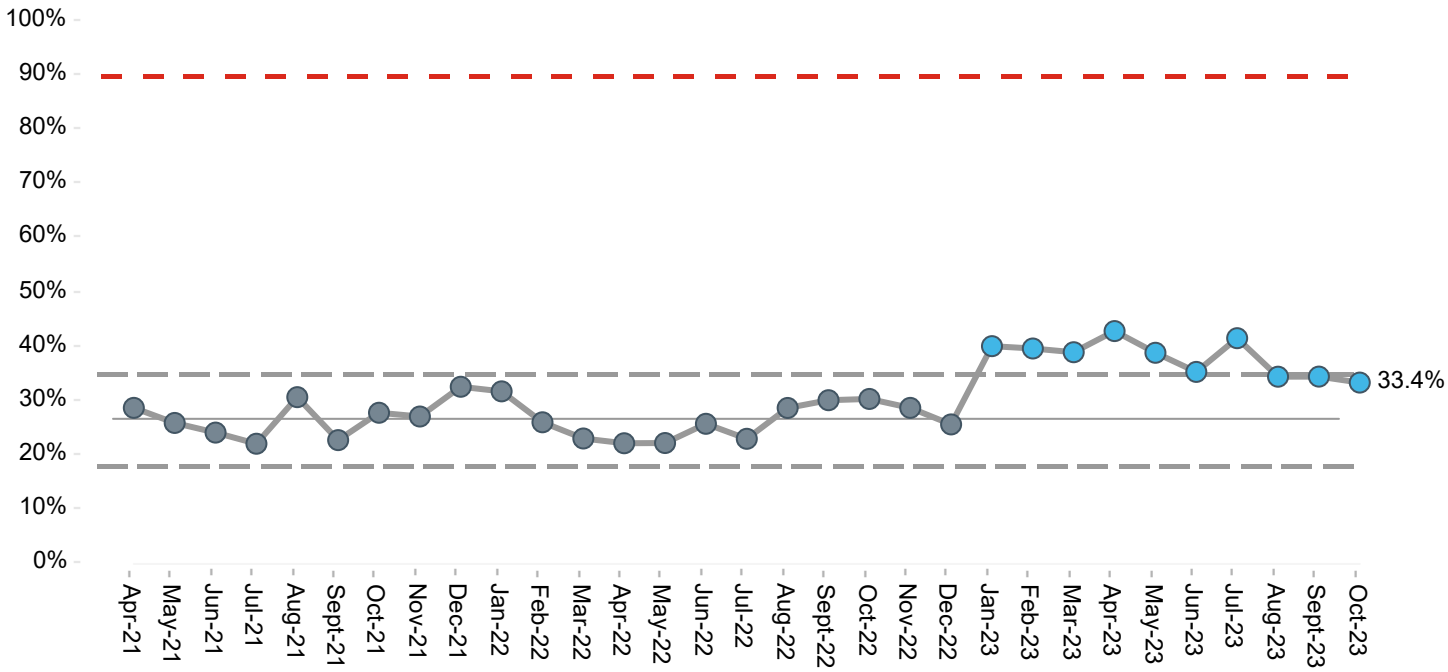
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 90.0%



Commentary

Time to be seen by a clinician has increased dramatically over the last three months and is currently sitting at just under two hours (114 minutes). This seems to reflect increases in waiting times overnight, so we are trying (as an ED) to get the appropriate resource allocated to ensuring these wait times don't become extended in the night-time hours.

Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

[4] 2 OF 3

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

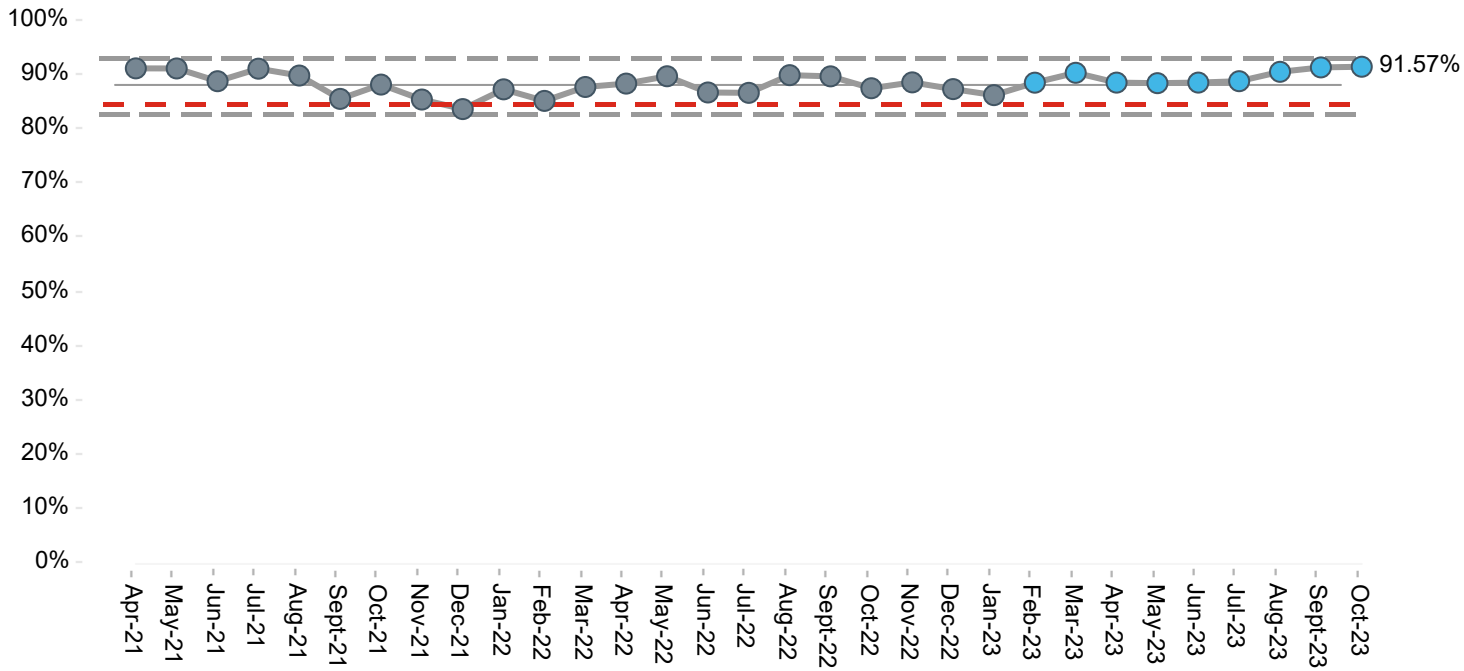
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[488] Intra-session theatre utilisation rate

Target: > 85.00%



Data Observations

[2] SHIFT

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Commentary

Overall GHFT capped utilisation achieved 75% in September 2023. Uncapped utilisation rate for emergency theatre lists across all sites in the same period is 79%.

Director of Operations - Surgery

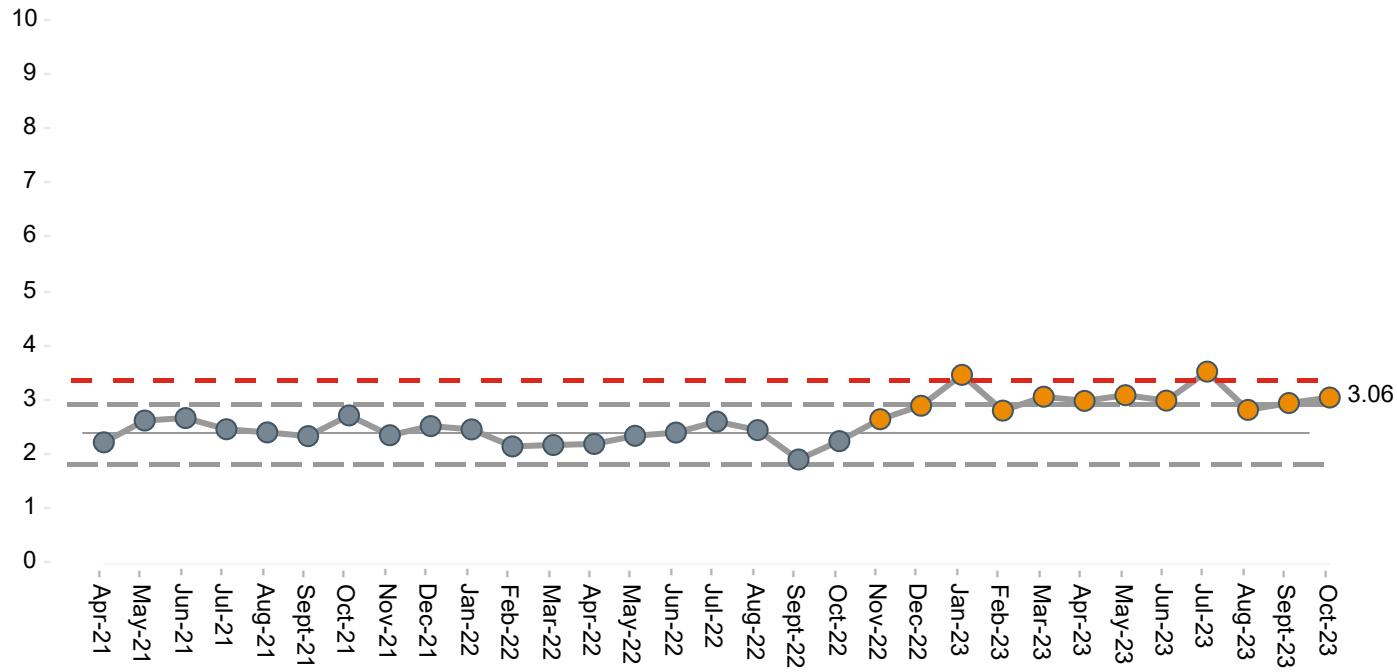
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 3.40



Data Observations

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[4] 2 OF 3

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Commentary

Negligible in month increase in elective LOS. Remains well below the target of 3.4days at an average of 3.13days.
Deputy Chief Operating Officer

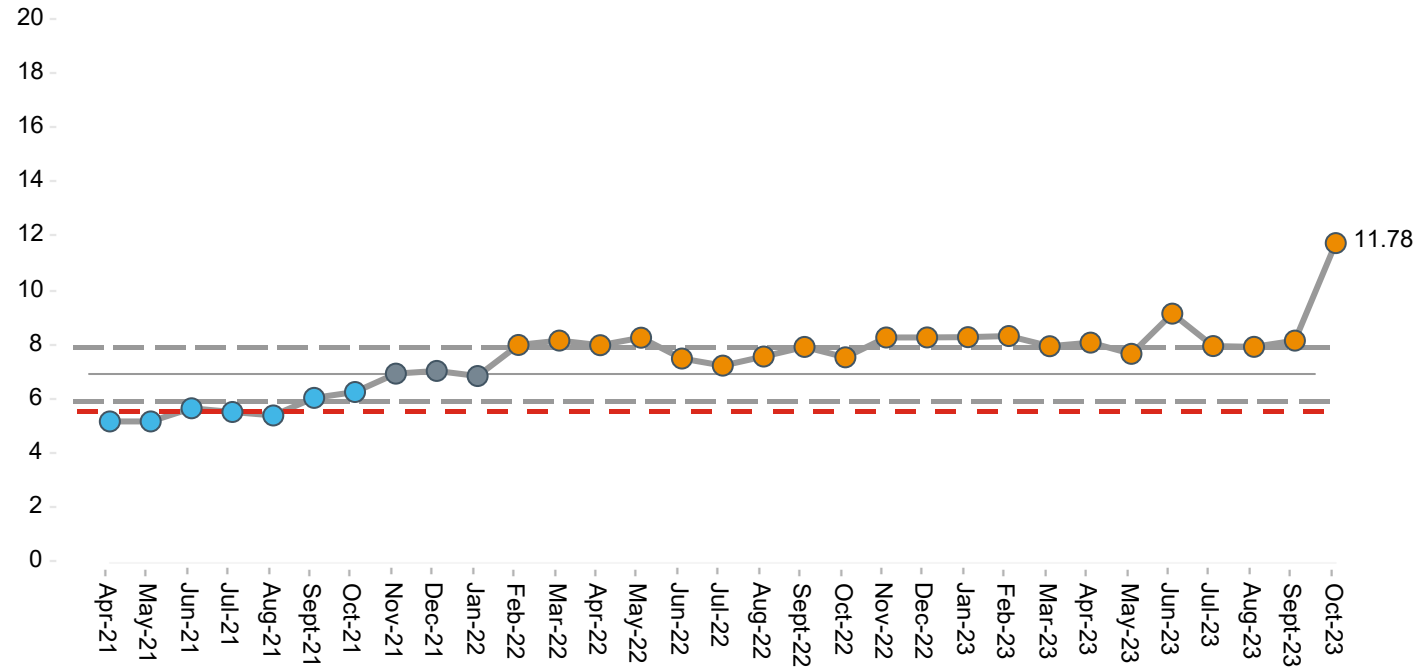
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 5.65



Data Observations

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[2] SHIFT

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Commentary

In month decline in performance directly related to increased long length of stay nCTR patients, as referenced in metric 188. In addition to the SBAR+ work at system level, also internal work undertaken to drive down 21+ day LOS for CTR patients.

Deputy Chief Operating Officer

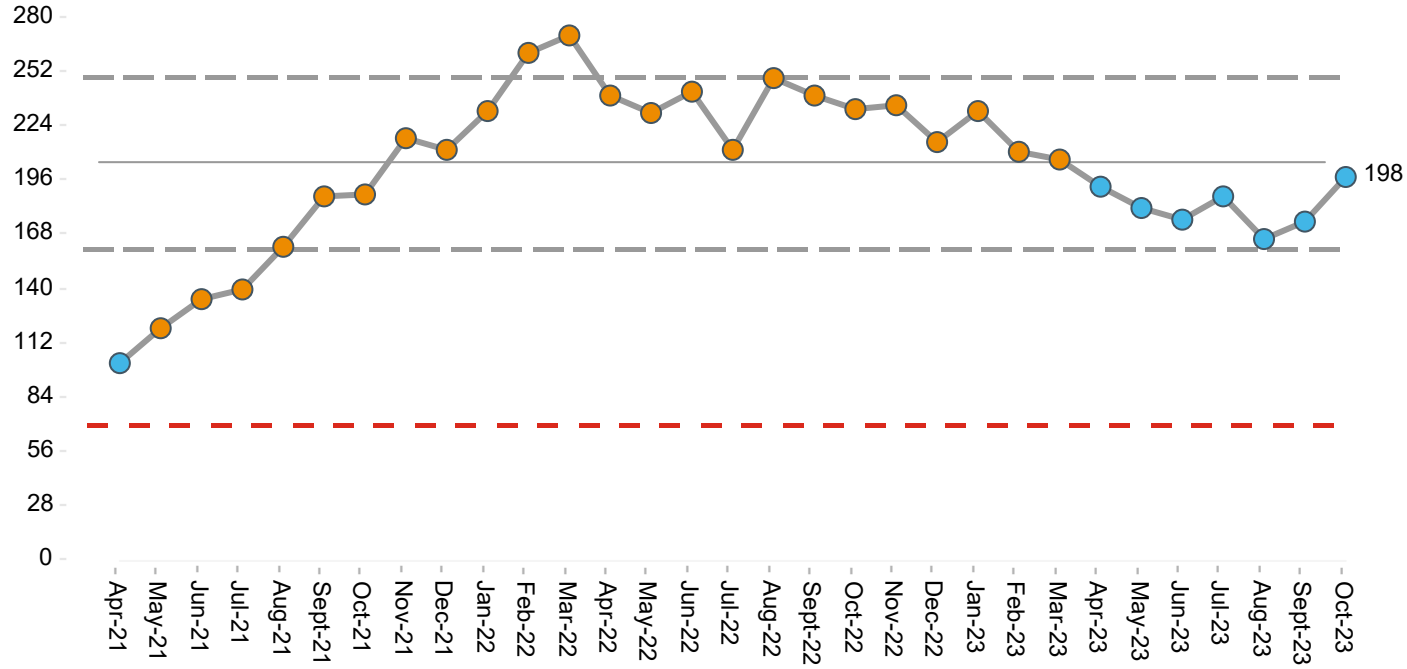
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[186] Number of patients stable for discharge

Target: ≤ 70



Commentary

Notable increase in nCTR numbers in October due to reduced flow into pathway 1 and 2. Raised through system processes with additional measures put in place to 'reset' the system back to the previous plateau point of 140-150. As of today 7/11/23, nCTR back down to 145.
Head of Therapy & OCT

Data Observations

[1] SINGLE POINT

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[2] SHIFT

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

[3] RUN

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

[4] 2 OF 3

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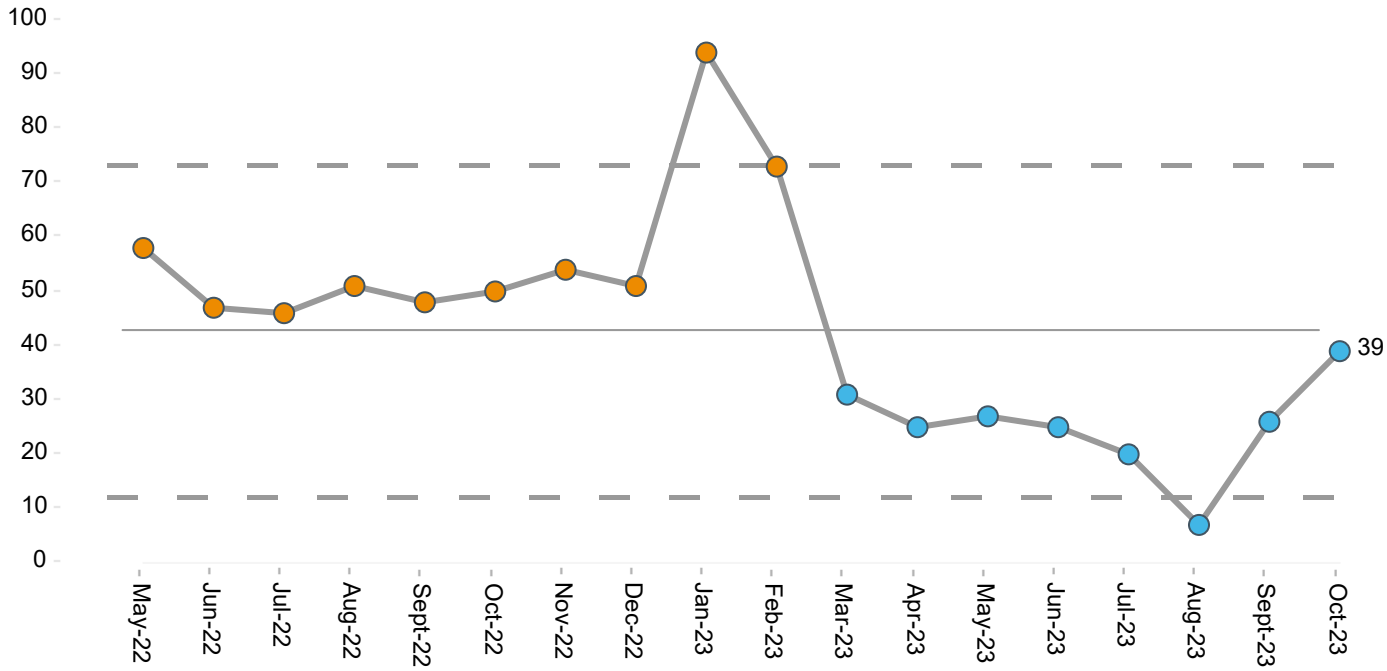
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



Data Observations

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Commentary

General Manager - Cancer

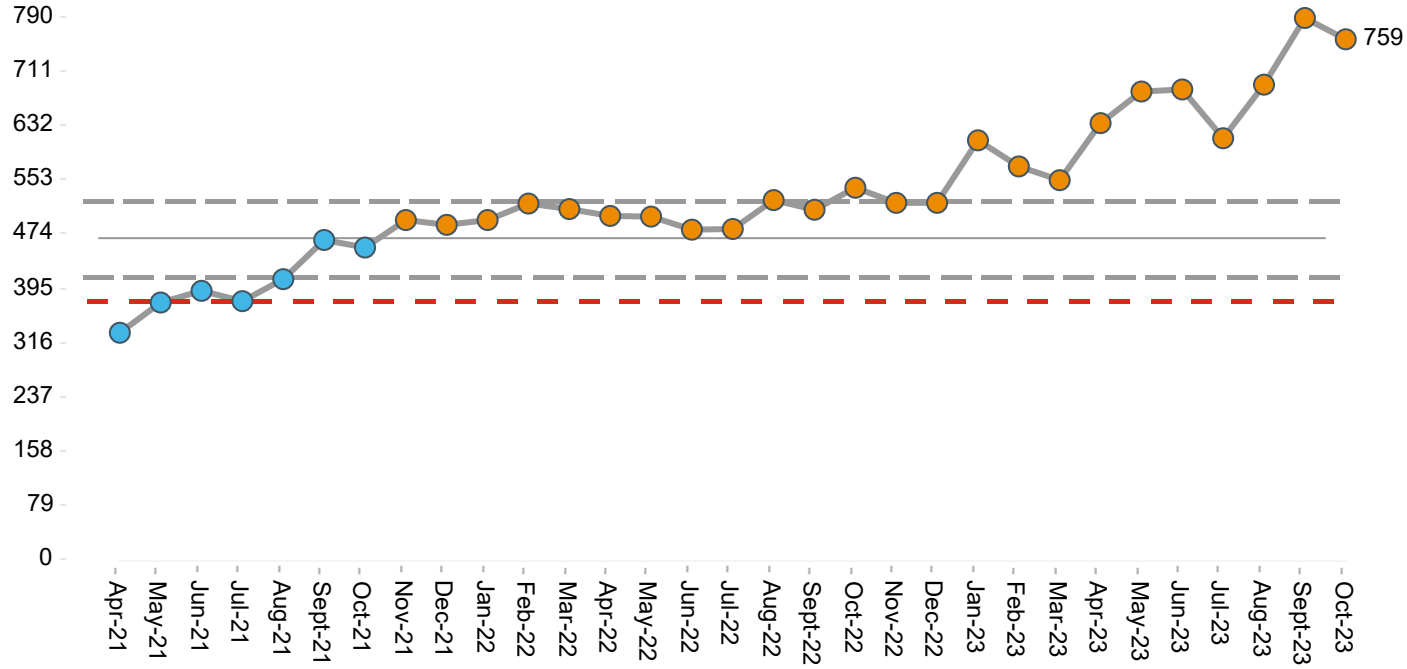
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 380



Commentary

Overall number of 7+ day patients has reduced in line with work to drive down LOS. Still significant way to go to reach target. Unfortunately growth in super stranded patients in terms of LOS as well as numbers drove a net increase in LOS.
Deputy Chief Operating Officer

Data Observations

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[4] 2 OF 3

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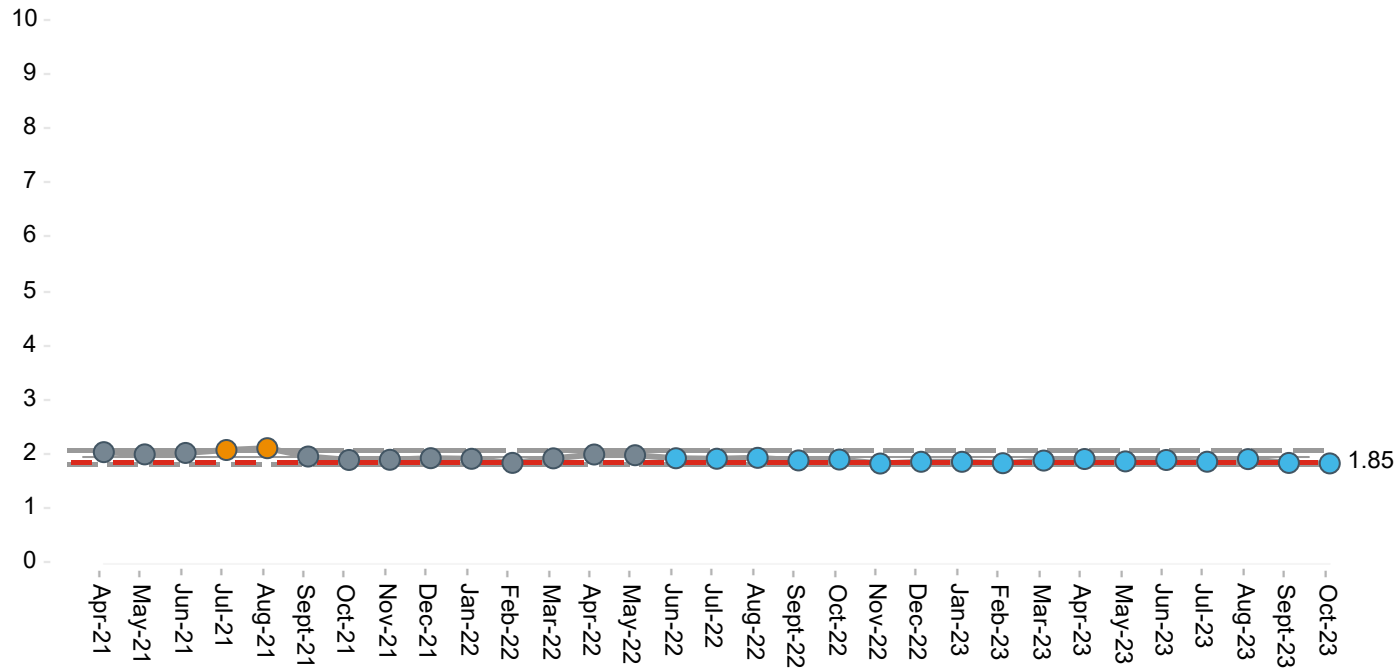
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[490] Outpatient new to follow up ratio's

Target: ≤ 1.90



Commentary

The new to follow up ratio has remained static at 1:1.86 (which remains within the target of 1:1.9).
Associate Director of Elective Care

Data Observations

[1] SINGLE POINT

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[4] 2 OF 3

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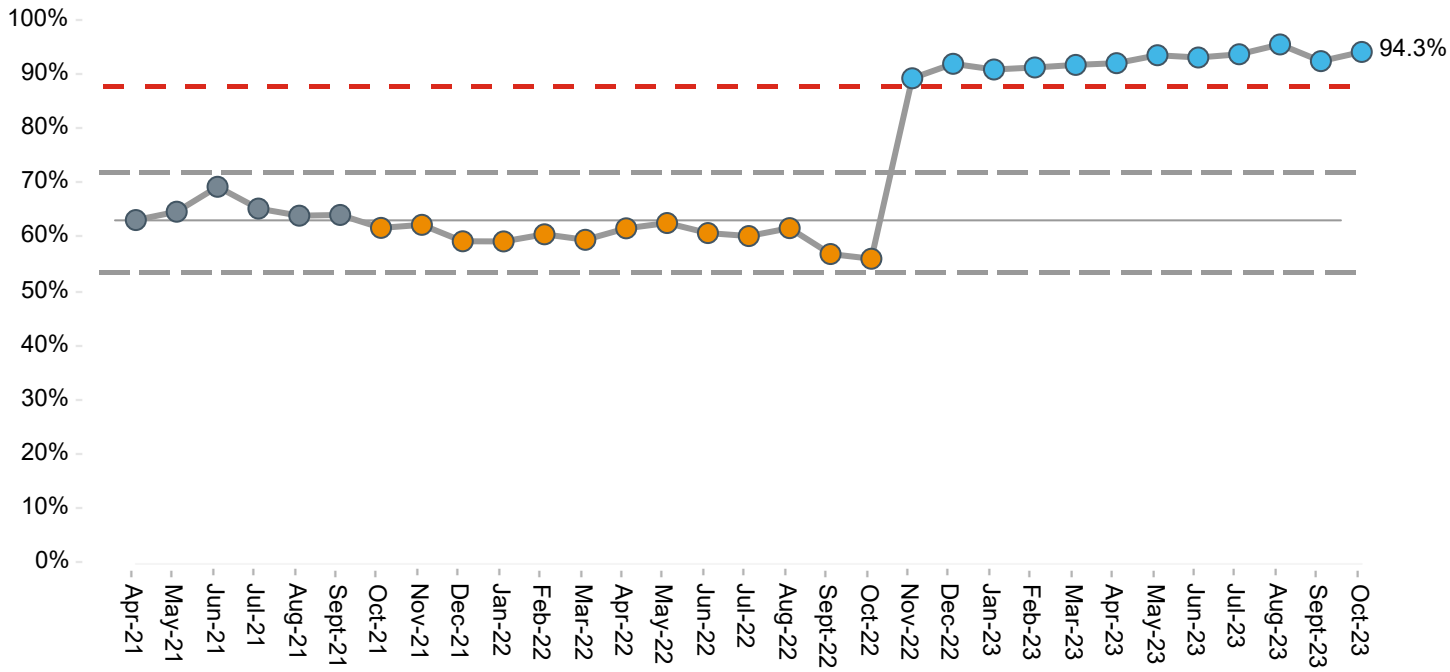
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 88.0%



Data Observations

[1] SINGLE POINT

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[4] 2 OF 3

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Commentary

Medical Director

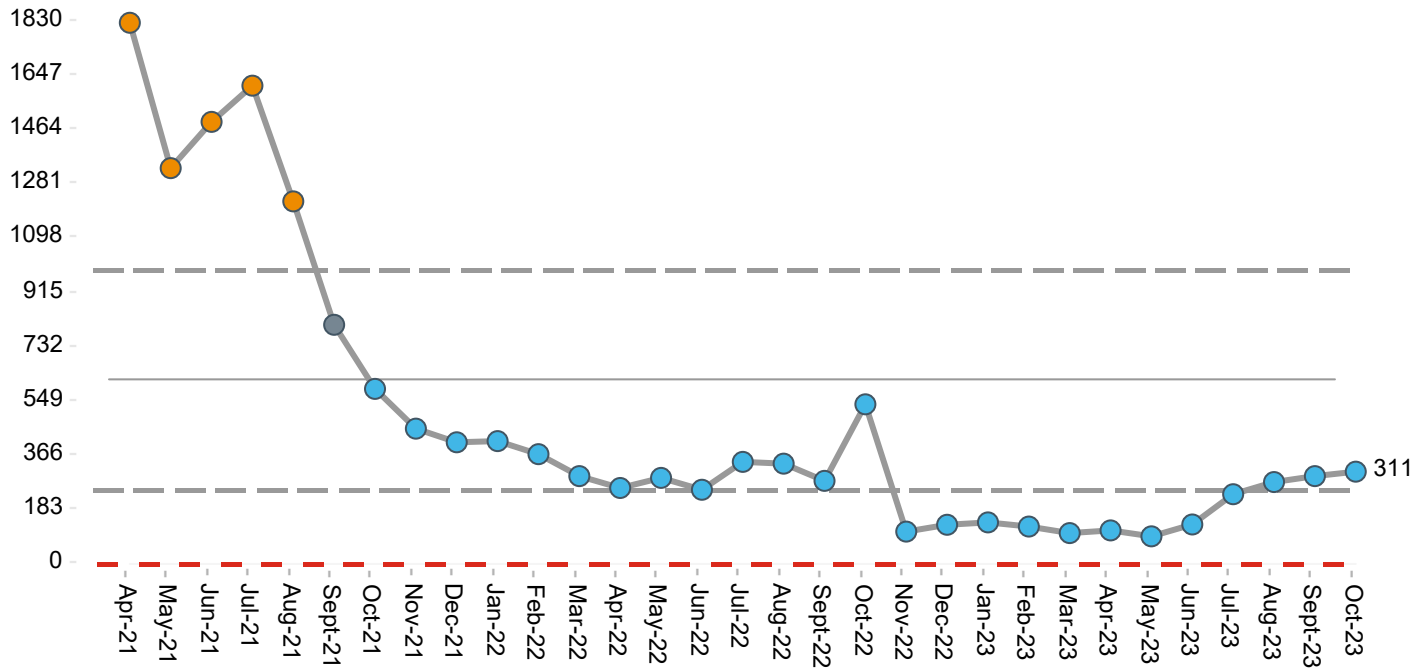
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Data Observations

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[4] 2 OF 3

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Commentary

The 70+ week category has increased very slightly in month. September was finalised with 296 patients and although Octobers position is currently being validated it is anticipated to be around 310

Associate Director of Elective Care

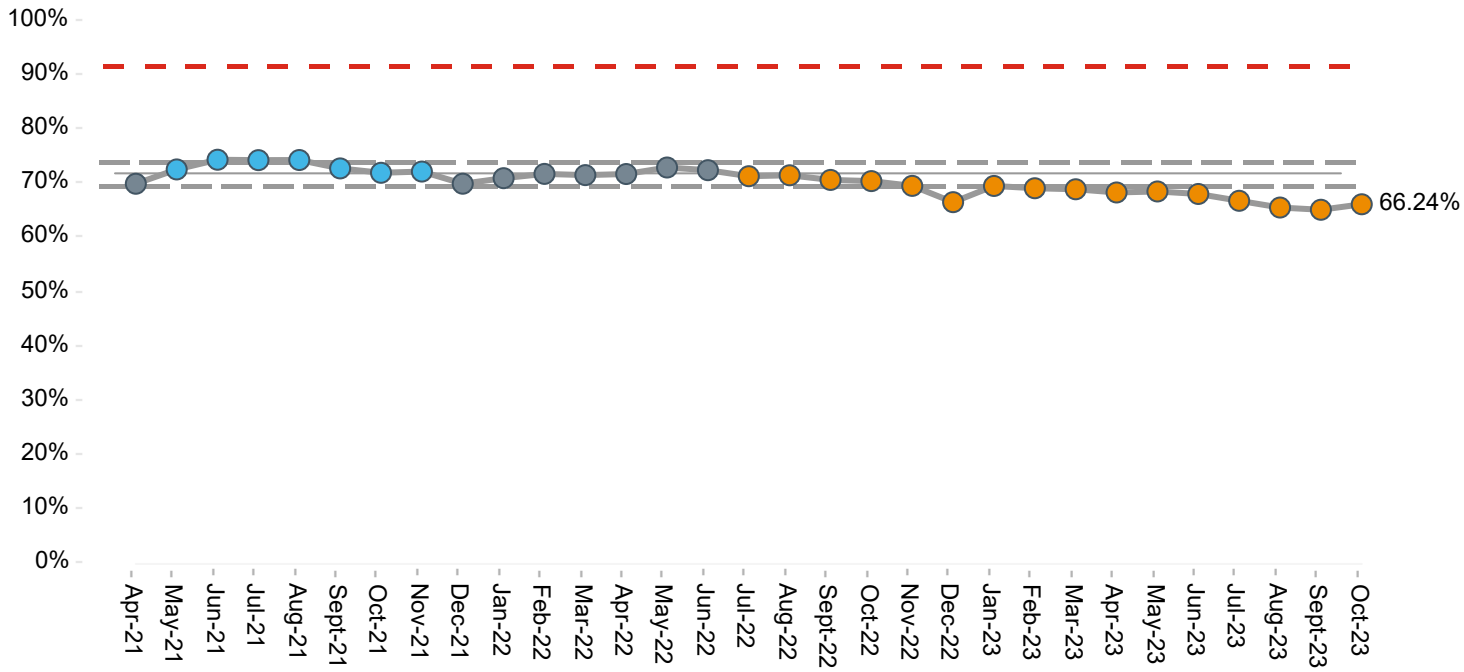
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 92.00%



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[2] SHIFT

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Commentary

See Planned Care Exception report for full details. The RTT October month-end position is likely to demonstrate a slight improvement on last month. At present performance is referenced as just over 65.3% but with further validation, this should finish around 65.5%, compared to 64.8% in August. This would be the second successive month where improvements have been observed, largely bolstered by ENT Glanso clinics, which have off-set some of the Industrial Action impact.

