GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
09.30, Thursday 13 July 2023
Bluecoat Room, Gloucester Guildhall
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			09.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 11 May 2023**	Approval	Enc 1	09.35
5	**Matters arising from Board meeting held on 11 May 2023**	Assurance		
6	**Patient Story** *Katherine Holland, Patient Experience Manager*	Information	Presentation	09.40
7	**Chief Executive's Briefing** *Mark Pietroni, Deputy Chief Executive/Medical Director and Director of Safety*	Information	Enc 2	10.00
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	10.15
9	**Trust Risk Register** *Mark Pietroni, Deputy Chief Executive/Medical Director and Director of Safety*	Assurance	Enc 4	10.25
10	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director*	Assurance	Enc 5	10.35
11	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director, Karen Johnson, Director of Finance* • **Community Diagnostic Centre Lease Agreement** • **Energy Performance Contract**	Assurance Approval Approval	Enc 6 Enc 7 Enc 8	10.50
	Break (11.15-11.25)			
12	**Quality and Performance Committee Report** *Alison Moon, Non-Executive Director, Matt Holdaway, Chief Nurse and Director of Quality, and David Coyle, Interim Chief Operating Officer*	Assurance	Enc 9	11.25
13	**Maternity Report** *Matt Holdaway, Chief Nurse and Director of Quality*	Assurance	Enc 10	11.55
14	**Annual Guardian of Safe Working Hours Report** *Mark Pietroni, Deputy Chief Executive/Medical Director and Director of Safety*	Assurance	Enc 11	12.05
15	**Annual Medical Appraisal and Revalidation Report** *Elinor Beattie, Emergency Medicine Consultant*	Assurance	Enc 12	12.15
16	**Audit and Assurance Committee Report** *Claire Feehily, Non-Executive Director*	Assurance	Enc 13	12.25
17	**NHS Provider Licence Self-Certification** *Kat Cleverley, Trust Secretary*	Approval	Enc 14	12.35
18	**CQC Statement of Purpose** *Kat Cleverley, Trust Secretary*	Approval	Enc 15	12.40
19	**Trust Seal Report** *Kat Cleverley, Trust Secretary*	Approval	Enc 16	12.45
20	**Any other business**		None	12.50
21	**Governor Observations**			
	Close by 13.00			

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 11 May 2023, 13.30, Bluecoat Room Gloucester Guildhall			
Chair	Deborah Evans	DE	Chair
Present	Helen Ainsbury	HA	Interim Chief Digital Information Officer
	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	Matt Holdaway	MH	Chief Nurse and Director of Quality
	Karen Johnson	KJ	Director of Finance
	Simon Lanceley	SL	Director of Strategy and Transformation
	Deborah Lee	DL	Chief Executive Officer
	Jaki Meekings-Davis	JMD	Non-Executive Director
	Alison Moon	AM	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director
	Mark Pietroni	MP	Medical Director and Director of Safety
	Claire Radley	CR	Director for People and Organisational Development
	Qadar Zada	QZ	Chief Operating Officer
Attending	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Katherine Holland	KH	Patient Experience Manager (item 6 only)
	Katrina Jones	KJo	Lead Clinical Psychologist (item 6 only)
	Sarah Mather	SM	Matron for Critical Care, Pain and Vascular Access services
	Debbie Seal	DS	Critical Care Nurse (item 6 only)
Observers	Three governors, two members of staff, and one member of the public observed the meeting in person.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting, noting that this was the last Board meeting for both QZ and SL.
2	**Apologies for absence** Vareta Bryan, Non-Executive Director, Kaye Law-Fox, Associate Non-Executive Director/GMS Chair, Mike Napier, Non-Executive Director, and Rebecca Pritchard, Associate Non-Executive Director.
3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 9 March 2023** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 9 March 2023** All matters arising were updated.
6	**Patient Story** The Board received a presentation from the Critical Care team on the Post-Critical Care Covid Follow Up Clinic, which had been piloted following the release of NICE rehabilitation recommendations. As part of the presentation, a video recording interview between KH and a patient of the clinic was played; the patient detailed how beneficial the clinic had been to his rehabilitation following his hospitalisation with covid. MP asked about the link between this clinic and social prescribing. DS explained that the clinic promoted healthy lifestyles and signposted and supported patients with weight loss, gym access, smoking cessation etc., and

	explained how health inequalities were a key part of the clinic and were constantly reviewed for patients to access different groups, social networking and financial support. DL reflected on whether the Trust was focusing enough on its staff who were suffering with long covid but could not access the service if they had not been admitted to CCU, and whether the service could be expanded to include them. SM acknowledged that there was much more the service could offer, and the team continued to monitor the progression of the clinic and how it could expand. CR asked if the clinic outcomes were contributing towards an evidence base. KJo responded that the team were aware that there was further evidence to collect, particularly relating to changes to the patient post-clinic, however it was a work in progress to prove the advocacy of the service. The Board commended the team for its important work and supported the progression of the service.
7	**Chief Executive's Briefing** DL briefed the Board on the following key points: • There had been positive performance in urgent and emergency care, with fewer patients in corridors and cohort areas over the last ten days. The number of No Criteria to Reside (NCTR) patients was currently 176. The Trust remained committed to cease boarding, and had begun the journey to end corridor care. • Some activity had been lost in elective care; however, this was not detrimental to the performance of the Trust in respect of national waiting time targets. • The organisation continued to effectively manage the Patient Treatment List (PTL). • The Board was advised that delivery of the Operational Plan for this year was a key focus. • The recent industrial action had had an impact on the Trust, however positive cancer performance had been maintained and was progressing well. • Events had been held across the Trust to celebrate Ramadan. • The CQC had revisited maternity and surgery services, and had provided broadly positive feedback. The Trust had made some significant improvements, with some further actions to review. The Section 29a notice remained, however good progress had been made. A full report on their visit had not yet been received, however the feedback letter was provided to the Board for information. • Primary care reforms were currently being discussed at system level, with a particular focus on mobilising community pharmacy. JMD commented on split site working complexities, with MP noting that there were some low-frequency, high-impact cases related to paediatric surgery which the Trust was required to ensure regulatory standards were in place for.
8	**Board Assurance Framework** KC reported that the BAF had now embedded into a business-as-usual process, with regular updates and alignment to committee agendas to ensure focus on key reports and discussions. Finance and Resources Committee had discussed an increase in *SR12 Cyber Security* score, to reflect the high impact risk. This would be taken through the usual governance process during May and June. MP provided a positive reflection on the BAF, noting that it was beginning to shape conversations and discussions held by Executives and at Committees. DL requested that the risk domain be included.
9	**Trust Risk Register**

Unconfirmed

	The Board received the report for information, noting that three new risks had been added to the register, and four downgraded following a reduction in risk score.
10	**Operational Plan 2023-24** Discussed under item 11.
11	**Finance and Resources Committee Report** JMD advised the Board of the key highlights from April's Committee meeting; the Committee had approved the financial plan for 2023/24, and approved the changes to the Operational Plan for 2023/24, which had been submitted on 4 May. JMD also noted the fantastic achievement of the year-end breakeven position, and commended the team. DL commented on the water safety item, adding that controls in place were increasingly strong, however the Trust needed to ensure that the controls were sustainable and not reliant on Infection Control teams. AM queried the Trust's agency spend against its year-to-date plans, as there appeared to be a sizeable variance. KJ advised that the budget was based on the premium cost of the agency; CR added that this would be reflected as part of the workforce sustainability programme. ***Finance Report*** KJ advised the Board of additional key highlights from the Finance Report: • KJ thanked the team who had worked so hard, in collaboration with operational teams and budget holders, to achieve the year-end breakeven position. • The overall ICS financial position was £0.1m surplus against a breakeven plan. • The provisionally reported capital outturn position was £66.1m, representing an overspend position of £0.4m. The Trust ended the year at £3k under the agreed position. • The Board was advised that pay spend was currently £45.5m over budget, however this was driven by income matching for pay awards and HCA re-banding; adjustments made for these drivers took the pay position down to £10m. ***Digital Transformation Report*** The report provided an update on projects that had been delivered during 2022/23 and an overview of an ambitious plan for 2023/24 which had been developed to include a focus on digital enablement and optimising solutions already implemented. The plan was a result of divisional and clinical input. AM commented that a benefits realisation exercise would be beneficial, particularly for non-financial benefits for colleagues and patients. DE suggested that a board development session on productivity could incorporate this. **Action** MAG asked HA if there were any key areas of concern. HA responded that improvements could be made to assurance frameworks particularly in relation to cyber security, and generally strengthen digital for the Trust's new strategy.
12	**People and Organisational Development Committee Report** BH highlighted key areas from April's meeting; the Board was advised that the agenda continued to evolve and was now more focused on key strategic areas related to the Board Assurance Framework. The Committee focused particularly on the People Performance Dashboard, and noted concern related to mandatory training compliance; information governance training was a key concern, however the Committee was assured that staff were provided with protected time to enable completion. The Committee had been pleased to hear that the Trust had welcomed eighty new international nurses. Positive work was underway to reduce time to hire. The Committee had noted that funding had not been supported for the marketing strategy and other avenues were being explored to progress this; CR noted that discussions with the system would be undertaken.

13	**Quality and Performance Committee Report** AM advised the Board of key highlights from April's meeting; the Committee had been pleased to hear of the Trust's commitment to cease boarding. The planned Quality Summit to discuss boarding had been postponed, however it had taken place at the end of April. Meaningful discussions continued to be held on the Board Assurance Framework risks, which were supporting good, focused conversations. The Committee had received a good Safer Staffing Report, with positive partnership working ongoing. The Committee had also commented on continued utilisation of the work that Newton had completed. ***Quality and Performance Report*** Other key highlights were noted as follows: • The Board was advised that the Trust had achieved 6 out of 10 cancer performance standards and had delivered on the two-week wait pathway for the fourth week running. By the end of this month, performance would indicate the first time the Trust would have achieved the two-week wait on every speciality. • The Trust continued to reduce the backlog. • GHT had been commended by NHSE as the only Trust in the South West to maintain performance during industrial action and bank holidays. • Urology and colorectal remained a particular challenge, with high volumes of patients. • MP advised the Board of a significant data coding issue within dementia; this would reflect in the report in due course and show movement in the right direction. • Pressure ulcers had increased significantly and was related to the number of patients within the hospitals. • The Trust would celebrate International Nurses Day on 12 May 2023. The Board agreed to delegate authority to Quality and Performance Committee to approve the Quality Account 2022/23.
14	**Audit and Assurance Committee Report** CF advised the Board that there had been good indications from external auditors on the progress of the year-end audit. Internal auditors had highlighted significant issues with response to reviews and follow ups, which was symptomatic of operational pressures within the Trust. CF advised that risk assurance remained a key concern for the Committee, however discussions had taken place to review the format of the report.
15	**Any other business** DE formally thanked QZ and SL for everything they had done for the Trust, and wished them well for the future.
16	**Governor Observations** AH thanked SM and her team for the critical care story and encouraged the Trust to share the work of the Staff Transformation Group more widely. AH was also pleased to hear positive feedback following the CQC's recent visit to Surgery and Maternity services. SM was pleased to hear that Board discussions reflected staff concerns, including boarding and staff survey results. ME commended the finance team for achieving the year-end balance. MP was pleased to hear reflections on how Board discussions were affecting colleagues and patients.
Close	

Actions/Decisions

Unconfirmed

Item	Action	Owner/ Due Date	Update
Quality and Performance Committee Report	The Board agreed to delegate authority to Quality and Performance Committee to approve the Quality Account 2022/23.		
Digital Transformation Report	A board development session on productivity would be arranged, to include digital programme benefits realisation.	DE/KC	In progress

CHIEF EXECUTIVE OFFICER'S REPORT
JULY 2023

1. Operational Context

The Trust continues on a broadly positive trajectory in respect of operational performance with significant improvements in ambulance handover delays and Category 2 response times. Inevitably, recent industrial action by junior doctors and nursing colleagues has introduced a number of operational challenges but our teams and leaders have worked incredibly effectively to maintain safe care.

We continue to make progress in respect of supporting patients with No Criteria To Reside (NCTR) to be discharged home or to onward care. The number of patients whose discharge is delayed has reduced further with an average of 195 for the month of April, and an average of 167 in the last seven days; this is from a peak of 257 in January. The Operational Planning Trajectory commits the system to achieve 160 by March 2024 although, as a system, we are aiming to improve on this. These recent improvements have enabled us to achieve our plan of closing our winter ward at Cheltenham General (Prescott) without a significant impact on flow. Last month, we held a Clinical Summit with clinical colleagues to develop a plan for reducing and, ultimately, eliminating the need to care for patients in corridors on our wards and care for patients in areas not intended for this purpose, including day surgery and Emergency Department cohort areas.

The Trust continues to perform well in respect of elective waiting times and Gloucestershire was the only system in the South West region to achieve the national standard of no patients waiting more than 78 weeks and is now well placed to achieve the 65-week standard. Of particular note, this was achieved despite the total number patients waiting for planned care being the highest in the SW which speaks to the diligence and focus of our teams in managing the Patient Tracker List (PTL). In Gloucestershire, there are 107 patients per 1,000 population on a waiting list, compared to 96 per 1,000 waiting in the South West; however, we have just 3 per 100,000 waiting more than 52 weeks, compared to 6 per 1,000 in the region. The greater number of patients waiting overall does underline the importance of delivering the operational plan requirement of 105% of 2019/20 cost weighted activity to enable us reduce the total number of patients waiting.