Associate Director of Elective Care

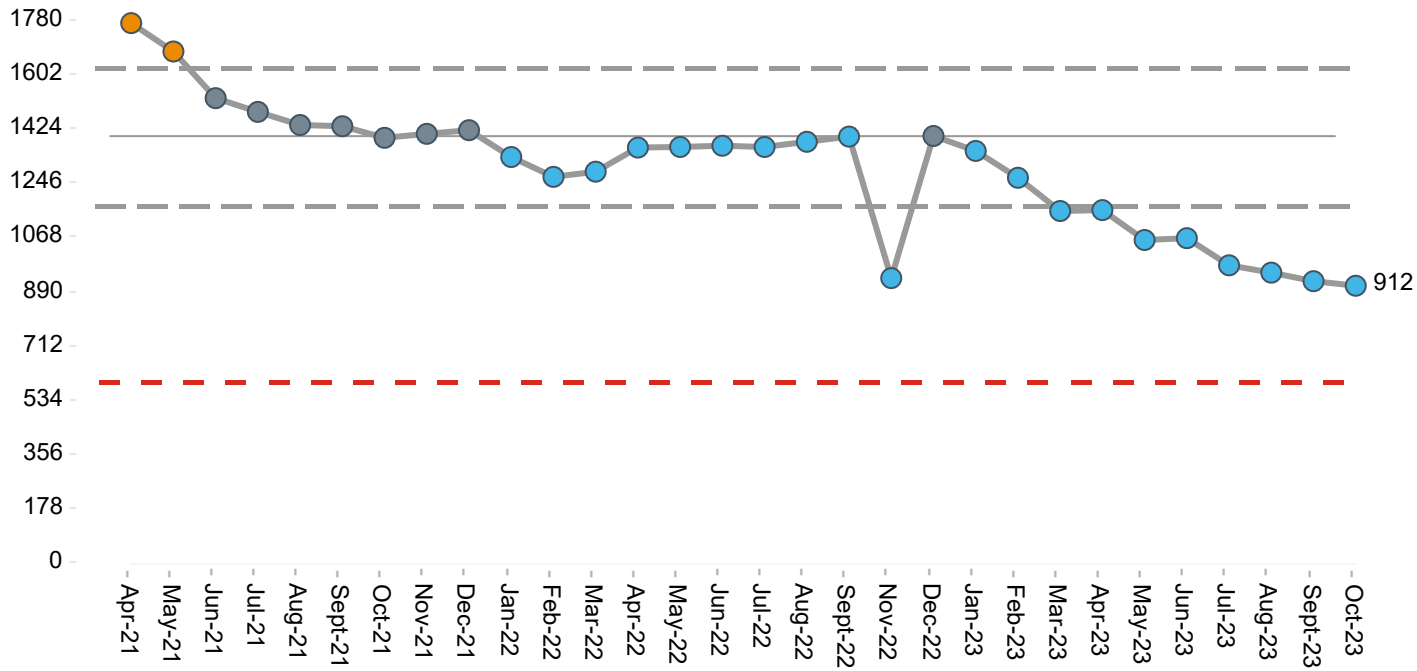
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 600



Data Observations

[1] SINGLE POINT

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[2] SHIFT

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Commentary

General Manager of Endoscopy

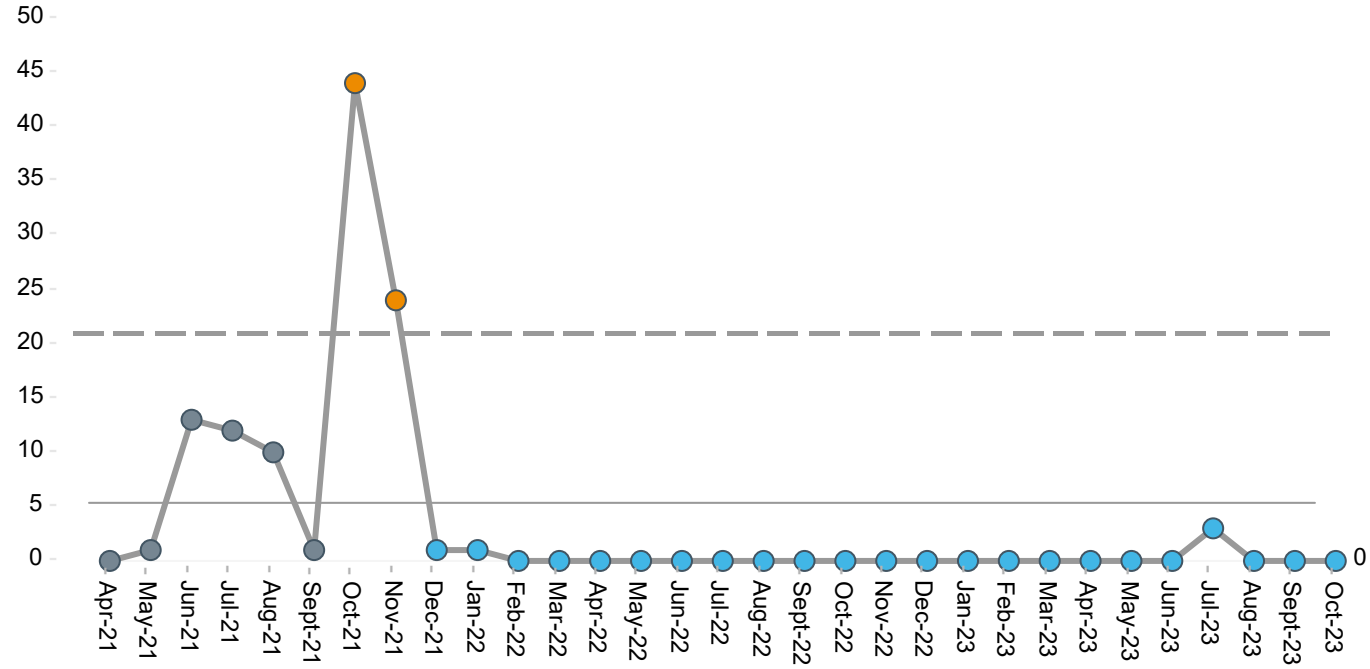
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[552] Urgent cancelled operations

- - - Target: ↓ Lower



Data Observations

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[2] SHIFT

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Commentary

Not given

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Friends & Family Test	ED % positive	No Target	Oct-23	73.2%	
	Inpatients % positive	No Target	Oct-23	90.1%	
	Maternity % positive	No Target	Oct-23	76.8%	
	Outpatients % positive	No Target	Oct-23	94.4%	
	Total % positive	No Target	Oct-23	91.0%	
Health Inequalities	Smoking Status Compliance	No Target	Oct-23	83%	
Infection Control	C. difficile - infection rate per 100,000 bed days	↓ Lower	Oct-23	29.9	
	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target	Oct-23	174	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target	Oct-23	524	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target	Oct-23	353	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target	Oct-23	293	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower	Oct-23	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7	Oct-23	4.3	
	Number of E. coli bacteraemia cases	No Target	Oct-23	4	
	Number of Klebsiella bacteraemia cases	No Target	Oct-23	3	
	Number of MSSA bacteraemia cases	≤ 8	Oct-23	1	
	Number of Pseudomonas bacteraemia cases	No Target	Oct-23	3	
	Number of bed days lost due to infection outbreaks	↓ Lower	Oct-23	59	
	Number of community-onset healthcare-associated C. difficile cases per month	≤ 5	Oct-23	0	
	Number of hospital-onset healthcare-associated C. difficile cases per month	≤ 5	Oct-23	8	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Infection Control	Number of trust apportioned C. difficile cases per month	< 10	Oct-23	8	
	Number of trust apportioned MRSA bacteraemia	= 0	Oct-23	0	
Maternity	% PPH >1.5 litres	< 2.00%	Oct-23	3.93%	
	% breastfeeding (discharge to CMW)	= 0.0%	Oct-23	0.2%	
	% breastfeeding (initiation)	≥ 81.00%	Oct-23	71.90%	
	% of women smoking at delivery	< 7.00%	Oct-23	10.12%	
	% of women that have an induced labour	≤ 33.00%	Oct-23	25.41%	
	% stillbirths as percentage of all pregnancies	< 0.200%	Oct-23	0.202%	
	Number of births less than 27 weeks	No Target	Oct-23	4	
	Number of births less than 34 weeks	No Target	Oct-23	24	
	Number of births less than 37 weeks	No Target	Oct-23	57	
	Number of maternal deaths	No Target	Oct-23	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target	Oct-23	2.4%	
	Total births	No Target	Oct-23	498	
Mortality	Number of deaths of patients with a learning disability	No Target	Oct-23	0	
	Number of inpatient deaths	No Target	Oct-23	168	
	Summary hospital mortality indicator (SHMI) - national data	No Target	Jun-23	1.092	
MSA	Number of breaches of mixed sex accommodation	≤ 10	Oct-23	37	
Operational Efficiency	Daily Average of Boarded Patients	No Target	Oct-23	17	
Patient Advice and ..	% of PALS concerns closed in 5 days	No Target	Oct-23	81%	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Patient Advice and ..	Number of PALS concerns logged	↓ Lower	Oct-23	318	
Patient Safety Incidents	Medication error resulting in moderate harm	↓ Lower	Oct-23	3	
	Medication error resulting in severe harm	↓ Lower	Oct-23	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Oct-23	34	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Oct-23	4	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Oct-23	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Oct-23	14	
	Number of falls per 1,000 bed days	↓ Lower	Oct-23	7.50	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Oct-23	3	
	Number of patient safety incidents - severe harm (major/death)	No Target	Oct-23	9	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Oct-23	12	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target	Aug-23	59.24%	
	Number of DoLs applied for	No Target	Oct-23	159	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Oct-23	103	
	Total admissions aged 0-17 with DSH	↓ Lower	Oct-23	30	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Aug-23	4	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Aug-23	0	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower	Aug-23	0	
	Total number of maternity social concerns forms completed	No Target	Aug-23	43	
Serious Incidents	Number of never events reported	= 0	Oct-23	0	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Serious Incidents	Number of serious incidents reported	↓ Lower	Oct-23	9	
	Percentage of serious incident investigations completed within contract timescale	> 80%	Oct-23	10,000%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%	Oct-23	10,000.0%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Oct-23	64.5%	

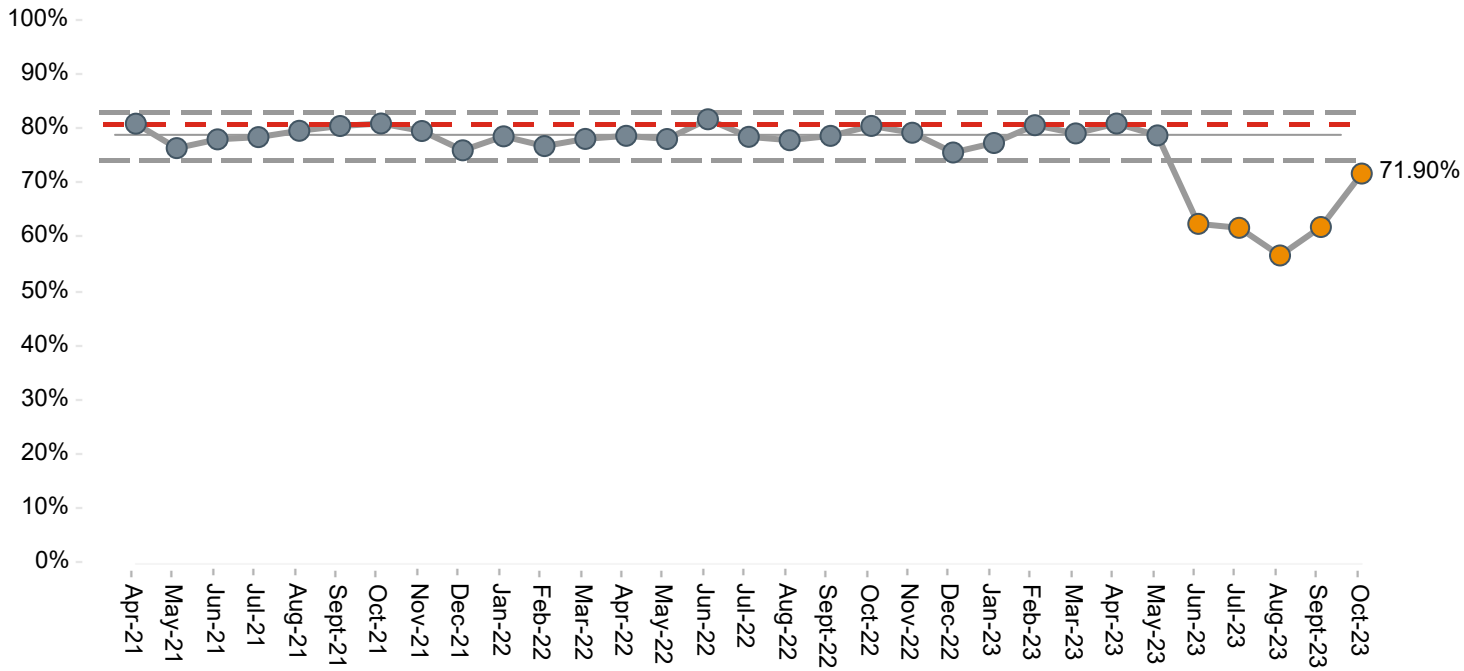
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[573] % breastfeeding (initiation)

Target: ≥ 81.00%



Data Observations

[1] SINGLE POINT

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Commentary

Divisional Director of Quality and Nursing and Chief Midwife

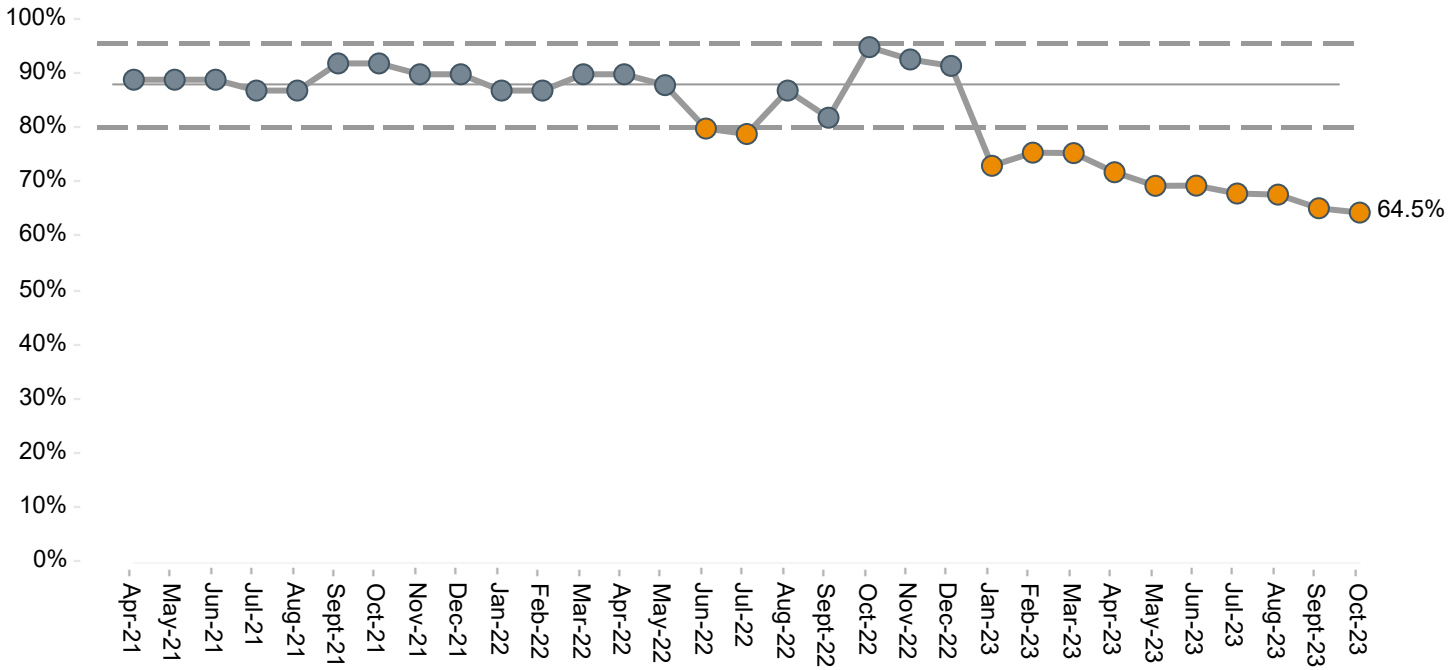
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



Data Observations

[1] SINGLE POINT

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[2] SHIFT

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Commentary

Quality Improvement & Safety Director

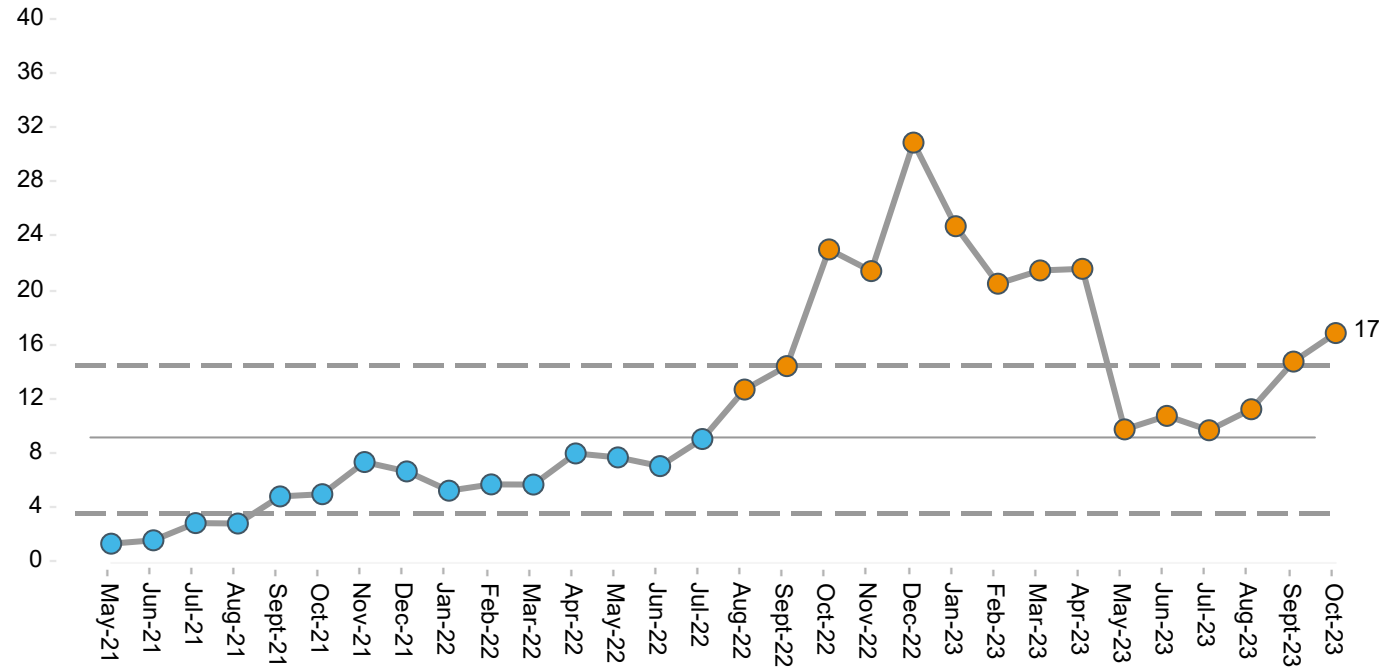
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[607] Daily Average of Boarded Patients

- - - Target: No Target



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[4] 2 OF 3

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Commentary

Director of Operations for Hospital Flow

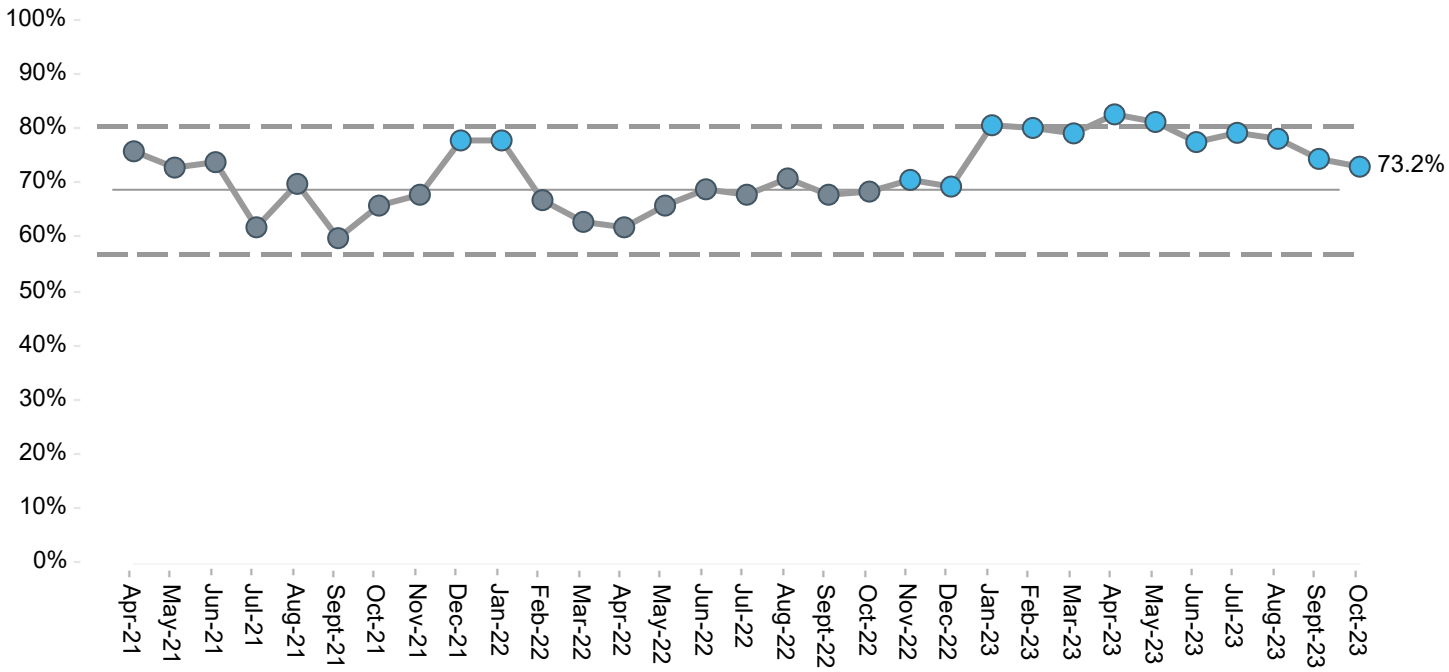
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[154] ED % positive

Target: No Target



Data Observations

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[4] 2 OF 3

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Commentary

The current positive FFT score for ED is at 73.2% across both sites, a decrease from 74.6% in September 2023.
This puts the score at the
lowest point in 9 months but still above average.
The main theme remains focused on wait times, the information provided while waiting
but increasingly about basic care in the department. A patient experience lead is being recruited to support improvement of patients and carers experience
Updates and monitoring is through to QDG.
Head of Quality

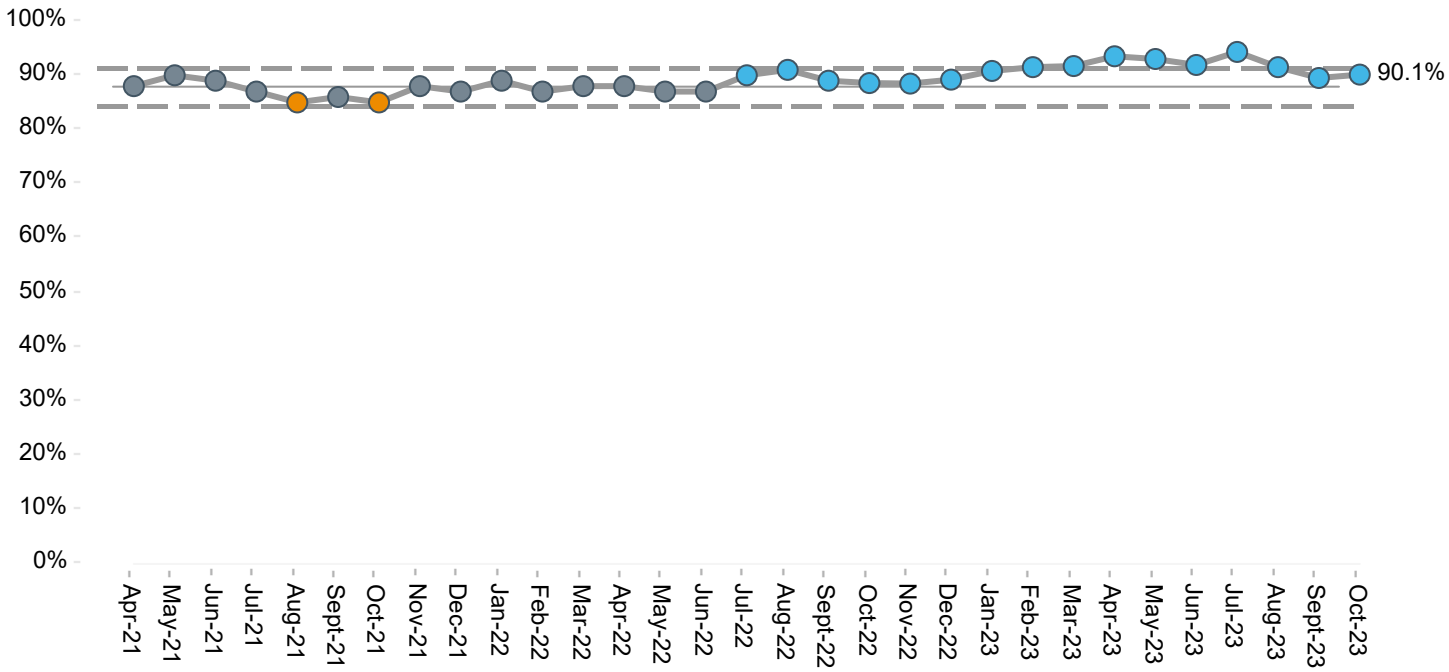
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[153] Inpatients % positive

Target: No Target



Data Observations

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[4] 2 OF 3

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Commentary

The current positive FFT score for Inpatient and Daycase is at 90.1%, an increase from 89.5% in Sept. The score remains below the upper control limit but above the average.
The scores for inpatient areas are less positive than for daycase and are affected by the challenges in flow leading to the need to reintroduce boarding are affecting patients experiences. Patients report that staff are overall kind and caring with acknowledgement that there are significant pressures due to staffing and resources. The trend in the concerns and comments relating to the organisation and management of our services and the impact of this on communication and basic patient care continues.
Updates and monitoring will be reported through Quality Delivery Group via divisional reports and the monthly Patient Experience Report.

Head of Quality

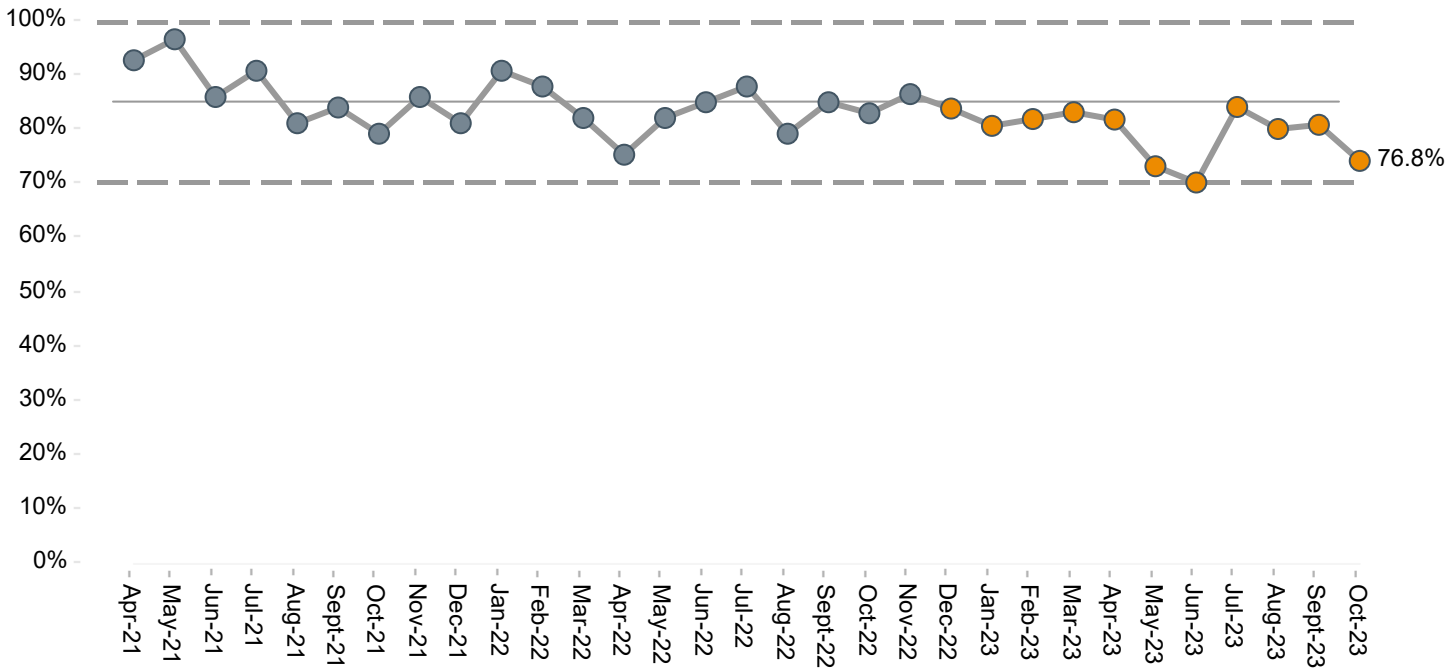
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[155] Maternity % positive

- - - Target: No Target



Data Observations

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[2] SHIFT

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Commentary

The current positive FFT score for Maternity services is 76.8%, which is a decrease from August 2023 (83.7%). The positive score remains below the average (88%).

The areas influencing this decrease are the score for the maternity ward (66.7% a 10% decrease on the previous month). The division are undertaking significant improvement work on the Maternity Ward as identified as part of collaborative working event. The new Maternity and Neonatal Patient Experience Group had its inaugural meeting in October and is monitoring insight data and improvement projects.

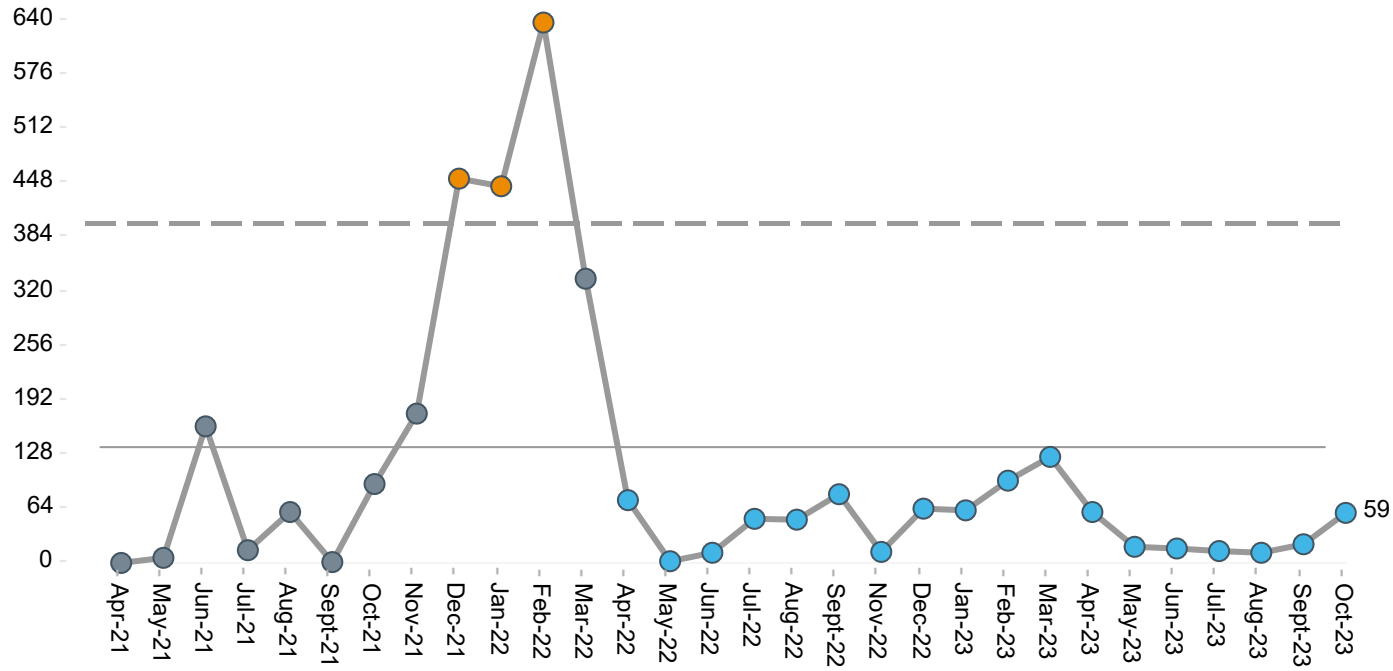
Head of Quality

Quality

SPC - Special Cause Variation

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

- - - Target: ↓ Lower



Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

Commentary

During October 2023, 59 bed days were lost due to outbreaks associated with transmission of COVID-19. The IPCT reviewed all outbreak affected areas and supported use of empty beds where possible for patients who were deemed safe to use them this significantly reduced the number of empty beds in closed areas. The IPCT continued to also support with ensuring implementation of effective IPC practices to minimise risk of transmission including use of single room isolation, testing and cleaning. Global staff communications on COVID-19 practices has been sent in response to the increased prevalence of COVID. All COVID action cards have been reviewed, updated and available on the intranet

Director of Infection Prevention & Control

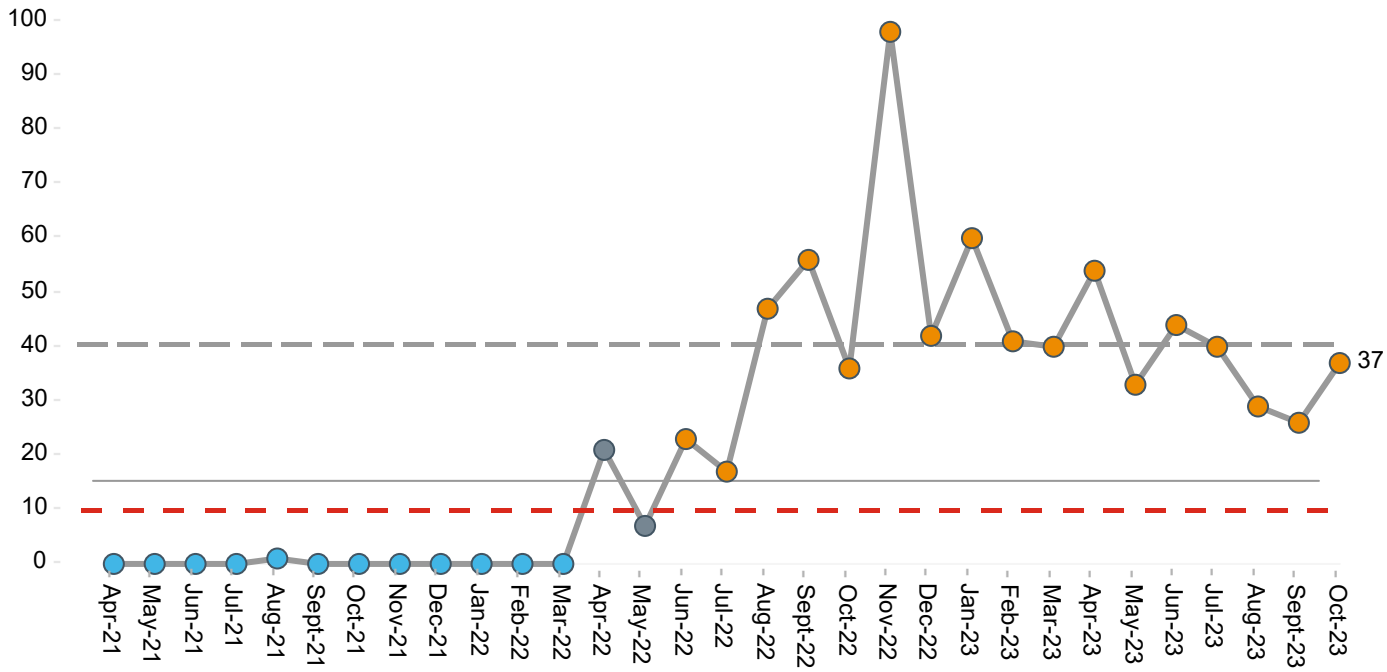
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[148] Number of breaches of mixed sex accommodation

Target: ≤ 10



Data Observations

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[2] SHIFT

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

[4] 2 OF 3

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

Commentary

The hospital sites remain busy and the need to mix sexes in sleeping accommodation has been required to support and maintain flow through the sites.

Deputy Chief Nurse

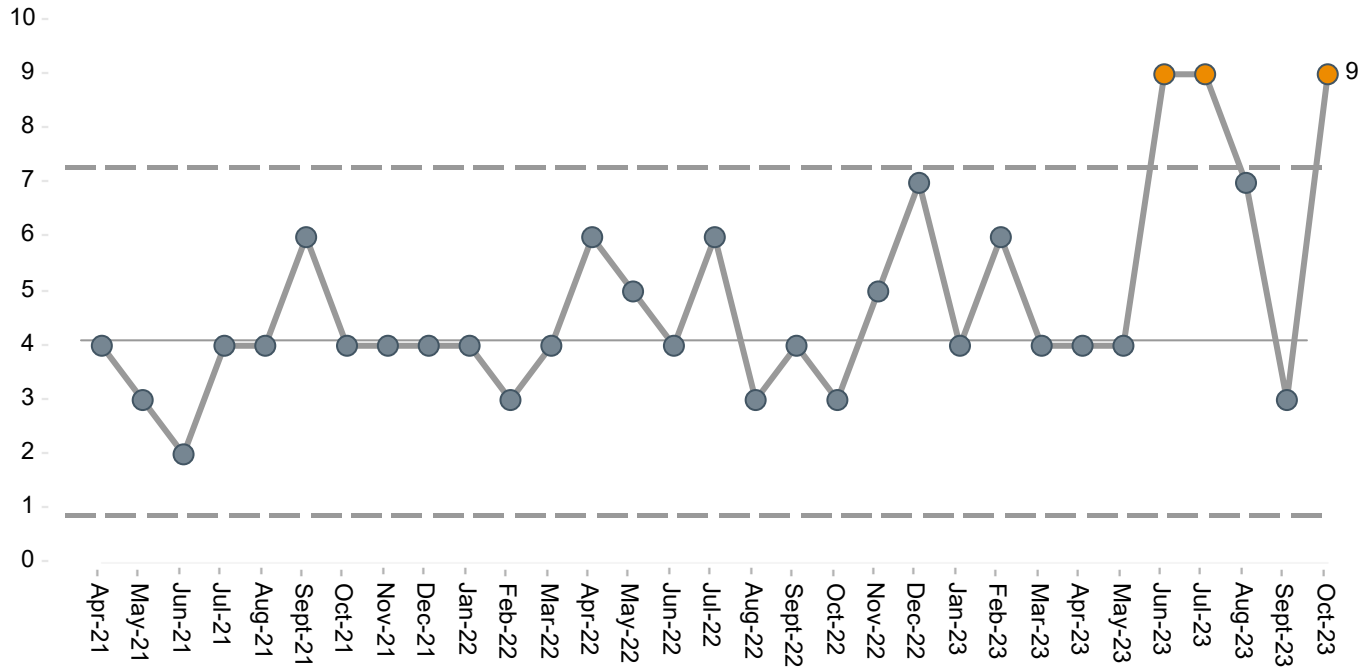
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[103] Number of serious incidents reported

- - - Target: ↓ Lower



Data Observations

[1] SINGLE POINT

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

Commentary

9

Quality Improvement & Safety Director

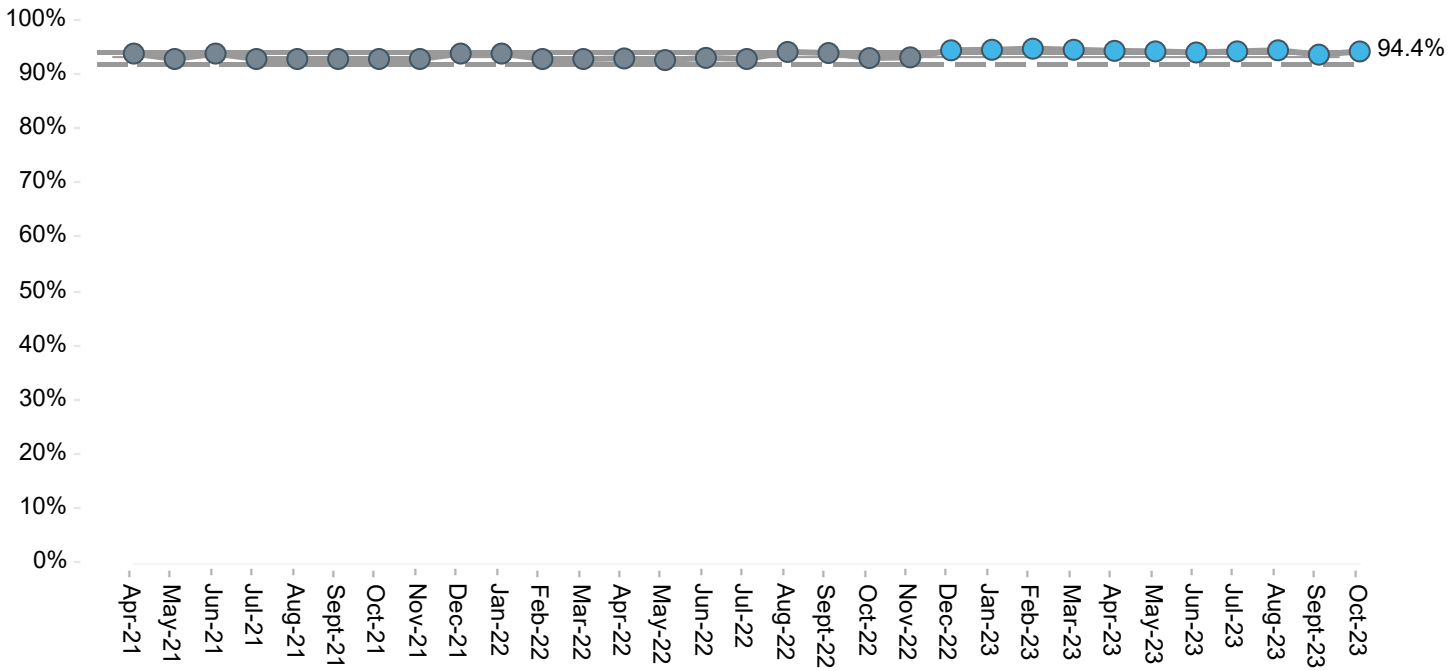
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[291] Outpatients % positive

- - - Target: No Target



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[4] 2 OF 3

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

Commentary

The current positive FFT score for Outpatients is 94.4%, a increase from 93.8% in September. This brings the score back in line with where scores had been tracking before September

having no industrial action this month helped with clinic availability. Comments do remain
positive overall with many saying 'thank you', however, the main themes for improvement continue to be waits for appointments, waits in the outpatient departments and patients not feeling they have enough time when in their appointment. This has been consistent for most of the year to date.

Head of Quality

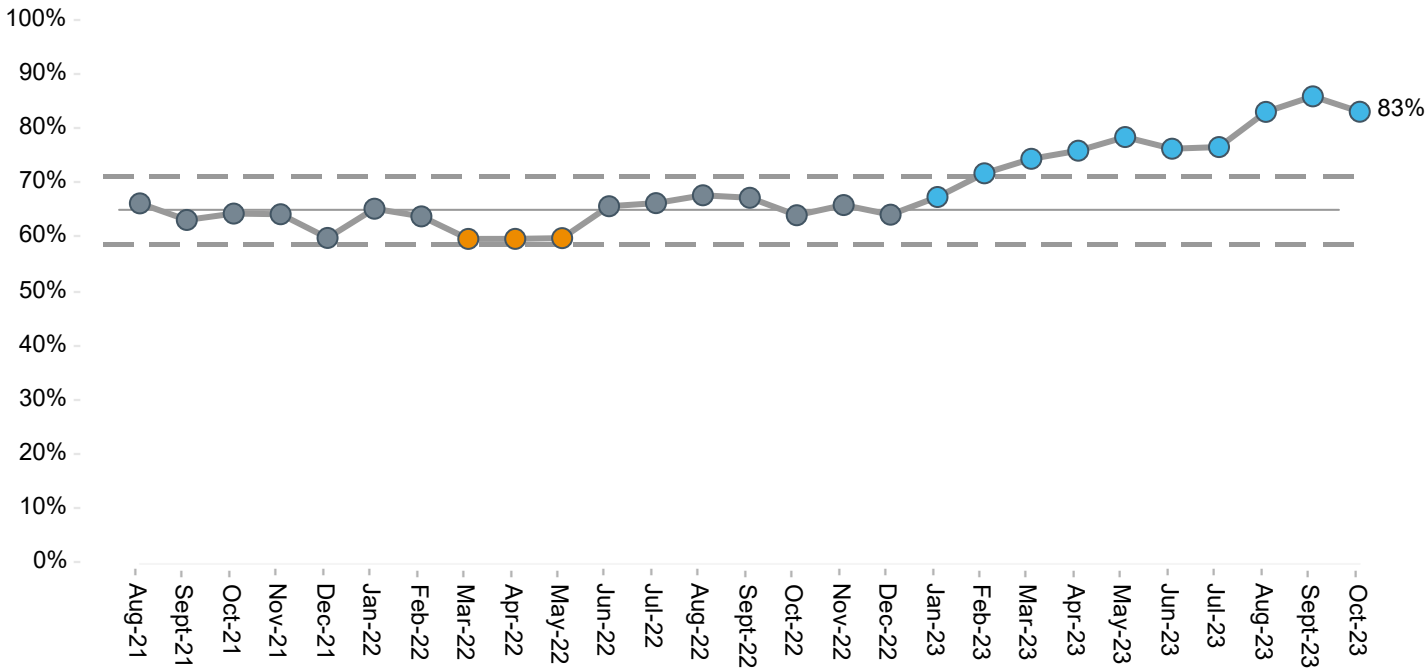
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[610] Smoking Status Compliance

- - - Target: No Target



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[4] 2 OF 3

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

Commentary

Trustwide compliance is at 82% for October and this varies by ward. Some wards have achieved 100% compliance this month.
Head of Inequalities, Health Improvement

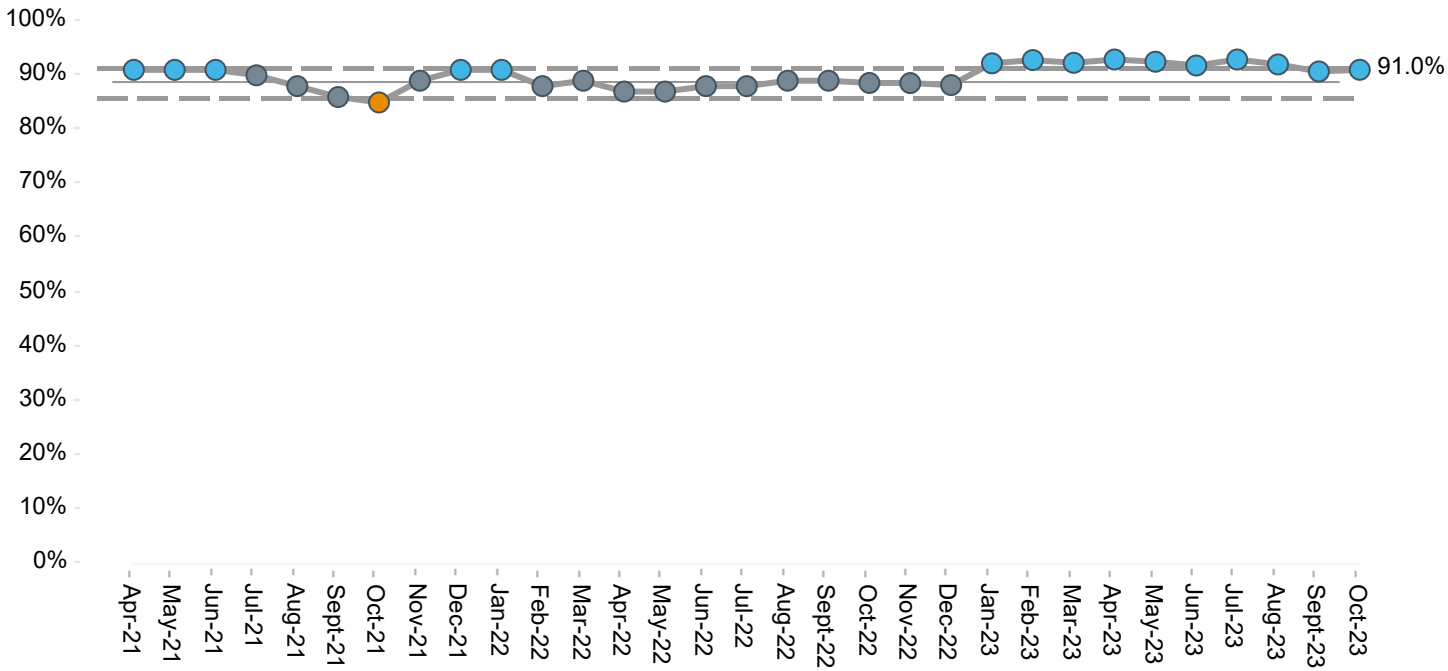
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[156] Total % positive

Target: No Target



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[4] 2 OF 3

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

Commentary

The overall Trust FFT positive score has seen a slight increase this month to 91.0% compared to 90.7% in September.

Our overall score
sees us still above average (89%) and just below the upper control (92%). The increase is as a result of increases in positive score across two of the four care types namely Outpatients. There are many contributing factors to this increase including no industrial action during October impacting on clinic availability, however, challenges with flow through our hospitals remains, adding pressure to our services, particularly in Emergency Department where a decrease was observed.
Head of Quality

Report to Board of Directors			
Date		11 January 2024	
Title		Winter Plan Update	
Author / Sponsoring Director/ Presenter		Duncan Bedford / Alan Sheward	
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 presentation highlights the current pressures on performance and actions related to the management of the:

- Emergency Department 4 Hour Target which has deteriorated more latterly at the end of December for GHFT alone to 55 %
- Ambulance Handover times throughout December also show a more challenged position after a period of decreasing handover times. This feeds into the total hours lost to the handover of patients, which has increased at the end of November into December.

The Bed modelling shows at the peak of Winter Pressures, a potential demand of an additional circa 120 beds and how these are managed through a range of measures.

During periods of extreme pressure, it has been necessary to Board patients to assist with Flow. Specific focus is on ensuring the time individual patients are in Boarding is kept to a minimum, and a range of measures are identified in the presentation to ensure this happens.

Critical to ensuring appropriate capacity and flow, is the appropriate management of patients who have 'No Criteria to Reside' but often can't leave the hospital as they are awaiting a Care Home placement for example. The current trend is shown in the slides, and the total at the beginning of January is now in excess of 200. Similarly, those patients waiting over 10 days since they were identified as ready to be discharged has increased to over 100 patients. These patients are categorized within specific pathways in line with National guidance, and the key reasons are also shown within the slides.

Finally the supporting work of our system partners, including NHS 111, the Ambulance service, GPs, and partnership working to manage Virtual Ward capacity, are also highlighted.

Risks or Concerns

Ability to offload patients in a timely manner.
The System four-hour performance target of 80%, will not be met unless GHFT performance is in excess of 70%.
Availability of external capacity to meet Residential Placements, where patients can't return to their own homes.

Financial Implications

Additional funding of £389k has been received to assist with the on-going management of Winter Pressures and will be utilised to assist manage the actions identified. The funding is directed at Cohorting capacity to assist timely offload of ambulances, extended hours for the Same Day Emergency Care Department, additional Doctors to assist with weekend discharges, and appropriate streaming of patients within the Emergency Department as well as additional consultant input at peak activity times.

Approved by: Director of Finance / Director of Operational Finance	**Date:** December 2023

Recommendation
The Board is asked to **NOTE** the contents of the presentation, and the relevant ongoing actions are a source of assurance related to the ongoing management of Winter Pressures.
Enclosures
Presentation

Report to Trust Board				
Date	11 January 2024			
Title	**Maternity Incentive Scheme (Year 5)**			
Author: **Sponsoring Director:** **Presenter:**	Lise Honeyman Matt Holdaway Lisa Stephens			
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

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

The purpose of this report is to provide assurance to the Trust Board that we are fully compliant with all 10 safety actions, presenting the standards and evidence of each safety action with the accompanying board deceleration form for submission to NHSR.

Submission

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **1 February 2024** and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board declaration form must be signed and dated by the Trust's Chief Executive Officer (CEO) to confirm that:
  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.

- There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before 1 February 2024.

- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.
- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

Risks or Concerns

Although we have met the minimum compliance for safety action 6, Saving Babies Lives Version 3, the service requires significant improvements to achieve full compliance, such as, our sonography service. We have some short-term funding that we intend to use to strengthen the team, we will then assess the options and any support required from the Board and/or commissioners to implement these service improvements.

Recommendation

This report has been reviewed by Maternity Delivery Group on 3 January and Quality and Performance Committee on 5 January 2024. We are currently awaiting any relevant LMNS and/or ICB (as of 8 January).

The Trust Board is asked to review the following items as part of our compliance for each of the following safety actions:

Safety Action 1

A summary of the Q1 Perinatal Mortality Review Tool (PMRT) report *(appendix 1-3)* was submitted to Trust Board through the Perinatal Quality and Safety Report in September.

The Q2 PMRT report is submitted in *appendix 1-4* and the final report to December is included in *appendix 1-5.* This has been reviewed at Quality and Performance Committee for assurance on 5 January 2023.

Recommendation - The Trust Board are asked to review and note these reports for compliance.

Safety Action 2

Recommendation - The Trust Board are asked to review and note that we passed the data quality criteria in the CNST: Scorecard.

Safety Action 3

We have reviewed the robustness of our avoiding term admissions into the neonatal unit (ATAIN) reviews in line with MIS guidance and increased the diversity of the multi-disciplinary team (MDT) team completing the reviews. With increased demand on the teams plus staff shortages, we had

a backlog of reviews to complete and some to re-audit with a full MDT. Therefore, the Trust Board is asked to review and sign off April and May 2023 report, June and July report and Aug and September report at this Trust Board. Also, please note 22/23 Q4 report which has been re-audited this has been added as the MIS was published in May 2023).

Transitional care (TC) is a service provided to avoid term admission into the neonatal unit and so forms part of these safety actions and audits of TC care are included with the ATAIN reports. Trust Board is asked to review and approve these alongside the Transitional Care action plan to expand TC provision to include babies born from 34 weeks onwards.

These reports have been approved by Divisional Board, and reviewed at the Maternity Delivery Group on 3 January 2024 and presented to Quality and Performance Committee on 5 January 2024.

Recommendation - The Trust Board is asked to review and approve the ATAIN and TC reports and the Transitional Care action plan to expand TC provision to include babies born from 34 weeks onwards.

Safety Action 4

A workforce paper covering January- June 2023 was presented to MDG and Quality and Performance Committee on 13 September, and Trust Board on 14 September 2023. This is included in *appendix 4-1*.

However, there was further work required to complete the relevant audits and it was considered that a quarterly paper would give the Trust Board more oversight of maternity and neonatal staffing. Therefore, the Trust Board are asked to note the Workforce Paper for Q2 23/24 *(appendix 4-2)* with 6 months of audit data. The paper has been shared with Board level safety champion and the LMNS at MDG on 3 January 2024.

The report includes the following action plans:

- Consultant attendance in emergency situations *(appendix 4-8).*
- The neonatal nursing workforce action plan *(appendix 4-10).*

Safety Action 5

A workforce paper covering January- June 2023 was presented to MDG and Q&P on 13 September, and Trust Board on 14 September 2023. This is included in *appendix 4-1*.

However, there was further work required to complete the relevant audits and it was felt that a quarterly paper would give the Trust Board more oversight of maternity and neonatal staffing.

Therefore, the Trust Board are asked to note the Workforce Paper for Q2 23/24 *(appendix 4-2)* with 6 months of audit data. The paper has been shared with Board level safety champions and the LMNS at MDG on 3 January 2024.

This includes the action plan to address the shortfall in one-to-one midwifery care in labour *(appendix 5-3).*

Recommendation - We ask the Board to review the Q2 workforce paper *(appendix 4-2)* presented at this meeting for compliance with safety action 4 and 5 including actions plans as listed.

Safety Action 6

We ask that the Trust Board confirm to the ICB the following as required for compliance:

- Within our organisation we have a dedicated lead midwife (0.4 WTE) and lead obstetrician (0.1 WTE) per consultant led unit for fetal monitoring have been appointed and are in post.

The job specifications are in *appendix 6-2* and we can confirm that these posts are appointed to.

We have in post:

- An obstetric consultant lead for pre term birth, delivering care through a specific pre term birth clinic, or within an existing fetal medicine service.
- An identified local preterm birth/perinatal optimisation Midwife Lead
- A Neonatal consultant lead for preterm and perinatal optimisation
- A Neonatal Nurse lead for preterm and perinatal optimisation

We have a consultant obstetrician in post, Dr Rebecca Evans-Jones, that leads on preterm birth and we have recently appointed a lead midwife who started on 12 October 2023. We have two consultant neonatal nurses in post that cover the consultant and nurse leads. Job descriptions are in *appendix 6-3*.

Safety Action 8

The Trust Board is asked to approve our local training plan for version 2 of the core competency framework, this includes fetal monitoring and surveillance, emergencies and MDT training and neonatal life support *(appendix 8-1 and 8-2).* The plan has been agreed with the quadrumvirate before sign-off by Maternity Delivery Group and the LMNS on 28 November.

Recommendation - We ask the Board to review and approve the 2023 Training Plan *(appendix 8-1)* presented at this meeting for compliance with safety action 8.

Safety Action 9

We produce a monthly PQS report (*appendices 9-1 to 9-5*) in line with the Trust internal reporting system that includes information regarding safety intelligence, a review of maternity and neonatal quality using a minimum data set including a review of thematic learning of all maternity Serious Incidents (SIs), concerns raised by staff and service users and progress and actions relating to local improvement plans, such as the patient safety walk-arounds. It also includes patient feedback from FFT and the patient and staff experience report, minimum staffing and training compliance. This is shared monthly with MDG and the LMNS, who share it with the ICB and region and bi-monthly to Quality and Performance Committee and Trust Board. Q4 22/23 paper was submitted to Trust Board in July 2023, Q1 paper was taken to an extra-ordinary Board in September. The monthly paper was taken to Q&P Committee in October with highlights and exceptions reported to Board in November.

Recommendation - We ask the Board to review the Q2 paper *(appendix 9-11)* presented at this meeting for compliance with safety action 9. This includes evidence that the Maternity and

Neonatal Board Safety Champions are supporting the perinatal quadrumvirate in their work and to identify any support required of the Board.

Safety Action 10

Recommendation - The Trust Board is asked to note reportable incidents within the Q2 Perinatal quality and safety report and the evidence that families receive a letter containing information on the role of HSIB/MNSI/EN Scheme and information that complies with our statutory duty of candour.

The corresponding MIS submission report is to provide assurance to the Trust Board that we are fully compliant with all 10 safety actions, presenting the standards and evidence of each safety action (including the evidence included above).

The Trust Board are recommended to give their permission to the CEO to sign the Board declaration form with compliance on all 10 safety actions prior to submission to NHS Resolution.

Enclosures
MIS Year 5 Submission Report Appendices (Zip Folder)

Gloucestershire Hospitals
NHS Foundation Trust

QUARTERLY MIDWIFERY, MATERNITY AND NEONATAL STAFFING REPORT

QUALITY AND PERFORMANCE COMMITTEE – 29th November 2023

BOARD – 11th January 2023

MATERNITY STAFFING REPORT

1. Purpose of Report

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

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

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

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

2 Background

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

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

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

2.4 Midwifery Staffing expectations include the following:

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

3 Executive Summary

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

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

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

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

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

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

3.6 Midwifery staffing remains on the risk register with RISKS:

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

4 Birthrate Plus Workforce Planning

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

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

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

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

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

5 Midwifery Staffing

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

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

5.3 During September 2023 there was combined **52.24 WTE** shortage of midwifery staff due to vacancies, maternity leave, and sickness absence, a reduction from the summer months which peaked at 63.57 for July.

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

Month (2023)	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
Combined shortfall (WTE)	44.26	35.74	53.69	51.76	56.44	57.81	63.57	62.38	52.24

5.4 The **vacancy of 23.5 WTE is multifactorial** due to resignations associated with retirement, dissatisfaction with midwifery, internal and external promotion or movement into non-clinical post and health related reasons as well as an increase in establishment associated with Ockendon clinical funding. In addition, some long-term sick is converting to leavers as illustrated in the reducing sickness rate. It is noted that many staff are opting to reduce hours or resign, whilst converting to Bank contract.

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

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

	Band	Funded establishment			WTE in Post			
		Dec 22	June 23	Sep 23	July 22	Dec 22	Jun 23	Sep 23
Managerial Position	8/9	6	9.2	9.2	6.8* (*1 WTE LTS)	5.8*	10.2*	10.2*
Specialist Midwives	6/7	15.71	17.07	17.67	22.63	21.65	20.35	25.32

5.7 Below is the breakdown of the midwifery clinical establishment

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

		Funded Establishment			WTE in post		
	Band	**Dec 22**	**June 23**	**Sep 23**	**Dec 22**	**June 23**	**Sep 23**
Team Leaders	7	22.16	27.52	20.34	25.36	25.80	24.8
Clinical Midwives	5/6	218.25	218.25	223.79	198.55	184.55	195.83
Total		**240.41**	**245.77**	**244.13**	**223.91**	**210.35**	**220.63**

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

		Funded			WTE in post			
Role	**Band**	**Dec 22**	**Jun 23**	**Sep 23**	**July 22**	**Dec 22**	**Jun 23**	**Sep 23**
Director of Midwifery	9	1.0	1.0	1.0		0	1.0	1.0
Head of Midwifery	8C	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Consultant Midwife	8B	0.6	0.6	0.6	0	0	0.6	0.6
Lead Midwife (Healthy Lifestyles & TDD)	8A	0.6	0.6	0.6	0	0	0.6	0.6

		Funded			WTE in post			
Role	**Band**	**Dec 22**	**Jun 23**	**Sep 23**	**July 22**	**Dec 22**	**Jun 23**	**Sep 23**
Midwifery Matrons	8A	3.0	5.2	5.2	3.8	3.8	5.2	5.2
Safeguarding Midwife	8A	0.4	0.8	0.8	0.4	0.4	0.8	0.8
Governance Lead	8A	1.0	1.0	1.0	1.0	1.0	1.0	1.0
Specialist Midwives	6/7	19.96	17.07*	17.67	22.62	21.62	20.35	25.32
	Total	20.96	18.07	18.67	23.62	22.62	21.35	26.32

6 Midwifery Recruitment and Retention

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

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

6.3 There are currently 23.5 WTE (Sept 2023) vacancies in the clinical workforce funded establishment.

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

6.5 In the period, Jul – Sept 2023 17 new Midwives have joined the trust having accepted the 'Golden Welcome'.

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

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

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

7 Turnover, absence and sickness

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

Table 8: Staffing leave/ absence and secondment Jul-Sept 23* *(Source: Health-Roster)* *
March 22 included as comparator

Month/Yr	WTE			
	Sickness	Maternity Leave	Vacancy	Total
Mar 22*	**35.13**	**13.96**	**28.73**	**77.82**
Jul 23	16.26	10.46	36.85	62.97
Aug 23	15.36	14.32	32.7	53.18
Sept 23	15.84	12.9	23.5	52.25

7.2 It is notable that the peak associated with absence in March 2022 led to a combined rate of 77.82 WTE. Now, vacancy rates, sickness and maternity leave are settling.

7.3 Temporary staffing fill has included both agency and bank. Whilst fill rate has varied between 19.96 and 20.01 WTE, it has not met the demands associated with midwifery absence and the vacancy rate however it has enhanced safer staffing.

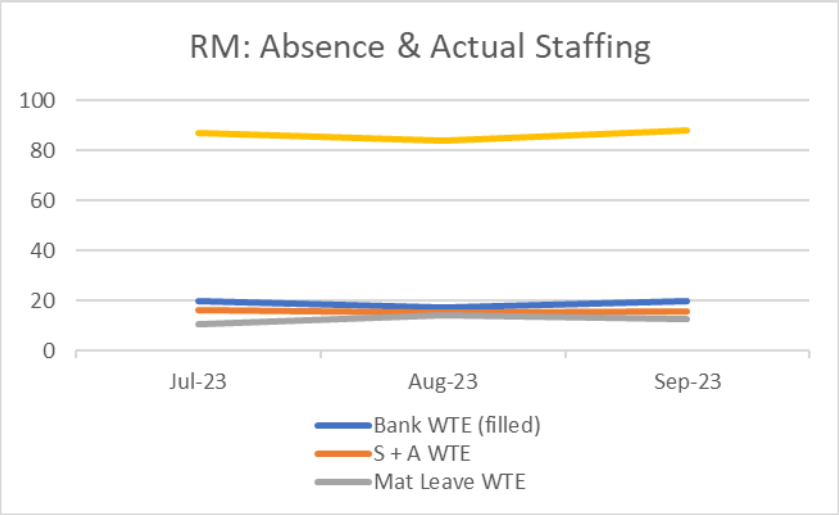
7.4 The use of Bank nurses has been well received supporting midwives on the maternity ward and on delivery suite to care for high risk surgical and medical patients and fixed term roles for Band 5 nurses now in place.

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

7.6 Eight HEE funded places have been acquired for March 2024 and communication about recruitment to these places are in progress. Currently

five RN's are in post on fixed Term Contracts on maternity ward with another 1.0 going out for a recovery nurse on Central Delivery Suite.

Graph – Midwifery Absence and Fill rates Jul- Sept 23:



7.7 In response to the poor staffing rates, actions within the service have included closure or reconfiguration of elements of the maternity service

8.0 Midwifery leadership

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

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

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

8.4 The Band 7 Flow & Quality midwife are supported 24 hours a day, 7 days a week either by the "Band 8 of the day" or the Senior Midwife on call. They are

responsible for liaising with all areas to ensure safe and effective use of resources to ensure safe delivery of care at all times.

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

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

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

9.0 Escalation and Trust risk register entry

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

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

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

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

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

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

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

10.0 Right skills – mandatory training, development and education

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

10.2 The service has identified the need to expand Administrative and clerical roles to release midwifery time. A paper has been submitted to the clinical safety group.

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

Mandatory Day	Overall Compliance		
	Jul	Aug	Sept
Maternity Mandatory Day (Midwives & MCA's Only)	76%	76%	77%
PROMPT (Combined 1&2) (MDT: Midwives, MCA's, Obstetricians & Anaesthetic Team – Theatre team not included in calculation)	82%	82%	77%
Fetal Monitoring (Midwives & Obstetricians)	87%	87%	73%

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

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

Table: Appraisal Compliance rates Jul-Sept 2023

Month	Appraisal compliance %
Jul 23	69%
Aug 23	69%
Sept 23	68%

10.5 The progress in completion rates for maternity has declined reflecting on the pressure over the summer months on our staff and managers. Completion rates averaged at 69% There is still some way to go to reach or exceed 90% completion which the summer months where staffing was very challenging has caused risk associated with compliance.