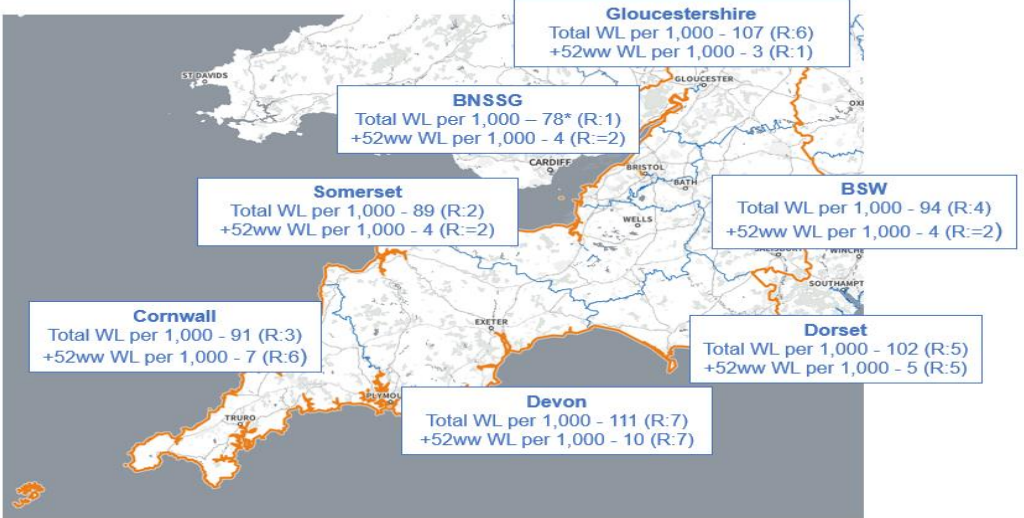


Figure 1 Patients on a hospital waiting list per 1,000 patients – admitted & non-admitted

Teams have worked incredibly hard to minimise the loss of elective activity associated with industrial action. Despite the short notice changes to the period of industrial action by members of the Royal College of Nursing (RCN), teams managed to re-book 90% of the activity that had been stood down meaning only 58 patients (41 outpatients and 17 elective procedures) were impacted by industrial action. Regrettably, the junior doctor strike days had a much more significant impact with 241 elective procedures cancelled and 715 outpatients. However, thanks to the efforts of our administrative teams, 89% of these patients have been re-booked.

The very significant focus on cancer is continuing to bear fruit with significant reductions in the number of patients waiting more than 62 days for their first definitive treatment following a GP referral. As of today, there are 150 patients waiting more than 62-days to commence treatment, from a position of 402 at the start of the calendar year. This does mean that the 62-day performance measure is declining (as expected) as we treat many more of our longest waiting patients who have already breached the standard. Our goal remains to achieve the national standard of 85% of patients being treated within 62 days of GP referral and teams are working hard to achieve this. Equally positively, every speciality is on track to achieve the two-week wait standard for the first time since before the pandemic – this is a hugely important milestone in supporting delivery of the 62-day target. None of this would be possible without the hard work and dedication of our staff. Finally, we remain one of only two Trusts in the SW Region achieving the 28-day Faster Diagnosis Standard.

2. Industrial Action

In terms of industrial action, the national picture is mixed. While the majority of unions representing NHS staff have now accepted the Government's pay rise and moves are now underway to implement the new deal for all staff employed under Agenda for Change terms and conditions, including nurses.

At the time of writing this report the BMA Junior Doctors' Committee has just announced the first ever 5-day strike in NHS history from July 13-18. The BMA Consultants' Committee had announced indicative strike dates of July 20-21 pending the outcome of the consultants' ballot. The ballot results were announced on 27/6/23 and were strongly in favour of strikes. We have not yet received formal notification of the strike but expect it soon. Members of the RCN have been re-balloted and have rejected further strike action.

The Trust made extensive plans during the most recent period of industrial action, a 72-hour walk out by the BMA held earlier in June. Our aim was two-fold: to support colleagues to exercise their right to strike, whilst keeping our hospitals safe. Teams worked incredibly hard to minimise the loss of elective activity associated with the unrest.

It's also worth noting that industrial action across other sectors, particularly education, can have an impact on our workforce. The Trust continues to follow national developments closely and is hopeful that resolution can be found that brings an end to the unrest.

3. Recruitment

The CEO recruitment process has been in full swing. There was a strong field with 3 shortlisted candidates and following an open and competitive recruitment process, I am pleased to announce the appointment of Kevin McNamara as our new Chief Executive.

Kevin is currently the Chief Executive at Great Western Hospitals NHS Foundation Trust and has worked in the NHS in a number of senior roles for over 20 years. Details are

still being finalised but Kevin will join the organisation with a planned transition before Deborah Lee leaves the Trust in March 2024.

It is planned that the new CEO will be involved in the recruitment of the Chief Operating Officer and Director of Strategy and Transformation. Both these posts have attracted a strong field; 6 candidates have been longlisted for each with 3 likely to be shortlisted for each position. The Focus Groups / Presentations are taking place 2 August at Sanger House with interviews taking place on 3 August.

4. Cultural Improvements

Great work is being done with good engagement with a significant number of colleagues who have joined the Taskforce. Initially, not many medical colleagues engaged but now we do have some colleagues stepping in to the programme.

There were 4 workstreams for the Taskforce which are being scoped and should be implemented by the end of December:

- Just Do it Fund
- 24 hr food
- New starter packs
- Roll out of FERF (staff recognition)

We are in the process of on-boarding the partner that will lead us through the team development work that we have committed to. This is a 3-year programme where all teams and managers have the opportunity to engage.

5. NHS75

On Wednesday 5 July 2023, the NHS will celebrate 75 years of service and our Trust will play its part, along with system partners, in marking this significant milestone. A wide range of activities are planned throughout the week as we come together with our community to mark the occasion. Plans include:

- NHS75 Commemorative Badge - paid for by our Charity
- Planting of 75 Trees across sites
- NHS75 Cakes for staff
- NHS75 Service – Gloucester Cathedral 6 July 2023
- NHS75 Parkrun - 8 July
- Themed Menus in restaurants

The celebration at Gloucester Cathedral is on 6 July 2023 and is open to staff as well as colleagues closely linked with the work of health and social care. The event is free, but you do need to book a place as space is limited: search 'cathedral evensong' & 'NHS75' on Eventbrite to book your place.

Three of our colleagues' images have been shortlisted in the national NHS75 photo competition organised by NHS England in partnership with Fujifilm. The categories were *Our People, Our Environment, Our Care, Our Partners* and *Our Innovations* and all three of the Trust's shortlisted candidates submitted in the latter category. The images, by Nigel Hayward of Medical Engineering, Pharmacy Technician Lee Edwards and Ophthalmic Imager Richard Aldred, will be displayed at an exhibition at Fujifilm House of Photography in Covent Garden, London and open to public viewing from 5 July 2023.

6. Inaugural UEC Transformation Programme Board (yet to be named)

Deborah Lee attended the above meeting on 19 June 2023 with respect to the piece of work done by Newton who the ICS had on-boarded to carry out some diagnostic work around urgent emergency care transformation.

Newton had involved front line staff, completing case studies which resulted in some really compelling recommendations for the way forward; if we realise 50% of the opportunities they identified, we would release 200 acute beds and be fully staffed.

Newton have now been on-boarded as the Delivery Partner and will be mobilising the programme. There will be launch events with many opportunities for staff to work on the programme (on a sessional basis). There are a number of roles available; design leads, delivery leads, workstream leads, with 7 major work streams that have sub-work streams.

7. Digital Journey

Our Maternity and Digital team went live with BadgerNet in June, which is a full electronic patient record (EPR) that supports clinical and administrative management of the entire maternity journey and will replace the current paper-based records.

The BadgerNet system will provide colleagues with a single point of access to the information they need to make fast, informed decisions to provide the best quality care to all our patients. It will also improve the patient experience and empower families by giving them easy access to their notes. To mark the advancements, the team purchased branded baby grows to give to the first babies who were born and put on the system.

The deployment of such technology takes significant planning and technical expertise and the roll-out marks another step in our digital maturity.

8. Freedom To Speak Up

The Trust has strengthened its approach to accountability, challenge and staff support through the appointment of a dedicated lead for Freedom To Speak Up (FTSU). There are a number of teams across the Trust who have 'Guardians' so plans are now in place to ensure clarity between the roles they all play.

The Freedom To Speak Up Guardians work alongside our leadership teams to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up safely.

FTSU is designed to contribute to creating a culture of openness throughout the organisation, to ensure that our speaking up processes are effective and continuously improved and to ensure all staff are supported appropriately when they speak up or support other people who are speaking up.

We also have a key role in helping to raise the profile of raising concerns in this organisation, and provide confidential advice and support to staff in relation to concerns they have about patient safety and how their concern has been handled.

9. Staff Awards

Our annual staff awards recognise the very best of our colleagues every year and the patient choice award, nominated solely by members of the public, is now open. For us, the awards are a celebration of the hard work, loyalty and dedication of individuals and teams across our hospitals (Cheltenham General, Gloucestershire Royal and Stroud

Maternity Unit). This year there are 16 categories covering the breadth and depth of the work we undertake at our hospitals. The event, split over two nights, will be held in November.

We are fortunate to have attracted sponsors to enable us to make the awards something really special for our staff. Their involvement allows us to create links with local businesses and gives them the opportunity to attend the evening and hear at first hand some of the wonderful things our staff have done over the year.

Our Staff Awards aims to thank staff for their hard work, their innovation and for the outstanding care they provide for patients in the county.

10. Marking Windrush

In June, we marked the 75th anniversary of the Empire Windrush arriving in Britain. On 22 June 1948, HMT Empire Windrush arrived in the UK, carrying more than 1,000 passengers from the West Indies who were invited by the government to help rebuild the country after World Ward 2. This was the first wave of post-war immigration with many of the passengers taking up roles in the NHS, which launched just two weeks later. We are proud that many of them decided to settle here and last month we celebrated their immense contribution to every aspect of British culture and daily life. To mark this historic event, we held celebrations at both main sites with music and refreshments which were both well received and attended.

11. Sponsored Run

Colleagues put their best foot forward as part of charity fundraising run at Cheltenham Racecourse last month (June). Thousands of pounds have been raised to help buy new equipment following the success of Cheltenham Running Festival. Competitors/fundraisers competed across four events ranging from a half marathon through to a kids run. It can't be overstated enough just how important these events are to help raise vital funds for our hospitals.

12. Biomedical Science Day

Last month, we marked Biomedical Science Day where we celebrated the huge contribution that biomedical scientists make to our Trust and the wider NHS. Often behind the scenes, biomedical scientists play a vital role and roughly 80% of all diagnoses in the NHS, will involve a biomedical scientist. `Most departments including operating theatres, wards and emergency departments would not be able to function without the service provided by biomedical scientists and others in the laboratory service.

Prof Mark Pietroni
Deputy Chief Executive Officer

27 June 2023

Report to Board of Directors			
Agenda item:	**8**	**Enclosure Number:**	**3**
Date	13 July 2023		
Title	Board Assurance Framework		
Author /Sponsoring Director/Presenter	Kat Cleverley, Trust Secretary		

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

Summary of Report

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

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

The Board Assurance Framework process is now business as usual, with the BAF used as a key assurance document to inform future strategy and committee discussions.

Updates:

- Finance and Resources Committee recommended that the risk score for SR12, Cyber Security, was increased due to the high impact risks related.
- The risk score for SR9, Financial Sustainability, has been reduced to 16 to reflect the amount of work underway to control the risk. Finance and Resources Committee recommended the increase in May.

Recommendation

The Board is asked to note the Board Assurance Framework.

Enclosures

- Board Assurance Framework, June 2023

June 2023

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges							
SR1	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	June 2023	CNO/MD/COO	3x3=9	N/A	5x5=25
SR2	Failure to implement the quality governance framework	Dec 2022	June 2023	CNO/MD	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	June 2023	DOP	3x4=12	3x2=6	5x4=20
SR4	Failure to retain our workforce and create a positive working culture	Dec 2022	June 2023	DOP	3x4=12	N/A	5x4=20
3. Quality improvement is at the heart of everything we do; our staff feel empowered and equipped to do the very best for their patients and each other							
SR5	Failure to implement effective improvement approaches as a core part of change management	Dec 2022	June 2023	MD/CNO	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	June 2023	COO/DST	2x3=6	4x3=12	5x3=15
5. Patients, the public and staff tell us that they feel involved in the planning, design and evaluation of our services							
SR7	Failure to engage and ensure participation with public, patients and communities	Dec 2022	April 2023	DST	1x3=3	3x3=9	3x3=9
SR8	Failure to ensure opportunities and capacity for staff to engage and participate	Jan 2023	April 2023	DOP	2x3=6	3x3=9	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	May 2023	DOF	4x3=12	5x4=20	4x4=16
8. We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact							
SR10	Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.	July 2019	April 2023	DST	4x3=12	4x4=16	4x4=16
SR11	Failure to meet statutory and regulatory standards and targets enroute to becoming a net-zero carbon organisation by 2040	Dec 2022	April 2023	DST	3x3=9	3x3=9	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	June 2023	CDIO	5x3=15	4x3=12	5x4=20
SR13	Inability to maximise digital systems functionality	Dec 2022	June 2023	CDIO	2x3=6	N/A	3x4=12

June 2023

Board Assurance Framework Summary

10. We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK							
SR14	Failure to invest in research active departments that deliver high quality care	Feb 2023	June 2023	MD	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.

Heat Map

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System**	We are recognised for the excellence of acre 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	COO/MD /CNO	SR2 SR3 SR4 SR5 SR8 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
		Aug 2022		DEC 2022
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	**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.	Newly developed BAF Risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Range of work programmes to support with managing demand internally and with system partners.	• Additional impact of Industrial Action being noted and mitigations developed as announced, compromised ability to plan in advance for all actions and operational changes. • Non-compliance with National operational standards and KPIs

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

• Boarding and Pre-empting and Trust Flow and Escalation Policies revised and operational • Establishments of CADU and Discharge Lounge supporting earlier capacity. • UEC System Programme Board chaired at ICB level • UEC Improvement Board established and Chaired by CEO • Standardised Data set and Operational Dashboard now BAU • Quality & Performance Committee Report to Board.	