10.6 The Organisational Development Lead post which commenced in August 2022 is supporting the overall compliance with appraisals.

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

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

11.0 Planned Versus Actual Midwifery Staffing Levels

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

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

Month	Fill rate - percentage
Jul 23	84%
Aug 23	84%
Sept 23	88%

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

Maternity Service Fill rate Jul-Sept 2023 Source: Bank

	Day qualified %	Night qualified %
July 23	82%	80%
Aug 23	78%	77%
Sept 23	78%	76%

11.2 Fill rates have dropped several reasons during school holidays and because of short term sickness, maternity leave, and long-term sickness. This is monitored daily, and staff redeployed based on the acuity. There have been several new starters recently which will improve these.

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

12.0 Birth to Midwife Ratio

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

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

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

Month	Midwife to Birth Ratio
Jul 23	1:27
Aug 23	1:25
Sept 23	1:25

13.0 Specialist Midwives

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

13.2 Some new posts have been recruited to following the BR+ review and there are additional posts that are being recruited to.

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

- Perinatal Mental Health Team
- Vulnerable Women's Team
- Safeguarding Team
- Risk Management Midwife
- Recruitment and Retention Midwife
- Digital Midwife – this team expanded in preparation for Go Live in June 23
- Screening Midwife
- Bereavement midwife
- Contraception Midwife
- Audit & Guidelines Midwife
- Practice Development Midwife

- MSW Project Midwife
- Fetal Monitoring Midwife
- Infant Feeding Support
- Frenulotomy Midwife
- Practice Facilitators (Delivery Suite/Community)

New posts recruited to:
Specialist Midwife: Preterm Birth/Complex Pregnancies
Quality Midwife: PMRT/HSIB/Audit and Guidelines
Specialist Midwife: Treating Tobacco Dependency

14.0 Birth Rate Plus Live Acuity Tool

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

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

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

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

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

- Request midwifery staff undertaking specialist roles to work clinically.
- Elective workload prioritised to maximise available staffing.
- Managers at Band 7 level and above work clinically

- Relocate staffing to ensure one to one care in labour and dedicated supernumerary labour ward co-ordinator roles are maintained.
- Activate the on-call midwives from the community to support labour ward.
- Request additional support from the on-call midwifery manager.
- Review birth unit activity

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

15. Clinical Activity and Staffing

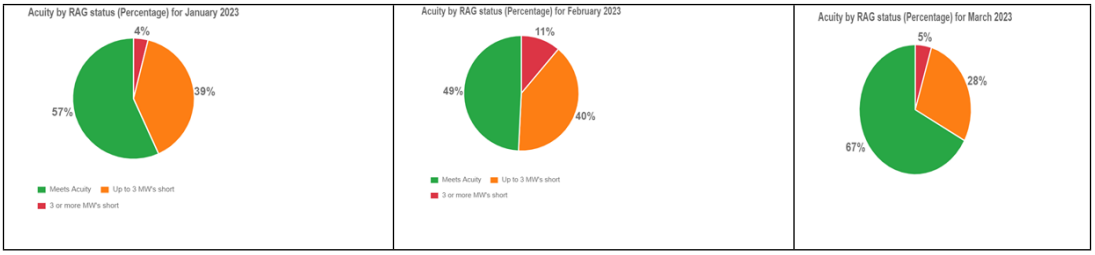
15.1 Acuity is assessed by four hourly recording of staffing and clinical activity is undertaken via the Birthrate Plus Acuity tool on both Gloucester Birth Unit and Central Delivery Suite. The confidence factor related to the Gloucester birth unit data remains consistently low and this will be prioritised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

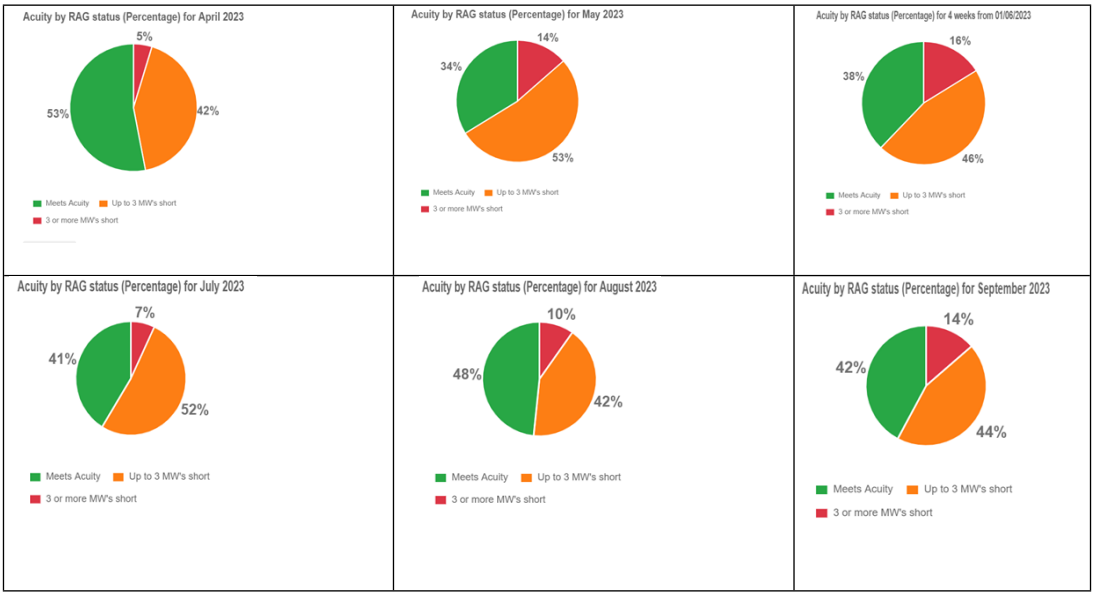
15.2 Despite a very favourable birth to midwife ratio associated with lower than monthly average birth-rates, the incidences of acuity exceeding staffing levels illustrate a variable trend when there are 3 or more midwives short on Central Delivery Suite during the period of January 23 – June 23. This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

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

Month	Jan 23	Feb 23	Mar 23	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23
Staffing levels met acuity	57%	49%	67%	53%	34%	38%	41%	49%	48%

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





16.0 Supernumerary Labour Co-ordinator

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

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

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

	Number of days per month	Number of shifts per month	Compliance
July 23	31	62	100%
Aug 23	31	62	100%
Sept 23	30	60	100%

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

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

17.0 One to One in Established Labour

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

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

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

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

Month	1:1 care in labour compliance
Jul 23	98%
Aug 23	99%
Sept 23	98%
YTD	**98%**

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

	Jul 23	Aug 23	Sept 23
Central Delivery Suite	99%	99%	98%
Gloucester Birth Centre	100%	96%	100%
Aveta Birth Centre	Closed	Closed	Closed
Stroud Maternity Unit	100%	100%	100%

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

18.0 Red Flag Incidents

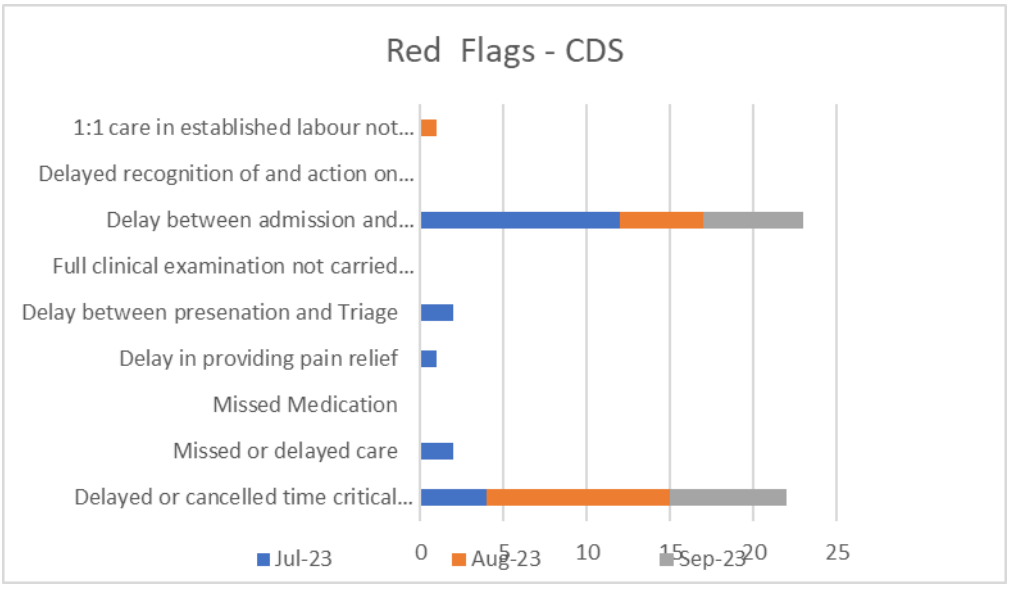
Safer Midwifery Staffing

18.1 Ongoing monitoring of safety metrics and data

- Safe midwifery staffing is monitored by the completion of the Birthrate Plus acuity tool (4 hourly), daily staffing safety huddles, monitoring of the midwife to birth ratio and monitoring of red flags as per NICE Guidance (NICE NG4, 2021).
- The Birthrate+ Acuity tool monitors compliance with supernumerary labour ward co-ordinator status and provision of 1:1 care in labour.
- Red flags are highlighted with a monthly breakdown below

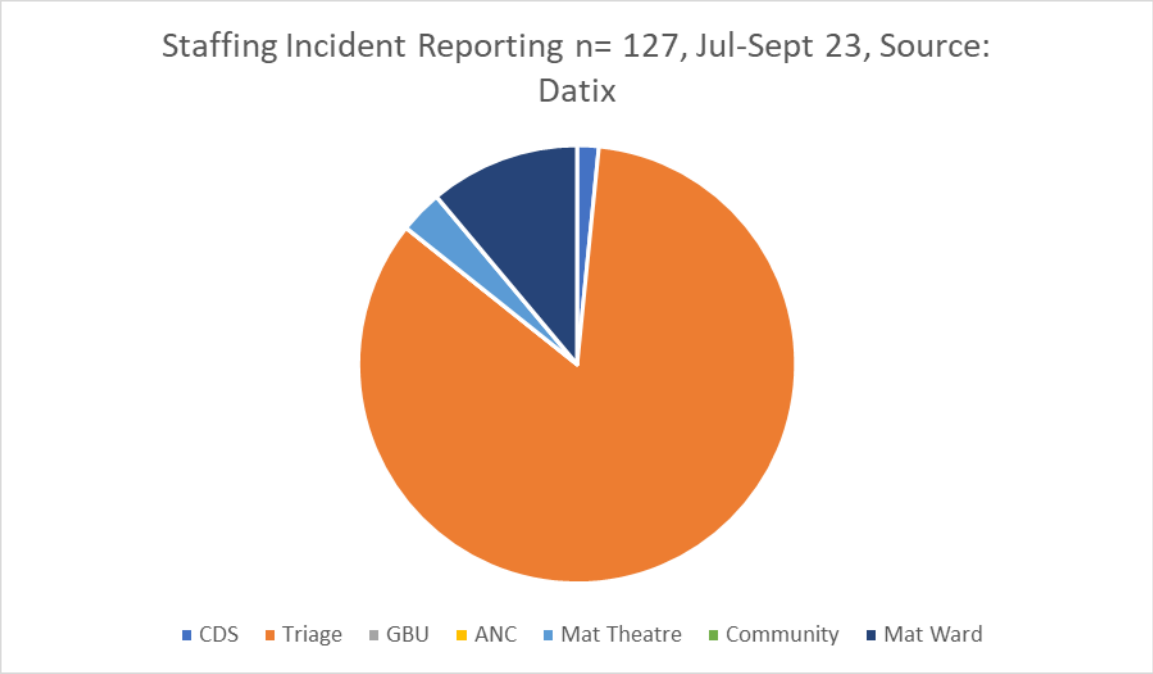
- A midwifery red flag event is a warning sign that something may be wrong with midwifery staffing (NICE 2015). If a midwifery red flag event occurs, the midwife in charge of the service is notified. The midwife in charge will then determine whether midwifery staffing is the cause and the action that is needed. Red flags are collected through the live Birth Rate Plus acuity tool.
- The following tables demonstrate red flag events on CDS during the reporting period:

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



18.2 During the months of January to June there were 123 Datix incidences reported related to midwifery staffing. The majority of these related to insufficient staffing in Maternity Triage. The largest reporting area was Triage particularly in relation to breeches of primary assessment time.

Graph: Incidences associated with staffing Source: Datix



18.3 HSIB referrals are monitored via the maternity dashboard. During the period of July-September 2023 the HSIB referrals fluctuated, with a total of 4 cases. This is monitored via the Quality and Safety Divisional Group and Maternity Clinical Governance.

Month	Jul 23	Aug 23	Sept 23
HSIB referral number	2	1	1

Midwifery Continuity of Care (MCoC) and impact on funded establishment

18.4 NHS England (NHSE) (Oct 2021) has provided guidance to Trusts for the delivery of the MCoC programme. The roll out of MCoC will impact on the establishments as there will need to be redesigned pathways and models of care. This will impact positively upon perinatal outcomes and empowers midwives to achieve excellence in care. The approach, which is underpinned by a changing service delivery, is supported by the NHSE Midwifery Work Force Tools.

18.5 The existing A MCoC service delivery model and business plan is being reviewed to revaluate how we can achieve the national ambition of the MCoC model locally in light of the most recent additional guidance. Three teams were rolled out. One has since paused and the remaining two continue to provide care in the MCoC model.

19.0 Obstetric staffing

19.1 The obstetric consultant team and maternity senior management team acknowledge and commit to incorporating the principles outlined in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service. This includes obstetric staffing on the labour ward and any rota gaps.

19.2 Trusts should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG document when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance. Trusts' positions with the requirement should be shared with the Trust board, the board-level safety champions as well as LMS.

19.3 Trust compliance has been audited for the period covering the 7th June to the 6th July 2023. The aim of the audit was to assess local compliance against RCOG standards for situations where the consultant must attend. The audit identifies compliance against the following situations:

1. Situations where consultant presence is mandated
2. Situations where the consultant should attend, if the registrar is not signed off as competent.

19.4 The audit concludes that a consultant was present in 100% of situations where they MUST attend, and documented compliance in 91% of 'should attend' situations.

19.5 Data collection was challenging as the audit timescale co-incided with the launch of the BadgerNet Maternity EPR. An action plan is included as an appendix to the audit. The findings have been circulated to Maternity Delivery Group and Safety Champions Meeting. Any recommendations following the audit will be monitored.

19.6 The Trust has implemented the RCOG guidance on the engagement of short-term locums in maternity care. An audit of short-term locum doctors working within the Obstetrics & Gynaecology service on tier 2 or 3 (middle grade) rotas for the period February – August 2023 demonstrates 100% compliance with the criteria contained within the guidance.

19.7 The Trust has implemented the RCOG guidance on engagement of long-term locums in maternity care.

19.8 Following an audit of long-term locums working within the Obstetrics & Gynaecology service for the period February – August 2023, the Trust has been unable to demonstrate full compliance with guidance.

19.9 During this time period, the Trust employed one long-term locum, a locum Consultant. An audit of the recruitment process for this individual has shown that the RCOG monitoring and effectiveness tool was not completed as part of the recruitment process.

19.10 As a result, an action plan to review and update the recruitment and onboarding process for all long-term locums working within maternity care has been developed. The recruitment and onboarding process now includes completion of the RCOG monitoring and effectiveness tool.

19.11 The Trust will undertake further audits covering the period September 2023 – March 2024 to provide assurance and evidence of improved compliance. Findings will be presented at Maternity Delivery Group and Safety Champions Meeting and any recommendations following the audit monitored.

19.12 The Trust has implemented the RCOG guidance on compensatory rest to ensure that all consultants/senior SAS doctors working as non-resident on-call out of hours are not undertaking clinical duties following busy night on-calls disrupting sleep, without adequate rest.

19.13 The Trust has an agreed standard operating procedure in place to support the provision of compensatory rest as recommended by the RCOG.

19.14 The job plans of the Obstetric Consultant Team reflect the requirement for compensatory rest with job plans arranged to allow for a day off following a Monday-Friday on-call and provision for any direct clinical care (DCC) activity following a Sunday or Bank Holiday to be either cancelled / covered by another member of the Consultant Team.

19.15 An audit of the Obstetric Consultant on-call rota for October 2023 demonstrated that all Consultants working non-resident on-call out of hours were able to take the required amount of compensatory rest in the period immediately following their on-call.

20 Anaesthetic staffing

20.1 There is not update to Anaesthetic staffing from the previous paper as fully compliant. For safety action 4 of the maternity incentive scheme evidence must be provided to demonstrate that a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should have clear lines of communication to the supervising anaesthetic consultant at all times.

20.2 Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

20.3 The obstetric anaesthetist is a member of the delivery unit team. Approximately 60 per cent of women require anaesthetic intervention around the time of delivery of their baby. The staffing of anaesthetics for maternity services is allocated according to the RCoA GPAS 2023 and ACSA standard 1.7.2.1.

20.4 The duty anaesthetist's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention. The duty anaesthetist will be a Consultant, an anaesthetic trainee or a staff grade, associate specialist and specialty (SAS) doctor. Gloucester Hospitals Maternity service is fully compliant with this recommendation.

20.5 There is a duty anaesthetist immediately available for the obstetric unit 24/7. This person's focus is the provision of care to women in labour or who, in the antenatal or postpartum period, require medical or surgical attention. The role should not include undertaking elective work during the duty period. GHT Maternity Service is fully compliant with this recommendation (Appendix 2 Obstetric Anaesthetic Rota GHNHSFT).

20.6 The duty anaesthetist has a clear line of communication to the supervising consultant at all times

The following demonstrates compliance with this standard by month.

	Jan 23	**Feb 23**	**Mar 23**	**Apr 23**	**May 23**	**Jun 23**
% compliance	100%	100%	100%	100%	100%	100%
	July 23	**Aug 23**	**Sep 23**			
	100%	100%				

20.7 In summary, to meet the NHSR MIS Standards (2021) GHT can confirm that there is a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant at all times. (RCoA GPAS 2023 and ACSA standard 1.7.2.1).

21.0 Neonatal medical staffing

21.1 To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing.

21.2 The Neonatal Unit are budget compliant with meeting the Local Neonatal Units Standards of Tier 1 and Tier 2 separate rotas for the junior medical workforce to meet BAPM requirements.

21.3 There are gaps within the rotas due to sickness absence and maternity leave, however these gaps are filled largely by internal locums. The LMNS have been informed of these standards being met through the SW NICU/LNU Medical Workforce Stocktake.

22 Neonatal nursing staffing

22.1 To meet safety action 4 of the maternity incentive scheme the neonatal unit needs to demonstrate that it meets the service specification for neonatal nursing standards.

22.2 The Trust is required to formally record to the Trust Board minutes compliance to BAPM Nurse staffing standards annually using the Neonatal Nursing Workforce Calculator (2020). For units that do not meet the standard, the Trust Board should agree an action plan and evidence progress against any action plan previously developed to address deficiencies. A copy of the action plan, outlining progress against each of the actions, should be submitted to the LMNS and Neonatal Operational Delivery Network (ODN).

22.3 The Neonatal Unit is part of the Paediatric Service Line and is part of the Women and Children's Division.

22.4 The Clinical Lead and Matron; together with the Senior Sisters and other Neonatal Consultants comprise the Neonatal Unit Management Team and will devise the strategic plan for the unit. The Team will meet regularly to discuss on-going issues and will participate in Neonatal Risk and other meetings.

22.5 The unit is funded for 10 neonatal nurses and 1 nursery nurse on every shift and this is amended based on occupancy and dependency of the babies as per BAPM guidelines. Unit activity for Jan to June 23 has varied from 55% to 91% cot occupancy (monthly averages – staffing funded figures are based on an average of 80% occupancy). Fluctuating activity makes staffing consistently to BAPM standards for ratios of nurses to babies, alongside the necessity to adhere to differing ratios for acuity of NNU patients challenging (nurse:pt ratio of 1:1 for ITU, 1:2 for HDU, 1:4 for Special Care/Transitional Care). This is addressed by trying to flex nurses off days/nights with less activity/acuity (whilst maintaining a safe minimum staffing level to cope with anything that may present) and onto busier days, using annual leave flexibly, flexing admin, teaching and study time. This often relies on the goodwill of staff to change shifts/take leave at short notice however.

22.6 The unit funding for nursing staff also covers provision of outreach support to ex-NNU patients on home oxygen (19 babies as of June 2023), providing developmental assessment in follow up clinics, weekly ROP clinic support, providing senior Education nurse to maternity PROMPT training monthly and staffing a Palivizumab clinic through the winter months.

22.7 The Unit had a GIRFT deep dive visit on 24th May 2022. At that point in time Neonatal Qualification in Speciality (QIS) rates were at 63% which is below national recommendation of 70%. In January to June 2023 QIS rates averaged 65%. This remains below national recommendations but will improve to 68% in September presuming satisfactory completion of the course by this year's cohort of two attendees and no other changes to workforce. The QIS course runs annually, four places for September/December 2023 have been funded by the ODN and members of staff identified to fill these which will improve QIS rates but not until course completion in the summer of 2024. The only other way to improve QIS compliance is to recruit in staff who already have the qualification however there is a small pool of such staff nationally and they are not traditionally a very mobile workforce.

22.8 The Unit remains challenged in relation to nurse staffing. August 2023 nurse staffing figures demonstrate a gap of 18 WTE (or 26%) comprised largely of maternity leave, long term sickness absence, a small number of vacancies and a small number of staff appointed but not yet in post. Maternity leave is predicted to rise from its current level of 6.2 WTE (August 2023) to a peak of 9.6 WTE (Oct/Nov/Dec 2023). The impact is roughly equally spread across both QIS and non-QIS nursing staff. Actions to mitigate have included attempts to boost the neonatal nurse bank through targeted recruitment adverts, liaison with DCC to identify any staff with transferable skills willing to

take on bank, efforts to boost support services (admin and clerical roles, housekeeping, Band 4 nursery nurses) to reduce non-nursing tasks being carried out by nursing staff, and liaison with bank office to source and manage temporary staffing options to fill gaps.

22.9 An action plan has been developed to provide oversight of all activity relating to recruitment and retention on the Unit.

Neonatal Workforce Action plan	Sept 23	Dec 23	March 24
Closed	28		
Overdue	16		
In Progress	15		
Complete	24		
Total number of elements	**83**		

22.10 Escalation plans have been instigated when activity increases/staffing is impaired to support nursing which has included utilising all nursing time into clinical shifts (cancelling/postponing study leave/admin time/teaching days), flexing staff on and off shifts to match demand and booking of bank/agency nurses.

22.11 Agency and bank are utilised if required however there is a very limited pool of bank/agency staff with neonatal skills, especially so if QIS cover is needed, and these staff tend to be employed with the higher agencies and are consequently more expensive.

22.12 Staffing is regularly reviewed with the South West Neonatal Network and Gloucester was awarded £52,600 from June 2023 for nurse quality roles (Education and Governance) to bring the unit closer to recommended staffing numbers in these areas. Whilst these posts have been filled they have been so from existing staffing pool.

22.13 The neonatal unit records all of its nursing numbers and acuity data on the electronic system Safe Care Live and this is reviewed daily by the senior nursing team to ensure the staffing is as per recommendation. Nursing skill mix is based on BAPM guidance and recorded on Badger which is also reviewed by the team locally as well as the Neonatal network.

22.14 A review is underway to review medical and nursing workforce. The outcome of this may lead to an action plan. Once completed this will be shared with the LMNS and Safety Champions and monitored via MDG.

23.0 Conclusions

23.1 The data within this report provides assurance that there are effective workforce planning tools being used currently to review current establishments. This report describes the urgent action being taken to tackle the staff shortages and the increased pressures this has on staff, which have been exacerbated by the Covid-19 pandemic and ongoing national maternity scrutiny.

23.2 Incident reporting on staffing, Red Flags and birth to midwife ratio illustrate a concerning picture within midwifery staffing. Initiatives to enhance recruitment and retention are being actioned and it is anticipated that the next 6 months will see an improved recruitment picture. Attrition continues to be of significant concern and actions to address this are ongoing.

23.3 Obstetric Consultant presence audit has concluded that in the period covering the 7th June to the 6th July 2023 that a consultant was present in 100% of situations where they MUST attend, and documented compliance in 91% of 'should attend' situations. There were data collection challenges which have been included in the action plan

23.4 Whilst the audit of short-term locum doctors demonstrates 100% compliance with the criteria contained within the guidance, the trust have been unable to demonstrate full compliance with guidance on long term locum. An action plan has been developed.

23.5 The Neonatal unit continues to be challenged around neonatal nurse staffing. An action plan has been developed which will be monitored in MDG

24.0 Recommendations

24.1 It is recommended for the Board to note the contents of the report and formally record to the Trust Board minutes non-compliance with BAPM standards for both neonatal nurse staffing and agree to the action plan

24.2 It is recommended that formally record to the Trust Board minutes non-compliance with RCOG audits and to note that an action plan has been developed and monitored through MDG.

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Perinatal Quality and Safety

Q2 2023-2024 (July-September data)

Glossary

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

Contents

Contents

Introduction

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

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

The report has been divided into:

- Mortality and Morbidity
- Safety
- Workforce
- Quality
- National Assurance Programmes

Monthly Dashboard

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

		2023/24											
	Benchmark		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Morbidity and Mortality														
1. Direct Maternal Deaths		0	0	0	0	0	0	0						
2. Serious Incidents														
2.1 New SIs (excluding MNSI referrals)		0	0	0	0	0	0	3						
2.2 Open SIs		0						4						
2.3 MNSI Referrals (also SI's)		0	0	4	1	2	1	1						
3. Moderate Harm Incidents		0	0	0	1	0	2	11						
4. Stillbirths rate per 1000 live & stillbirths	LMNS Target	<=2.52	4.7	5.9	2.1	0.0	2.3	2.2						
5. Neonatal mortality rate per 1000 live births	LMNS Target	<=0.89	0.0	0.0	0.0	0.0	6.9 (4.6> 24 wks)	2.2						
6. Coroner Reg 28 made directly to Trust		0	0	0	0	0	0	0						
7. Incidents														

	2023/24													
	Benchmark		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
7.1 Reported			123	124	137	147	185	171						
7.2 Overdue (incidents open> 30 days, i.e. at 1st day of the preceding month being reported)	=/<20	0	217	271	198	166	71	15						
Safety														
8. Risks														
8.1 Risks on register		NA	18	18	19	19	18	18						
8.2 Overdue actions on risk register		0			5	3	2	6						
9. Training Compliance YTD														
Mandatory Training	National													
Midwives	(by 1/12/23)	90%	85%	75%	84%	70%	78%	74%						
MSW's/MCA's		90%	72%	65%	71%	72%	72%	57%						
Prompt Part 1														
Midwives			80%	85%	84%	84%	84%	83%						
MSW's/MCA's			75%	75%	68%	67%	67%	69%						
Obstetricians			61%	90%	100%	100%	100%	62%						
Anaesthetics			58%	61%	69%	66%	66%	60%						
Theatre Staff			57%					82%						
Prompt Part 2														
Midwives			84%	85%	94%	88%	88%	84%						
MSW's/MCA's			74%	68%	75%	69%	69%	69%						
Obstetricians			67%	98%	100%	100%	100%	62%						
Anaesthetics			58%	61%	69%	68%	68%	60%						
Theatre Staff			66%					84%						
Fetal Monitoring														
Midwives			83%	86%	96%	89%	59%	73%						
Obstetricians			46%	82%	74%	75%	75%	72%						
10. Periprem Births <27 wks		0	1	1	0	2	1	1						
11. Term Admissions to Neonatal Unit (ATAIN) percentage		5%	2.6%	3.9%	3.9%	4.6%	2.2%	3.3%						

	2023/24												
	Benchmark		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
12. NICE Guidance														
Number action plans overdue		0	22	2		3	3	3						
13. Audit/Guidelines Programme														
14. POPAM Storage		95%	99%	99%	100%	98%	100%	100%						
Workforce														
15. Annual Survey														
15.1 Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment – reported annually			36.9	36.9	36.9	36.9	36.9	36.9						
15.2 Proportion of speciality trainees in Obstetrics & Gynaecology responding with 'excellent' or 'good' on how they would rate the quality of clinical supervision out of hours – reported annually			90.7	90.7	90.7	90.7	90.7	90.7						
16. Medical Staffing														
16.1 Gaps in Medical Rota- Mid Staff Grade	TBA		44	49	39	31	16	16						
16.2 Obstetric Consultants	TBA		6	4	0	0	0	2						
17. Midwifery Staffing														
17.1 Midwifery vacancy rate %	TBA		12.8	13.9	14.9	14.4	13.3	9.6						
Quality														
18. Service User Voice Feedback														
18.1 FFT- % of responses that are positive			86.7	83.1	72.7	87.1	80.4	76.9						
19. Legal Scorecard	Quarterly Review													

	2023/24													
	Benchmark		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
National Assurance Programmes														
20. Ockenden 2														
Actions Completed	National	92												
21. CQC Section 29a	Local	41												
Actions graded as blue								27						
Actions graded as green								6						
Actions graded as amber								6						
Actions graded as green								2						
22. Maternity Incentive Scheme Y5	National													
Safety Action		Current Compliance RAG Status												
1: National Perinatal Mortality Review Tool														
2: Maternity Service Data Set (MSDS)														
3: Transitional Care and ATAIN														
4: Medical Workforce Planning														
5: Midwifery Workforce Planning														
6: SBLCB														
7: Patient Feedback														
8: In-House Training														
9: Board Assurance on Maternity and Neonatal Safety and Quality Issues														
10: HSIB/NHST Reporting														
Denotes no available or comparable data														

Morbidity and Mortality

1. Direct Maternal Deaths

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

2. Serious Incidents

2.1 New Si's

Incident No.	Incident Detail	Latest Update
Sept W221531	24+5 Pre-term birth. High risk for pre-term birth, not seen in pre-term birth clinic **Immediate problems/concerns:** - Not referred to pre-term birth clinic - Capacity issue in pre-term birth clinic - Tertiary NICU not contacted and advised of situation	To be presented to SI panel
Sept W220170	ELCS, AFE, cardiac arrest, DCC admission **Immediate problems/concerns:** - Some staff unaware who is alerted when black anaesthetic 'bell' is used	Harm level agreed by SI panel
Sept W220683	EMCS, PET, liver capsule haematoma, DCC admission **Immediate problems/concerns:** - RN not trained to recognise deteriorating picture in antenatal patients - Escalation, check and challenge theme identified - Patient not cared for in correct location - Out of hours diagnostic USS service not utilised - Patient not reviewed by Obstetrician when presenting to A&ED - Badgernet risk assessment/PET screening requires review - Aspirin not prescribed at booking - Verbal order for meds	Harm level agreed by SI panel

2.2 Open Si's

Incident No.	Category	Latest Update
W206531	Therapeutic Cooling	Draft Report
WC3602Obs	Screening	Trust Patient Safety Investigation ongoing
W213115	Neonatal Bowel Perf	Trust Patient Safety Investigation ongoing

2.3 HSIB/MNSI Referrals (accepted investigations are deemed as Serious Incidents)

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

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

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

- Maternal Deaths: Direct or indirect maternal deaths of women while pregnant or within 42 days of the end of pregnancy
- Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.
- Early neonatal death: when the baby died within the first week of life (0-6 days) of any cause.
- Severe brain injury diagnosed in the first seven days of life, when the baby:
- Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) or
- Was therapeutically cooled (active cooling only) or
- Had decreased central tone and was comatose and had seizures of any kind

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

4 incidents met criteria for referral during the Quarter:

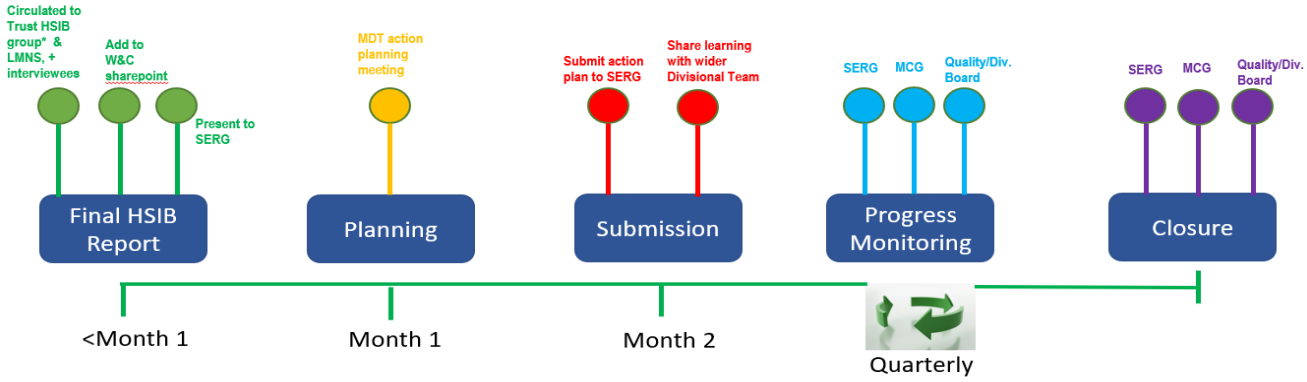
Datix Ref	Ref Category	Incident/Detail	Accepted for MNSI Investigation		Reason for Rejected Investigation
			Yes	No	
July W215202	Cooling	41+2, SRM- review in SMU- ?Thick mec. Arrived in triage and thick particulate meconium confirmed. CTG pathological- CAT 2 LSCS. Mec aspiration, PPHN. On arrival to tertiary unit with SONAR, seizure activity and actively cooled **Immediate problems/concerns** There was senior discussion around contemporaneous documentation, specifically adding notes to patient records after a care episode has finished. Consensus opinion was reached and it was agreed and communicated to all midwives that every effort must be made to maintain contemporaneous records, in exceptional circumstances where this is not possible (i.e. 2nd stage of birth), *the record must be* updated as soon as possible following the episode of care, but within an absolute maximum of 24 hours. Entries after this timeframe, to ensure an accurate audit trail, must be first discussed and agreed by either the Matron for the area or the Patient Safety & Governance Team (formerly known as Risk), who will advise if a further entry should be added to Badgernet or if a formal statement is required	✔		
July W216108	Cooling	IOL transferred from Mat Ward with abnormal CTG. Bradycardia shortly after arrival in CDS - CAT 1 GA EMCS. Thick mec. Baby born in poor condition apgars 0,2,4 **Immediate problems/concerns** There was a potential missed opportunity to have offered	✔		

		earlier IOL which may have prevented the subsequent need for emergency transfer to L3 NNU for therapeutic cooling			
Aug W217227	NND	40+2 previous c-section. Attended triage tightening, ? in labour, abdominal pain. CTG suspicious. EMCS Cat 2. No scar dehiscence or abruption seen. Baby born in poor condition and subsequent neonatal death **Immediate problems/concerns** 2 opiates were given too close together which included an incorrect dose of Diamorphine *Action: Communication to all staff reminding them of timing and dosages of opiates* The patient had previously been discharged with scar pain *Action: Discussion with staff involved*			
Sept W219309	NND	40+1, Pathological CTG, SVB, baby born in poor condition- CFM abnormal, meconium aspiration and PPHN, preparing for transfer to tertiary unit with SONAR but decision made to reorientate care- RIP 6.5 hours of age **Immediate problems/concerns** • Appropriate equipment to be available for all staff • CTGs are not digitalised onto Badgernet system • Checking of centralised fetal monitoring system when in handover • Encourage an environment where staff feel they can interrupt handover • Debrief for staff involved	✔		

Ongoing MNSI investigations:

Incident No.	Category	Latest Update
W212905	Therapeutic Cooling	Interviews complete, information analysis
W215202	Therapeutic Cooling	Referral, info gathering

W216108	Therapeutic Cooling	Referral, info gathering
W217227	Early NND	Referral, info gathering
W210683	Intrapartum Stillbirth	Draft report received; no recommendations made
W211523	Therapeutic Cooling	Interviews complete, information analysis



3. Moderate Harm Incidents

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

There were **13 moderate harm incidents** during the quarter.