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	July 2023	PIP reaching final iteration and will be BAU for the UECIB

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Friends and Family scores continue to be positive • De-escalated from Tier 1 to Tier 3 monitoring with SWRegion 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. Trust Risk Register An improvement programme had been established to coordinate all discharge improvement activity, with an aim to support congestion in Emergency Departments.	• Delivery of operational standards remains non-compliant (61.4% 4hr; Handover time greater than 15mins) UEC Improvement Board - Total handover delays have been increasing over the last 3 weeks to an average 558 per week compared to a weekly average of 528 year to date. - The average number of hours lost per day to handover delays between 17th April and 1st May was 130, - The average time spent in corridor locations at ED GRH increased to almost 8hrs during the week commencing 10th April, however this has decreased to an average of 6.5hrs during the past 3 weeks.	Continued monitoring by SWRegion at Tier 3 Planned Pilot system wide CQC Inspection of UEC Dec 2021 (report published March 2022) Internal audit reviews 2022-2025

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR2: Quality governance framework June 2023

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x4=16	A refresh of the quality governance framework is being implemented. 3 services (subcontracted service, maternity and surgery) have CQC Section 29A warning notices related to governance CCQ inadequate ratings for maternity and surgery Well led requires improvement rating for Trust and a MUST DO action to improve governance	**2022/23 Q3** **3x4=12**	Implementation and embedding of the quality governance framework and CQC Requires improvement rating and no inspection until Autumn 2023.	Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Quality and Performance Committee Report to Board • Trust Risk Register Report to Board • Quality and Performance Report (QPR) to Board - Key Issues and Assurance Report (KIAR) • Quality and Performance Committee oversees progress of risks, safety, experience, access/performance and outcome improvement plans in areas where significant issues/concern highlighted • Delivery Group Exception Reporting (Maternity, Quality, Planned Care and Cancer) • Urgent and Emergency Care Board • Monitoring of performance, access and quality metrics via Quality & Performance Report • Inspection and review by external bodies (including CQC inspections) reported through the Regulatory Report • Quality Strategy (insight, involve, improve) • Risk Management processes • Quality priorities and reporting through Quality Account • Improvement programmes	New CQC Inspection Framework to be delivered awaiting timeline No control of CQC inspections Links to BAF with Trust Risk Register

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

• 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
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	CNO	Q2	In progress and reported to June QDG Engagement and involvement with Divisional Quality Leads. Feedback provided by Good Governance Institute that plan is robust and will support/advise.
Work in progress for the closure of the CQC S29A warning notice action plans	CNO	Overdue Q3 2022/23	Await report from CQC for recent inspections due June 2023.
Work to improve the ratings of the core services rated as inadequate to improve governance	CNO	Q2 2023/24	MDG and QDG have oversight of the CQC improvement plan for the S29a, Must do and Should do improvement action plans Prepare for inspections in Oct/Nov 2023
Formal governance review, focusing on quality ward to Board processes	CNO/DOF/ Trust Sec	Dec 2023	Review underway by GGI.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
Operational Plan 2023/24 Quality Account following national required process Trust Risk Register – highlighting key risks to the delivery of services Reduction of boarding – only pre-empting	• Cancer performance (haematology, urology and lower GI) • Quality and Performance Report – metrics	• 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 - Recruitment and Attraction   June 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR3	Inability to attract a skilful, compassionate workforce that is representative of the communities we serve.	**We have a compassionate, skilful and sustainable workforce, organised around the patient which describes us as an outstanding employer who attracts the very best people.**	Increased demand. Reduced pipeline locally and nationally to fill workforce gaps. Reduced training commissions. Hard to fill specialty posts across multiple professions on a national scale.	Reduced capacity to deliver key strategies, operational plan and high-quality services. Increased staff pressure. Increased reliance on temporary staffing. Reduced ability to recruit the best people due to deterioration in reputation.	People and Organisational Development Committee	Director for People & OD	SR1 SR4 SR5 SR9

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

CONTROLS/MITIGATIONS	GAPS IN CONTROL
▪ International recruitment pipeline ▪ UK RN graduate cohorts ▪ Increased apprenticeships, TNA Cohorts and student placement capacity ▪ Induction pilot of cohorts for HCA/HCSW ▪ Advanced Care and other alternative speciality roles ▪ Accreditation of Preceptorship module ▪ Formalised workforce Operational Plan submission 2022/2023 to NHSE, integrated with the ICS, with ongoing focus for 23/24 ▪ Technology Enhanced Learning and Simulation Based Education ▪ NETS Group created to promote survey, to review and action results. ▪ AHP HCSW Associate Educator Post created with funding bid from NHSE for 9 months FT or 12 months PT	▪ Delays in time to hire ▪ No formalised marketing and attraction strategy / plan ▪ Inability to match recruitment needs (due to national and local shortages) ▪ High dependency on temporary staffing ▪ Poor establishment controls

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

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
To drive forward a transformation programme of the end-to-end transactional recruitment process, to create efficiencies in time to hire and improve both candidate and appointing manager experience	DDfPOD	Detailed project plan in place with key delivery milestones	Reporting into the Workforce Sustainability Programme Board, the focussed review continues with clear benefit realisation being evidenced with time to hire and improved customer survey / experience outcomes. Key areas of focus in the last 2 months include: ▪ Continued support for the online TRAC VCP process for W&C and D&S with all new VCPs going through this route ▪ Continued development of an online onboarding process ▪ Design of a monthly newsletter for appointing managers Milestones for the next 2 months include: ▪ Meetings with Medicine and Surgery scheduled to roll out the online VCP process through TRAC. Go live planned for July with roll out in August for Corporate Services ▪ Ongoing refinement of KPI data and sharing with divisions along with new applicant attrition data sets ▪ Launch of the newsletter as part of the wider engagement plan
Development of a marketing and strategy / plan	DDfPOD	Delayed To be re-assessed in July 2023	This is a key work-stream within the Workforce Sustainability Programme and is to include the procurement of an external marketing company to support the design and implementation of innovative and creative attraction solutions, and a unique recruitment brand for the Trust. Together with the appointment to a new role (fully funded within existing financial envelope) of a Marketing & Attraction Lead. The invest to save case presented to DOAG in March 2023 was not fully supported by all Divisions and therefore a further review is required in order to achieve the funding stream.
Interventions and activities to deliver the workforce plan across the Trust	DDfPOD	Ongoing By September 2023	A further overseas nurse recruitment bid has been submitted in May 2023 for an additional 55 nurses. This is part of the winter pressures planning support from NHSE. The 55 will be in addition to the 80 nurses confirmed from the successful bid placed in March 2023. Further ICS collaborative recruitment events are being planned for 23/24. A comprehensive recruitment plan is to be developed with the aim of proactively addressing the Trust vacancies across all staff groups, with a focus on hard to fill specialties. First draft to be in place by September 2023.

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

Temporary staffing controls and compliance	DDfPOD	Detailed project plan in place with key delivery milestones	This workstream continues under the Workforce Sustainability Programme. Focus over the last 2 months has been on: ▪ Establishing Grip and Control meetings ▪ Development of a triangulated dashboard between BI, Finance and HR, with the aim of publishing one version of data for monitoring and tracking temporary staffing spend and use. ▪ Full recruitment to the posts created through the investment in the Bank team ▪ Commencement of the non-clinical temporary staffing migration plan
Focussed planning of a Preceptorship Academy and commencement of a master accredited module	ADELC	Launched Evaluations have been commenced and will complete Nov 2023	The first cohort of Preceptees have commenced on the Level 7 accredited Preceptorship Module in Sept 2022 and have now completed, assessed and been verified. The second cohort started March 2023; completing September 2023. Evaluation of this is imbedded with the Masters by Research being undertaken within Professional Education**.** Further funding discussions taking place for September 2023 cohort; via CPD funding as a possibility. This is an attraction to newly qualified clinicians to the Trust. The Preceptorship Academy has launched, with branding and a SharePoint for Preceptees and Preceptors to access.
NETS (National Education and Training Survey) Group created	ADELC	Ongoing progress Next NETS Group Meeting August 2023	NETS Group (consisting of key stakeholders and leads from placement areas) met at the end of March 2023 to discuss the results of the NETS Survey. 2/3 themes have been requested by service leads from their areas/learners, actions and timelines. This will continue to have oversight by the NETS Group.
AHP HCSW Associate Educator Post created using BID funding from NHSE	ADELC	Delayed Review to be undertaken in July 2023	Funding from NHSE for a fixed term AHP specific HCSW Associate Educator role, specifically aimed at the attraction to AHP HCSW posts for the Trust, working in collaboration with recruitment and the One Gloucestershire System. Focus will be on AHP HCSW development areas to support attraction and retention. Post went out to recruitment, but no suitable appointment. Review of objectives with NHSE WTE being undertaken with Simon Lovett, Chief AHP. Simon leading on plans for this funding to be utilised within the wider field of AHP Education and Development and will support the recruitment and attraction for AHP HCSWs via the creation of a different role combining other funding opportunities.

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

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

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.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR4: Workforce - Culture, Experience and Retention — June 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR4	**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	SR1 SR3 SR5 SR9

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

- 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

GAPS IN CONTROL

- 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

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 - September 2026	The first stage evaluation of bids for the Leadership and Teamwork development programme has been carried out with five suppliers invited to the second stage. Second stage evaluation will take place on 28th June with up to three bidders invited to deliver presentations for the final stage of the tender process. Contract award is planned for September 2023.

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

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	August 2023	The Culture and Staff Experience Project Coordinator has commenced in post with work underway to deliver the organisational map and scheduling of teams to go through the development programme. Engagement has commenced at Divisional Boards to identify priority service lines to work through the programme. The Staff Experience Programme team will work with Divisions to explore how to operationalise/release teams and leaders to participate.
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	Proposed deliverables and milestones will be presented to PODC on 27th June 23 for comment.	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) ▪ Working on the anti-racist practice of our leaders Full scoping of the workstream is to take place in June now the new Associate Director of Education Learning & Culture is in post.
Raising Concerns and Speaking Up Delivery of 12-month workstream plan	Lead FTSU Guardian	December 2023	Delivery of the workstream plan has commenced with full review of current FTSU processes as the first key action to fully refresh the FTSU service and bring in line with national requirements.
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	The Taskforce has been established with projects and interventions which will address staff concerns will be finalised by mid-June. Project groups and facilitated QI sessions are in place to support delivery of the initiatives and interventions at pace, with the aim to complete December 2023.
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	ADofW&R	Timeframes to be scoped and agreed	Full scoping of this workstream will commence with the new Associate Director of Workforce & Resourcing now in post.
Establish a Trust wide Retention Group focussing on 2-3 core initiatives at a time, informed by expert exit data analysis	DDfPOD	To commence July 2023	First Retention Group to be held in July 2023 with a focus on 2-3 retention initiatives. These will be informed by shared learning from national retention initiatives and also feedback received through the Trust's staff survey and Taskforce. The Group will oversee deep dives into a suite of people metrics and exit data, with the aim of establishing triangulation of analysis.
Financial Wellbeing Support	AD of EL&C	To be confirmed	Half-price food and free tea/coffee (when bringing own mug) from GHT food outlets offer extended for all staff for 2023-24. Set up of Hardship fund being explored in partnership with Hospitals charity, for launch in autumn 2023. Implementation to be re-assessed with staff shortages in the 2020 Hub and transition of senior management responsibilities.

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

Mental Health Wellbeing Support	Staff Psychology Lead	Transfer date to be agreed. Expected between July and September 2023	Discussions are taking place to confirm the transfer of the Staff Psychology team, which currently sits within P&OD, to sit back under the wider umbrella of the Clinical Psychology team. 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 Programme to be delivered by 31 March 2024	Programme commenced with an established group of key stakeholders meeting fortnightly. Ongoing discussions being held with ICS partners and Staff-Side (Unison and RCN). Immediate next step is to propose the approach for migrating Band 2 HCSWs to Band 3 roles. The programme is also addressing the current hybrid of employment contracts in place in GHFT. This will offer a significant positive impact on staff engagement and retention.
Becoming a Real Living Wage Employer (ICS collaboration)	DDfPOD	June 2023 Timescales not yet set	Application of the 2023/24 Pay Award has been a key focus over the last 6 weeks. Staff will see the award paid in June 2023. 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.
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	August 2023	Initial baseline and target figures being developed Trust-wide and for the divisions. First draft scheduled to be ready by end June 2023. This will be shared with POD SLT and the EDI Steering Group. Divisional versions will be piloted for feedback over the summer.
Cultural Awareness Pilot site for National Programme	AD of EL&C	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.
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	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 will see promotion across both sites with a clear call to action ▪ Key focus on staff engagement as part of NHS75 activities is underway ▪ Work to be reviewed on ESR following national change of direction ▪ Preparation of Staff Survey 2023 is underway

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR4: Workforce - Culture, Experience and Retention **June 2023**

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.

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

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
4x4=16	Staff and CQC feedback – too many initiatives 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 and reviewed by May QDG
Introduction of PSIRF	MD	Q3 2023/24	In progress. Resource has been funded for embedding but not for initial implementation. This is detailed in the separate Risk Report submitted to the June 2023 Q&P Committee.
Establish A3 thinking approach to establish a recognised planning and monitoring approach for improvement	CN\MD \SL	Q3 2023/24	In progress

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 June 2023

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE			RATIONALE	RISK HISTORY	
		Jan 2023	Jun 2023	Jan 2024		Q2 2021/22	
5x3=15	Development of an Integrated Gloucestershire system (Completed)	4x3=12	4x3=12	2x3=6	Developed and embedded system working	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 108%; Financial gap identified and not fully mitigated).

ACTIONS PLANNED

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

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

Continuation of Operational Plan (2023/24) delivery monitoring at system level	COO	Jun 2023	BAU

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) • CQC S29A Warning notice for maternity and Surgery • Trust CQC Rating "Requires Improvement" • Deterioration of National Staff Survey Results	• 'Flow' focussed strategy and delivery group planned • Internal audit reviews 2022-25: ○ Outpatient Clinic Management ○ Discharge Processes ○ Cultural Maturity ○ Clinical Programme Group ○ Patient Safety: Learning from Complaints/Incidents ○ Patient Deterioration ○ Equalities, Diversity and Inclusion ○ Infection Prevention and Control

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR7: Community engagement and participation April 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	
		April 2023	**Jan 2024**		Feb 2023	**3x3=9**
					March 2022	**3x3=9**
3x3=9	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	Aug 2022	**3x2=6**
					Nov 2022	**3x2=6**

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Board approved Engagement and Involvement Strategy • Annual Review of Engagement and Involvement published • Quarterly Strategy and Engagement Governors Group • 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	• Objective measurement of impact of public and patient engagement and involvement • Resource gap for engaging, involving and growing Trust Membership. • 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
First NHS Community Iftar (13 April) which was a collaborative project involving all three NHS organisations	DEI&C	April 2023	Iftar successfully delivered with over 180 people in attendance. Followed up with a Community Iftar at Friendship Café on 17 April.
Development of an engagement tracker – in part for NHS CT and also for publication	DEI&C	April 2023	Tracker complete. Plan to publish as part of Annual Review in May/June 2023
Joint Engagement Toolkit (with ICS partners) – to improve the quality and consistency of public/patient involvement	DEI&C	July 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.

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

<table>
<tr><td colspan="2">Membership Strategy 2023-2025</td><td>Corp Gov</td><td>April 2023</td><td colspan="2">Development of refreshed Membership Strategy – engagement workshop with Governors to help influence plan and approach.</td></tr>
<tr><th colspan="3">POSITIVE ASSURANCES</th><th colspan="2">NEGATIVE ASSURANCES</th><th>PLANNED ASSURANCE</th></tr>
<tr><td colspan="3">• Codesign of One Gloucestershire 'Working with People & Communities' Strategy
• Positive feedback from the Consultation Institute on Fit for the Future engagement and consultation programme
• Progress demonstrated in publication of Engagement & Involvement Annual Review 2021/22 & 2022/23
• 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.
• FFTF programme completed</td><td colspan="2">• 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.</td><td>Internal audit reviews 2022-25:
• Patient Safety: Learning from Complaints/Incidents
• Equalities, Diversity and Inclusion
• ICS Citizens Panel</td></tr>
</table>

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	GAPS IN CONTROL
• 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.	• 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 May 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.	• The Trust and ICS continues to have an underlying financial baseline deficit which may grow in size. • Higher sustainability targets for the following year. • Creating an adverse impact on patient care outcomes. • Inability to deliver the current level of services. • Impact on future regulatory ratings and reputation; regulatory scrutiny/intervention leading to increased risk of reduced autonomy. • Prevention of investment to enhance services and inability to achieve the strategic objectives	Finance and 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, £9m gap on the transformational FSP target, £1.6m on the Divisional FSP target 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. • The lack of flow in the hospital causing restrictions on elective recovery impacting on the ability to earn ERF. • Pressure on operational capacity, limiting the focus on how to drive out efficiencies whilst improving patient outcomes.	**Dec 2022** **April 2023** **June 2023** **Dec 2023**	**5x3=15** **3x4=12** **3x4=12** **2x4=8**	• 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. • Full review of all vacant posts with a view to removing those that have been vacant for 12 months or more	Aug 21 April 21 Sept 20 July 19

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

	• Productivity information is showing a reduction in activity but not a corresponding reduction in costs to match.		• Development of system transformation programmes to support longer term financial health included Newton • Development and acceptance of a financial recovery plan if applicable – showing clear executive leads. • Review and implementation of divisional governance related to financial controls and forecasting	

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• PMO proactively supporting operational and corporate colleagues to generate and deliver future sustainable schemes using tools such as model hospital etc • Programme Delivery Group for financial sustainability chaired by the CEO to raise importance of financial balance • Pay Assurance Group (PAG) • ICS one savings programme to share ideas, resources and drive consistency • Monthly monitoring of the financial position • Controls around temporary staffing • Driving productivity through transformation programmes i.e., theatres and OP • Weekly financial recovery meetings in place with those adversely deviating from plan • Relaunch business planning for 23-24	• Clear line of accountability with no accountability framework • Robust benefits identification, delivery and tracking across major projects • Controls on the approval of WLIs/overtime payments needs strengthening • Inability to generate ideas • Capacity issues to generate and implement ideas at pace i.e., RMN decision making thresholds • System deficit agreement and system financial framework yet to be implemented

ACTIONS PLANNED

Action	Lead	Due date	Update
Robust benefits identification, delivery and tracking across major projects	DOF/ DOS	Sep 23	Capacity not in place, 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 timeframe.
Trust wide communication is being developed and sent out to inform the organisation of the financial position to get the message understood	DOS/PMO	Aug 23	Development of Trust wide workshops to gain more traction on ideas for medium term plan during the financial year.
Drivers of the pressures understood and communicated to system and regulator partners	DOF	Monthly	This would form part of the regular monthly monitoring, if the financial position starts to move into a deficit then more formal plans will be developed.
HFMA self-assessment recommendations to be implemented	DOF	Sept 23	HFMA self-assessment tool completed, Report presented to Audit Committee in November. Action plan now being addressed.
WTE growth from 19/20 actuals to 22/23 establishment understood and challenged	DOP	Jul 23	WTE growth was presented to F&D in Sept 22 but further work needed to understand whether WTE growth is still required.
Implementation of system deficit agreement and financial framework	DOF	Jul 23	Draft presented to FRC and has full engagement of CEO.
Relaunch of business planning for 23-24	DST	Aug 23	
Implementation of divisional governance	DOF	Jul 23	

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR9: Financial sustainability   May 2023

<table>
<tr><th>POSITIVE ASSURANCES</th><th>NEGATIVE ASSURANCES</th><th>PLANNED ASSURANCE</th></tr>
<tr><td>• 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</td><td>• Temporary staff spend consistently above target.
• Planned Trust and System underlying deficit moving into 23/24 a significant concern.
• Continuing under-delivery of recurring efficiency programme.
• ERF achievement for 2023/24is a cause for concern
• Lack of benefit realisation on schemes that should be delivering financial improvement
• No real consequences of financial deviation
• No review on whether to continue to stop a project if overspending</td><td>• 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.</td></tr>
<tr><th colspan="3">UPDATE</th></tr>
<tr><td colspan="3">May 2023: Recommendation to reduce risk score to reflect the amount of work undertaken to control the risk.
Planned action due dates updated with a number of further actions applicable to the new financial year.</td></tr>
</table>

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

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

REF.	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR10	**Inability to access level of capital required to ensure a safe and sustainable estate and infrastructure that is fit for purpose and provides an environment that colleagues are proud to work in.**	We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact.	• National Capital Department Expenditure Limits (CDEL) • Age, condition and inefficiency of GHFT buildings & infrastructure • Previous equipment purchase profile resulting in peaks in end-of-life equipment • Scale of backlog maintenance: £72M of which £41M is Critical Infrastructure Risk (2021 6-facet survey)	• Unable to address backlog and critical infrastructure risks resulting in service interruptions impact on patient access, safety and quality • Poor quality theatre and ward environment impacting on patient outcomes & patient & colleague experience • Equipment failures leading to service interruptions impacting on patient access and diagnosis timescales	Finance and Resources Committee	DST	SR9 SR11

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE
		Jan 2023	Jan 2024	
4x4=16	One Gloucestershire CDEL results in an annual capital budget of c£24M per year for GHFT. This is split across estates, digital and equipment. This allocation is insufficient to address the scale of backlog maintenance (£72M) risk within an appropriate timescale as well as a refurbishment, equipment replacement & digital programme.	**4x4=16**	**4x3=12**	• CDEL limits constrain the level of capital investment One Gloucestershire can commit to • Estate backlog maintenance schemes compete with other strategic and operational priorities, including strategic estate schemes, digital and equipment replacement • Equipment Managed Equipment Service (MES) procurement on hold as business case did not demonstrate value for money and impact of IFRS16 was unknown in 21/22. • ICS Partners have greater awareness of risk GHFT is carrying across estates in particular, which could lead to a change in CDEL allocation from 2023/24. • GHFT have a good track record of securing capital from NHSE schemes (UEC, TIF, CDC etc) and these schemes include backlog maintenance element.

RISK HISTORY	
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 • 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	• Lack of alternative routes to capital other than NHSE/I. • Lack of alternatives to a reliance on capital to address estate, refurbishment and digital investment due to Trust and ICS revenue position e.g. MES • Lack of clarity on scale of national funding and application route for New Hospital Programme post 2025.

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

• 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	

ACTIONS PLANNED

Action	Lead	Due date	Update
Review equipment MES business case learning from how other Trusts/ ICSs have managed IFRS16	DoF/ DST	Q2 23/24	Project to be re-launched from April 2023. Will require project resource.
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
Review scope, function, priorities and resourcing of ICS Estates Strategy Group	DST	Q1 23/24	Raise via ICS Strategic Executive
Explore partnership opportunities to develop GHFT estate and/or adjacent sites	DST/ GMS	From Q3 22/23	Opportunities in progress/ being explored with GCC and other potential partners.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Trust ability to respond to and secure ad-hoc capital funding in-year from NHSE&I. Schemes include backlog maintenance element • PFI is being maintained to 'Condition B' in line with contract • New estate comes on line in 2023 (GSSD) providing good quality estate with reduced maintenance requirement. GSSD has addressed areas carrying backlog e.g., Gallery Wing, DSU at CGH. • Estate capital investment has been prioritised in 2023/24 at £14/£24M CDEL. • Recent investment in Radiology has reduced equipment risks (but resulting in lumpy replacement profile)	• Level of estate risk is increasing as reflected through risk scores • Unable to fund a ward refurbishment programme until 2024/25	Internal audit reviews 2023-25: • Environmental Sustainability • Estates Management

UPDATE

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

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR11: Sustainable healthcare **April 2023**

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

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE		RATIONALE	RISK HISTORY	
		Jan 2023	Jan 2024		Apr 2023	
					Feb 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	Dec 2022	

CONTROLS/MITIGATIONS

- All new strategic estate schemes designed to meet BREEAM good (refurb) or excellent (new build) ratings
- Continue to pursue external grant funding (Public Sector Decarbonisation Scheme – PSDS) to retro-fit existing buildings and migrate energy supplies away from fossil fuels
- Invest in GHFT electrical infrastructure to support transition to Hybrid and Electric Vehicles (EV)for i) GHFT/ ICS fleet ii) visitors and colleagues
- Board approved Green Plan and supporting governance structure: Executive Lead, Green Champions, Green Council, Climate Emergency Leadership Group reporting into F&R Committee
- ICS Sustainability Group established to oversee delivery of ICS Green Plan (Statutory requirement)

GAPS IN CONTROL

- Lack of a programme to determine costs associated with achieving statutory and regulatory standards and targets between now and 2040 to inform investment priorities and impact on estate capital schemes
- Lack of clarity on support to be made available to NHS Trusts to achieve NHS Green Plan/ objectives defined in NHS Long Term Plan
- Unclear on consequence of not achieving standards and targets, which could influence GHFT and ICS investment decisions
- Reliance on goodwill within GHFT to develop and progress sustainability schemes i.e. GMS Sustainability resource is 0.5 wte, Green Council is voluntary, team and individual objectives are not cascaded from Green Plan.

ACTIONS PLANNED

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

Action	Lead	Due date	Update
Progress on delivery against GHFT Green Plan reported through F&R Committee	DST	From 2021	Process established. Last update in July 2022
Continue to research and respond to external grant applications	GMS (THu)	Ongoing	GHFT secured £11M from latest PSDS scheme
Establish EV Task & Finish Group	DST	Q4 2022/23	Term of Reference produced. Group to mobilise in Q1
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	Q4 2022/23	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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR12: Cyber security — June 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
		Dec 2023		
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.	**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
- Completion of cyber security action plan - Review and evolution of cyber-security action plan including review of operating model between cyber governance and technical - Completion of device asset register Trust-wide - Proposals for device management Trust-wide - Joint planning across ICS for incident response	CDIO	July 23 Dec 23 Sept 23 Sept 23 Sept 23	The proposal is to increase the risk from an impact of 4 to 5. And an increase of likelihood from 3 to 4.

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.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR13: Digital systems functionality — June 2023

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
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	
Internal-referral Rollout/expansion		July 2023	Internal medical referrals to deploy in July with surgical to follow soon after.
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 on track for delivery in July. Further specialities to follow.
Clinical Documentation Expansion		Ongoing	Next drop of 5 documents planned to commence development in June. Includes high risk and benefit documentation such as Shared Care Plan and SDEC Assessment Documentation
Pre-Assessment Clinic Process / Documentation		Q4 2023/24	To commence in summer.
Sunrise Mobile		Autumn 2023	
Patient Portal Implementation		September 2023	Procurement by September 2023, implementation leading into next financial year.

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.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR14: Research June 2023

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
		Feb 2024		
3x4=12		**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
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
Review research sessions for clinical staff	CS	April 2023	June 2023: Ongoing as part of finance workstream processes review.

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.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
Strong pipeline of research studies Engaged staff High engagement within Trust	Potential reduction in commercial income nationally Ongoing impact of pandemic	• Internal audit reviews

Report to Board of Directors			
Agenda item:	**9**	**Enclosure Number:**	**4**
Date	13 July 2023		
Title	Trust Risk Register		
Author **Director/Sponsor**	Lee Troake, Head of Risk, Health & Safety Mark Pietroni Medical Director and Director of Safety		

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

Summary of Report

<u>Purpose</u>

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 7June and 5 July 2023 the following changes were made to the Trust Risk Register.

<u>Key issues to note</u>

TRR updates:

- 1 risk was approved onto the TRR
- 1 risk was approved with a TRR score to be held at divisional level
- 1 risk already on the TRR was noted and agreed in relation to a score increase
- 1 risk was downgraded from the TRR
- Risks leads were required review those risks on the TRR that are overdue a review
- Where risks on the TRR had overdue actions in place to mitigate a risk on the TRR– action owners were required to update and/or sign these off on DATIX
- It was noted that a number of risk review, incidents and actions belonged to GMS; assurance was provided by GMS that these would be addressed as a priority
- If improvement in performance was not seen next month, divisions and GMS will be asked to provide a trajectory for improvement / compliance

For further details see enclosed report.

Single score approach:

- A paper was presented to RMG on the single score approach (see below)

- The **RMG agreed a single score approach** to risks to simplify the scoring process and allow a transfer of risks to DATIXCloud
- All risks will be reviewed of the next few weeks to ensure the correct score is in the current score field ready for the transfer of risks to DATIXCloud
- The Executive Director for Digital will review all 57 IT risks with a view to consolidating and removing obsolete risks before the transfer to DATIXCloud
- The POD team are reviewing all risks with a workforce score of 10 before these are presented at RMG for approval on to the TRR. Where a risk on the divisional risk register has Workforce score of 10 (triggering the TRR) but has another domain with a higher score (that does not trigger TRR), the RMG agreed to apply the TRR trigger score rather than the existing highest score when converting to a single approach. This issue will only occur on transition from multiple to singular domain. Once the transition is made this will no longer be an issue.

Water Safety and Fire Risks

- An update was provided by GMS on the water risk. The RMG was advised that progress had been made in relation to a number of actions namely:
  - that the Water Safety Plan and Water Safety Policy have been approved and will be published shortly
  - a number human factors had been identified that impacted on the carrying out and recording of flushing in accordance with the requirements – solutions to these are being considered
  - an IT software package to digitalise water safety records is awaiting approval via the Trust and GMS
  - GMS advised that a water audit has been completed and will be presented to the Water Safety Group

- GMS advised that there was still an issue with recruitment into the fire team and are in discussion with the Deputy Director of POD regarding recruitment options / incentives

Recommendation

The Board is asked to note the report.