Categories:

MOH (WBL of >2000mls)

10 - 3 were instrumental births, 4 were caesarean sections, 3 spontaneous vaginal birth (1 of which was a secondary pph)

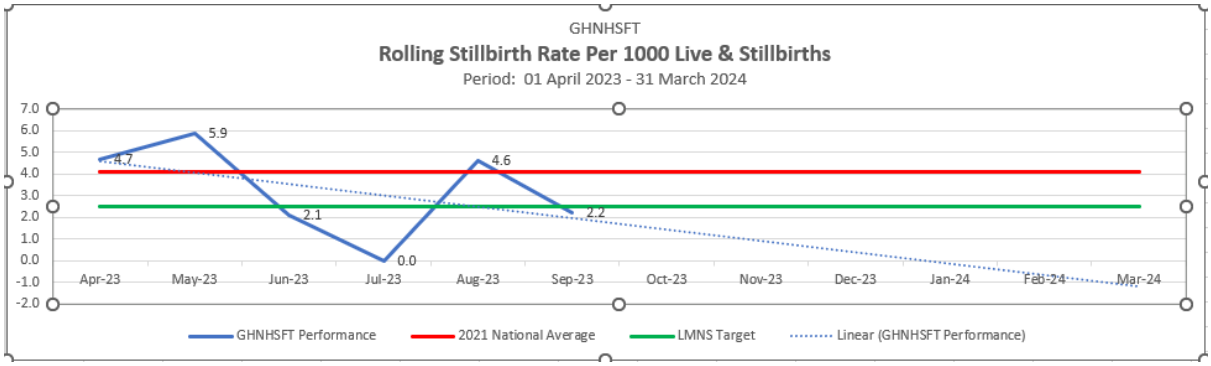
Learning identified and disseminated:

- blood stained liquor/APH = risk factor for PPH -> cannulate & CTG
- Prolonged 2nd stage = risk factor for PPH. Escalate timely If any delays in 2nd stage
- Weight EBL post birth. Call out amounts so MDT aware – allowing early recognition & therefore timely treatment
- Timely administration of uterotonics – think prevention not treatment
- Ensure documentation of events narrates the situation, actions taken and by whom

Shoulder Dystocia

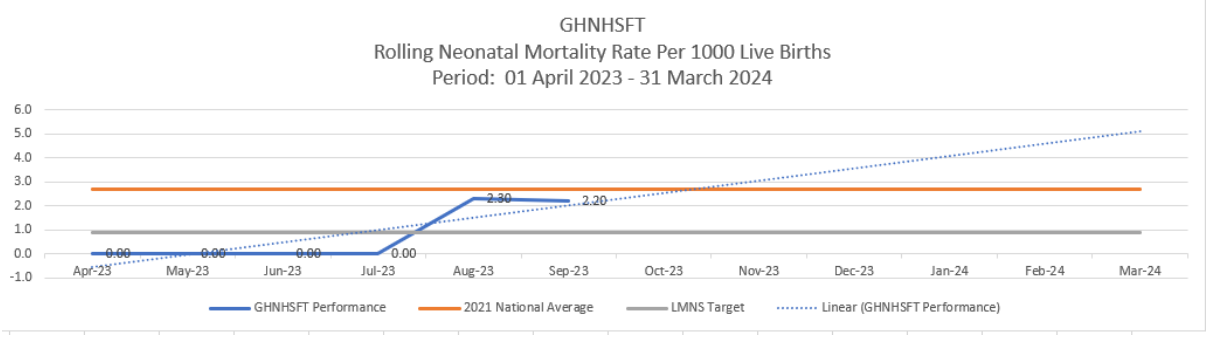
3 – all babies were admitted to the neonatal unit – reviews regarding these cases are ongoing – any learning identified to be disseminated.

4. Stillbirths rate per 1000 live & stillbirths



The Perinatal Dashboard reports 1 stillbirth during September, (2.2/1000 births), however was an incorrect Badgernet data entry, it was added as stillbirth but was fetocide/TOP. This has been reported and the dashboard is awaiting amendment.

5. Neonatal mortality rate per 1000 live births



There were 3 reportable neonatal deaths >24/40, plus 1 20/40 TOP born with signs of life

July: Nil

Aug:

20/40 Termination of pregnancy due to T21, AVSD – born showing signs of life

08/52 8 weeks of age admitted with lethargy and seizures (subsequently diagnosed with genetic/metabolic disorder

40/40 Cat 2 EMCS, RIP 28 minutes of age, SI/HSIB investigation

September (See MNSI/HSIB referral above) :

40/40 baby born in poor condition- CFM abnormal, meconium aspiration and PPHN, preparing for transfer to tertiary unit with SONAR but decision made to reorientate care- sadly died at 6.5 hours of age ().

6. Coroner Reg 28 made directly to Trust

None

7. Incidents

7.1 Reported

503 incidents reported during the quarter

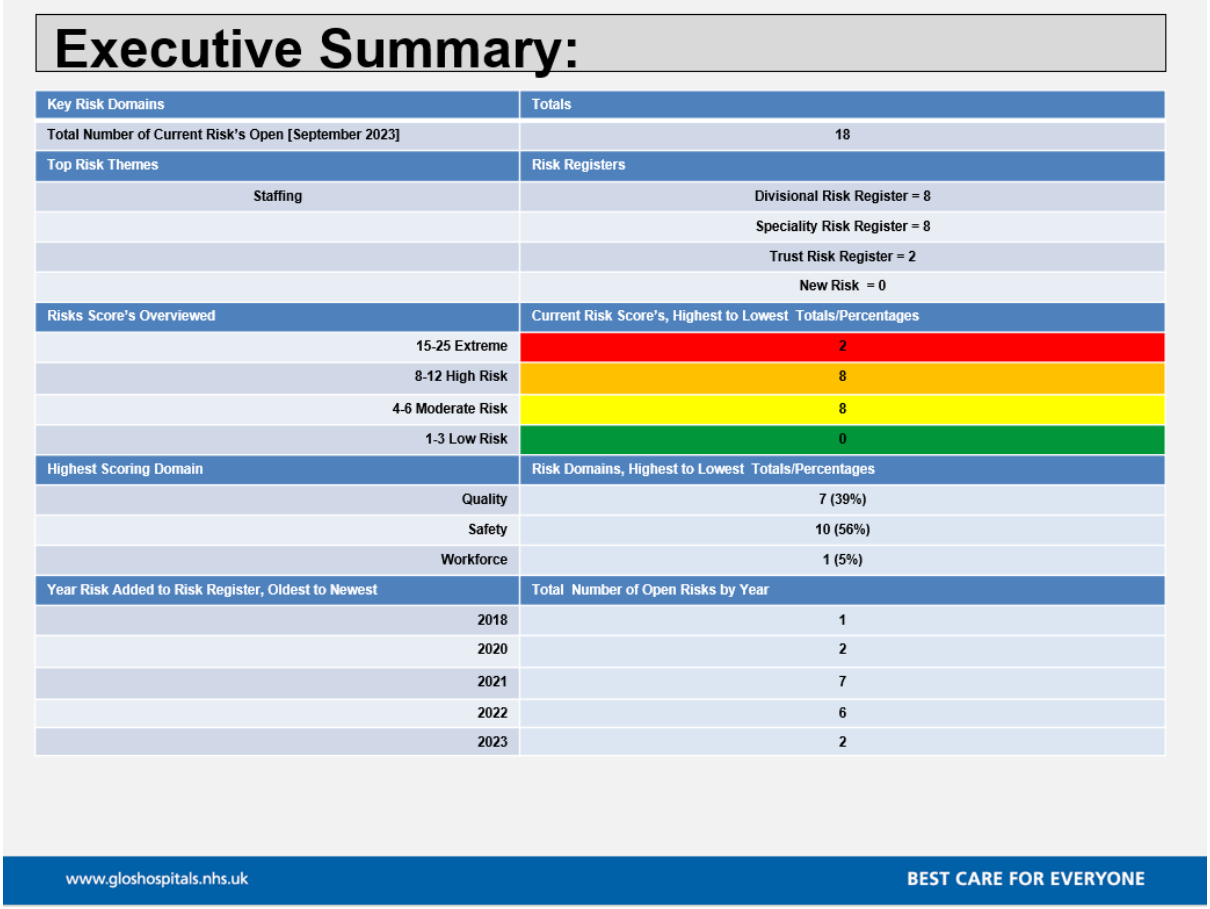
7.2 Overdue (incidents open> 30 days, i.e. at last day of the preceding month being reported).

Overdue incidents were one of the main concerns reported by CQC and formed part of the section 29a served to the Trust. At the end of May 2023 there were 271 overdue incidents. Focused effort has resulted in this figure reducing to **16 by the end of the quarter**. This has largely been achieved through the introduction of a daily safety huddle, which reviews incidents that have occurred in the preceding 24 hours (or 72 hours on a Monday). This ensures a multi-disciplinary real time floor to board overview of both reported and non-reported incidents, highlights any immediate safety actions and enables responsibility to be assigned. Incidents where low or no harm has occurred are closed, however any learning from those incidents is collected and correlated to identify any recurring themes.

Safety

8. Risks

8.1 Risks on register



Executive Summary:

Key Risk Domains	Totals
Total Number of Current Risk's Open [September 2023]	18
Top Risk Themes	**Risk Registers**
Staffing	Divisional Risk Register = 8
	Speciality Risk Register = 8
	Trust Risk Register = 2
	New Risk = 0
Risks Score's Overviewed	**Current Risk Score's, Highest to Lowest Totals/Percentages**
15-25 Extreme	2
8-12 High Risk	8
4-6 Moderate Risk	8
1-3 Low Risk	0
Highest Scoring Domain	**Risk Domains, Highest to Lowest Totals/Percentages**
Quality	7 (39%)
Safety	10 (56%)
Workforce	1 (5%)
Year Risk Added to Risk Register, Oldest to Newest	**Total Number of Open Risks by Year**
2018	1
2020	2
2021	7
2022	6
2023	2

There are two extreme risks on the 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

WC3845Obs Risk of first trimester screening offer being missed (if dating scan occurs after 14+1 weeks gestational window for screening), affecting patient pregnancy options and care pathway

No new risks were added to the register in September, due to the migration from datixweb to datixcloud. At the time of writing this report, concerns have been voiced regarding the efficacy of datixcloud, as nationally there have been issues with its roll-out. There have been ongoing discussions outside of the division regarding reverting to datixweb or continuing with datixcloud. At this point in time the Trust are looking to continue with datixcloud and are reviewing potential work-arounds. The Datix risk system however remains frozen.

8.2 Overdue actions on risk register

Inadequate fire Doors - Obstetric Theatres

- Procurement of new doors, to replace those currently in use, in line with recommendations of Trust Fire Safety Team (obstetric theatre risk)

Surgical Site Infection

- Prepare business case for use of warming gowns for patients having caesarean section
- Liaise with Digital Team regarding post-natal information following c-section on Badgernet

Safeguarding Education

- Develop action plan

Induction of Labour

- QI Project

Management/Transportation of Maternity Notes

- Audit of notes completion and correct filing of records

9. Training

9.1 Safeguarding Children L3

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

Safeguarding training compliance was raised as a concern by the CQC and for this reason the training being offered to staff is currently being reviewed by the Lead Safeguarding Midwife.

At the point of composing this report, safeguarding training comprises of two elements; multi-agency training requires updating every three years, whilst the local training is yearly.

External 3 Yearly Multi-Agency

	Compliance
GHT Total	**56%**
Corporate Division	0%
Diagnostic & Specialty Division	91%
Medicine Division	46%
Surgery Division	22%
Women & Children Division	68%

In order to improve compliance for junior doctors, those employed by the Trust and who will be here until January 24 have been allocated a time slot on the multi-agency training day

Local Yearly

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

Safeguarding training remains in the red with <70% compliance throughout the Division, and whilst in comparison to other Divisions within the Trust our non-compliance is not the worst, it is a CQC concern and therefore requires attention.

9.2 Maternity and Neonatal Training

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

Currently the education team are working on producing the training plan for 2024 and have providing additional training dates to increase our compliance. Once agreed this plan will be formally circulated

10. Periprem Births

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

July: 2

1. 24+2 – Unsafe to transfer due to maternal seizures
2. 24+3 – Arrived at GRH fully dilated

August: 1

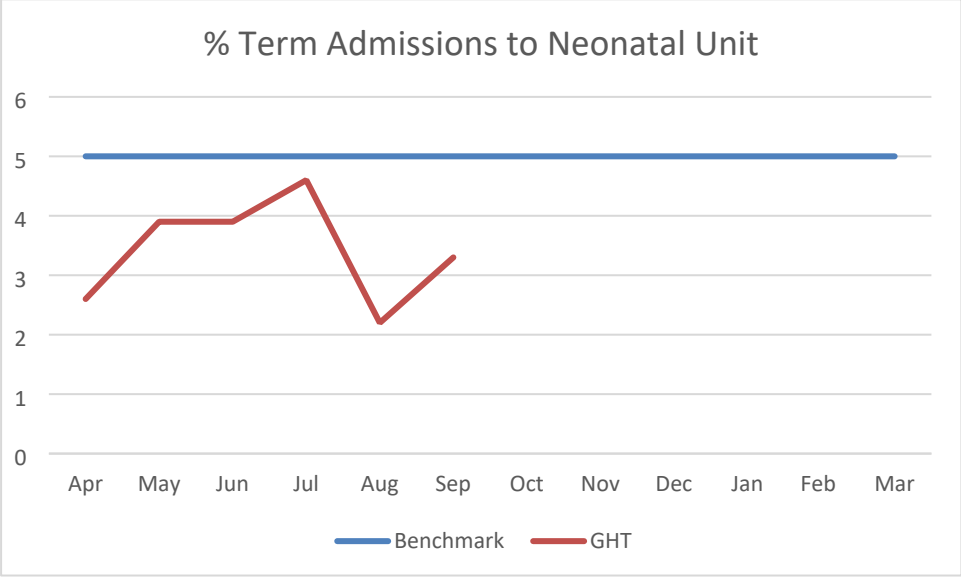
26+4 days singleton: Admitted with known PPROM and APH. Discussed transfer to other unit in view of gestation + bleeding + tightening - not keen to go to Southmead as has 1 & 2 year old children and felt very isolated there last time. Understands in the event of requiring delivery (due to either labour or bleeding) then optimal place of birth would be with neonatal intensive care facilities. Baby born at GRH

September: 1 (also graded as a Serious Incident):

24+5 – previous LSCS at fully dilated – therefore met criteria for pre-term birth clinic. Referral not made until 20+6 – but due to capacity issues was not seen. Admitted at 24+5 in with ruptured membranes and in advanced labour, therefore unsuitable for transfer. Baby transferred ex-utero to Southmead Hospital – this baby remains an inpatient

11. Term Admissions to Neonatal Unit (ATAIN)

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



The September figure of 3.3% is broken down in to the following categories:

	%
respiratory distress	73.0
Other cardio/respiratory issue	6.7
NAS	6.7
Feeding/weight loss	6.7

Hypoglycaemia	6.7

A full ATAIN and TC report with action plan can be found in appendix **11A.**

12. NICE Guidance

Number action plans overdue: 3

Title	Nice Ref	Lead	9 month deadline to confirm action plan completed and/or close via risk register	Comment
Postnatal Care	NG194	K Lilly	01/02/2022	Inherited from SM
I/P Care	CG190	T Jorgenson	01/09/2023	Inherited from AL
Fetal Monitoring in Labour	NG229	L Elbashir/ S Wainfur/	01/09/2023	

13. Audit & Guidelines

There are currently in the region of 46 policies out of date within Maternity, meaning around 35% of our policies are out of date. The newly formed Perinatal Audit and Guideline Committee is a governance group created to review and approve the content of policy and procedural documents prior to presentation to GOGG (Gloucestershire Obstetric Guidance Group) and ratification by TPAG.

The team are currently creating an audit tracker that can be shared with the LMNS to monitor our progress and an update on this will be provided in the November report.

14. POPAM Storage

3 standards are reviewed as part of the Quality & Safety report:

1. Drugs cupboard locked
2. Drugs left out
3. Fridge temperature checked

Overall Compliance %		
July	August	Sept
98	100	100

Workforce

15. Annual Survey

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

Not applicable – yearly report – remains at 36.9%

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

Not applicable – yearly report – remains at 90.7%

16. Medical Staffing

16.1 Medical Gaps in Rota- Mid Staff Grade

16 gaps – all covered with locum posts

16.2 Obstetric Consultants

2 rota gaps – covered with locum posts

17. Midwifery Staffing

17.1 Midwifery vacancy rate %

Midwifery vacancies remain of concern, despite sustained efforts by the Recruitment and Retention team. The vacancy rate remains high but is decreasing at 9.63%.

Initiatives in September include:

- Reward and Recognition ‘Everyday Hero’
- Monthly staff update webinars
- Monthly R&R newsletter continues
- Increased uptake of Registered Nurses additionally to those contracted on both the Maternity Ward and on Delivery Suite.
- Further development on IR recruitment – on track to meet target of 9 by December.
- Continued incentivised bank shifts
- Weekly comms of uptake of shifts.

The Senior Midwifery Team are now all in post. Fill rate remains Green; however, this is still to be benchmarked against other LMNS single provider trusts. Clinical red flags are

captured through 4 hourly Birthrate plus acuity tool. The most common red flag is Delay in continuing the Induction of Labour Process. Compliance of 100% in One-to-one care in labour is still not achieved, August rates are reported at 98%. This is tracked via the Maternity Scorecard. Daily Staffing is assessed via the OPEL tool by the Flow Midwife and escalated to the Band 8 of the Day. The OPEL tool is being reviewed for a web-based tool and is in final stages. There has been delay to this due to capacity of the web-based team and support is requested to expedite this.

Level of fluctuation in staffing numbers on a week-by-week basis is being reviewed by the Head of Midwifery with Matrons being supported to present and monitor KPI's on safer staffing and rota management.

The impact of audit findings arising from consultant presence and Gap analysis of the Roles & Responsibilities of Obstetricians is being used to inform Obstetric Workforce planning

The full report is available as **appendix 17A.**

Quality

18. Service User Voice Feedback

The newly formed Patient and Staff Experience Group functions as a forum that reports to the Maternity Delivery Group via the Women and Childrens Quality and Safety Board. Reports from the meeting are also shared with the LMNS Board. It exists to triangulate all data on patient and staff experience to accurately inform learning and continual improvement of the service.

The purpose of the Patient and Staff Experience Group is to:

- Provide a bi-monthly overview of patient and staff experience within the maternity and neonatal service.
- Identify and share trends and themes not only with those directly involved but all of the team to ensure there is learning and continual improvement of the service.
- Outline work and co production with the MNVP and other patient partnership groups

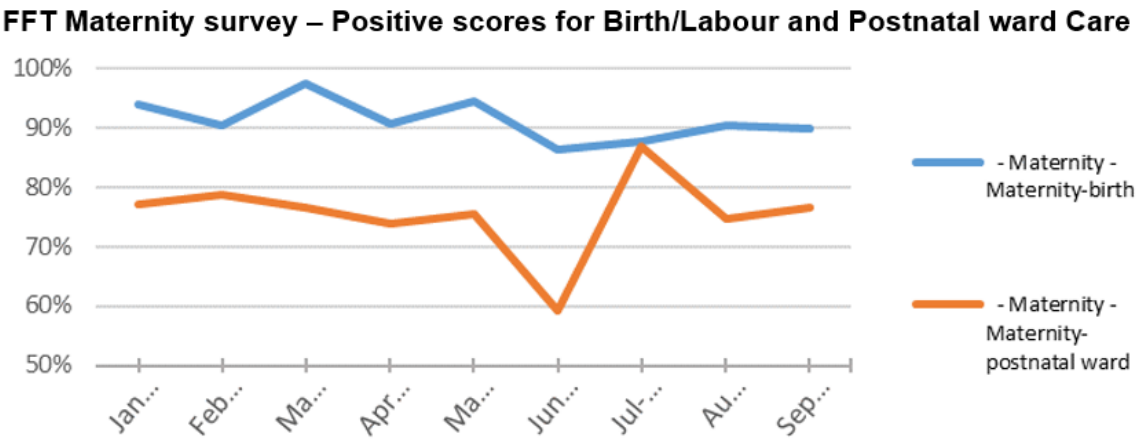
A report on the outcomes of the first meeting can be found in **appendix 18A.**

18.1 FFT- % of responses which are positive Responses

Maternity-birth (Delivery suite/Glos Birth Unit) Feedback is poorer overall, with very complex and unique experiences described. There were a couple of comments about poor experiences in Triage; not being listed to and having to wait longer than ideal. Several people mentioned delays to their induction causing anxiety and stress, and potentially preventable complications. There were also other concerns raised about not being listened to and feelings that last minute decisions may have caused additional pain and complications, increasing risk to mother/baby. Within the positive ratings, there were also a couple of safety concerns raised about being left alone and not feeling safe with the midwife in charge of care.

Maternity-postnatal (Maternity Ward) Very mixed reviews on the Maternity ward, although a more positive tone overall. Compliments on good support with feeding, and general caring attitude of midwives/MCAs. However, there were also comments about general lack of staff and noise on the ward (from other patients and families). There were a couple of mentions about feeling left alone for long periods of time, not receiving pain relief when needed, delayed discharges, and errors with medication.

Row Labels	Very good	Good	Neither good nor poor	Poor	Very poor	Dont know			
⊞Triage Obstetrics Assessment, GRH	1	0	1	0	0	0	2	50.0%	0.0%
⊞Birth Unit, GRH	2	0	0	0	0	0	2	100.0%	33.3%
⊞Delivery Suite, GRH	59	17	4	1	2	0	83	91.6%	-1.2%
⊞Home/Other	0	0	0	0	0	1	1	0.0%	0.0%
⊞Maternity Ward, GRH	35	25	10	5	3	0	78	76.9%	4.6%



18.2 Maternity & Neonatal Voices Partnership

The Q1 MNVP Birth Experience, Engagement and Highlight reports are available in **appendix 18B**.

The MNVP Highlight Report for has been circulated and incorporates data from the MNVP Birth Experience Survey, as well as feedback from engagement in the community. The main areas of concern were:

1. Staffing issues
2. Birthplace choice
3. Delayed pain relief and accurate reporting on notes
4. Feeding support
5. Mental health
6. Triage
7. The need for tours of units

18.3 PALs Summary

14 people raised concerns through PALS in September, which is an improvement when compared with the same period last year when concerns raised were in the early sixties. The predominant theme was around communication, followed by dispute over diagnosis and Trust administration issues.

The full maternity experience report is available as **appendix 18C.**

18.4 Patient Safety Champion Walkabout

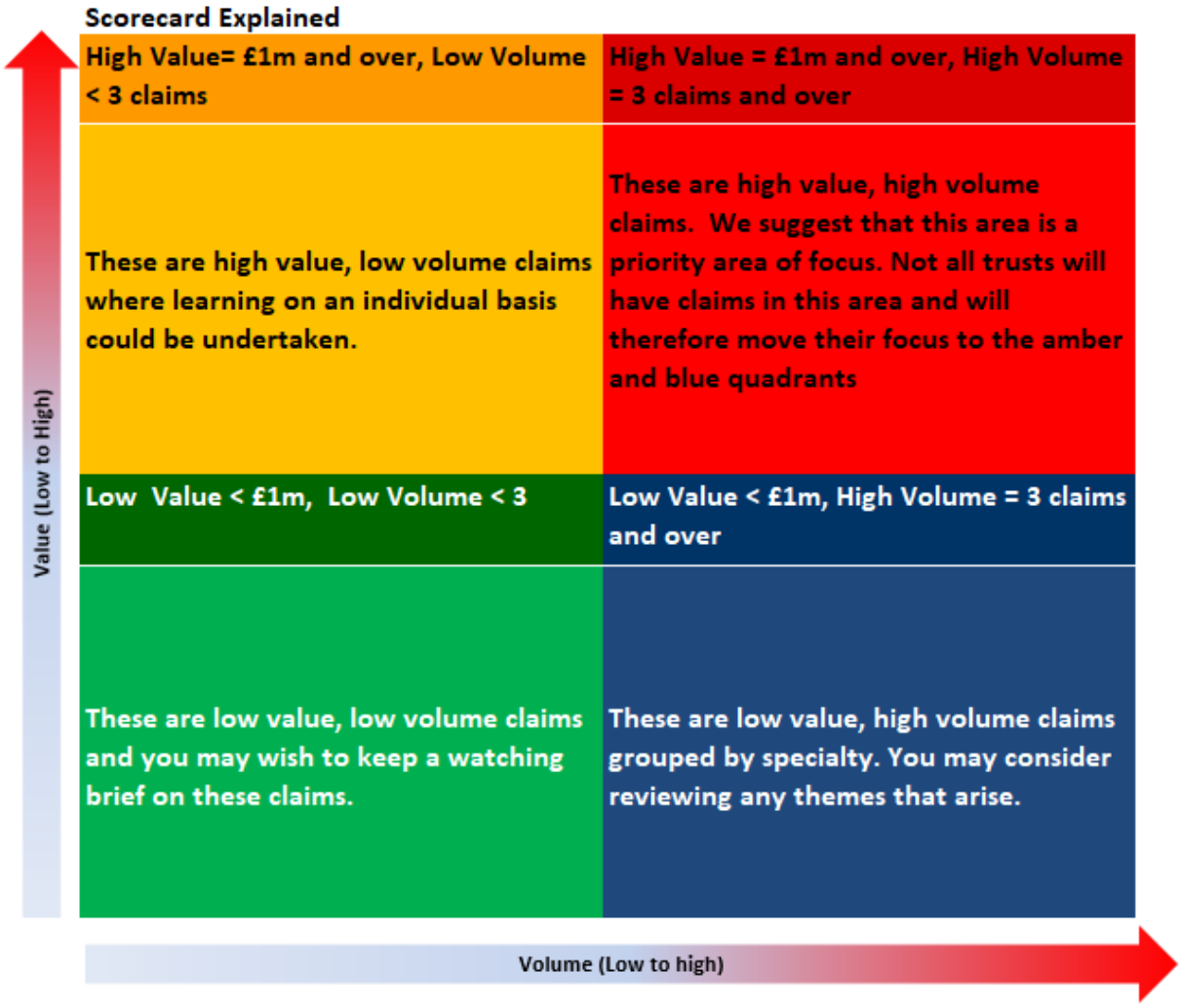
The September walkabout was undertaken at Stroud, where a positive and insightful discussion with the Birth Unit Manager demonstrated what the Maternity Unit means to staff, women and the wider community with a palpable sense of belonging to somewhere special. Staff are now settling into a new type of routine following a difficult time since the closure of beds and adjustments in providing care including excelling with breastfeeding support, coffee mornings for new parents, antenatal education and yoga. More women

from the wider geographics of the County are choosing to birth at Stroud, and this is notable since the relocation of GBU. The main points of concern were around cascade of communication and staffing issues .

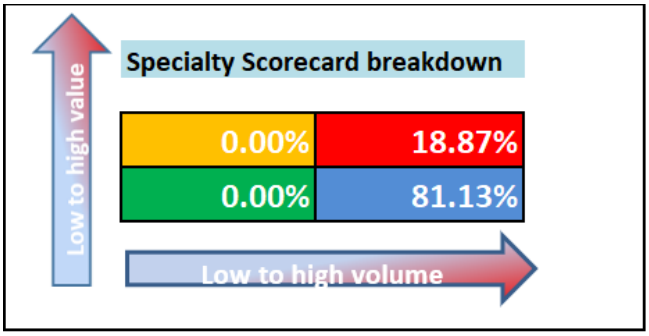
The update and staff communications can be found in **appendix 18D.**

19. Legal Scorecard

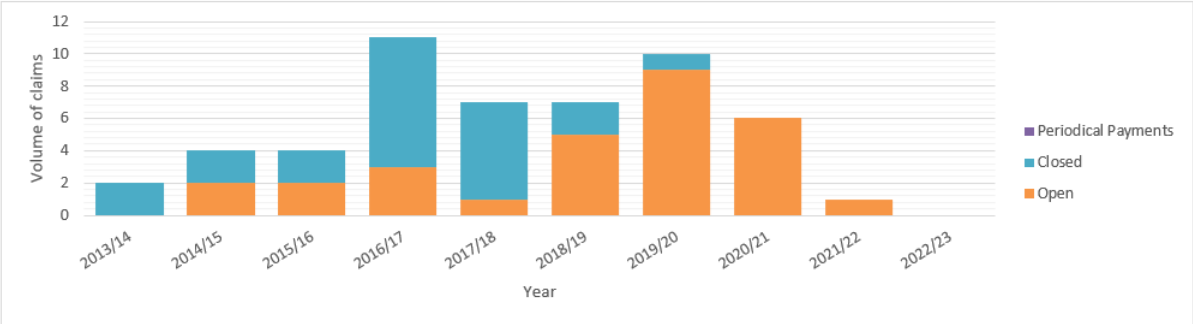
Appendix 19a provides details of the full scorecard data, focusing on the red zone.

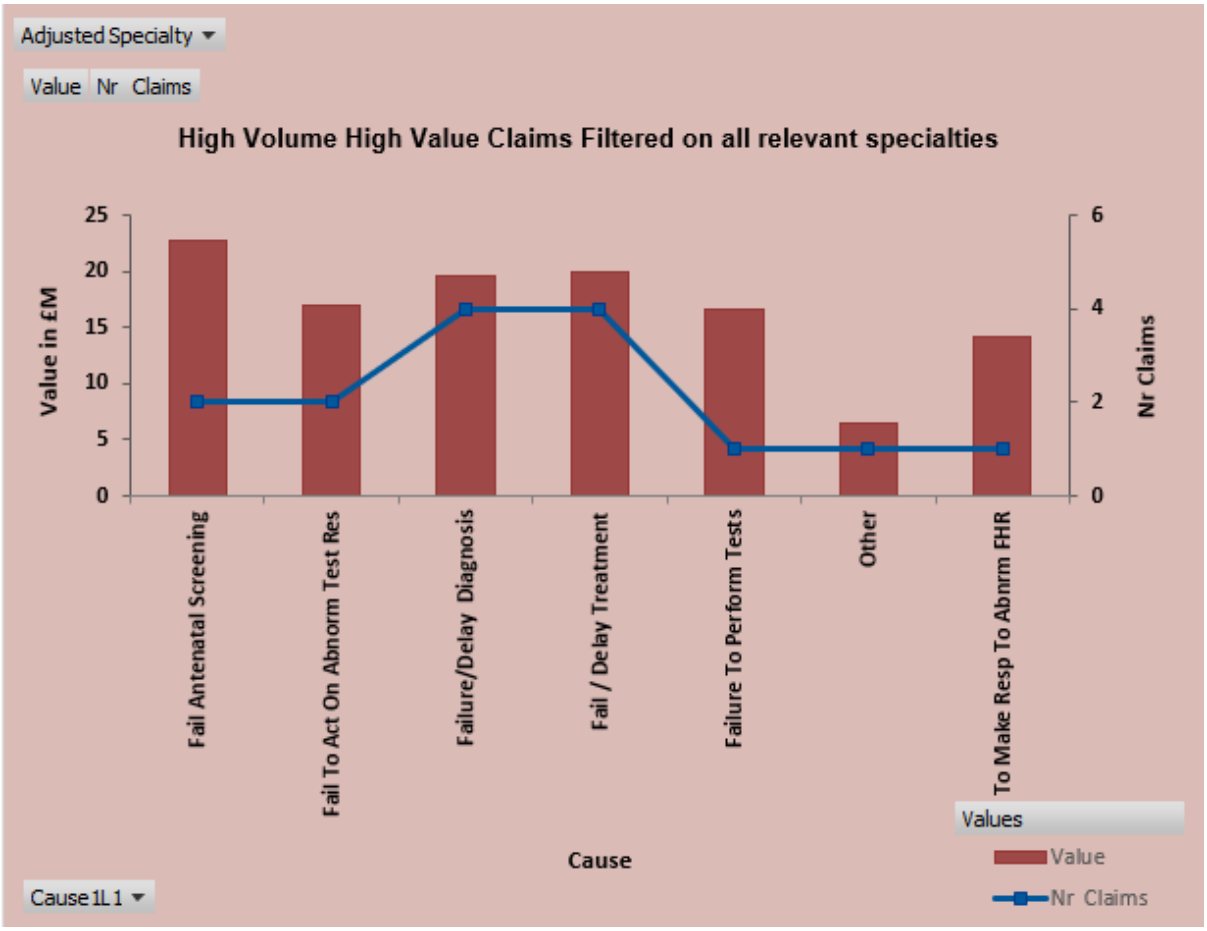


The latest Obstetric scorecard received (October 2023) refers to CNST claims received with an incident date between 01/04/2013 and 31/03/2023



Volume of Claims	% of Trust Clinical Claims Volume	% of Trust clinical Claims - Value
53	11%	68%





There are only two claims without incident investigations:

M21CT619/020

The Claimant's mother was transferred to Walsall Healthcare NHS Trust during her antenatal care so our Trust would not have been aware of the outcome of the delivery.