Enclosures

Trust Risk Register

TRUST RISK REGISTER

BOARD REPORT- JULY 2023

1.0 NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

S3968Oph
Risk Lead: Cathryn Biston
Sponsor: Mark Pietroni

Inherent Risk
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.
Cause
GIRFT recommendations (2017) include four actions are for all Ophthalmology providers to: • develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients; • undertake a clinical risk and prioritisation audit of existing ophthalmology patients; and • undertake eye health capacity reviews to understand local demand for eye services and ensure that capacity • match demand – with appropriate use of resources and risk stratification. Ophthalmology has 1 Failsafe Officer to manage 20,886 patients compared to 1 person managing 5734 on an open RTT pathway. Current failsafe officer has additional tasks so is tracking less than 5000 patients. In comparison to other Trusts/Nationally, GHNHSFT falls short on the number of staff manage the patient capacity and support the prevention of patient harm. Two other Trusts have implemented a team after serious incidents where patients lost vision and an adequately sized Failsafe Team was a mandatory recommendation of their subsequent investigation.
Impact & Effect
Effect: • Current failsafe officer has additional tasks so is tracking less than 5000 patients, leaving 15,000 patients potentially untracked • Currently 20,886 adult follow-up patients on our wait list, of which over 55% are over recall date • Insufficient Failsafe staff to review pathways of Amber and all Green and Routine delayed follow-up patient prioritisation and policy to manage risk of harm to ophthalmology patients. Therefore, general and routine patients (the majority of delayed follow-ups) are not able to be monitored. • Insufficient Failsafe staff to monitor all review ophthalmology patients, ensuring that each has their intended date for follow up documented and that appointments are booked, as appropriate, and not cancelled or postponed • Insufficient Failsafe staff to identify, investigate, report and escalate all overdue appointments • Insufficient Failsafe staff to book, rebook and discharge patients in outpatient clinics, audit, evaluate and report on DNAs and cancellations • Insufficient Failsafe staff to identify gaps, inconsistencies, errors and/or unwarranted variation in clinical risk stratification or prioritisation • Insufficient Failsafe staff to manage follow ups, ensuring pathways are completed, with outcomes recorded and monitored. • Validation of patients cannot regularly happen to ensure patients are on the correct pathway resulting in out of turn booking or correct prioritisation of patients Impact • Patients present for appointments after significant delays, presenting with reduced vision (patient harm) • We are not able to prioritise clinic capacity to those most urgent patients which could lead to loss of vision

- Increase in serious incidents / DoCs / claims / complaints
- Staff are overworked due to the number of patients that require pathway reviews.

Scoring

Safety, Quality, Workforce and Business C4 x L3 = 12 and C3 x L3 = 9

Evidence of scoring

- Ophthalmology Failsafe Staffing Plan Paper / Patient Harm Report (see appendix 2)
- 25 linked incidents:
    - 4 major harm incidents (May 2022, March, May and June 2023)
    - 2 moderate harm incidents (July 2021, March 2022)
    - 8 minor harm incidents
    - 11 no harm incidents

Key Controls

- Funding has been allocated for immediate additional resources and for long-term recruitment
- Specialty tri are offering validator work as bank to existing staff within the department for an initial 8-week period
- For Red validated patients and DNBs, ensuring that these patients receive follow-ups within a clinically safe time.
- Monitoring those, ensuring each has their intended date documented and that appointments are booked, not cancelled or postponed. This includes evaluating patients in these criteria who DNA.
- There is a review of some Amber cases to ensure they are also prioritised.

Gaps in Controls

- Recruitment of additional failsafe officers to address the 20,886 adult follow-up patients on the waiting list, and reduce the 55% that are over recall date.
- Potentially have over 15,000 patients we are not able to provide failsafe tracking for. If staff fully at 6 people, then the number of cases per failsafe would be in the region of 5000. Additional staff are needed to be able to:
    - monitor all review ophthalmology patients particularly the 1:10 urgent patients, ensuring that each has their intended date for follow up documented and that appointments are booked, as appropriate, and not cancelled or postponed;
    - identify, investigate, report and escalate all overdue appointments;
    - book, rebook and discharge patients in outpatient clinics. Audit, evaluate and report on all DNAs and cancellations; and
    - identify gaps, inconsistencies, errors and/ or unwarranted variation in clinical risk stratification or prioritisation of follow-up, ensuring pathways are completed, with outcomes monitor

Actions

- Recruitment of additional failsafe officers
- Inform elective care recovery board of issue
- Update the business case to:
    - clearly illustrate the short-term plan that is going to be implemented 'now',
    - include a pre-recruitment plan for implementation,
    - provide an immediate trajectory of catch up, for the next week, next month, 6 months etc.
- Follow up GIRFT actions:
    - develop failsafe prioritisation processes and policies to manage risk of harm to ophthalmology patients;
    - undertake a clinical risk and prioritisation audit of existing ophthalmology patients; and
    - undertake eye health capacity reviews to understand local demand for eye services and ensure that capacity
    - match demand with appropriate use of resources and risk stratification

2.0 RISKS WITH AGREED TRR SCORE FOR HOLDING AT DIVISIONAL LEVEL

M3874
Operational Lead: Helen Mansfield
Executive Sponsor: Mark Pietroni

Inherent Risk
The risk to providing appropriate supervision and training to junior doctors in the Emergency Department through lack of sufficient staff with senior decision maker competencies and supervisory expertise for the demand of the department.
Cause
• Inadequate number of senior decision makers (SDMs)(defined as ST4+ competency) and supervisors, especially on night shifts. • The large footprint of the ED at GRH stretches the existing supervisory ability of consultants and other SDMs on shift. • Having 2 sites requiring consultant presence stretches supervisory availability and spreads the number of SDMs more thinly. • Higher congestion and decreased flow impacts safety drawing consultant attention away from supervision. • Demand and capacity work supported by ECIST shows a required number of SDMs of 39. We currently have 26.1 available. • Appropriate numbers of consultants for clinical and educational supervision would be 24 WTE. From July '23 we will have 17.9.
Impact & Effect
Effect: • Poor patient care and experience. • We are regional negative outliers for time to clinician and seniority of review for major trauma patients as per TARN data. • Poor time to antibiotics for sepsis patients. • Poor training and experience of PGDiTs • Unsustainable work intensity for trainees and trainers. Impact • Increased mortality for major trauma patients. • Regional Trauma Network scrutiny. • Adverse trainee feedback leading to regulatory inspection and actions from HEE. • reduction in recruitment • reduction in retention • Poor reputation
Scoring
Statutory C4 x L4 = 16, Safety & Quality C3 x L3 = 9, Workforce C3 x L4 = 12, Reputational C2 x L3 = 6
Evidence of scoring
• 5 linked risks • HEE quality interventions report
Key Controls
• Successful recruitment of 8 overseas doctors who are currently being trained to undertake middle grade role. • 2nd senior decision maker locum shifts available for night shifts • Consultants acting down • Educational infrastructure to support training (dedicated EDT time) Regional training days for PGDiT • In-house weekly training • Clinical educator available (1x weekly)

Gaps in Controls
• The overseas doctors employed have a developmental need before undertaking fully the middle grade doctor role. This has an increased supervisory burden at present for the consultant team to invest time for adequate clinical and education supervision and assessment. • The requirements for educational supervision of junior clinicians outstrips the current available job plan time from the existing consultant body. • Maintaining services across 2 sites compromises the quality of care achievable in both settings. • Enact the findings from the demand and capacity work. • Tannoy not yet available to help with communication issues caused by geographical split of GRH ED • DECT phones not viable due to network coverage which would allow for staff to be contacted more easily.
Actions
• Review case for tannoy system in ED • Deliver an expansion in ED consultant numbers • Educational development of IMG recruits

3.0 INCREASE IN SCORE OF EXISTING TRR RISK

C3034N
Operational Lead: Matt Holdaway
Executive Sponsor: Matt Holdaway

Comment: Paper presented to Q&PC on Safe Staffing for nursing across Trust. Identified shortfall in nursing hours. Increased scores for safety, quality and finance.

Inherent Risk
The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability) and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.
Cause
Overall shift fill of registered nursing staff is below 90% for surgery and below 95% for medicine. Overall substantive shift fill is below the organisation agreed standard of 75%
Impact & Effect
Effect: • Inability to fill all registered nurse rota gaps Impact • High temporary workforce requirement from agency registered nurses. • Agency workers unable to consistently and accurately adhere to Trust policies and procedures. • Insufficient registered nurses have been linked to substandard escalation of the deteriorating patient, harm from pressure ulcers and falls. • Poor compliance with 'high reliability' procedures such as infection control cleaning /equipment checks. • Additional workload intensity being placed on existing registered nurses and team members. • Lack of flexibility in deployment of registered nurses to meet unpredictable demands in patient care, especially during the winter.
Scoring
Safety Quality and Finance scores increased from C3 x L5 = 15 **to C4 x L5 = 20,** Statutory and Business C3 x L3 = 9, Reputational C4 x L3 = 12 remain the same
Evidence of scoring
• 2 linked incidents • 6 linked risks
Key Controls

- Temporary Staffing Service on site 7 days per week.
  Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team.
- Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts.
- Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns.
- Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses.
- Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards.
- Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure.
- Long lines of agency approved for areas with known long-term vacancies to provide consistency, continuity in workers supplied.
- Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked.
- Regular Monitoring of Nursing Metrics to identify any areas of concern.
- Acute Care Response Team in place to support deteriorating patients.
- Implementation of eObs to provide better visibility of deteriorating patients.
- Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes.
- Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes.

Gaps in Controls

- Strategy for international recruitment
  Review and update of relevant retention policies and retention strategy
- Staff engagement and wellbeing - understanding what makes staff stay
- Implementation of a real-time staff feedback tool to gain feedback on ward/department based issues.

Actions

- No open actions

4.0 RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

M2353Diab
Operational Lead: Vinod Mani
Executive Sponsor: Matt Holdaway

Comment: Safety score reduced as Band 5 development role now recruited to. Band 7 and 8a still not recruited.

Inherent Risk

The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.

Cause

- Unable to recruit Nurses to Diabetic Nursing Service leading to an increased risk of diabetic and insulin related incidents (actual & potential). The job has been advertised and there were no interested candidate and no application received for B6 DSN, Band 7/Band 8a.

Impact & Effect

Effect:

- A limited (reactive) nursing service can only be offered to patient with diabetes who have e-referred and may have experienced episodes of hypoglycemia, hyperglycemia, DKA, HHS, and other diabetes management queries. Some of which is due to lack of education and support in diabetes management, which impacts length of stay, poor patient experience and actual harm.

Impact

• Patients with diabetes receiving sub-optimal care resulting in; poorer clinical outcomes, longer lengths of stay, higher rates of complications & increased mortality. Inability to provide a proactive service to prevent patient harm and increase patient safety. Poor patient experience.
Scoring
Safety C3 x L4 = **12 reduced to C3 x L3= 9**, Statutory C2 x L3 = 6, Quality C2 x L4 = 8, Workforce C2 x L4 = 8, Business and Finance C3 x L3 = 9
Evidence of scoring
• 5 linked risks • HEE quality interventions report
Key Controls
• E referral system in place which is triaged daily Monday to Friday. • 10.0wte DSN funding in place to cover inpatient, outpatient, pump clinic and GDM. • Limited inpatients diabetes service available Monday - Friday provided by 1.5wte DISN, additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. • Honorary contract for a diabetes nurse trainer in post, offering 0.2wte to the DSN team. This will add extra mentoring and training opportunity. 3.0 WTE Band 5 development role to be advertised and to grow our own specialist nurses.
Gaps in Controls
• Provision of dedicated funded DISN team in relation to the bed base of GHT. • Demand and capacity model of DISN team. • 1.0wte Lead Diabetes Nurse post is vacant • Advertised 18months fixed term contract for band 8a to attract DSN's but there was no applicant. This post is empty delayed due to difficulties in recruiting
Actions
• Recruitment events and staff development opportunities

4.0 RISKS CLOSED ON THE TRR

None

5.0 OVERDUE REVIEWS OF TRR RISK

The following risks on the TRR are overdue for review.

Risk ref	Lead	Description	Review Date
M3682Emer	Chester Barnes	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.	13/01/23
M2631Card	Kelly Matthews	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	26/05/23
C3876EOL	Samantha White	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.	02/06/2023

Actions were assigned at RMG on 5 July to ensure these risks were reviewed.

6.0 OVERDUE ACTIONS ON TRR RISKS

The following TRR risk have overdue actions. Those actions due in 2021 and 2022 are highlighted in red. Actions pre-May 2023 are in amber.

Risk action linked to:	Action Owner	Action Description	Due Date
S2424TH	Terry Hull	Five Year Theatre Replacement/Refurbishment Plan	30/06/21
	Daniel Pike	Provide comprehensive update on Theatre ventilation	28/04/23
C3876EOL	Samantha White	Review new data around in-patient deaths who were coded as NCTR	08/05/23
	Samantha White	Revie job description	08/05/23
C3930S&T E&F	Daniel Pike	To review hazard rooms with clinical teams and Fire team	18/12/22
	Daniel Pike	Identify any works required for alternative locations	25/11/22
	Bernie Turner	Set up lessons learnt event	20/01/23
	Bernie Turner	To roll-out new SVF process	30/12/22
	Daniel Pike	Fire team trainer to add information to mandatory training package	31/01/23
	Steven Hardy	Rolling replacement programme for batteries	28/02/23
	Daniel Pike	Conclude RAG audit of areas across the Trust	11/11/22
C1437POD	Shirley Daniels	Establish Task and Finish Group for Radiographer Vacancies	15/06/23
WC3845Obs	Christine Edwards	Review Job Plans	31/05/23
	Rebecca Evans-Jones	Fetal medicine meetings	01/06/23
M2815Stroke	Chester Barnes	Reducing ED pressures to allow staff to work safely and prioritise patients appropriately	21/06/23
S2976BIMA	Richard Hunt	Develop escalation process for when Breast Radiologist is not available to provide service	29/07/22
C3941EFD	Daniel Pike	Provide list of outlets	07/04/23
	Daniel Pike	Conclude water testing on Avening	31/03/23
	Daniel Pike	Purchase water safety system	28/04/23
	Steven Grantham	Formalise process to prioritise augmented care flushing	31/05/23

Actions were assigned at RMG on 5 July to ensure these actions were updated. Assurance was provided by GMS that those actions assigned to GMS dating from 2021 and 2022 would be addressed.

A copy of the TRR as of 5 July 2023 is provided in Appendix 1

RISK REGISTER - SINGLE SCORE APPROACH

BOARD REPORT- JULY 2023

SUMMARY

In June 2023, the following report was presented to RMG with a proposal to move to a single score approach for risks on the new DATIXCloud risk module. The proposal was discussed and accepted and will be implemented in September 2023 when the Trust transfers risk to the new system.

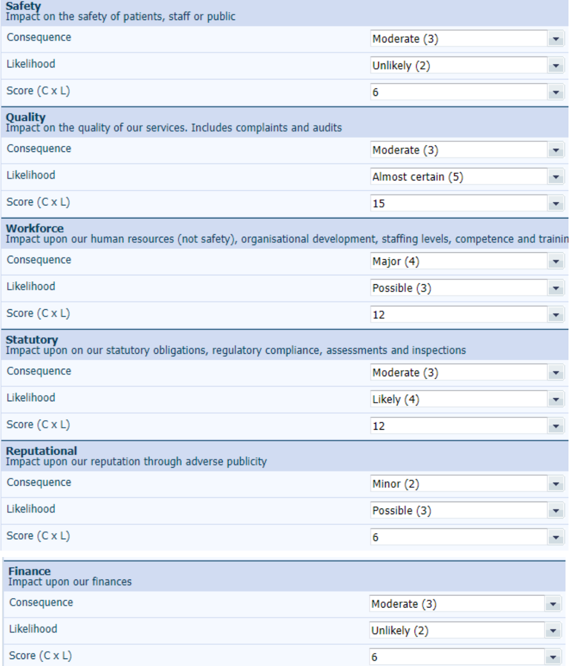
1. CURRENT SCORE APPROACH

The Trust has eight domains which are safety, quality, workforce, statutory, reputational, business, finance and environmental. These are known as risk categories and should be used to identify which areas of the organisation are prone to risk events.

The risk score attached to any domain is a numerical value, which represents the amount of risk that is associated with that domain and indicates the risk owner's confidence in the system to which the risk relates.

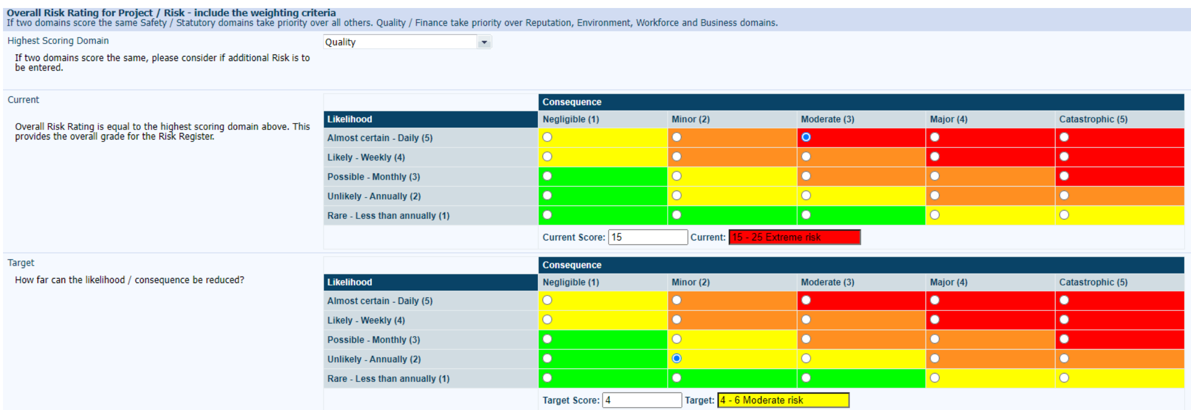
The Trust developed a **multiple domain score** approach around 15 years ago where risk owners score against each relevant domain then select the highest of those scores as the singular **current score and domain (risk category)**. This means there may be multiple domains scores recorded in addition to the identified **current score**. However, only the current score is used to determine the level of the risk and which risk register the risk is placed on. The current score is mapped against a **target score,** which the Trust aims to achieve through risk mitigation measures.

As an example, C3963 which related to Boarding patients has the following multiple domain scores.



Safety Impact on the safety of patients, staff or public	
Consequence	Moderate (3)
Likelihood	Unlikely (2)
Score (C x L)	6
Quality Impact on the quality of our services. Includes complaints and audits	
Consequence	Moderate (3)
Likelihood	Almost certain (5)
Score (C x L)	15
Workforce Impact upon our human resources (not safety), organisational development, staffing levels, competence and trainin	
Consequence	Major (4)
Likelihood	Possible (3)
Score (C x L)	12
Statutory Impact upon on our statutory obligations, regulatory compliance, assessments and inspections	
Consequence	Moderate (3)
Likelihood	Likely (4)
Score (C x L)	12
Reputational Impact upon our reputation through adverse publicity	
Consequence	Minor (2)
Likelihood	Possible (3)
Score (C x L)	6
Finance Impact upon our finances	
Consequence	Moderate (3)
Likelihood	Unlikely (2)
Score (C x L)	6

The highest score is 15 for quality and this is recorded as the current score as shown below.



2. Why use a multiple domain score?

This approach is unusual in that risks would generally be associated with a singular category and singular current score applied to that category. There is no organisational memory which can answer the question as to why this approach was originally adopted. Evidence on DATIX indicates it was in practice in 2013 when the current DATIXWeb system was introduced. However, the additional domain scores are 'add-ons' to the DATIXWeb system which were put in place by Trust Administrators creating additional system fields and are not part of the normal format of the system.

DATIXCloud follows the same principle of a singular risk category which can be selected from a list and a singular consequence, likelihood and risk rating score. It does not have fields to accommodate additional background scores on other domains. As before, these fields can be added but with the caveat that they will no longer be searchable, and there is no appetite by the system providers to introduce multiple scoring or searchable additional score fields. This is because no other clients use this approach.

The advantage of multiple domain scoring is that it gives an overview of the risk owner's perception of the risk in relation to all the relevant domains. However, this information can also be captured in a narrative within the progress notes of the risk when initially scoring and at each review.

There a number of barriers to multiple domain scoring:

- Only the current score is used to dictate the register; other scores do not impact on this unless they meet a threshold
- Only the current score shows on risk reports – DATIXWeb and DatixCloud
- There is no coding link between the C, and L scores on the 'add-on' domains scores. This has always led to errors in the risk rating as owners manually miscalculate scores
- When a score is changed in any background domain which supersedes the current score or category, risk owners may omit to update the current score and the category. This leads to errors in the current scoring, category and which risk register it is on
- Increased and decreased scores in additional domain are not trackable and can be easily missed

- The risk team have to complete a minimum of 24 manual searches in the add-on score fields to detect errors and changes in each risk. Across 630 risks this is approx. 15,000 searches just to validate scoring
- On DATIXCloud add-on domain scores will no longer be searchable. This creates a high-risk of scoring errors and presents a significant issue when producing risk report for divisions, RMG, TLT, Board and Audit and Assurance
- As there is no appetite by DATIX to include multiple scoring or searchable fields; this will have a significant impact on all users' ability to search for or manage multiple scores
- It is a complex task to track the progress of a risk with multiple domain scores – a defunct audit trail function is currently used to review previous scores in add-on fields which will not be available in the new system.

3. Analysis of TRR

The table below reflect an analysis of TRR risks by their scoring and illustrates the complexity of a multiple scoring approach.

For example, of the 33 risks on the TRR, 30 of these have a safety score between 1-25 but only 16 of these risks meet the safety threshold score for the TRR. Of those that meet the threshold score, only 13 of these were placed on the TRR with safety as the lead score; the other three have a higher score in a different domain that meets the TRR threshold. For example, S3481Obs has a safety score of 15, but has a quality score of 16.

Domains	Risk Appetite Threshold Score	No. of risks mapped against the domain	No. of risks meeting threshold score	No. of risks where this domain is the highest
Safety	12	30	16	13
Quality	15	30	13	9
Workforce	10	23	8	3
Statutory	15	22	5	5
Reputational	15	23	0	0
Business	15	14	1	1
Finance	15	15	2	1
Environmental	12	8	1	1

4. Worked Examples of a Transition to a Single Score

The table below shows three examples of risks on the TRR. The bold score under the multiple domain scores is the current score of the risk already used to dictate the risk register level. This would be taken as the singular score of the risk going forward. The other domain scores would be removed in a singular score approach but may be added to the narrative in the process notes to give context if needed.

ID	Description	Cause	Effect and Impact	Multiple domain scores (current score in bold)	New single score
C3941 EFD	The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal hospitals	The governance of water safety management programme within GHFT requires improvement. Issues have been identified in relation to compliance with the relevant healthcare memorandum for water safety - HMT04-01. For example: • pseudomonas sampling not completed to the required frequency • missed flushing in augmented care and other areas • poor record keeping for temperature checks, sampling • poor cleaning techniques applied • cleaning audits not carried out at the required frequency • schematic drawings not updated • training and competency issues for those with roles in water safety • thermal mixing valve (TMV) serving not completed at the required frequency • water risk assessments require improvement • failure to take appropriate remedial measures following a positive result • failure to descale and maintain tanks and cisterns as required • • out of date policy and procedure notes; poor document control	• Failure to comply with HTM04-01 may lead to an increased number of positive samples and /or a higher bacteria count in positive samples for pseudomonas or other water contaminants • Cross contamination between outlets during cleaning process • Hospital acquired Pseudomonas / legionella infection from positive water outlets • Patients in augmented care settings who are immunocompromised, and neutropenic or vulnerable may become seriously ill following infection • poor quality experience for patients, distress for patients and families • Staff who are immunocompromised, and neutropenic or vulnerable may become seriously ill following infection • Serious incident investigations • HSE under RIDDOR and/ or CQC enforcing authority intervention, fine or prosecution • Patient or family complaints relating to hospital acquired infection • Access may be restricted to water outlets, including showers, due to risk when used by vulnerable patient groups	**Statutory C4 x L3 =12** Quality C3 x L3 =9 Safety C5 x L2 = 10	**Statutory C4 x L3 =12**
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.	Theatres in GRH are unable to provide a team to open a second obstetric theatre between the hours of 16:00 – 08:00. This is due to a rise in elective and emergency c-sections. The risks are delays to emergency obstetric surgery and operating against National Institute for Health and Care (NICE) and Royal college of Obstetricians and Gynaecology (RCOG). Association for Preoperative Practice (AfPP) Standards for safer staffing have a minimum staffing requirement which is recognised nationally. Working outside these	• Patient delays in receiving emergency surgery. Anxiety/stress to mothers and partners • Staff inability to manage potential haemorrhage requiring hysterectomy in an emergency. • Staff clinical decision making altered by the availability of theatre • Staff increase of stress/anxiety • Failure to meet NICE standards decision to delivery time • Risk to delay, or not meeting staffing guidelines for other emergency surgeries as required, due to reallocation staffing to support obstetric emergency. • Negative impact on other services e.g. perineal trauma • Poor clinical outcome for mothers and babies including risk to life	**Quality C4 x L4 = 16** Workforce C4 x L4 = 16 Safety C5 x L3 = 15	**Quality C4 x L4 = 16**

		guidelines would result in non-compliance. The provision that is currently funded needs to be increased to ensure compliance of AfPP standards when the clinical decision to open a second theatre outside of these hours is made.	• Increase risk of staff sick leave / pay / anxiety levels • Reputational Damage • Risk of fines/prosecution • Recruitment / retention issues/ agency staff	Reputational C3 x L3 = 9	
M281 55	The risk to patient safety due to delays in the acute stroke pathway for patients attending GRH ED.	Lack of a 24/7 stroke focussed presence in Emergency Department GRH resulting in delayed assessment and scanning of patients Despite the direct admit stroke pathways some strokes will present at either ED.	Delays to thrombolysis and thrombectomy. Delays to management of ICH. Delays to swallow assessment. Delays to timely to admission to acute stroke unit Poor patient outcomes, including disability by failing to provide thrombolysis or thrombectomy for infarcts or early management of ICH.	**Safety C4 x L3 =12** Quality C3 x L3 = 9 Reputational C3 x L2 = 6	**Safety C4 x L3 =12**

The table below shows three examples of risks on the divisional risk registers, applying the same principle as above.

ID	Description	Cause	Effect and Impact	Multiple domain scores	New single score
D&S399 2 Pharm	Risk of patient harm due to reduced ability to manage drug errors appropriately, delayed treatments, prolonging inpatient stays.	Impact of EPMA (takes 50% longer to manage each prescription). Increased activity and decreased capacity, which is leading to recruitment & retention issues and issues with managing the on call rota. Need increased training & development opportunities to ensure team are working to the top of their license.	Pharmacists are able to manage fewer patients (currently seeing 36% fewer patients - see attached document) patients are being assessed by Pharmacists later in their inpatients stay. Reduced staffing, difficulties recruiting, deteriorating job satisfaction. Reduced Pharmacy capacity to dispense medicines in a timely fashion, reduced Pharmacy support to wards. Fewer drug errors are being picked up or are being picked up later. Delayed treatments, prolonging inpatient stays, reduced patient flow.	**Safety C4 x L3 =12** Quality C4 x L3 =12 Workforce C4 x L3 =12	**Safety C4 x L3 =12**
C3937E OL	The risk of poor-quality care of dying patients if Shared Care Plan for Expected Last Days of life is not completed due to it being in paper form.	The Shared Care Plan for Expected Last Days of Life is a paper document. Since the creation of medical notes on EPR, the use of the Shared Care Plan is diminishing.	Poor quality care for dying patients. There is national guidance and best practice set out for care of dying patients, which includes the need to have an individualised plan of care. Also require evidence that significant conversations around dying process and rationale for changing plan of care is understood by patient and those important to them. Without the Shared Care Plan, this plan of care will not be followed. Dying patients receiving sub-optimal care as well as inadequate evidence of assessment and documentation of care delivered.	**Quality C3 x L4 = 12** Safety C3 x L3 = 9 Statutory C3 x L4 = 12 Reputational C2 x L3 = 6	**Quality C3 x L4 = 12**

WC3932	The risk to patient safety due to the inability to meet the recommendations by the RCN for safe staffing on children's inpatients at GRH.	* Funding requirements do not meet the recommended staffing guidance * Establishment not correct for the diversity and complexity of the ward - HDU, Oncology, PAU COPD * 15 gaps in establishment despite fully recruited due to sickness/maternity/seconded/not started date * Nursing establishment (historic) for only two HDU beds	* Poor staffing and skill mix * Reliance on agency but many shifts not being covered poor staff morale increase agency spend complaints Increased volume of staff concern via datix system inability to safely care for children - inability to follow trust guidelines relating to patient care (IVAB, Feeds)	**Safety C4 x L4 =16** Quality C3 x L4 = 12 Workforce C3 x L4 = 12	**Safety C4 x L4 =16**

The table below shows an example of a risk on the divisional risk register, which has Workforce score of 10 (triggering the TRR) but has another domain with a higher score. A decision will need to be made whether to apply the TRR trigger score or the existing highest score when converting to a single approach. This issue will only occur on transition from multiple to singular domain. Once the transition is made this will no longer be an issue.