M19CT619/056

This concerns an alleged delay in treating chorioamnionitis resulting in the Claimant being exposed to untreated intrauterine sepsis causing brain damage.

Both of the above claims relate to historic incidents from 2018 and 2016 respectively. To ensure capture of reportable incidents, the Patient Safety Team now reviewsthe Maternity and Neonatal EPR systems on a daily basis, and report any incidents meeting investigation criteria.

National Assurance Programmes

20. Ockenden 2

Awaiting review.

21. CQC Section 29a

Awaiting update and most recent CQC report.

22. Maternity Incentive Scheme Y5

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

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

An overall RAG status can be found in the monthly dashboard, **appendix 22A** with more information on each safety action, monthly progress, focus and risks can be found in **appendix 22B.**

23. Maternity Production Board

GHNHSFT MATERNITY SERVICES - Clinical Scorecard Year 2023/2024

MEASURE	Apr	May	Jun	Jul	Aug	Sep
MOEWS Chart Present	96%	95%	No data	No data	No data	100%
MOEWS Escalated Appropriately A/N	100%	N/A	No data	No data	No data	No data
MOEWS Escalated Appropriately P/N	50%	100%	No data	No data	No data	No data
1:1 Care in Labour	98%	96%	98%	100%	99%	99%
Emergency Equipment Checks	99%	94%	81%	88%	89%	85%
L3 Safeguarding Training Compliance	No data	No data	No data	No data	No data	63%*
Elearning Compliance	79%	80%	79%	78%	78%	77%
Appraisal Compliance	79%	76%	73%	69%	69%	68%
PROMPT Training - part 1		74%	81%	No data	80%	71% #
PROMPT Training - part 2		81%	89%		83%	72% #
Overdue incidents	217 (16	271 (13	198	166	71	15
Overdue Actions (Risk Register, Incidents, Complaints)	2	5	19	16	12	
CO Monitoring at 36/40	No data	No data	No data	No data	No data	No data
PMA RCS Sessions	5	9	No data	No data	No data	No data
External Opinion - Requested	1	0	1	1	1	5
External Opinion - Attended	1	0	1		1	2
Intrapartum Risk Assessment Completed						

Gloucestershire Hospitals
NHS Foundation Trust

Maternity Incentive Scheme

Year 5

January 2024

Version 0.3

Document Control

Version	Date	Amendment description	Circulation	Author
V0.01	20/12/23	Draft	Quad Safety Action Leads	L.Honeyman
V0.01	22/12/23	Draft	Womens & Childrens Quality Board	L.Honeyman
V0.1	02/01/24	Added SA4 audits	MDG	L.Honeyman
V0.2	04/01/24	Post MDG amendments	QPC	L.Honeyman
V0.3	05/01/24	Post QPC amendments	Trust Board	L.Honeyman

Glossary

Term	Description/Definition
ATAIN	Avoiding Term Admissions into the Neonatal unit
GOGG	Gynae and Obstetrics Guideline Group (Now MOGG- Maternity and Obstetrics Guideline Group)
ICB	Integrated Care Board
LMNS	Local Maternity and Neonatal System
MCG	Maternity Clinical Governance
MDG	Maternity Delivery Group
MNVP	Maternity and Neonatal Voices Partnership
MSDS	Maternity Services Data Set
Panda-P	Paediatric and Neonatal Documentation and Policies
PMRT	Perinatal Mortality Reporting Tool
PQS	Perinatal Quality and Safety
QPC	Quality and Performance Committee
SBL(v3)	Saving Babies Lives Care Bundle (Version 3)
TC	Transitional Care

Contents

Appendices

Safety Action	No	Appendix	Included/ Available
1	1-1	MBRRACE Report	Included
	1-2	GHT PMRT Monitoring	Included
	1-3	PMRT Report April- July 2023	Included
	1-4	PMRT Report August- September 2023	Included
	1-5	PMRT Report October- November 2023	Included
2	2-1	MSDS report for July 2023	Available
	2-2	MSDS Dashboard evidence	Available
3	3-1	TC Guideline	Available
	3-2	TC SOP	Available
	3-3	ATAIN and TC 22/23 Q4 Report	Included
	3-4	ATAIN and TC 23/24 April & May Report	Included
	3-5	ATAIN and TC 22/23 June & July Report	Included
	3-6	ATAIN and TC 22/23 Aug & Sep Report	Included
	3-7	ATAIN Action Plan	Included
	3-8	ATAIN Newsletter Nov 23	Available
	3-9	TC Expansion Action Plan	Included
4	4-1	Workforce Paper Jan-June 2023	Included
	4-2	Workforce Paper Q2 23/24	Included
	4-3	Obstetric locum audit	Included
	4-4	Obstetric Compensatory Rest SOP	Available
	4-5	Obstetric Compensatory Rest Audit	Included
	4-6	Consultant Obstetrician Attendance Audit and Action Plan	Included
	4-7	Anaesthetist Rotas	Available
	4-8	Neonatal Nursing Workforce Action Plan	Included
5	5-1	Birthrate Plus Report	Available
	5-2	Midwifery budget	Available
	5-3	CQC Action Plan	Included
	5-4	Midwifery R&R Action Plan	Available
6	6-1	SBLv3 Implementation Tool 19-12-23	Included
	6-2	Obstetric FM Lead Job Description	Included
	6-3	Preterm Job Descriptions	Included
	6-4	SBL Quarterly Assurance Meeting Minutes	Available
7	7-1	MNVP Strategy 23/24	Available
	7-2	MNVP Funding	Available
	7-3	GHT Maternity and Neonatal Experience Action Plan	Included
	7-4	LMNS Maternity Experience Meeting- Agenda and Minutes	Available

Safety Action	No	Appendix	Included/ Available
	7-5	GHT Maternity and Neonatal Experience Meetings- Agenda and Action Log	Available
	7-6	Maternity Partnership Meetings- Agenda and Minutes	Available
	7-7	Staff Meetings	Available
	7-8	MNVP Engagement and Experience Reports	Available
	7-9	GHT Patient and staff experience reports	Included
8	8-1	GHFT TNA	Included
	8-2	Training Overview	Included
	8-3	MNVP and service user training input	Available
	8-4	Local learning for training plan	Available
	8-5	Emergency Drills	Available
	8-6	Training Compliance Dec 23	Available
9	9-1	PQS Report June 2023	Included
	9-2	PQS Report July 2023	Included
	9-3	PQS Report August 2023	Included
	9-4	PQS Report September 2023	Included
	9-5	PQS Report October 2023	Included
	9-6	Quad and Safety Champion Agenda and Actions	Included
	9-7	MDG and Safety Champions Meeting Minutes August 2023	Included
	9-8	Safety Champions Pathway	Available
	9-9	Staff Comms re Safety Champions	Available
	9-10	Staff Comms re Safety Champions	Available
	9-11	PQS Q2 23/24 Report	Included
	9-12	Regional PQS Reporting	Available
10	10-1	Reporting spreadsheet	Included
	10-2	Patient Letters (example)	Included
	10-3	CMS	Available

Introduction

NHS Resolution is operating year five of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) to continue to support the delivery of safer maternity care.

The MIS applies to all acute Trusts that deliver maternity services and are members of the CNST. As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

The scheme incentivises ten maternity safety actions as referenced in previous years' schemes. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund but may be eligible for a small discretionary payment from the scheme to help to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

The purpose of this report is to provide assurance to the Trust Board, presenting the standards and evidence of each safety action with the accompanying board deceleration form for submission to NHSR.

Maternity incentive scheme year five: conditions

In order to be eligible for payment under the scheme, Trusts must submit their completed Board declaration form to NHS Resolution nhsr.mis@nhs.net by **12 noon** on **1 February 2024** and must comply with the following conditions:

- Trusts must achieve **all** ten maternity safety actions.
- The declaration form is submitted to Trust Board with an accompanying joint presentation detailing position and progress with maternity safety actions by the Director of Midwifery/Head of Midwifery and Clinical Director for Maternity Services
- The Trust Board declaration form must be signed and dated by the Trust's **Chief Executive Officer** (CEO) to confirm that:
  - The Trust Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required safety actions' sub-requirements as set out in the safety actions and technical guidance document included in this document.
  - There are no reports covering either year 2022/23 or 2023/24 that relate to the provision of maternity services that may subsequently provide conflicting information to your declaration (e.g. Care Quality Commission (CQC) inspection report, Healthcare Safety Investigation Branch (HSIB) investigation reports etc.). All such reports should be brought to the MIS team's attention before **1 February 2024**.
- The Trust Board must give their permission to the CEO to sign the Board declaration form prior to submission to NHS Resolution. Trust Board declaration form must be signed by the Trust's CEO. If the form is signed by another Trust member this will not be considered.

- In addition, the CEO of the Trust will ensure that the Accountable Officer (AO) for their Integrated Care System (ICB) is apprised of the MIS safety actions' evidence and declaration form. The CEO and AO must both sign the Board declaration form as evidence that they are both fully assured and in agreement with the compliance submission to NHS Resolution.

Overview

Safety Action 1	Compliant
Safety Action 2	Compliant
Safety Action 3	Compliant
Safety Action 4	Compliant
Safety Action 5	Compliant
Safety Action 6	Compliant
Safety Action 7	Compliant
Safety Action 8	Compliant
Safety Action 9	Compliant
Safety Action 10	Compliant
Overall	Compliant

Safety Action 1

Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Compliant

All eligible perinatal deaths have been notified to MBRRACE-UK within seven working days. For deaths from 30 May 2023, MBRRACE-UK surveillance information has been completed within one calendar month of the death. The evidence of our compliance is included in the MBRRACE reports *(appendix 1-1)* and within our monitoring *(appendix 1-2)*.

Parents should have their perspectives of care and any questions they have sought from 30 May 2023 onwards. This is for 95% of all the deaths of babies in our Trust eligible for PMRT review. We are compliant and details of dates that we have written to parents are included in *appendix 1-2.*

Deaths of babies who were born and died in our Trust from 30 May 2023 have had multi-disciplinary reviews using the PMRT. 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed to the draft report stage within four months of the death and published within six months. This is evidenced in *appendix 1-1*, the MBRRACE report. All reviews were started within 2 months. We had one eligible case and this was reviewed to draft PMRT report within 4 months (requirement 5), however it has not yet been published but is still within the 6 months from death (requirement 6) so we remain compliant.

A summary of the Q1 PMRT report *(appendix 1-3)* was submitted to Trust Board through the Perinatal Quality and Safety Report in September. The Q2 report is submitted in *appendix 1-4* and the final report to December is included in *appendix 1-5.* This has been reviewed at Quality and Performance Committee on 5th January 2023. The Trust Board are asked to review and note these reports for compliance.

Prior to Trust Board these are presented to Maternity Delivery Group, co-chaired by Chief Nurse and Board level safety champion, Matt Holdaway and then to the Trust board sub-committee, Quality and Performance Committee, chaired by Alison Moon, Non-executive Director and Board level safety champion.

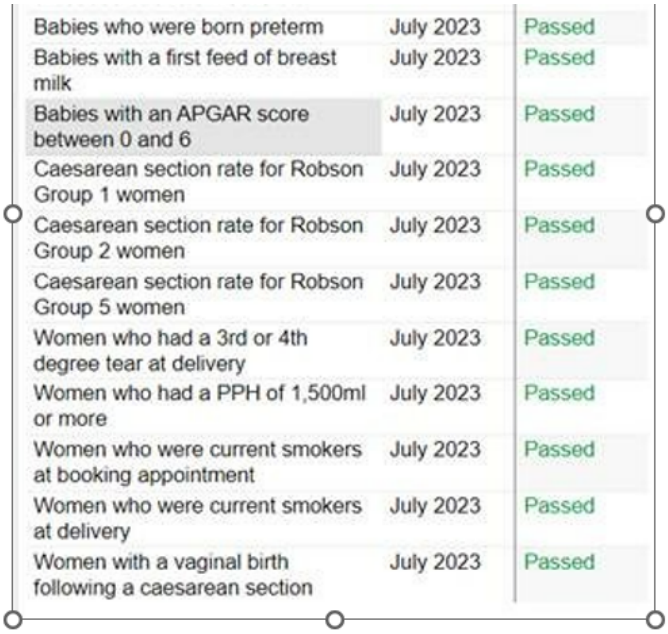
Safety Action 2

Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?

Compliant

The requirement is that Trust Boards assure themselves that at least 10 out of 11 Clinical Quality Improvement Metrics (CQIMs) have passed the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2023.

We were compliant on all 11 CQIMs and this can be seen in our MSDS submission report for July 2023 *(appendix 2-1)* and below taken from the dashboard.



Babies who were born preterm	July 2023	Passed
Babies with a first feed of breast milk	July 2023	Passed
Babies with an APGAR score between 0 and 6	July 2023	Passed
Caesarean section rate for Robson Group 1 women	July 2023	Passed
Caesarean section rate for Robson Group 2 women	July 2023	Passed
Caesarean section rate for Robson Group 5 women	July 2023	Passed
Women who had a 3rd or 4th degree tear at delivery	July 2023	Passed
Women who had a PPH of 1,500ml or more	July 2023	Passed
Women who were current smokers at booking appointment	July 2023	Passed
Women who were current smokers at delivery	July 2023	Passed
Women with a vaginal birth following a caesarean section	July 2023	Passed

July 2023 data contained valid ethnic category (Mother) for at least 90% of women booked in the month. Not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances.

We are compliant with a rate of 95% and this can be found in *appendix 2-1,* row 31.

The Trust Board is asked to confirm that they have passed the associated data quality criteria for the following metrics:

Midwifery Continuity of carer (MCoC)

i. Over 5% of women who have an Antenatal Care Plan recorded by 29 weeks and also have the CoC pathway indicator completed.

Evidence obtained from the dashboard *(appendix 2-2):*

Data quality

Indicator	Data quality rating
Number of women placed on Midwifery Continuity of Carer pathway by 28 weeks	Passed (Green)
Number of women with Midwifery Continuity of Carer ongoing	Passed (Amber)

Note: If maternity services have suspended all MCoC pathways, criteria ii is not applicable:

ii. Over 5% of women recorded as being placed on a CoC pathway where both Care Professional ID and Team ID have also been provided. N/A

We have 2 people registered to submit to MSDS, Yas Randall, Data Warehouse Manager and Rob Ford, Data Warehouse Developer.

Safety Action 3

Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

Compliant

Pathways of care into transitional care (TC) have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.

The TC pathway forms part of the guideline (*appendix 3-1*) and SOP (*appendix 3-2*), this is based on BAPM principles including admission criteria and auditable standards. The staffing model is included within the SOP. This has been approved by maternity at GOGG on 13th October 2023 and neonatal team at Panda-P on 6th November 2023. This has been approved by TPAG on 8th January 2024, has been circulated and is in use.

The TC audit results are within the joint ATAIN and TC reports *(appendices 3-3, 3-4, 3-5 and 3-6)* and the audits have showed 100% for neonatal teams being involved in decision making and planning for babies in TC. The auditable standards have been updated within the updated pathway.

Joint maternity and neonatal reviews of all admissions to the NNU of babies equal to or greater than 37 weeks have been undertaken and summarised in the ATAIN and TC reports *(appendices 3-3 to 3-6)*. The focus of the review is to identify whether separation could have been avoided. Action plans are summarised in each of these reports, that were complete at the time of report. The full (redacted) action plan can be found in *appendix 3-7,* this is continually updated including status of actions contained within the individual reports. We have included an ATAIN newsletter *(appendix 3-8)* as an example of how this learning is disseminated. There was difficulty in retrieving some notes as they had not yet been returned to the Trust by women and families after discharge, these are chased but is they are still unavailable the reports are completed to prevent further delay and will be resolved with the introduction of Badgernet. These reports and included action plans have been signed off by the director or head of midwifery, neonatal and obstetric clinical leads and are presented for oversight and approval at MCG and MDG and shared with the LMNS and ICB. These reports then go on to QPC and Trust Board within the PQS report.

We have reviewed the robustness of our ATAIN reviews in line with MIS guidance and increased the diversity of the MDT team completing the reviews. With increased demand on the teams plus staff shortages, we had a backlog of reviews to complete and some to re-audit with a full MDT. Therefore, the Trust Board is asked to review and sign off the 3 23/24 reports at this Trust Board. Also, please note 22/23 Q4 report which has been re-audited.

Drawing on the insights from the data recording undertaken in the Year 4 scheme, which included babies between 34+0 and 36+6, Trusts should have or be working towards implementing a transitional care pathway in alignment with the BAPM Transitional Care Framework for Practice for both late preterm and term babies. There should be a clear, agreed timescale for implementing this pathway.

An action plan *(appendix 3-9)* to implement a transitional care pathway for babies from 34+0 by October 2024 was presented and approved by MDG on 8th November and LMNS board on 27th November 2023.

The Trust Board is asked to review and approve this action plan.

Safety Action 4

Can you demonstrate an effective system of clinical workforce planning to the required standard?

Compliant

A workforce paper covering January- June 2023 was presented to MDG and Quality and Performance Committee on 13th September, and Trust Board on 14th September 2023. This is included in *appendix 4-1*.

However, data collection for the required audits was proving difficult and it was felt that a quarterly paper would give the Trust Board more oversight of maternity and neonatal staffing. Therefore, the Trust Board are asked to note the Workforce Paper for Q2 23/24 *(appendix 4-2)* with 6 months of audit data. The paper has been shared with Board level safety champions and the LMNS at MDG and QPC in November 2023.

Obstetric medical workforce

All short-term locum doctors in Obstetrics and Gynaecology on tier 2 or 3 rotas currently work in their unit on the tier 2 or 3 rota or have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) *(appendix 4-3).* There is one exception and they hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.

We have implemented the RCOG guidance on engagement of long-term locums, however, we have not had any long-term locum obstetricians in post during the reporting period, 30 May to 7 December 2023 to audit this.

We have implemented RCOG guidance on compensatory rest for consultants and senior Speciality and Specialist (SAS) doctors through a SOP *(appendix 4-4)* which was agreed at GOGG on 8th September 2023 and email ratified in lieu of MCG in September. Please see audit in *appendix 4-5.*

Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG guidance. The audit concludes that a consultant was present in 100% of situations where they 'must attend', and documented compliance in 91% of 'should attend' situations. Episodes where attendance has not been possible have be reviewed at unit level and action plans implemented (*appendix 4-6*) to prevent further non-attendance.

These audits and any subsequent action plans have been presented to Trust Board level safety champions and LMNS at MDG on 3rd January 2023 and the Trust Board are also asked to note these.

Anaesthetic medical workforce

We are fully compliant with this element as a duty anaesthetist is immediately available for the obstetric unit 24 hours a day *(appendix 4-7).*

Neonatal medical workforce

The neonatal unit currently meets the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing.

Neonatal nursing workforce

The neonatal unit does not currently meet the BAPM neonatal nursing standards.

Therefore, an action plan *(appendix 4-8)* to address deficiencies has been developed and agreed with the LMNS (28th November 2023) and Neonatal Operational Delivery Network (ODN) on 10th November 2023.

The Trust Board are asked to approve this action plan.

Safety Action 5

Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Compliant

A workforce paper covering January- June 2023 was presented to MDG and Q&P on 13th September, and Trust Board on 14th September 2023. This is included in *appendix 4-1*.

However, data collection for the required audits was proving difficult and it was felt that a quarterly paper would give the Trust Board more oversight of maternity and neonatal staffing.

Therefore, the Trust Board are asked to note the Workforce Paper for Q2 23/24 *(appendix 4-2)* with 6 months of audit data. The paper has been shared with Board level safety champions and the LMNS at MDG on 3rd January 2024. It includes information on specialist midwives, midwife to birth ratio and planned versus actual midwifery staffing levels.

Birthrate Plus has been used to calculate the required midwifery staffing establishment *(appendix 5-1)* and evidence midwifery staffing budget reflects establishment is included in *appendices 4-2 and 5-2.*

Fill rates have been stable since October 2022 and currently sit at 88% however summer staffing saw a decline as low as 84%. This is monitored on a daily basis and staff are redeployed across the service based on activity and the acuity. Full details can be found in *appendix 4-1 and 4-2.* The retention and recruitment action plan to address the deficit in midwifery staffing is included in *appendix 5-4.*

There were no occasions when supernumery status of the co-ordinator was reported to be compromised, full details can be found in *appendix 4-1 and 4-2.*

All women in active labour receive one-to-one midwifery care. Currently our compliance for YTD is 98%. This continues to be monitored via the CQC action plan *(appendix 5-3)* and has now been enhanced to increase focused work and communication by the clinical Maternity Patient Safety Champions. The Trust Board are asked to sign off this action plan.

Safety Action 6

Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?

Compliant

We are on track to fully implement all 6 elements of SBLv3 by March 2024 by achieving the minimum 50% compliance in each of the 6 elements and 70% overall. The SBLv3 implementation tool can be found in *appendix 6-1*.

Element 1	70%
Element 2	55%
Element 3	50%
Element 4	80%
Element 5	81%
Element 6	83%
Overall	71%

We ask that the Trust Board confirm to the ICB the following as required for compliance:

- Within our organisation we have a dedicated lead midwife (0.4 WTE) and lead obstetrician (0.1 WTE) per consultant led unit for fetal monitoring have been appointed and are in post.
  The job specifications are in *appendix 6-2* and we can confirm that these posts are appointed to.
- We have:
  A) An obstetric consultant lead for pre term birth, delivering care through a specific pre term birth clinic, or within an existing fetal medicine service.
  B) An identified local preterm birth/perinatal optimisation Midwife Lead
  C) A Neonatal consultant lead for preterm and perinatal optimisation
  D) A Neonatal Nurse lead for preterm and perinatal optimisation

  We have a consultant obstetrician in post that leads on preterm birth, we have recently appointed a lead midwife who started on 12th October 2023. We have two consultant neonatal nurses in post that cover the consultant and nurse leads. Job descriptions are in *appendix 6-3*.

We have held quarterly quality improvement discussions with the LMNS and ICB on 17th August 2023 and 13th December 2023, using the new national implementation tool *(appendix 6-4).*

Although we have met the minimum compliance for safety action 6, Saving Babies Lives Version 3, the service requires significant improvements to achieve full compliance, such as, our sonography service. We have some short-term funding that we intend to

use to strengthen the team but will assess the options and the support required from the Board and/or commissioners to implement these service improvements.

Safety Action 7

Listen to women, parents and families using maternity and neonatal services and coproduce services with users.

Compliant

A funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with MNVP Guidance (*appendix 7-1*). *Appendix 7-2* evidences that workplans are funded and MNVP leads, formerly MVP chairs, are appropriately employed or remunerated and receive appropriate training, administrative and IT support.

An action plan was coproduced with the MNVP and LMNS following the annual CQC Maternity Survey data publication, this includes analysis of free text data *(appendix 7-3).* Progress is monitored regularly by safety champions and LMNS at the maternity experience meeting *(appendix 7-4).* Furthermore, a bi-monthly GHT experience meeting commenced in October 2023 *(appendix 7-5)* to allow better overview and traction of the action plan. This group ensures neonatal and maternity service user feedback is collated and acted upon, with evidence of reviews of themes and subsequent actions monitored through *appendix 7-3*. It is chaired by Lisa Stephens who is a safety champion and regularly attended by local safety champions and it feeds back to MDG, chaired by board level safety champion, Matt Holdaway *(reports in appendix 7-9)*. The Board are asked to note this action plan.

The Maternity Partnership Meetings are attended by service users and staff and are an opportunity for gaining feedback and service developments *(appendix 7-6)*. Staff feedback is sought through staff surveys and safety walk arounds but also regularly through ward forums *(appendix 7-7)* and maternity touchpoint meetings in addition to acting upon and disseminating service user feedback through these channels.

The MNVP Engagement and Experience reports *(appendix 7-8)* evidence that the MNVP is prioritising hearing the voices of neonatal and bereaved families as well as women from Black, Asian and Minority Ethnic backgrounds and women living in areas with high levels of deprivation. It details places they have visited, includes neonatal groups, as well as groups identified as part of the Equity asset map. They are working with the Forget me not peer support group to update the MNVP website, to increase feedback from bereaved families and in discussions with early pregnancy unit regarding feedback from families experiencing early pregnancy loss.

Safety Action 8

Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Compliant

A local training plan is in place for implementation of Version 2 of the Core Competency Framework *(appendix 8-1 and 8-2).* The plan has been agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS on 28th November. The plan is developed based on the "How to" Guide developed by NHS England. This includes service user involvement in planning *(appendix 8-3),* and it is based on local learning *(appendix 8-4)*. Our PROMPT training days include all members of the multidisciplinary team and use scenario training for members to train in these emergencies as a team. At least 3 of the 6 emergency scenarios are conducted in a clinical area *(appendix 8-5).* We are a single provider LMNS however our Obstetric lead for training, Sharan Athwal, is a lead Obstetrician at the PROMPT Maternity Foundation and so regularly works with national bodies and other Trusts including those in the South West and shares learning and best practice as part of this role.

Our compliance is documented in *appendix 8-6* and summary provided below:

PROMPT Part 1	
Staff Group	Compliance
Midwives	97%
MCA/MSWs	92%
Obstetricians	91%
Anaesthetists	91%

PROMPT Part 2	
Staff Group	Compliance
Midwives	95%
MCA/MSWs	91%
Obstetricians	91%
Anaesthetists	91%

NLS	
Staff Group	Compliance
Neonatal Consultants	100%
Neonatal Junior Doctors	100%
Neonatal Nurses	90%
ANNP	100%
Midwives	95%

Fetal Monitoring	
Staff Group	Compliance
Midwives	90%
Obstetricians	92%

Please note midwives complete NLS training during PROMPT Part 2 and neonatal junior doctors complete it during their mandatory induction.

RC-trained staff will deliver our in-house NLS training from 2024. We have recently trained two midwives in addition to the ANNPs and consultant neonatologists. The in-house basic NLS update is going to be taught on the Maternity Mandatory Days from January 2024. The ANNPs are leading a plan for all NLS courses to be provided in-house by end of March 2024. The issue preventing implementation currently is space to run

the courses as they require multiple rooms at a time. However, they are exploring options. This is detailed in the TNA and 2024 training plan which was agreed with the quadrumvirate before sign-off by the Trust Board and the LMNS on 28th November.

Safety Action 9

Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

Compliant

We produce a monthly perinatal quality and safety (PQS) report (*appendices 9-1 to 9-5*) in line with the Trust internal reporting system that includes information regarding safety intelligence and a review of maternity and neonatal quality using a minimum data set. This includes a review of thematic learning of all maternity Serious Incidents (SIs), concerns raised by staff and service users and progress and actions relating to local improvement plans, such as the patient safety walk-arounds. It also includes patient feedback from FFT and the patient and staff experience report, minimum staffing and training compliance. This is shared monthly with MDG, Quality and Performance Committee and bi-monthly to Trust Board. Q4 22/23 paper was submitted to Trust Board in July 2023, Q1 paper was taken to an extra-ordinary Board in September. The monthly paper was taken to Q&P Committee in October with highlights and exceptions reported to Board in November. We ask the Board to review the Q2 paper *(appendix 9-11)* presented at this meeting for compliance with safety action 9.

Please note that although MIS guidance states the Board should undertake a monthly review of quality and safety, NHSR have since acknowledged that most Trust Boards do not meet monthly and have confirmed they will accept a bi-monthly review.

The PQS report is reviewed and discussed at the LMNS Perinatal Quality Surveillance workstream and a highlight report from this workstream reported to LMNS Board. The LMNS share this PQS report to region through regional PQSSG template and their governance framework. They also share learning from Incidents with our buddy LMNS BSW *(appendix 9-12).*

The Trust has not yet implemented PSIRF in maternity due to concerns regarding its suitability in a perinatal setting, the team are currently planning how it can be implemented. We have been reassured that this is a common concern and situation nationally and NHSR have confirmed this is not required for compliance with safety action 9. Furthermore, we have robust processes currently in place to provide assurance to the Board on maternity and neonatal safety and quality issues that we have further strengthened this year. We have also welcomed a deep dive in to our governance processes by the national team and are working them to continue to strengthen this and to improve on our foundations to enable us a successful implementation.

Alison Moon, a non-executive director (NED) has been appointed and is working with the Executive Board safety champion, Matt Holdaway to address quality issues. They are both registered to the dedicated FutureNHS workspace. The Trust Board is asked to note that they are meeting with the Perinatal 'Quad' leadership team a minimum of quarterly to identify and implement any support required of the Board. *Appendix 9-6* contains actions from their meeting with the Quad on 24th November 2023 and the next meeting is arranged for 29th January 2024.

The Trust's claims scorecard was reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at MDG in August 2023 *(appendix 9-7).* This triangulation was further strengthened and themes presented at MDG in December (*appendix 9-5*) , this is included in the Q2 PQS report for Board oversight and will continue to be reviewed quarterly.

The safety champion pathway has been revised and is included in *appendix 9-8*. The safety champions complete a monthly walk around of all the units to gain feedback from staff on safety issues. The findings and progress with issues identified, alongside the pathway have been shared in the Trust global communications regularly, they are uploaded to the dedicated intranet page and the Trust News Intranet page and have been shared through the maternity touchpoint meetings. Examples in *appendices 9-9 and 9-10.*

Safety Action 10

Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme from 6 December 2022 to 7 December 2023?

Compliant

All qualifying cases have been reported to HSIB/ MNSI and EN scheme from 6 December 2022 to 7 December 2023 *(appendix 10-1)* and are reported to Trust Board bi-monthly through the PQS report (*appendices 9-1 to 9-5*).

All families receive a letter containing information on the role of HSIB//MNSI and NHS Resolution's EN scheme and to inform them of any investigations or findings in line with Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of the duty of candour. These have not been included in the appendices due to the patient information included but can be seen on request and a redacted example is included in *appendix 10-2*. This has been reported on the Claims Reporting Wizard (CMS) *(appendix 10-3).*

KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 30 November 2023

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
Recruitment and Attraction	Updates included reducing length of time to recruit, improving both candidate and recruiting manager experience, medical time to hire and attraction, candidate onboarding, the Employer Value Proposition (EVP) project and the refresh of existing marketing assets to broaden the media solutions currently being used. Given the importance of the EVP project which will see new marketing branding concepts designed, a focussed PODC Development Committee will be considered on this in the context of the wider recruitment and attraction agenda, to ensure broader engagement and ownership. February's PODC Development Session is likely to focus on the Staff Survey results.	Important that SMART targets with timescales are reflected on the BAFs. The Retention Workstream under the Workforce Sustainability Programme will look at staff exit data and the 'retire and return' policy as priorities. Summary of specific areas/services most impacted by vacancies and plans to address those, i.e., vascular to be presented through the developing Recruitment Plan. Assurance will be given of the organisational readiness for / impact of the transformational focus across transactional activities such as time to hire.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Staff Survey	Good to see overall response rate improved, but Committee keen to understand how well we understand why. Despite a strong engagement programme with the Staff Survey, many staff still did not complete survey. What can be done to reduce perception that nothing changes, staff voices are not heard	Feedback on post survey review to be presented to next PODC Learning from GMS positive results
Culture, Experience & Retention	3-year programme drafted with reporting to follow. Cultural awareness pilot commenced with 'Train the Trainer' course identified.	Further work on the RAG ratings reflected in the BAF is required.
Performance Appraisals	Educational Development Group reviewing staff perception of appraisals and what is needed to improve. Key area of focus which needed to be reviewed was EDI aspect.	Outcome from EDG to come back to next PODC, setting out key actions to improve appraisal process.

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.

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Internal Audit Report on organisational readiness	The BDO audit will commence, but there will be further focus on organisational readiness through the recently published NHSE IMPACT self-assessment which contains all the key aspects of organisational development and design.	Learning will be taken from the internal audit alongside the national framework assessment
Items not Rated		
Risk Register		
Impact on Board Assurance Framework (BAF)		
SR3: Discussion on scoring in relation to ongoing confirmed that the score needed to be high due to ongoing pressures, but agreed to maintain score at 20. SR4: Staff Experience Taskforce work commended.		

NHS
Gloucestershire Hospitals
NHS Foundation Trust

People and Organisational Development Performance Dashboard

November 2023

Deborah Tunnell
Deputy Director for People & Organisational Development

the Best Care for Everyone
care / listen / excel

Executive Summary

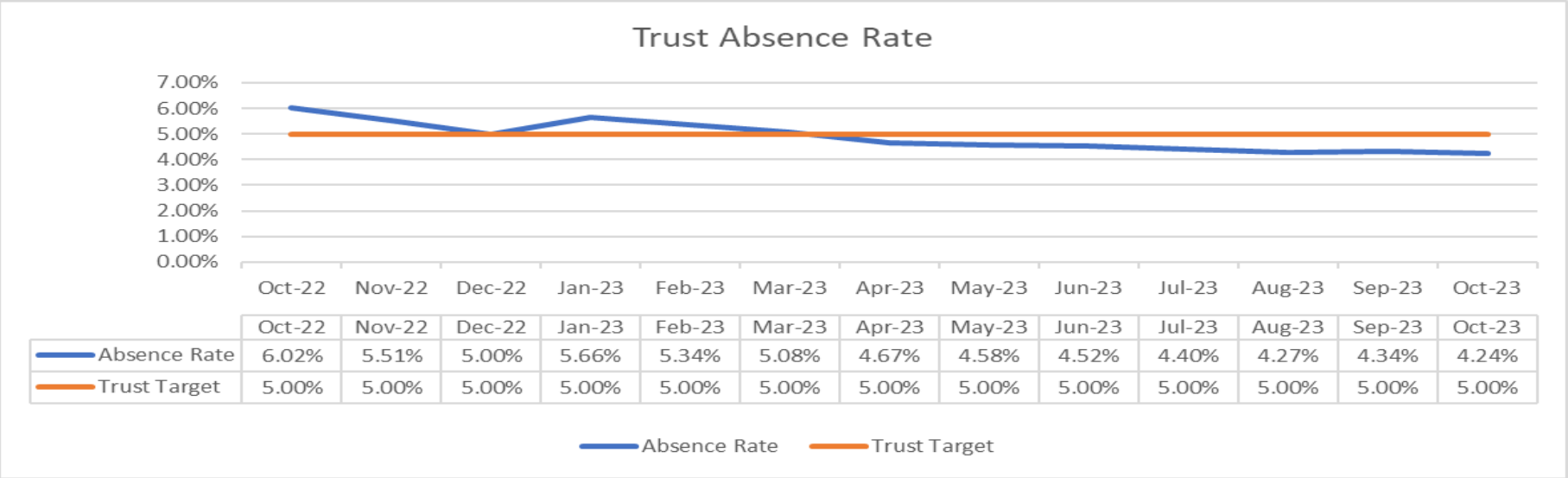
Performance Indicator	Target	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	April-23	May-23	June-23	July-23	Aug-23	Sept-23	Oct-23
Turnover	**13%**	14.11%	14.06%	13.60%	13.70%	12.92%	13.05%	12.62%	12.23%	12.12%	11.65%	11.56%	11.38%
Vacancy	**8%**	9.99%	9.62%	8.69%	7.58%	7.16%	7.61%	7.67%	7.40%	7.05%	7.05%	6.31%	6.43%
Sickness	**5%**	5.51%	5.00%	5.66%	5.34%	5.08%	4.67%	4.58%	4.52%	4.40%	4.27%	4.34%	4.24%
Appraisal	**90%**	78%	79%	78%	79%	81%	81%	80%	80%	79%	79%	79%	79%
Essential Training	**90%**	86%	86%	86%	85%	86%	87%	88%	88%	87%	87%	87%	86%
Agency (FTE & % of workforce)	**2%**	215 (2.67%)	180 (2.24%)	195 (2.44%)	190 (2.32%)	211 (2.55%)	144 (1.78%)	144 (1.79%)	176 (2.16%)	177 (2.50%)	167 (2.34%)	160 (2.20%)	122 (1.65%)
Bank (FTE & % of workforce)	**6.5%**	559 (6.95%)	544 (6.76%)	517 (6.47%)	649 (7.93%)	726 (8.78%)	598 (7.39%)	575 (7.15%)	555 (6.79)	571 (8.07%)	585 (8.20%)	589 (8.09%)	550 (7.03%)

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

Absence: Sickness (BAF SR4 Workforce - Culture, Experience and Retention)

Key Points To Date
Sickness absence has increased slightly from the previous month (by 0.07%), bringing the overall Trust absence rate to 4.34%
September 2023 is the sixth consecutive month that the absence rate is below the Trust target of 5%.
September 2023 is 1.68% lower than the highest month (October 2022), in the last 12 month period.

Improvement actions	Due Date	RAG
HRBP's and Matrons to maximise use of unavailability reports from Allocate to track performance.	Dec 2023	
Line managers to work closely with the People Advisory Team to drive the sickness absence management process for staff on long term sickness absence. This focus will ensure compliance with process and policy, facilitating return to work and/or appropriate next steps, and targeted wellbeing support.	Dec 2023	
Focus continues on the Sickness Absence project with a review of the sickness policy, manager guidelines and manager training included in the delivery plan.	May 2024	

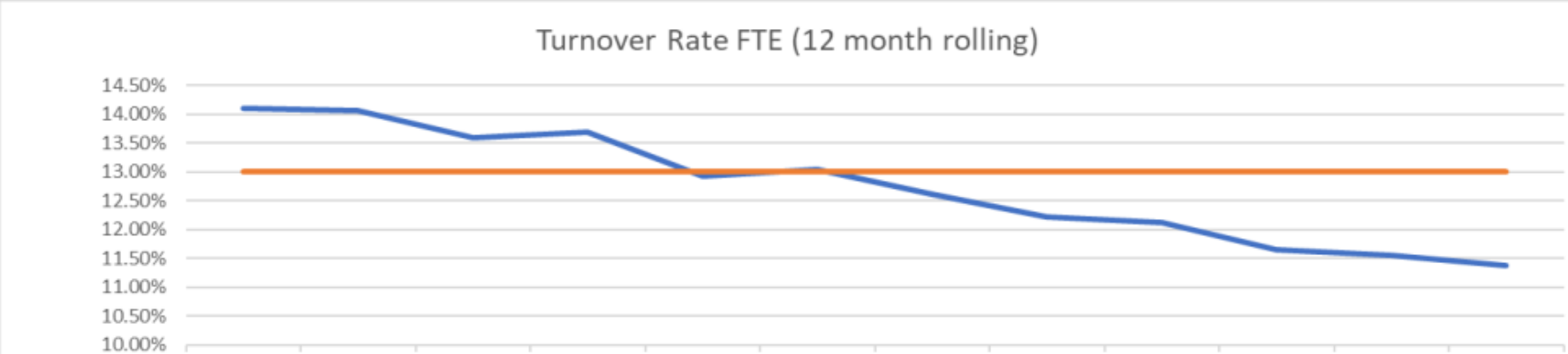


	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Absence Rate	6.02%	5.51%	5.00%	5.66%	5.34%	5.08%	4.67%	4.58%	4.52%	4.40%	4.27%	4.34%	4.24%
Trust Target	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%	5.00%

Turnover (BAF SR4 Workforce - Culture, Experience and Retention)

Key Points To Date
Turnover has decreased slightly from the previous month (0.18%), bringing the overall Trust turnover rate to 11.38%.
October 2023 is the sixth consecutive month that the turnover rate is below the Trust target of 13%.
October 2023 is 2.73% lower than the highest month (November 2022) in the last 12 month period.

Improvement Actions	Due Date	RAG
Delivery of a pilot of the New Leaders' Welcome event has been held. Early evaluation was positive. Scheduled 2-monthly from Dec 23.	Oct 23	
Staff Experience Improvement Programme continues with its focus across four core workstreams.	Ongoing	
The new Retention Group is scheduled with an ongoing series. Core focus will be on the Exit interview process/data, the Substantive to Bank process, Retire and Return Policy.	Timeframes to be confirmed as project plans develop	



	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23
Turnover	14.11%	14.06%	13.60%	13.70%	12.92%	13.05%	12.62%	12.23%	12.12%	11.65%	11.56%	11.38%
Trust Target	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%	13.00%

Statutory & Mandatory Training (BAF SR4 Workforce - Culture, Experience and Retention)

KPI - 90% compliance target

	Compliance (See Notes)	
	31 Aug	30-Sept
CSTF Statutory and Mandatory Training Competencies		
GHT Total Compliance	87%	87%
Breakdown by Division		
Corporate	91%	91%
Diagnostics & Specialty	89%	88%
Medicine	87%	86%
Non-Division	83%	85%
Surgery	88%	87%
Womens & Children	80%	80%
Breakdown by Training Competency		
318|LOCAL|Moving and Handling Level 2 (2yr)|	80%	80%
318|LOCAL|Safeguarding Adults Level 2|	52%	51%
NHS|CSTF|Equality, Diversity and Human Rights - 3 Years|	96%	95%
NHS|CSTF|Fire Safety - 1 Year|	89%	88%
NHS|CSTF|Health, Safety and Welfare - 3 Years|	95%	95%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	95%	96%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	86%	84%
NHS|CSTF|Information Governance and Data Security - 1 Year|	90%	88%
NHS|CSTF|Moving and Handling - Level 1 - 2 Years|	94%	94%
NHS|CSTF|NHS Conflict Resolution (England) - 3 Years|	90%	90%
NHS|CSTF|Resuscitation - Level 2 - Adult Basic Life Support - 1 Year| *	86%	86%
NHS|CSTF|Safeguarding Adults - Level 1 - 3 Years|	88%	87%
NHS|CSTF|Safeguarding Children (Version 2) - Level 1 - 3 Years|	88%	86%
NHS|CSTF|Safeguarding Children (Version 2) - Level 2 - 3 Years|	87%	87%
Breakdown by Staff Group		
Add Prof Scientific and Technic	85%	85%
Additional Clinical Services	91%	90%
Administrative and Clerical	94%	93%
Allied Health Professionals	88%	88%
Estates and Ancillary	93%	94%
Healthcare Scientists	92%	91%
Medical Staff - Consultants	83%	82%
Medical Staff - SAS	78%	78%
Medical Staff - Training Grades	51%	49%
Nursing and Midwifery Registered	87%	86%
Selected Essential Training Competencies		
318|LOCAL|Code of Conduct	90%	90%
318|LOCAL|Code of Confidentiality	91%	90%
318|LOCAL|Resuscitation L2 Adult and Paed BLS Practical (2yr)| *	86%	86%

Key Points To Date

Overall Trust compliance has remained consistent at 87%.

Non division was the only division to see an increase (2%) in compliance from the previous month. D&S, Medicine and Surgery saw a decrease in compliance, with Corporate and W&C remaining at the same compliance as the previous month.

Safeguarding Adults L2 and IG are the only two competencies that deteriorated, seeing a further decrease in compliance from the previous month. Infection Control L1 is the only competency that sees an increase (1%) compared to the previous month.

Medical Staff-Training Grades are the only staff group to deteriorate with the largest decrease in compliance (2%) bringing their total to 49% this month.

Improvement Actions	Due Date	RAG
Head of Corporate Learning & Development, Head of Education Learning & Development and Head of Prof Education & Apprenticeships are now appointed to. These posts offer the capacity to commence a full Stat/Man review, working with stakeholders to review the numbers of programmes, relevancy and ability to undertake.	Review to commence Dec 2023	
Task and Finish Groups established to review training Passporting (Across Organisation and System); subject and staff group specific. Starting with Consultants reviewing mandatory and essential to role relevancy, together with a TNA.	March 2024	
eLearning pre-test alignment still progressing. There are now 4 topics live. 2 topics are awaiting approval for final sign off and 2 topics are in production.	March 2024	

Appraisal (BAF SR4 Workforce - Culture, Experience and Retention)

KPI - 90% compliance target

	Compliance	
	31 Aug	30 Sep
GHT Total	**79%**	**79%**
Breakdown by Division		
Corporate	72%	73%
Diagnostics & Specialty	78%	77%
Medicine	83%	83%
Non-Division	71%	67%
Surgery	83%	84%
Womens & Children	74%	71%
Breakdown by Staff Group		
Add Prof Scientific and Technical	64%	63%
Additional Clinical Services	82%	82%
Administrative and Clerical	74%	74%
Allied Health Professionals	75%	74%
Estates and Ancillary	92%	78%
Healthcare Scientists	73%	75%
Medical Staff - Consultants	93%	92%
Medical Staff - SAS Senior	79%	75%
Nursing and Midwifery Registered	81%	81%

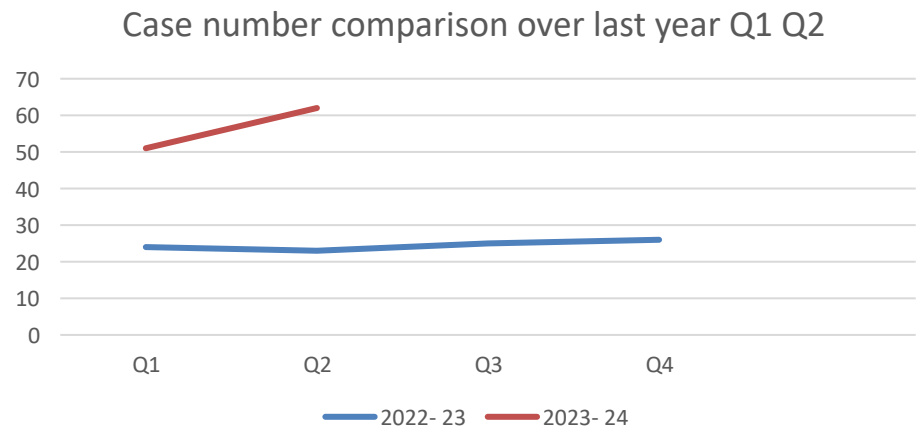
Key Points To Date
Overall Trust compliance has remained at 79%.
Corporate Services and Surgery are the only two divisions that see an increase (1% each) compared to the previous month. D&S, W&C and Non-Division have seen a decrease in compliance from the previous month.
AddProfScientic&Technical are the only staff group to remain non-compliant against target. Healthcare Scientists are the only staff group to increase compliance (2%) compared to the previous month.

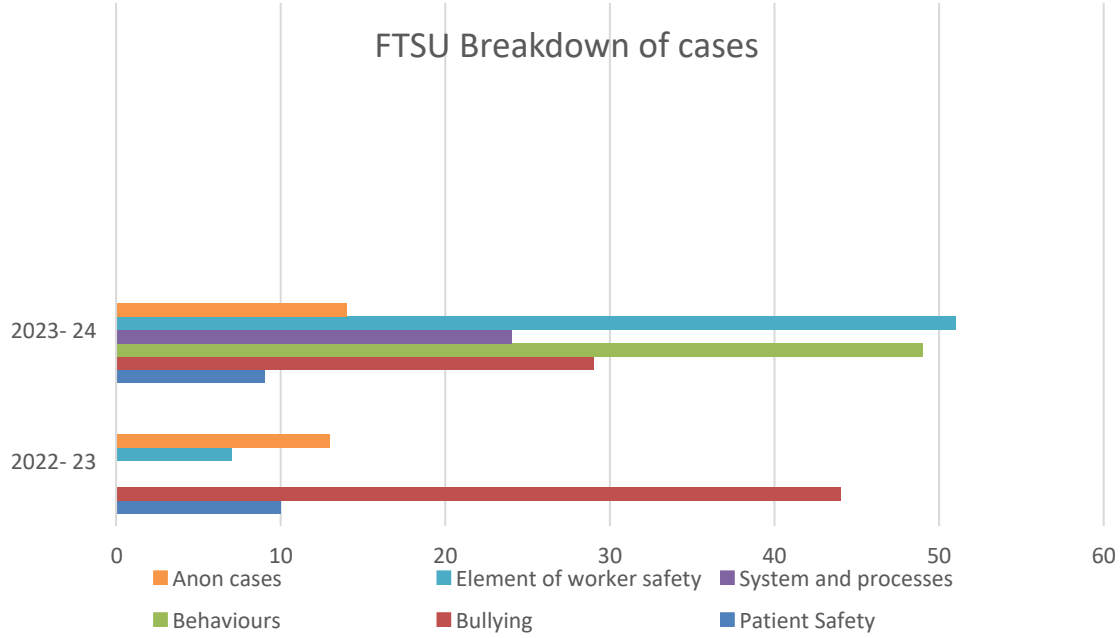
Improvement Actions	Due Date	RAG
Non-Medical Appraisals project plan established with key deliverables against clear timescales including: stakeholder engagement, updated policy, processes, paperwork, and training/support	March 2024	
Stakeholder engagement workshops completed. Report of findings and recommendations being finalised	December 2023	

Freedom to Speak Up (BAF SR4 Workforce - Culture, Experience and Retention)

Key Points to Date
Freedom to Speak up cases continue to increase as expected with the additional support and investment given to the service. Anonymous reporting (recorded by NGO as %) has reduced to 13% in Q2 compared with an overall 37% last year. A gap analysis review is complete with work identified to continually improve the service.
Data is being captured and will be held in accordance with National Guardian Office guidance of System and Processes, Bullying and Harassment, Element of worker safety, Element of patient safety/ quality and Elements of inappropriate attitudes or behaviours. Worker safety data has increased this year and this may be due to the change in the team. To date, there are 95 closed cases with 18 open and still in progress.

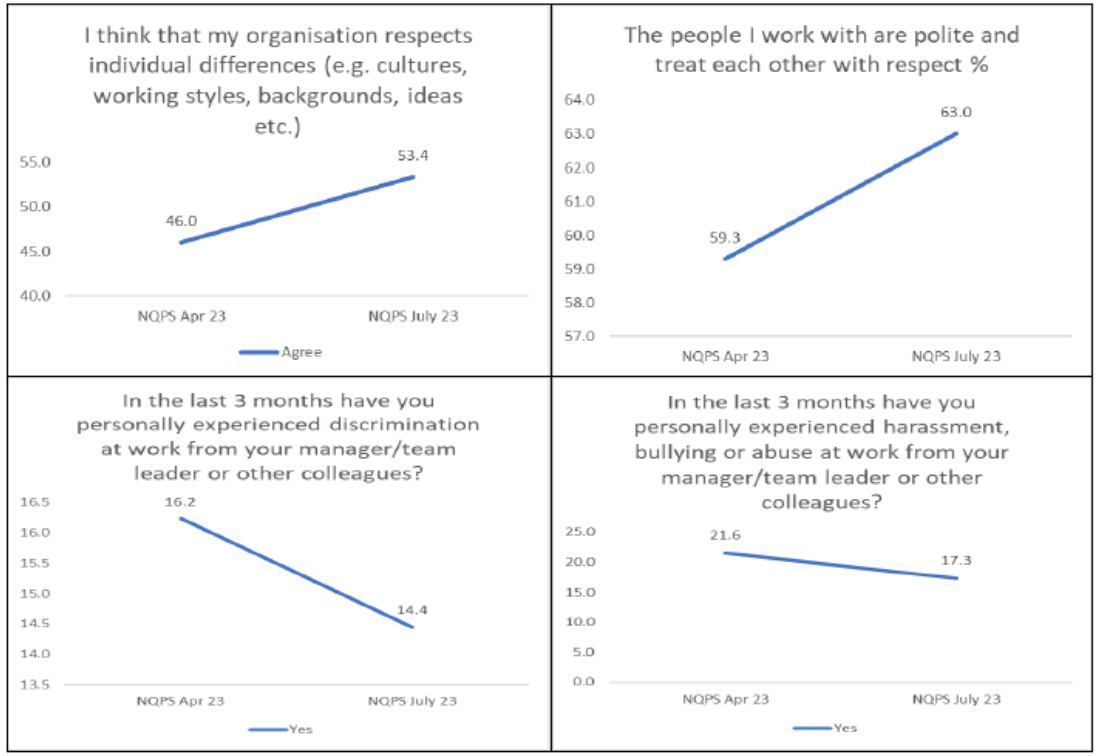
Improvement Actions	Date Due	RAG
Review of patient safety concerns raised to FTSU. TOR to be set and work to be completed within 3 months.	Feb 2024	
Review model of service with recruitment of additional FTSU Guardian	Feb 2024	



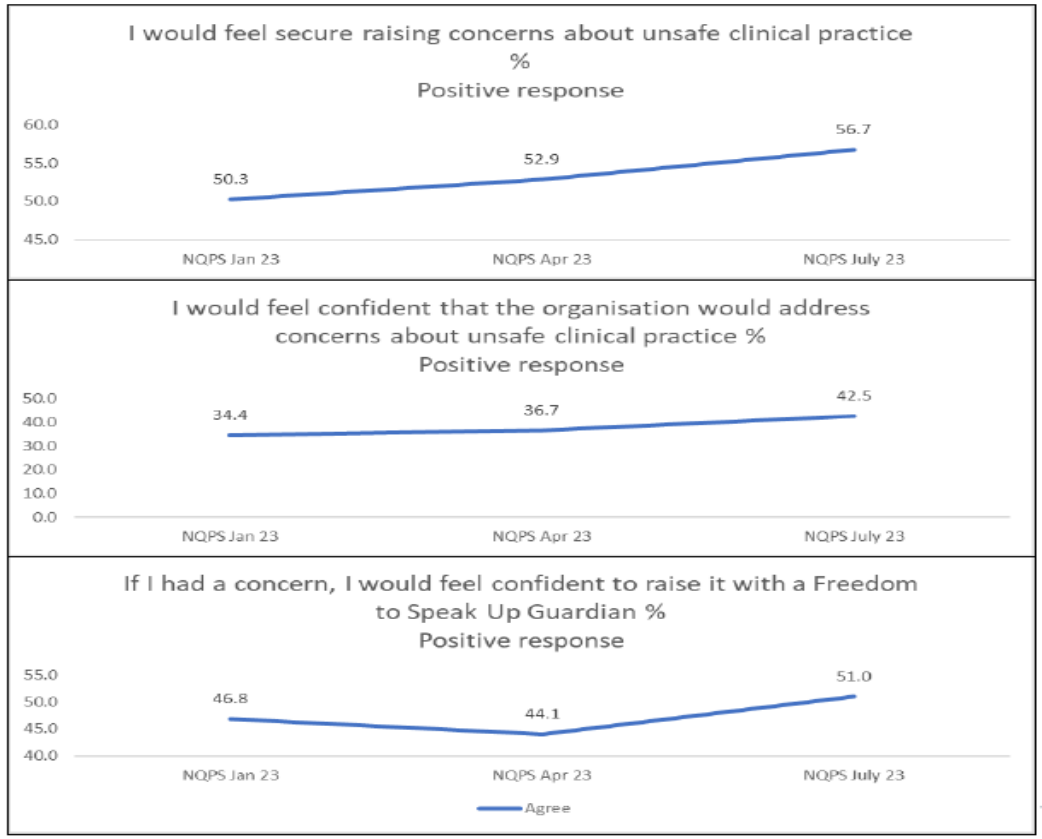


Staff Engagement and Experience (BAF SR4 Workforce - Culture, Experience and Retention)

People Promise element 7: We are a team



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



Staff Engagement and Experience (BAF SR4 Workforce - Culture, Experience and Retention)

People Promise element 1:
We are compassionate and inclusive

Key Points to Date	Date Due	RAG
Staff Experience Improvement Programme KPIs will be further developed in addition to the Staff Survey and NQPS in order to monitor full impact of the programme.	January 2024	

Improvement Actions

The Leadership and Teamwork development programme design is progressing well with The Wellbeing Collective. One to one and small group meetings have been held between The Wellbeing Collective and Executives, selected NEDS and senior professional leads. An introductory meeting has been held between The Wellbeing Collective and the broader LOD team to establish partnership working approach.

Meetings have continued with divisional and service line leads to start mapping out teams, leaders, specific requirements and backfill requirements. Mapping of delivery schedule has commenced for selected service lines in partnership.

Backfill costs largely calculated and paper drafted nearing finalisation. Paper was scheduled to be presented to DOAG and TLT in November however this has been pushed back by one month to allow for full stakeholder engagement to be undertaken.

Work has been undertaken to develop an anti-discrimination intranet page which will include links to the Mutual Respect policy, a single point of reporting for discrimination and details of where staff can receive support.

Discussions have been held to review the report mechanisms. Datix is to be the single point of reporting and ratified at October's Programme Board.

A review of the Mutual Respect policy commenced.

The Taskforce are progressing the 4 projects at pace and are preparing for the final session in December. The project teams have been asked to present recommendations in relation to achieve wider roll out where appropriate.

Full scoping of the Restorative & Just workstream has commenced, with deliverables agreed. Milestones and Timeline to be developed and presented to the November Staff Experience Improvement Programme Board.

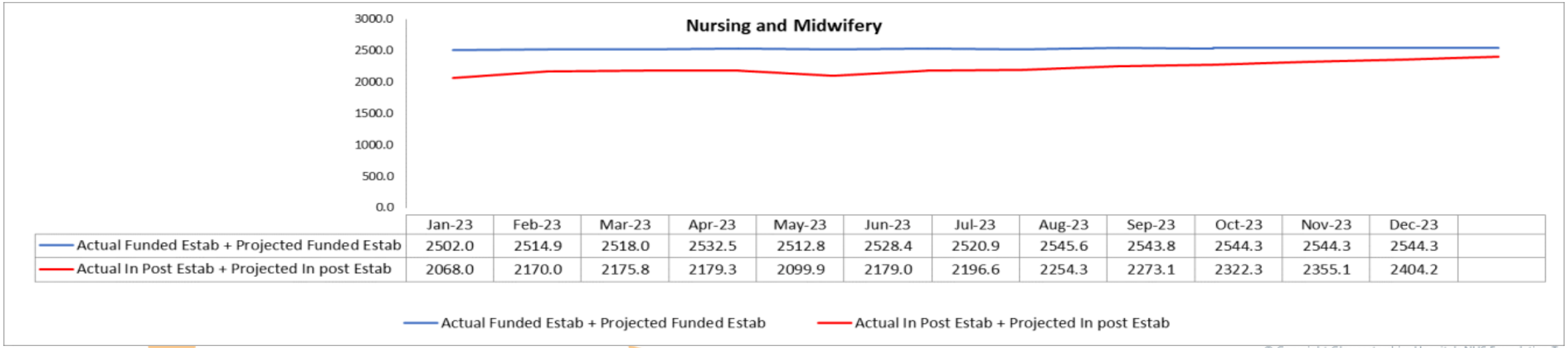
A paper will be developed for Executives and TLT which will demonstrate the expectations and requirements of the organisation to achieve a Restorative, Just and Learning Culture.

Business Intelligence support has been assigned to the programme.

Recruitment Pipeline (BAF SR3 Workforce - Recruitment & Attraction)

Key Points to Date
October 2023 saw the gap between funded establishment and in post the smallest it has been this year (222 FTE).
With the data from the recruitment pipeline, this forecasts that the gap will continue to close over the next two months. Predicting that in December 2023 the gap will be reduced to 140.1 FTE. Ongoing close monitoring will continue.

Improvement Actions	Date Due	RAG
The Nurses, Midwives & ODP Open Day took take place on 14th October 2023 with a successful event. Planning is now in place to support the next Open Event in April 2024	April 2024	
Discussions continue through the Nursing Operational Group to promote GHFT through greater exposure at universities for domestically trained newly qualified nurses. Further plans to be discussed on attendance at future career fairs within the universities.	Ongoing	
Confirmation awaited on further financial support from NHSE beyond January 2024. The International Oversight Governance Group is to review the plan for international recruitment in to 2024/25 to understand demand and financial sustainability to maintain international recruitment as part of the longer term workforce plan.	Ongoing	

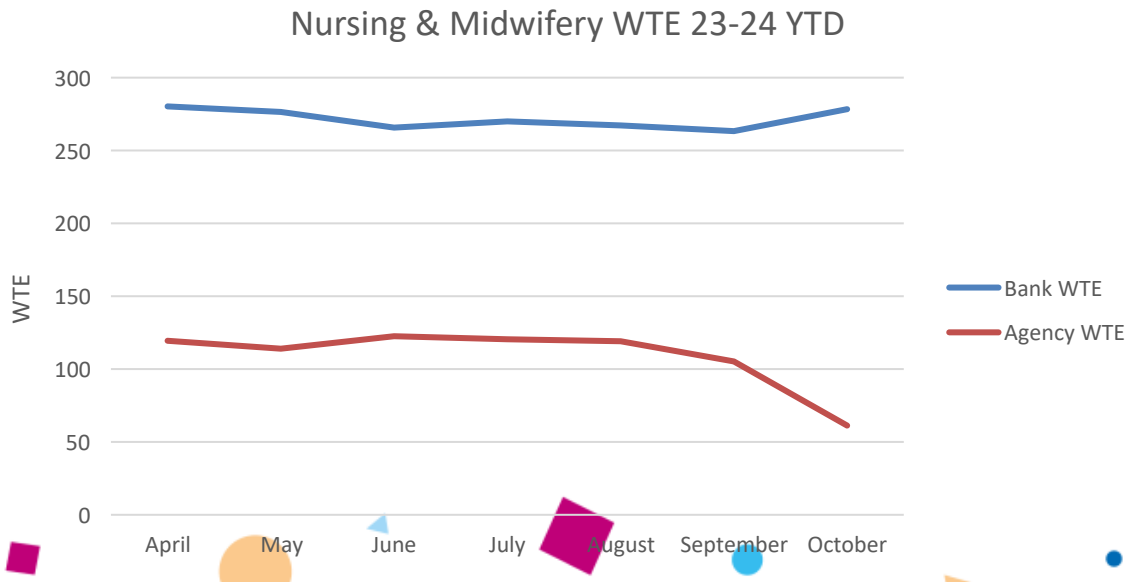


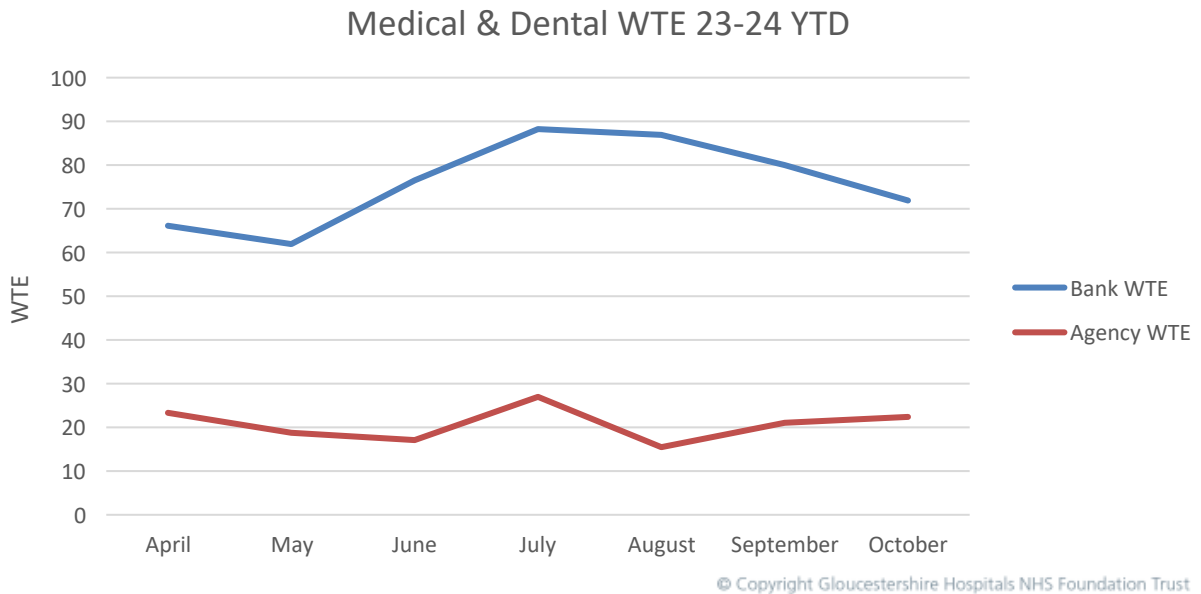
	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Actual Funded Estab + Projected Funded Estab	2502.0	2514.9	2518.0	2532.5	2512.8	2528.4	2520.9	2545.6	2543.8	2544.3	2544.3	2544.3
Actual In Post Estab + Projected In post Estab	2068.0	2170.0	2175.8	2179.3	2099.9	2179.0	2196.6	2254.3	2273.1	2322.3	2355.1	2404.2

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

Key Points to Date
Bank spend for Medics in M7 -- £1,294,579 Agency spend for Medics in M7 -- £474,131
Bank spend for Nursing & Midwifery in M7 -- £2,441,752 Agency spend for Nursing & Midwifery in M7 -- £488,149
Agency usage for Nursing has decreased month on month since the July implementation of a HealthRoster system setting which allows bank workers to view shifts filled by agency workers, replacing agency shifts with bank shifts.

Improvement Actions	Date Due	RAG
Vacancies and long term sickness absences have impacted the progress of the non-clinical Bank project, which is now delayed until recruitment is complete.	Full roll out extended to March 2024	
Changes to the Locums Nest (Medical Bank system) were implemented on 01/11/23 with the aim of improving grip and control around locum use and spend. Adherence to these changes will be monitored at future Grip & Control meetings.	November 2023	
On-going work with BI to produce automated temporary staffing reports, reducing manual intervention and human error	March 2023	

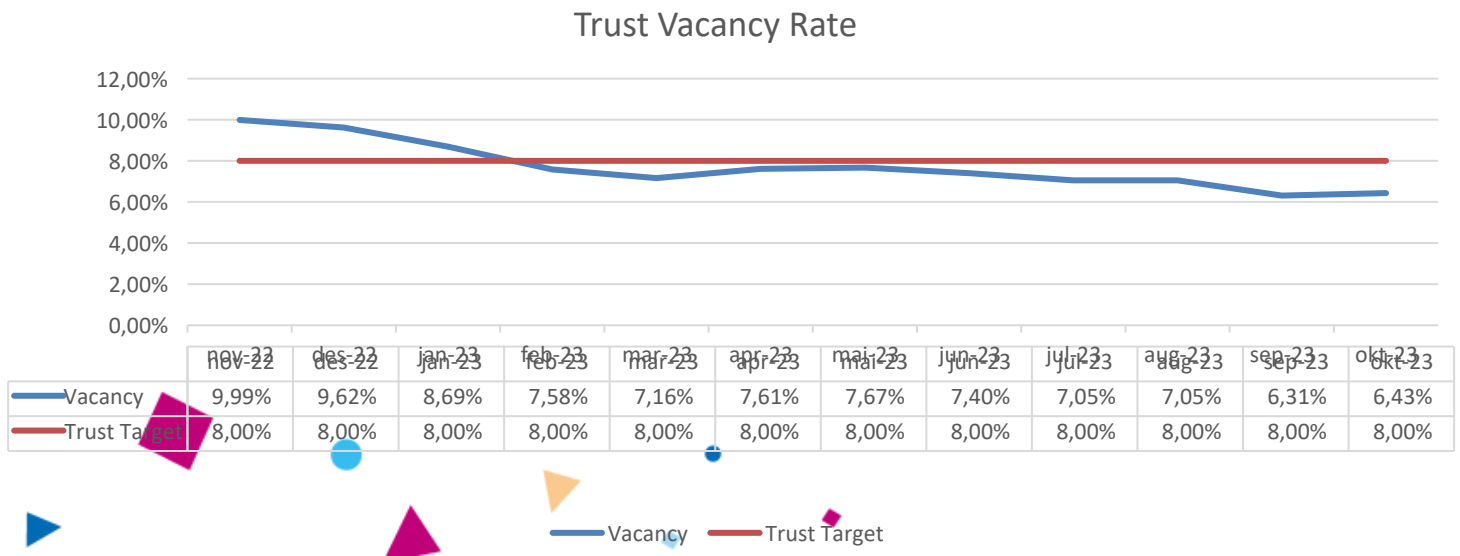




Vacancies (BAF SR3 Workforce - Recruitment & Attraction)

Key Points to Date
Trust Vacancies have seen a slight increase compared to the previous month (0.12%), bringing the overall vacancy rate to 6.43% for this month.
October 2023 is the ninth consecutive month the vacancy rate is below the target.
October 2023 is 3.56% lower than the highest recorded vacancy rate (November 2022) in the last 12 month period.