ID	Description	Cause	Effect and Impact	Multiple domain scores	New single score
C3104	The risk of decreased safety and additional harm coming to victims of domestic abuse and their children as a result of multi-agency partners being unaware of key information GHFT holds and clinicians not being aware of multi-agency information and therefore this not being factored into risk decision-making & safety plans.	The domestic abuse workload has consistently increased over the last 48 months and with this the volume of individual risk level information being shared. Additional resource to date has helped but not reduced the risk.	Not meeting referral and information sharing time and quality targets for whole of 2021/2022, not to-date in 2022/2023; not placing alerts onto patient records in a timely manner and now 1 year delay in uploading alerts. Essential information not being available to multi-agency partners at the time that safety plans for high risk victims of domestic abuse and their children have to be made. Essential information not being available to GHFT clinicians at the point they have to make decisions. There is now a one year gap in intelligence provided to our clinicians.	**Quality C3 x L4 = 12** **Workforce score C2 xL5 = 10** Statutory Cc x L3 = 9	**Choose current highest or TRR trigger score?**

TRR Report

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Consequence	Likelihood	Current Score	Current	Executive Lead title	Date Risk to be reviewed by	Operational Lead for Risk	Approval status
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.	Support being offered by Quality Assurance and Imms team. USS manager has a staffing/workforce plan to address sonography workforce challenges Number of women who miss FTCS are being monitored and tracked to ensure	undertake review of ANSCO hours audit bookings review job plans create newsletter review of admin hours fetal medicine team meetings review booking system	Diagnostics and Specialties, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse	31/07/2023	Maxwell, Sue	Trust Risk Register
C3963	Risk of increased harm, breach in regulations, distress and poor quality experience to patients, staff and visitors when boarding patients in wards.	Ward Boarding criteria in SOP to ensure unsuitable patients are not boarded Risk Assessments completed for all wards Consultation has taken place with wards Weekly Boarding Meeting and Matrons Boarding group led by Director for Quality and Safety Addendum produced for the ward evacuation plans to evacuate boarded	weekly boarding meetings being held- end date to be reviewed in April 2023 simple discharge group to be commenced and discharge processes to be reviewed Develop action plan Quality Summit on corridor care	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk		30/06/2023	Seaton, Andrew	Trust Risk Register
D&S2404CHaem	Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 - Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in	Develop Business case to meet capacity demand succession planning for consultant retirement Raise with divison to bring recruitment incentive requirements to PODDG Develop a business case for non-medical prescriber to help with clinics Division to explore whether other Trusts can take some patients, or can we buy capacity from another Trust	Diagnostics and Specialties	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	18/07/2023	Johny, Asha	Trust Risk Register
C1437POD	The risk of being unable to recruit and retain sufficient suitably qualified clinical staff including; - Medical & Dental; Registered Nurses & Midwives and AHP professionals, thereby impacting on the delivery of the Trust's strategic objectives.	Trust Workforce Planning include as part of the Trust Business Planning Cycle template. Central workforce planning for the ICS is overseen by the ICS Workforce Steering Group Introduction of alternate/Advanced practice/new including Associate Specialists, Non- Medical Consultant, ACP, PA offering alternative solutions to	Implementing Recruitment and Retention action plans ACP Business Case Multiple Recrtuitment and Retention Actions Workforce Planning Review 2022 Person-centred career 'plans on page' Establish Task and Finish Group for Radiographer Vacancies	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Workforce	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director for People & OD	19/09/2023	Daniels, Shirley	Trust Risk Register
S2976BIMA	The risk of breaching of national breast screening targets due to a shortage of specialist Doctors in breast imaging.	staff. Have reduced screening numbers identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are similar.	meeting with HR to progress replacement of staff in Breast screening Arrange meeting to discuss with Lead Executive Develop escalation process for when Breast Radiologist is not available to provide service Discuss the possible set up of national reporting center widen recruitment net to include head hunter agencies using Trust agreed supplier listlist	Diagnostics and Specialties, Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	03/08/2023	Hunt, Richard	Trust Risk Register
D&S3558PharmEquip	The risk of breakdown of air handling unit (due to age)leading to poorer patient outcomes for oncology and parenteral nutrition patients. The risk of loss of service and that that some	Planned preventative maintenance by GMS Outsourcing for some products in place which would reduce impact somewhat - however this is not reliable due to	Liaise with GMS AHU motors report of AHU status check on chiller at weekends	Diagnostics and Specialties, Gloucestershire Managed Services	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk		02/08/2023	White, Amanda	Trust Risk Register
M3682Emer	The risk of death, serious harm or poor patient outcome due to delayed assessment and treatment as a result of poor patient flow in the Emergency Department.	Since October, the ED team has implemented several changes to processes in order to mitigate the impact on the department when there is no admitting capacity. This includes: - Revised roles and responsibilities of key roles in the ED - Reintroduced Patient Safety Huddles 5 times a day - Reconfigured ED layout, bringing cohort area closer to Pitstop and Ambulance bay - Recruited agency paramedics to staff cohort area and release SWAST crews	Please can you review Risk, discuss at Specialty Governance or Escalation to Div Board to review and sign off. Progress VCPs for Flow Coordinator and ED Assistants Submit workforce paper to Exec COO Ensure meeting to discuss ICS risks is re-established and risk M3682 is discussed with partners	Medical	Safety	Catastrophic (5)	Likely - Weekly (4)	20	15 - 25 Extreme risk	Medical Director	31/01/2023	Barnes, Chester	Trust Risk Register
D&S3743CHaem	The risk of failing to deliver the necessary support to the Laboratory due to insufficient staffing levels and lack of appropriate skill sets, leading to a delay to diagnosis or treatment within the clinical service and harm to the patient.	Provision of consultant for 1 day a week Increase in turn around time for film reporting Communication of reduced resource to all involved Recruitment process	Consultant to start in July 2022	Diagnostics and Specialties	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Medical Director	17/07/2023	Johny, Asha	Trust Risk Register

C3930 S&T E&F	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	Some of the units are placed in fire-rated hazard rooms. Some of the units have a better level of installation.	To review hazard rooms with clinical teams and Fire team Identify any works required for alternative locations Set up lessons learnt event To sign off installation as required standard To review usage and risk report to inform prioritisation To roll-out new SVF process To ascertain staff training requirements and roll-out Fire team trainer to add information to mandatory training package Rolling replacement programme for batteries Check required on risk assessments To broker discussions regarding funding impacts Conclude RAG audit of areas across the Trust	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Statutory	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk		31/08/2023	Turner, Bernie	Trust Risk Register
C3767COO	The risk of harm to patients and staff due to being unable to discharge patients from the Trust.	Clinical review and prioritisation Onward care team in place supporting discharge Prioritisation of end of life patients Currently GHT CHC process is reliant on ward staff to complete a number of the stages. OCT and SPC support where they are able, but there is not a constant provision of resource.	To resolve outstanding areas of concern	Ambulance Trust, Corporate, Diagnostics and Specialties, GP Services / NHS England, Gloucestershire Health and Care NHS Foundation Trust, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	COO	30/06/2023	Zada, Qadar	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Falls prevention assessments on EPR 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6. Falls prevention champions on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR Discuss flow sheet for bed rails on EPR at documentation group W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell Review use of slipper socks with N Jordan SIM training to use hoverjack on 7a Following presentation of W168912 N Jordan to attend ward to review completion of falls documentation and required management of patient following assessment by staff Following presenntation of W171436 to PHH N Jordan to forward information to purchase slippers for patients in ED W165353 Nadine Jordan to review with 9a x-ray identifying # and communication of #	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/07/2023	Bradley, Craig	Trust Risk Register
	The risk of harm to patients, staff and visitors in the event of an adolescent 12-	1. The paediatric environment has been risk assessed and adjusted to make the	Develop Intensive Intervention programme	Medical, Surgical, Women's and						Interim Director of Quality			

C1850NSafe	18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour whilst on	area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's	Escalation of risk to Mental Health County Partnership Escaled to CCG	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	30/06/2023	Freebrey, Clare	Trust Risk Register
C3084	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc.	Governance process Reporting structure Patient safety and H&S advisors monitoring the system daily Monthly performance reports on new, overdue risks, partially completed risks, uncontrolled risks and overdue actions etc	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis test risk module Weekly meeting and action plan for DATIX Cloud	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	04/09/2023	Troake, Lee	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Proide training to 5b in the use of cavilon advance + Provide training to ward on completion of 1st hour priorities Provide training to AMU GRH on completion of first hour priorities and staff signage sheet to be completed Bespoke training to DCC staff for categorisation of pressure ulcers Bespoke training to ward 4a to include 1st hour priorities produce training document on wound measurements for Rendcomb The provision of RCA support/training for TV issues to be take to pressure ulcer council Work with Knightsbridge to support staff TVN training Bespoke training in management of pressure ulcer [revention on ward 7a TVN to d/w TVN lead regarding use of share care pathway in regards to EPR. Implement training programme in management of patient pressure ulcers in ED	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/07/2023	Bradley, Craig	Trust Risk Register

			Ward 7a W170891 training with HCA's to allow them to assist registered nurses with assessing patient skin and documenting on EPR										
D&S2517PathEquip	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate). Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Estates and Strategy	11/09/2023	Brown, Sarah	Trust Risk Register
WC3536Obs	The risk of not having sufficient midwives on duty to provide high quality care ensuring safety and avoidable harm, including treatment delays.	Daily review of staffing across the service and reallocation of staff Twice daily MDT huddles to prioritise clinical workload Allocated 8a of the day allocated to support flow and staffing/ activity coordination. Patient flow and quality coordinator (band 7) allocated on a daily basis	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required. staff consultation on call enhancement discussion	Women's and Children's	Workforce	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Interim Chief Nurse	31/07/2023	Stephens, Lisa	Trust Risk Register
M2268Emer	The risk of patient deterioration, harm and poor patient experience when care is provided in the corridor during times of overcrowding in ED	Patient to staff ratio 1:4 Clinically ready to proceed patients only to be moved to the corridor and those awaiting discharge . Clear criteria in place (recorded on escalation ambulance policy)to ensure only low risk patients are placed in corridor. Patients that have been identified as at risk of fall Risk of absconding / wandering should not be placed in the corridor. Patients with that cannot access the toilet facilities by chair or walking should not be placed in corridor.	Complete CQC action plan Compliance with 90% recovery plan Monies identified to increase staffing in escalation areas in E, increase numbers in Transfer Teams, increase throughput in AMIA. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR audit form fo NIC re patients suitability Fire risk assessment Risk assessment of corridor care Review of SOP and escalation policy	Medical	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse & Director of Quality	30/06/2023	Forrest, Matthew	Trust Risk Register
C3034N	The risk of patient deterioration, poor patient experience, poor compliance with standard operating procedures (high reliability)and reduce patient flow as a result of registered nurse vacancies within adult inpatient areas at Gloucestershire Royal Hospital and Cheltenham General Hospital.	1. Temporary Staffing Service on site 7 days per week. 2. Twice daily staffing calls to identify shortfalls at 9am and 3pm between Divisional Matron and Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSi Retention programme - cohort 5 Trustwide support and Implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director of Quality and Chief Nurse	02/08/2023	Holdaway, Matt	Trust Risk Register
C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The	COVID T&F Group to develop Recovery Plan to minimise harm To resolve outstanding areas of concern	Corporate	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	COO	06/09/2023	Hardy-Lofaro, Neil	Trust Risk Register
C3876EOL	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.	Follow up by staff to pursue suitable arrangements for patient choosing to EoL in community. Specialist Palliative Care working with individual cases with evidence, for these patients, they get home more quickly.	Map current process Upload sample CHC forms onto intranet site Solution for the digital storage and completion of national documents for application for CHC funding Develop a systemwide MDT to expediate EoL Discharges Obtain robust data set Flow chart for roles and responabilities for rapid discharge process Resource checklist for rapid discharge	Ambulance Trust, Diagnostics and Specialties, Gloucestershire Health and Care NHS Foundation Trust, Medical, Surgical, Women's and Children's	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse and Executive Director for Quality	02/06/2023	White, Samantha	Trust Risk Register