Improvement Actions	Date Due	RAG
The Trust remains on target to meet its recruitment of 135 Internationally Educated Nurses (IEN), with 75 recruited by the end of October 2023. A further 30 were onboarded in November 2023, with the last 30 due in January 2024.	January 2024	
Meeting took place with Chief Registrars in Medicine during October 2023 to review the Trust offering to Locally Employed Doctors (LEDS) and IMG (International Medical Graduates). Further discussion to take place with Trust IMG Lead to look at a pastoral support package to attract recruitment for the next August 2024 intake.	Februar y 2024	
Establishment Controls working group continues to set up processes for an improved control between Finance and ESR establishment data. These controls under Financial Sustainability will include robust VCP processes set at Exec level for new posts and roles Band 8a and above.	Februar y 2024	

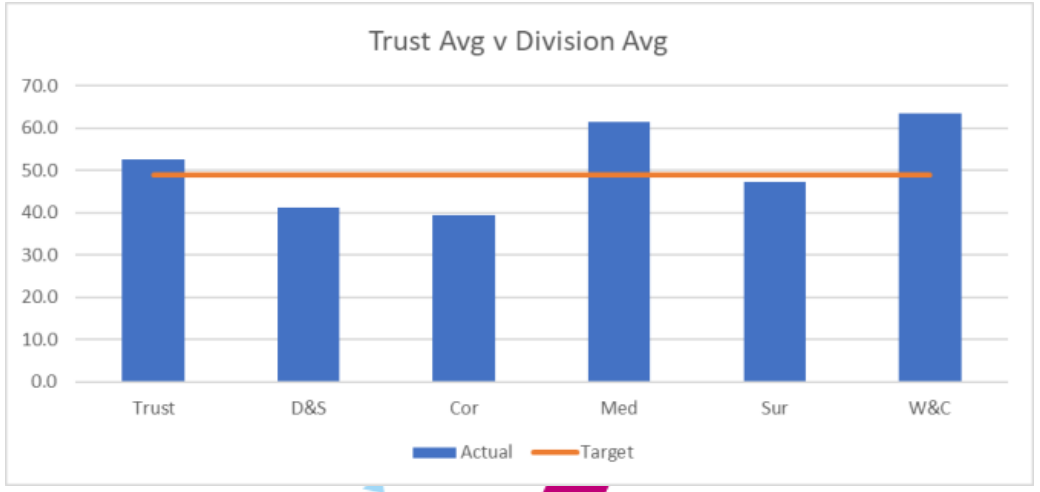


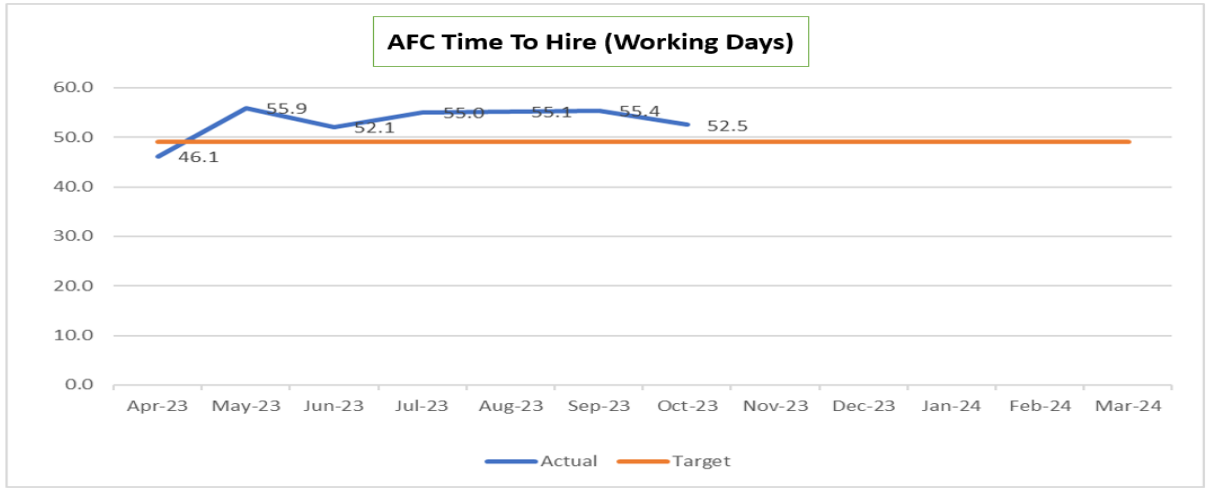
	nov-22	des-22	jan-23	feb-23	mar-23	apr-23	mai-23	jun-23	jul-23	aug-23	sep-23	okt-23
Vacancy	9,99%	9,62%	8,69%	7,58%	7,16%	7,61%	7,67%	7,40%	7,05%	7,05%	6,31%	6,43%
Trust Target	8,00%	8,00%	8,00%	8,00%	8,00%	8,00%	8,00%	8,00%	8,00%	8,00%	8,00%	8,00%

Time to Hire (BAF SR3 Workforce - Recruitment & Attraction)

Key Points to Date
A review of the time to hire KPIs has been undertaken to establish consistency with other Trusts. This has seen the data being converted to working days rather than calendar days, which although sees the data remaining relative if recorded in calendar days, it provides an improved reflection of when the recruitment activity is managed by departments.
Part of this review has seen both the duration of the advertising and interview notice stages amended to show an average time rather than a target, which describes the process more accurately.

Improvement Actions	Date Due	RAG
TRAC VCP rollout commenced in November for Medicine Division, with Surgery planned for end of November. This will improve the divisional VCP for both visibility and speed of managing the request.	November 2023	
TRAC starter module delayed from September due to amendments required following initial testing. Agreed rollout is planned for the end of November 2023.	November 2023	
Deep dive in to KPIs per division reflects where there are challenges and where plans/discussions are needed to support departments to reduce time to hire	January 2024	
A re-set of the Recruitment Transformation Programme has taken place to assess progress and identify key priorities for moving forward and achieving key outcomes by March 2024.	March 2024	
Continuous improvement surveys are being prepared. These are to be sent to new starters, recruiting managers and the recruitment team. Feedback will help inform further transformational activity.	December 2023	





Attrition (BAF SR3 Workforce - Recruitment & Attraction)

Key Points to Date
Highest attrition rate during recruitment is still at the Interview Process stage with the main reason given by candidates as having received another job offer and decided to withdraw from GHFT.
The Admin and Clerical staff group still remain with the highest attrition through the recruitment process
Overall, 196 candidates withdrew their applications during the recruitment stages shown below in October 2023

Improvement Actions	Date Due	RAG
Attrition data continues to be reviewed to understand candidates reasons for withdrawal. Data suggests applicants are applying for multiple posts and accepting through one job, meaning candidates retract their application	Ongoing monitoring	

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

Recruitment Stage	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Nursing and Midwifery Registered	Grand Total
Interview	35	65	13	9	1	24	147
Longlisting	3	6	4	1		7	21
Offer	7	3	1	2		8	21
Shortlisting		4				1	5
Starting			1	1			2
Grand Total	**45**	**78**	**19**	**13**	**1**	**40**	**196**

Gloucestershire Hospitals NHS Foundation Trust

Key:

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

KEY ISSUES AND ASSURANCE REPORT
FINANCE AND RESOURCES COMMITTEE – 21 DECEMBER 2023

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
Capital Programme	Treatment of the financial impact of the delay in delivery of the 5th Orthopaedic Theatre had yet to be agreed with Region. Failure to secure agreement to a carry forward of funds could lead to the scheme not being delivered as planned. The impact of IFRS16 continued to unfold with consequent implications for spending limits.	The Committee noted the seriousness of the position and received assurance that positive discussions were taking place with the Region. Discussions with Region, System partners and external auditors were underway with a view to mitigating this risk. A potential reprograming of medical equipment expenditure between financial years was under consideration.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Financial Performance Report	At M8 there was a small overspend of £0.6m and an improving run rate in a number of staffing related areas. Planned industrial action in December and January would impact upon financial plans and a forecast outturn position would be confirmed at the close of month 9. The current ICS position was achievement of break even for the year. The deficit at the close of M8 was £7m - £1.9m adverse to plan.	The Committee noted the seriousness of the position and looked forward to receiving the outcome of the forecast outturn exercise at its next meeting.
Financial Sustainability Report	The Committee noted the position at the end of M8 – to date £17.4m of savings had been delivered (£12.7m recurrent, £4.7m non-recurrent) and £2.4m behind plan. Significant risk remains around delivery of over £8m "red" rated schemes during the remainder of the year.	The Committee noted the position, risks around delivery and mitigating actions. Early preparations had begun for 24/25 schemes with a view to achieving a rapid take off come April. The requirement for additional staffing resource in this area was under consideration.

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.

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None.		

Items not Rated			
None			

Investments

Case	Comments	Approval	Actions
CARR Contract (Cardiac equipment)	The Contract Award Recommendation report recommended approval of this revised contract by the Committee. The contract had been approved by the Committee in June 2022 but re-approval was required as a consequence of delays in awarding the contract (by partner organisations) which had resulted in price rises. The Committee were assured that the price increase would be matched by value offsets so that the contract was comparable to that awarded in 2022.	APPROVED	The Committee confirmed the approval of the revised contract.

Impact on Board Assurance Framework (BAF)

Not considered – this was a short meeting focussed on a small number of items.

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

Report to Board				
Date	11 January 2024			
Title	**Financial Performance Report (Month 8)** Month Ended 30 November 2023			
Author /Sponsoring Director/Presenter	Hollie Day, Caroline Parker, Craig Marshall Karen Johnson			
Purpose of Report		Tick all that apply ✓		
To provide assurance		✓	To obtain approval	
Regulatory requirement			To highlight an emerging risk or issue	
To canvas opinion			For information	
To provide advice			To highlight patient or staff experience	

Summary of Report

Purpose

This purpose of this report is to present the financial position of the Trust at Month 8 (M8).

Revenue

The Trust is reporting a year to date (YTD) deficit of £7.0m which is £1.9m adverse to plan. This is the position after adjusting for donated assets impact and Salix grant.

The ICS YTD deficit position of £5.4m which is £0.6m adverse to plan. This is the result of a £1.9m adverse to plan position from GHFT, a £2.7m YTD favourable position at GHC and a £1.4m deficit position at GICB.

Capital

The Trust is reporting a YTD position of £32.2m against a planned spend of £36.8m which is a variance of £4.6m. This excludes IFRS 16 capital.

Recommendation

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

- the Trust is reporting a deficit of £7,024k which is £1,887k adverse to plan
- the Trust capital position as of the end of November 2023.

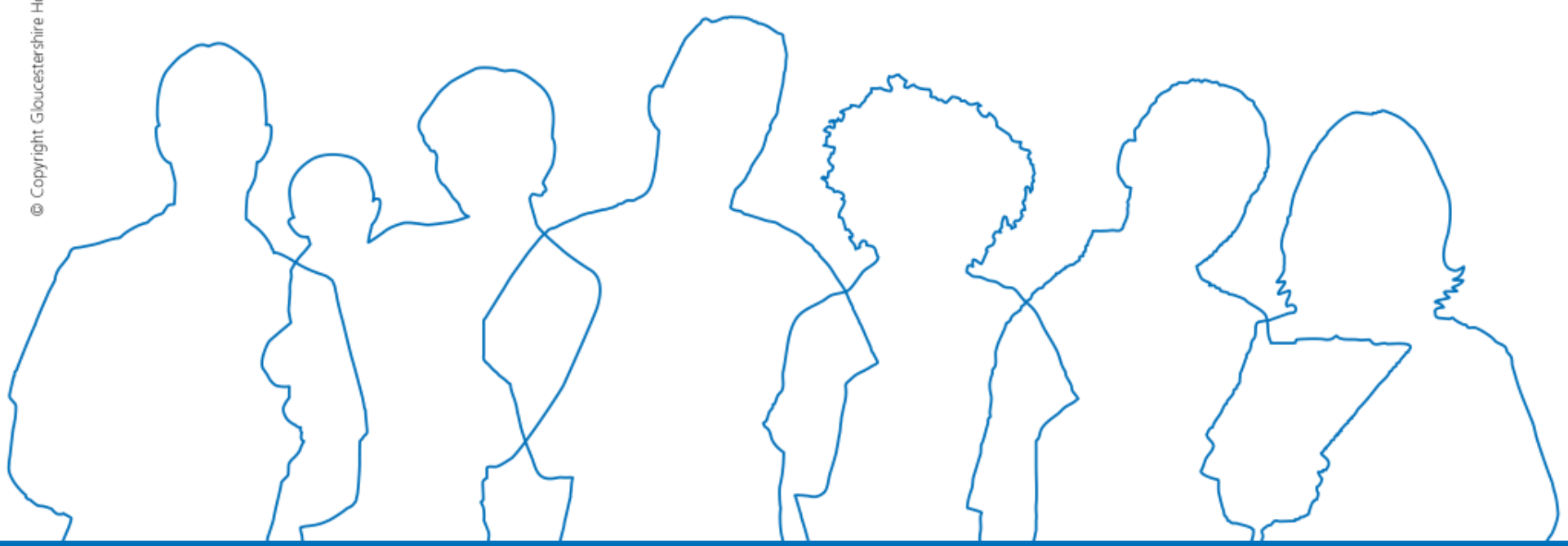
Enclosures

M8 Financial Performance Report

Gloucestershire Hospitals
NHS Foundation Trust

Report to Board

Financial Performance Report
Month Ended 30 November 2023



Revenue & Balance Sheet

Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

System Overview

The ICS is required to breakeven for the year. At month 8, all organisations within the system are forecasting to deliver to a breakeven financial position at year-end in line with the plan.

The ICS year-to-date (YTD) deficit position of £5.4m which is £0.6m adverse to plan. This is the result of a £1.887m adverse to plan position from GHFT, £2.735m favourable position at GHC and a £1.405m adverse variance at GICB due to prescribing cost pressures.

In line with national guidance, individual organisational are reporting their positions against the original plan values and not against the revised 22nd November submissions. This is expected to be updated for month 9 reporting.

Month 8

M8 YTD Financial position is reporting a deficit of £7,024k which is £1,887k adverse to plan. The position includes :

- Industrial Action costs £2,148k (there was no IA in M8)
- PFI indexation above planned inflation £496k
- Net impact of elective activity underperformance £2,895k, including £2,792k due to IA and £103k due to productivity
- GICB support to fix elective element of contract to offset underperformance £1,188k benefit
- Unfunded nursing for Courtyard (10-18 patients) and AMU at GRH (26 unfunded beds open) £1,845k
- SDEC open after 23:00 £222k
- FAS - up to 8 additional patients £254k
- Guiting - 3 additional patients £403k
- Ward 4b - swing bay is open without funding (6 patients) £661k
- Ward 7b - 2 RNs providing care for one patient each day £512k
- DTAs in ED - can be up to 50 (budget can cover 20) £2,558k
- Overseas Nursing Supernumerary costs £1,820k
- Divisional pay pressures in medical staffing and nursing £4,900k
- Interest receivable and payable lower than plan £3,000k benefit
- Reserves £9,000k benefit including release of remaining Health & Well Being accrual £1,000k
- Release of prior year accruals (corporate) £1,274k
- Non recurrent benefits £2,200k including ERF

The Financial Sustainability Plan (FSP) target for the Trust is £34.7m in 23/24 and YTD the programme has delivered £17.4m (£12.7m recurrent; £4.7m non-recurrent). The programme is behind plan by £2.3m. There remains risk of delivery due to £8.1m red-rated schemes.

Month 8 headlines

Gloucestershire Hospitals NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £7m deficit which is £1.9m adverse to plan		I&E Position YTD is £7m deficit which is £1.9m adverse against the plan of £5.1m deficit.
Income is £507m YTD which is £20.3m favourable to plan		M8 income position is £507m YTD which is £20.3m favourable to plan. This is driven by GMS reporting additional income due to pay award funding and capital margin. It is also driven by overperformance of pass through drugs and HEE income which is netting off underperformance on elective contracts. Further information is on the Activity slide.
Pay costs are £314.5m YTD which is £17.3m adverse to plan		Pay costs are £314m YTD which is £17.3m adverse to plan. Pressures include Industrial Action costs and covering escalation & vacancies within ED, Acute Medicine, theatres and trauma.
Non Pay costs are £194m YTD which is £4.9m adverse to plan.		Non Pay costs (included non-operating costs) are £194m YTD which is £4.9m adverse to plan. This position includes overspends on clinical supplies within the Surgery Division, increased PFI costs due to indexation and undelivered FSP.
Delivery against Financial Sustainability Schemes		The Financial Sustainability Plan (FSP) target for the Trust is £34.7M. In Month 8, the Trust had planned efficiencies of £19.8M and achieved £17.4M.
The cash balance is £47.9m		Cash has reduced by £0.6m in month.

Oversight Framework – Financial Matrix

Gloucestershire Hospitals NHS Foundation Trust

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

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

The Financial Matrix used by the Trust to monitor the Finance and Use of Resources for Month 8 YTD position is below. The System is also required to monitor against these metrics plus achievement of Mental Health Standard.

Group Position	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Financial efficiency – variance from efficiency plan	19,838	17,365	(2,473)
Financial stability – variance from breakeven*	(5,137)	(7,024)	(1,887)
Agency spending against ledger budget	(5,253)	(13,111)	(7,858)
adjusted position			

The Trust is adverse to plan against each metric. Financial Efficiency is now an adverse variance to plan because many FSP plans are phased to deliver in the latter part of the year and there remain high risk schemes totalling £8.1m.

M8 Group Position versus Plan

Gloucestershire Hospitals NHS Foundation Trust

The financial position as at the end of November 2023 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity, and excludes the Hosted GP Trainees (which have equivalent income and cost) each month.
In November the Group's consolidated position shows a deficit of £7m deficit which is £1.9m adverse to plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 8 Financial Position	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	448,897	454,365	5,467			0	448,897	454,365	5,467
PP, Overseas and RTA Income	2,778	3,785	1,007			0	2,778	3,785	1,007
Other Income from Patient Activities	8,387	9,273	886			0	8,387	9,273	886
Operating Income	32,492	35,927	3,435	47,568	60,747	13,179	26,586	39,545	12,959
Total Income	**492,555**	**503,351**	**10,796**	**47,568**	**60,747**	**13,179**	**486,649**	**506,968**	**20,320**
Pay	(288,798)	(296,210)	(7,412)	(16,128)	(18,520)	(2,392)	(297,128)	(314,452)	(17,324)
Non-Pay	(196,752)	(205,160)	(8,407)	(29,706)	(41,931)	(12,224)	(182,050)	(190,239)	(8,190)
Total Expenditure	**(485,551)**	**(501,370)**	**(15,819)**	**(45,834)**	**(60,451)**	**(14,617)**	**(479,178)**	**(504,692)**	**(25,514)**
EBITDA	**7,004**	**1,981**	**(5,023)**	**1,734**	**296**	**(1,438)**	**7,471**	**2,277**	**(5,194)**
EBITDA %age	**1.4%**	**0.4%**	**(1.0%)**	**3.6%**	**0.5%**	**(3.2%)**	**1.5%**	**0.4%**	**(1.1%)**
Non-Operating Costs	(6,662)	(3,525)	3,137	(1,734)	(296)	1,438	(7,128)	(3,821)	3,307
Surplus / (Deficit)	**342**	**(1,544)**	**(1,887)**	**(0)**	**(0)**	**(0)**	**343**	**(1,544)**	**(1,888)**
Dontated Asset, Impairment & Salix Grant Adjustment	(5,480)	(5,480)	0	0	0	0	(5,480)	(5,480)	0
Adjusted Surplus / (Deficit)	**(5,138)**	**(7,024)**	**(1,887)**	**(0)**	**(0)**	**(0)**	**(5,137)**	**(7,024)**	**(1,887)**

* Trust position excludes £30m of Hosted Services income and costs. This relates to GP Trainees
** Group position excludes £57m of inter-company transactions, including dividends

Balance Sheet

Gloucestershire Hospitals NHS Foundation Trust

	Group Closing Balance 31st March 2023 £000	GROUP Balance as at M8 £000	B/S movements from 31st March 2023 £000
Non-Current Assests			
Intangible Assets	16,483	13,528	(2,955)
Property, Plant and Equipment	357,717	371,937	14,220
Trade and Other Receivables	3,901	3,815	(86)
Total Non-Current Assets	**378,101**	**389,280**	**11,179**
Current Assets			
Inventories	12,312	13,353	1,041
Trade and Other Receivables	46,622	38,058	(8,564)
Cash and Cash Equivalents	49,193	47,964	(1,229)
Total Current Assets	**108,127**	**99,375**	**(8,752)**
Current Liabilities			
Trade and Other Payables	(104,686)	(90,380)	14,306
Other Liabilities	(11,160)	(28,716)	(17,556)
Borrowings	(5,904)	(6,049)	(145)
Provisions	(7,929)	(5,005)	2,924
Total Current Liabilities	**(129,679)**	**(130,150)**	**(471)**
Net Current Assets	**(21,552)**	**(30,775)**	**(9,223)**
Non-Current Liabilities			
Other Liabilities	(7,603)	(5,063)	2,540
Borrowings	(41,793)	(42,488)	(695)
Provisions	(2,824)	(2,824)	0
Total Non-Current Liabilities	**(52,220)**	**(50,375)**	**1,845**
Total Assets Employed	**304,329**	**308,130**	**3,801**
Financed by Taxpayers Equity			
Public Dividend Capital	397,288	402,635	5,347
Reserves	28,113	28,113	(0)
Retained Earnings	(121,073)	(122,618)	(1,545)
Total Taxpayers' Equity	**304,329**	**308,130**	**3,801**

The table shows the M8 balance sheet and movements from the 2022/23 closing balance sheet.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

Funding

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m, of which £1.5m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £55.8m.

In November (M8), the Trust was awarded £0.1m of NHSE funding as part of the Cyber Improvement Programme. Year to date, additional NHSE funding of £2.3m had been approved and additional System contingency of £0.3m has been allocated to the Trust. This brings the forecast programme funding (including IFRS 16) to £59.9m.

YTD Position

As of the end of November (M8), the Trust had goods delivered, works done or services received to the value of £32.2m, against a planned spend of £36.8m, equating to a variance of £4.6m behind plan. In month, the Trust delivered a £3.8m gross capital spend against a forecast of £5.3m.

The current internal forecast outturn position is showing a gross capital spend of £61.4m versus a gross funded position of £59.9m, a £1.6m overspend. This position comprises a £3.1m overspend within System capital, a £5.5m overspend on IFRS 16, and a £7.1m underspend in National Programme funded projects.

The IFRS16 forecast overspend has been reported to NHSI in the M8 Provider Financial Return (PFR). *Since the end of Month 8, the national team have agreed a £1.3m system funding allocation in respect to IFRS16, against a planned funding of £1.5m. This increases the pressure on our IFRS16 programme to £5.7m. The Region is currently working with systems to identify any further slippage on IFRS16 and are hopeful that the IFRS16 allocation can be managed across the region.*

The System capital and national programme variances have yet to be reported within the PFR. The Region are aware.

The Trust is looking at various mitigations to the forecast outturn positions internally as well as involving our System partners and the region should the variances require some additional support to resolve. *Since the end of M8, the Trust / system have identified mitigations for the system capital overspend and there have been positive discussions around reprofiling £4.2m of national programme funding in relation to the 5th Orthopaedic Theatre scheme into 2024/25 in order to match the spend.*

23/24 Programme Funding Overview

Gloucestershire Hospitals NHS Foundation Trust

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m, of which £1.5m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £55.8m.

In November (M8), the Trust was awarded £0.1m of NHSE funding as part of the Cyber Improvement Programme. Year to date, additional NHSE funding of £2.3m had been approved and additional System contingency of £0.3m has been allocated to the Trust. This brings the forecast programme funding (including IFRS 16) to £59.9m. The breakdown of secured funding is shown in the below.

in £000's

		Plan	Forecast	Variance	Secured
DIGITAL	Digital	5,700	5,700	0	5,700
MEDICAL EQUIPMENT	Medical Equipment	5,996	5,981	15	5,981
ESTATES	Estates	14,192	14,207	(15)	14,207
CENTRAL CONTINGENCY	Central Contingency	0	286	(286)	286
Total Charge against Capital Allocation (excluding impact of IFRS 16)		**25,888**	**26,174**	**(286)**	**26,174**
RIGHT OF USE ASSET	Right Of Use Asset	1,478	1,478	0	1,478
Total Charge against Capital Allocation (including impact of IFRS 16)		**27,366**	**27,652**	**(286)**	**27,652**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Image Sharing	326	174	152	174
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	iRefer	0	152	(152)	152
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Digital Pathology	115	115	0	115
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Equipment 22/23	451	451	0	451
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Enabling works	4,185	4,185	0	4,185
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Digital	2,540	2,540	0	2,540
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	5th Orthopaedic Theatre	8,703	8,703	0	8,703
NAT PROG: RIGHT OF USE ASSET: NEW	Leases: Community Diagnostic Centre	4,098	4,098	0	4,098
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	CT Scanner	0	954	(954)	954
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	Endoscopic Retrograde Cholangiopancreatography (ERCP)	0	1,251	(1,251)	1,251
NAT PROG: CYBER IMPROVEMENT PROGRAMME	Cyber Improvement	0	100	(100)	100
STP PROGRAMME: GSSD	Gloucestershire Hospitals Strategic Site Development	561	561	0	561
IFRIC 12	PFI Lifecycle	1,126	1,126	0	1,126
DONATIONS VIA CHARITABLE FUNDS	Gamma Camera	514	514	0	514
DONATIONS VIA CHARITABLE FUNDS	Jet Ventilator	61	61	0	61
DONATIONS VIA CHARITABLE FUNDS	2 incubators for SCBU GRH	0	31	(31)	31
DONATIONS VIA CHARITABLE FUNDS	Other potential charitable donations	500	469	31	0
GRANT	PSDS 3a Salix (Grant Funded)	6,724	6,724	0	6,724
Total Additional Capital		**29,904**	**32,209**	**(2,305)**	**31,740**
Gross Capital Funding Total (including IFRS 16)		**57,270**	**59,861**	**(2,591)**	**59,392**
Excluding IFRS16		(1,478)	(1,478)	0	(1,478)
Gross Capital Funding Total (excluding IFRS 16)		**55,792**	**58,383**	**(2,591)**	**57,914**

Gross Capital Funding Total (including IFRS 16)		**57,270**	**59,861**	**(2,591)**	**59,392**
Less Donations and Grants Received	Less Donations And Grants Received	(7,799)	(7,799)	0	(7,799)
Less PFI Capital (IFRIC12)	Less PFI Capital (IFRIC 2)	(1,126)	(1,126)	0	(1,126)
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	Plus PFI Capital On A Uk GAAP Basis (E.G. Res. Interest)	335	335	0	335
Total Capital Departmental Expenditure Limit (CDEL)		**48,680**	**51,271**	**(2,591)**	**50,802**

23/24 Programme Spend Overview

Gloucestershire Hospitals NHS Foundation Trust

As of the end of November (M8), the Trust had goods delivered, works done or services received to the value of £32.2m, against a planned spend of £36.8m, equating to a variance of £4.6m behind plan. In month, the Trust delivered a £3.8m gross capital spend against a forecast of £5.3m.

The current internal forecast outturn position is showing a gross capital spend of £61.4m versus a gross funding of £59.9m, a £1.6m overspend. This position comprises a £3.1m overspend within System capital, a £5.5m overspend on IFRS 16, and a £7.1m underspend in National Programme funded projects.

Capital Programme Year-to-Date expenditure and forecasts by programme area are shown below.

in £000's

	In Month			Year to Date			Forecast		
	Last Forecast for this Month £000's	In Month Actual £000's	Variance to Last Month Forecast £000's	Plan £000's	Actual £000's	Variance to Plan £000's	Funding £000's	Forecast £000's	Variance
DIGITAL	394	(22)	416	3,025	2,361	663	5,700	4,758	942
MEDICAL EQUIPMENT	238	202	36	3,310	846	2,464	5,981	2,640	3,341
ESTATES	2,080	2,128	(48)	10,317	13,116	(2,799)	14,207	20,394	(6,187)
22/23 VAT RECLAIMS	0	0	0	0	(593)	593	0	(793)	793
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**2,712**	**2,309**	**403**	**16,652**	**15,730**	**922**	**26,174**	**29,316**	**(3,142)**
RIGHT OF USE ASSET	731	12	719	1,053	4,407	(3,354)	1,478	6,996	(5,518)
Total Charge against Capital Allocation (including impact of IFRS 16)	**3,443**	**2,321**	**1,122**	**17,705**	**20,137**	**(2,432)**	**27,652**	**36,312**	**(8,660)**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	1	8	(8)	441	40	401	441	267	174
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	882	608	274	5,888	3,040	2,848	7,176	5,642	1,534
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	200	(55)	255	5,390	562	4,828	8,703	4,515	4,188
NAT PROG: RIGHT OF USE ASSET: NEW	0	0	0	0	375	(375)	4,098	2,910	1,188
NAT PROG: DIAGNOSTIC RECOVERY AND RENEWAL PROGRAMME	0	125	(125)	0	131	(131)	2,205	2,205	0
NAT PROG: CYBER IMPROVEMENT PROGRAMME	0	0	0	0	0	0	100	100	0
STP PROGRAMME: GSSD	0	0	0	561	561	0	561	561	0
IFRIC 12	94	94	0	751	751	0	1,126	1,126	0
DONATIONS VIA CHARITABLE FUNDS	0	(26)	26	575	581	(6)	1,075	1,075	0
GRANT	691	690	1	5,495	5,981	(486)	6,724	6,724	0
Gross Capital Spend Total	**5,310**	**3,766**	**1,545**	**36,806**	**32,160**	**4,646**	**59,861**	**61,438**	**(1,577)**
Excluding IFRS16	(731)	(12)	(719)	(1,053)	(4,407)	3,354	(1,478)	(6,996)	5,518
Gross Capital Spend Total (excluding IFRS 16)	**4,580**	**3,754**	**826**	**35,753**	**27,753**	**8,000**	**58,383**	**54,442**	**3,941**

Gross Capital Spend Total	**5,310**	**3,766**	**1,545**	**36,806**	**32,160**	**4,646**	**59,861**	**61,438**	**(1,577)**
Less Donations and Grants Received	(691)	(665)	(27)	(6,070)	(6,562)	492	(7,799)	(7,799)	0
Less PFI Capital (IFRIC12)	(94)	(94)	(0)	(751)	(751)	(0)	(1,126)	(1,126)	0
Plus PFI Capital On a UK GAAP Basis (e.g. Res. Interest)	28	28	0	224	224	0	335	335	0
Total Capital Departmental Expenditure Limit (CDEL)	**4,553**	**3,035**	**1,518**	**30,209**	**25,071**	**5,138**	**51,271**	**52,848**	**(1,577)**

Gloucestershire Hospitals NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a deficit of £7,024k which is £1,887k adverse to plan.
- Note the Trust capital position as of the end of November 2023

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

KEY ISSUES AND ASSURANCE REPORT
AUDIT AND ASSURANCE COMMITTEE – 28 NOVEMBER 2023

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
	There were NO items rated as RED	

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Internal Audit	**Progress report** – Good progress noted. Rated amber in light of previous concerns and would wish to see continued sustained progress but excellent progress between meetings	Continued sustained performance needed
	Allied Health Professional (AHP) waiting list audit report – Overall moderate assessment with a range of helpful recommendations, all of which were accepted by management. Helpful feedback from Chief Allied HHP around audit process and potential lessons learned around areas that are rarely audited and the improvements that can come from a well-structured and scoped review. Rated as amber pending implementation and follow up	Evidence of implementation and improved performance as a result.
	Follow up report – Generally looking far better and clearly a lot of work has gone in to get us to this point. Appear on track to deliver the plan by the end of financial year along with some additional work. Rated amber pending further output from Feb 24 meeting	Good sustained progress and delivery of the annual plan.
External Audit	**Lessons learned report received** - Very helpful to see very honest, candid and reflective process from which both parties had clearly learned with good enhancements planned for coming year	Good plan which now needs to be seen actioned and will be kept under review by the Committee
	Action plan – helpful level of granular detail which will hopefully be a very useful tool at year end	Good plan which now needs to be seen actioned and will be kept under review by the Committee
Gloucestershire Managed Services (GMS)	Some areas of concern noted around progress but based on matters arising update on new governance arrangements there is a plan to enhance this and the Committee expects to receive regular KIARs from the monthly GMS Governance and Compliance Committee meetings which are intended to deliver greater progress against areas of concern to Audit and Risk Committee	Implementation of GMS governance arrangements and delivery through these
Board Assurance Framework	BAF out of sync for this meet. Full report to January 2024 Board. Risk register position noted. Concern around Datix, impact on workloads and compromising	Committee supported escalation to NHS England given that this is a corporate solution and

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.

(BAF) and Risk Register	ability of risk management as tool to support effective management	should be far more effective
Accountability Framework (AF)	Accountability report received to show how exec manage performance and escalate as needed. Welcomed by Committee and full roll out supported. Committee agreed that AF should be referred to other Committees to consider in planning their annual work plans	Refer to other Committees for consideration

Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
High quality papers - circulated well in advance of the meeting which made prep easier		
Follow up actions between meetings – Very good progress		
Good focus on non-traditional audit Committee areas, with focus on patient added value		
Matters arising. All four outstanding matters were closed off.		
Counter fraud report – Excellent, clear digestible report. Good progress reported against various ongoing cases. Evidence of added value particularly around input to Junior Doctors around fraud awareness		
GMS accounts – Noted as complete and satisfactory		
HFMA self-assessment - Ownership and continued progress on actions identified from self-assessment and audit. Most actions now completed		
Single tender actions report - No retrospective tenders, total value of single action tenders £296,020		
Losses and compensations – Two low value ex – gratia payments made and approved write off of 134 low value invoices totalling approx. £2K.		
Trust seal – Noted several sealings since last report in July 2023		
Annual debt report - Noted		

Items not Rated
AOB item - Member of staff receiving exceptional hospitality award following third party recognition of their work – fully separate to the Trust, no contractual relationship and was judged by independent panel. Trust exec aware and fully supportive as is Audit Chair

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

Impact on Board Assurance Framework (BAF)
None noted

ANY OTHER BUSINESS - Patient Safety Incident Response Framework			
Date	January 2024		
Title	**Patient Safety Incident Response Framework**		
Sponsoring Director **Author**	Prof Mark Pietroni Director for Safety & Medical Director Victoria Wills, Associate Director of Patient Safety (Human Factors & Improvement)		
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:

The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

The Trust is required to produce and publish a Plan and Policy that describes how the Trust intends to work in accordance with the Patient Safety Incident Response Framework, and which have been approved by the Trust Board and the Integrated Care Board (ICB).

The process for approval was reported to the Trust Board in September 2023.

The Plan and Policy have been produced in draft and were reviewed by Quality Delivery Group (QDG) in December 2023. As there was no Quality and Performance Committee (QPC) in December, the documents have not as yest been sighted by QPC.

The ICB Quality Committee, which will grant the final approval is scheduled for 15 February 2024 and as such, submission to Trust Board in March 2024 is precluded if we are to remain on target for ICB approval and a proposed transition to the Framework from 1 March 2024.

To meet these deadlines and continue with the Trust implementation of the PSIRF, it is therefore requested that the Board consider granting delegated authority for the approval of the Patient Safety Incident Response Plan and Policy, to the Quality and Performance Committee, on 24 January 2024. Subject to satisfactory approval, this will enable the documents to be submitted for approval to the ICB Quality Committee on the 15 February 2024.

Recommendation:

The Board is asked to **DELEGATE APPROVAL** of the Patient Safety Incident Response Plan and Policy, to the Quality and Performance Committee, on 24 January 2024.