			Develop outcome spreadsheet for rapid discharge MDT Regualr meeting with CHC leads Job description review Review new data around in-patient deaths who were coded as NCTR										
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	01/08/2023	Foo, Andrew	Trust Risk Register
C3941EFD	The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal hospitals	- Water Safety Group in place (monthly meetings) - Water Safety Policy - approved and current - Annual water audit by external Authorised Engineer completed (November 2022) and actions added to action plan. Latest status is 11/18 completed actions with 2 awaiting approval, 3 in progress and 2 requiring further clarification. - Audit plan created for staff practices related to cleaning and disinfection, checklists and spot-checks introduced - SOP created for IPC actions post positive water results - Procedure Notes and Method Statements created covering procedures and practice for estates and domestics teams. Procedure Notes have all been reviewed by Authorising Engineer with systematic review for approval at Water Safety Group (for example, PN04-22 and PN04-03 coming to next WSG in May for sign off) - Capital team have undertaken training on Water Safety	review of water safety policy training records ensure flushing undertaken in each area To provide list of outlets Trust wide audit of outlets Formalised process to prioritise augmented care flushing To create staff engagement methods for water safety To use paraceti acid for drain cleaning across all augmented care areas To conclude water testing Avening ward Remove sensors Conclude risk assessment Rendcomb ward Complete evaluation of waterless bathing trial Review water tanks Review of birthing pool testing Purchase of water safety system	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical	Statutory	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	Director for Strategy and Transformation	30/06/2023	Turner, Bernie	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months.	Develop draft business case for additional cooling Submit business case for additional cooling based on survey conducted by Capita Rent portable A/C units for laboratory	Diagnostics and Specialties, Gloucestershire Managed Services	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	10/08/2023	Rees, Linford	Trust Risk Register
C2803POD	The risk that staff morale, productivity and team cohesion are eroded by adverse workplace experiences and/or significant external events, which in turn adversely impacts patient safety, job satisfaction, colleague wellbeing, and staff retention.	Divisional staff survey action plans, monitored by Executive Reviews. Divisions are offered support by PACE. Trustwide staff survey action plan. Patient and Colleague Experience Group (PACE) - leading on the triangulation of experience data and delivery of compassionate culture work streams. 2020 Hub is staffed with 3.3 WTE staff to deliver a range of health-wellbeing support. EDI team established comprised of substantive roles (EDI Lead, EDI Coordinator, EDI Administrator) and fixed-term 18 months EDI Training Specialist. Colleague Wellbeing Psychology Lead in place, with 1.6 WTE Psychology Link Workers appointed for 23 months. 1 year fixed term 0.3 Resilience Trainer appointed. Compassionate Leadership training rolled out and all leaders/managers must complete. OD Specialists linked with divisions to provide more strategic and tailored support to these areas. Widening Participation Review held Oct 20 - Jun 21. Report published September 21.	Create Dashboard to underpin SPEIG work priority workstreams feeding into SPEIG Review Staff Survey results EDI/Cultural Improvement plans being devised in light of DWC and staff survey results Short, medium and long-term interventions being proposed to address health-wellbeing concerns 2 x OD Specialists (fixed term) being recruited to offer additional support to a) maternity and b) junior nurse leadership development Staff Engagement and Internal Comms Manager being appointed to support internal communications effectiveness To deliver the first year (phase 1) of the Teamwork/Leadership workstream as part of the Staff Experience Improvement Programme	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Workforce	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director for People & OD	04/08/2023	Hopewell, Abigail	Trust Risk Register
F3806	The risk that the organisation is not able to manage resources within delegated budgets.	The controls that are in place to prevent the risk materialising are -sustainability programme Annual budget planning - Monthly System review and NHSEI Returns -Monthly Management Accounts including detailed forecasts	Development of Divisional Recovery Plan Performance Management of Delivery of Recovery Plans Financial Recovery Plan developed and reported to Finance & Digital Committee	Corporate	Finance	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Karen Johnson	03/08/2023	Johnson, Karen	Trust Risk Register
			Write risk assesment Update busines case for Theatre refurb programme										

S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	Agree enhanced checking and verification of Theatre ventilation and engineering. meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan arrange replacement valve and acurator for air handling unit TH1 reinstate quarterly ventilation meetings To provide comprehensive update on theatre ventilation Review of infections in Theatre 7	Gloucestershire Managed Services, Surgical	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	03/08/2023	Dobb, Michael	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS 4. C.Diff reduction action plan in place	1. Delivery of the detailed action plan, developed and reviewed by the Infection Control Committee. The plan focusses on reducing potential contamination, improving management of patients with C.Diff, staff education and awareness, buildings and the envi	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	30/06/2023	Bradley, Craig	Trust Risk Register
M2613Card	The risk to patient safety as a result of lab failure due to ageing imaging equipment within the Cardiac Laboratories, the service is at risk due to potential increased downtime and failure to secure replacement equipment.	Modular lab in place from Feb 2021 Maintenance was extended until April 2021 to cover repairs Service Line fully compliant with IRMER regulations as per CQC review Jan 20. Regular Dosimeter checking and radiation reporting.	This has been worked up at part of STP replace bid. Submission of cardiac cath lab case Procure Mobile cath lab Project manager to resolve concerns regarding other departments phasing of moves to enable works to start To update on IGIS programme	Gloucestershire Managed Services, Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	26/05/2023	Matthews, Kelly	Trust Risk Register
M2815Stroke	The risk to patient safety due to delays in the acute stroke pathway for patients attending GRH ED.	Stroke patients attending GRH ED should be managed by ED/medical teams and offered thrombolysis/thrombectomy referrals if possible in GRH and then transfer to CGH HASU, unless felt more timely to transfer direct onto CGH. Monthly stroke breach meetings to review SSNAP data with feedback to ED. Regular feedback provided to ED and teaching of triage staff regarding pathway. Updating pathways and sharing via teaching to ED and medical staff. Specialist nurses when full complement provide 7/7 0700-2300 and can provide telephone support to GRH ED staff.	Increase pre alerts via SWAST to ED Increase pre alert from ED nurse to SSN Streamline process to request CT from ED Write business case to increase SSN service to 24/7 Recruitment to medical rota Change to medical rota to increase presence in HASU to 12 hours Please can you review and update risk and action Enhanced training for ED staff (nurses and doctors) re the stroke pathway and timelines to work to Stroke awareness training of ED triage nurses To work with ICB to improve patient awareness of stroke services not going to GRH Reducing ED pressures to allow staff to work safely and prioritise patients appropriately	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk		01/11/2023	Hellier, Kate	Trust Risk Register

S3481Obs	The risk of severe harm to patients requiring emergency obstetric surgery caused by an inability to meet a minimum staffing requirements when opening a second obstetric theatre. The risk of harm to the wellbeing of staff when working outside minimum staffing requirements.	If available the emergency team from theatres can attend (this prevents emergency surgery from taking place in theatres). Potentially second team from CGH to assist in main theatres to allow GRH theatre staff to attend obstetrics. Team assigned to emergency obstetric	ongoing audit recruitment of staff identify impact on other theatre staffing levels provide funding to allow recruitment of theatre staff Arrange meeting with Chief Midwife and BD 2nd Obstetric theatre paper Gateway to TLT by 18 April	Surgical, Women's and Children's	Quality	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk		08/08/2023	Ball, Natalie	Trust Risk Register
S3337	The risk to quality of continued poor patient experience on SAU for patients requiring admission to a ward	20 chairs and 2 side room capacity + swabbing room NEWS 2 taken by nursing team 4hrly at least Escalation via site to obtain inpatient bed SOP with criteria for admission Referral to Registrar/ ACRT if patients deteriorate whilst waiting for assessment Use of assessment rooms as side rooms for patients with gold approval only Staff visible within bay/ just outside of bay Trainee ACPs to review patients	Works to change colorectal office on 5a to bedded bay with bathroom works in orchard centre to allow relocation of colorectal office space on 5th floor escaltion via division tri to stop use of assessment rooms for inpatients 1-3 year strategy plan for SAU and 5th floor update SOP to reflect current situation recruitment drive for SAU	Surgical	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Quality and Chief Nurse	01/08/2023	Jones, Lisa	Trust Risk Register
S3968Oph	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.	Funding has been allocated forimmediate additional resources and long-term recruitment (failsafe officers) •Specialty tri are offering validator work as bank to existing staff within the department for an initial 8 week period For Red validated patients and DNBs, ensuring that these patients receive follow-ups within a clinically safe time. Monitoring those, ensuring each has their intended date documented and	GIRFT actions Contacting other Hospitals re Failsafe staffing Recruitment of additional Failsafe Officers Update the business case Inform elective care recovery board of the risk / situation	Surgical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Executive Director for Safety	02/10/2023	Biston, Cathryn	Trust Risk Register
F2895	There is a risk the ICS/ Trust is unable to secure sufficient (CDEL) capital and/or 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	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group;	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system To ensure prioritisation of capital managed through the	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Environmental	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of Finance	31/08/2023	Johnson, Karen	Trust Risk Register

KEY ISSUES AND ASSURANCE REPORT People and Organisational Development Committee, 27 June 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**
Staff Survey Feedback	Following the publication of the staff survey results, a letter had been issued to all staff to ask for feedback on the one key change that staff want to see to improve their experience at the Trust. Key themes from the feedback received related to culture and line manager behaviour, and the boarding process.	A Staff Experience Taskforce had been established to review actions and projects that would lead to a positive change in culture and behaviour issues.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Performance Dashboard	Key points were highlighted as follows: • Key performance indicators now had targets in place. • Focused nursing recruitment had successfully secured funding to support the Trust with winter planning. • Bank and agency controls continued to be reviewed. • An effectiveness review was underway into the E-Rostering system. • Vacancy rates continued to be challenging across all roles.	A deep dive into attrition rates would be undertaken and an assurance report developed for the Committee meeting in September.
Freedom to Speak Up Report	An update on activity was provided, along with benchmarking data from the South West and national. During 2022/23, 98 staff accessed the FTSU process, which was lower than the South West average. Anonymous reporting at the Trust was higher than average. Key themes to concerns during the year related to poor behaviour, bullying, poor support and staff experience.	To fully analyse staff experience in the future, the team would share an anonymous survey for staff to fill in and report on the results, providing an opportunity to capture learning and improve the service.
Engagement and Involvement Annual Review	Over the last year, the Trust had been an active part of 58 groups and community events, reaching over 8,700 people, enabling the Trust to gain valuable insight into how access to services could be improved. The review also detailed information about the local communities and the challenges of health inequalities across the county.	Revised regulations from CQC and NHSE mean that People and Communities/Patient and Community Engagement would continue to be a key focus for the Trust. The review would be published on the Trust's website, alongside the Annual Report and Quality Account.
Equality Delivery System 22	The Trust was assessed against the EDS22 framework, which organisations completed on a system level. The Trust was rated against three domains (Commissioned or Provided Services; Workforce Health and Wellbeing; Inclusive Leadership) with an overall score of 11, which was a rating of "Developing".	The Trust's existing EDI action plan, along with recent WRES, WDES and Gender Pay Gap data would be reviewed at an EDI workshop scheduled for 6 July to determine next steps.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None.		
Items not Rated		
Risk Register	ICS Update	Audits
Impact on Board Assurance Framework (BAF)		
SR3: continue to reflect actions and progress, including staff health and wellbeing and reflection of culturally specific training. SR4: milestones to be included to reflect progress against a number of significant pieces of work, including the Staff Experience Taskforce. Consider inclusion of organisational risks associated with the transformational approach to co-design.		

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.

KEY ISSUES AND ASSURANCE REPORT Finance and Resources Committee, 29 June 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**
Cyber Security and Information Governance Bi-Annual Report	The DSPT submission would be made at the end of June which was likely to see non-compliance with Information Governance Training and qualified responses with end-of-life software updating. Compliance against the Data Security Protection Toolkit had risen to 90%, however this was still below the required 95% compliance.	Due to the continuing gap in compliance for IG training, additional sanctions had been discussed with the Caldicott Guardian, SIRO and DPO and was also being monitored by directorates. The Chair asked the Interim Chief Digital Information Officer to give further consideration to how the position could be improved.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Digital Transformation Report	The overview of the digital programme for the current financial year, delivered as part of the five-year digital strategy 2019-24 was noted. Updates were provided on projects, reported under the five programmes: • Sunrise EPR [a separate report has been submitted to F&RC] • Clinical Systems Optimisation • Business Intelligence & TrakCare • Infrastructure • Cyber Security	The Committee noted the update.
Financial Performance Report	The Committee noted that at M2, the Trust was reporting a deficit of £5,165k; £747k adverse to plan. The drivers of this position were noted. The Financial Sustainability Plan (FSP) target for the Trust is £34.7M in 23/24 and year-to-date the programme had delivered £4.5M of savings (£4.2M recurrent; £0.3M non-recurrent).	The Committee received the contents of the report as a source of assurance that the financial position was understood.
Financial Sustainability Report	The M2 YTD performance was better than plan by £0.1M driven primarily by procurement and medicines optimisation benefits and a corporate NR benefit. Divisions were working on mitigations to assure delivery against plan. Temporary staff continued to be a concern.	The Committee noted that agency caps had now been shared with the Divisions and SROs of the temporary staffing control groups. Focus would move to next year and benchmarking would be undertaken. A wider look on the longer-term vision would be provided in September. Additional transparency on the £12.4M transformation / central schemes and the governance of this element would be provided in the next report.
Costing BAU	The Committee received the pre-submission planning report; a summary of the requirements expected for the national cost collection 2023 submission in September. It highlighted the costing plan and the reasons for the delayed deadline and provided an update of the changes to the Approved Costing Guidance. NHS England's delay in publishing the national costing standards and guidance, and the delay in issuing the data validation tool were noted; this had led to challenges for the trust in completing the submission on	The Committee was assured by the process in place to successfully complete the national cost collection and endorsed the approach.

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.

	time. The impact and risk of strike action was also noted.	
Capital Programme Report	At M2 the Trust was reporting a deficit of £5,165k which was £747k adverse to plan. The drivers of this position were outlined and the Committee noted that the position would have been overspent by £2,487k in M2 if reserves had not been released and corporate areas were not underspent.	The Committee noted the M2 capital position detailed within the report and endorsed the approach to business cases taken.

Items Rated Green

Item	**Rationale for rating**	**Actions/Outcome**
None		

Items not Rated

Commercial and Innovations Review Group KIAR	Digital Risk Register	Annual Debtors Report

Business Cases and Investments

Case	**Comments**	**Approval**	**Actions**
TIFF Orthopaedic Theatre Procurement	The Committee noted that engagement with Kier Construction on the TIFF Orthopaedic Theatre. External funding was already approved; the exi Design Team had been appointed and were currently working towards RIBA Stage 3 Design and issuance of tender documents.	Approved	The Committee SUPPORTED the TIFF Orthopaedic Theatre project to proceed to the next stage where the building surveys and detailed design were completed and Kier formally priced the works, noting that this phase had been costed at c.£407k.
Energy Performance Contract 2	The original Energy Performance Contract (EPC) with Vital Energi provided a full Managed Services Contract for energy supply to the Trust. It was no longer possible to instruct additional variations to the contract and GMS was unable to deliver works identified as part of the funding successfully obtained under PSDS 3a (c. £10.96m). Therefore, GMS had procured a second EPC contract.	Approved	The Committee SUPPORTED the proposal for GMS sign the Energy Performance Contract 2 with Vital Energi and RECOMMENDED its progression to Trust Board for approval.
CDC Agreement for Lease	GMS were seeking authorisation to sign the Agreement for Lease (AfL) x 2 with Gloucestershire County Council for the Community Diagnostics Centre (CDC) project.	Approved	The Committee APPROVED the proposal for GMS to sign the 2Nr. Agreement for Leases and to RECOMMENDED its progression to Trust Board.

Impact on Board Assurance Framework (BAF)

Work continued to review and update the Cyber Security BAF risk - *Failure to detect and control risks to cyber security*; *Inability to maximise digital systems functionality*. The Finance BAF - *Failure to deliver recurrent financial sustainability* had been updated and changes were noted.

KEY ISSUES AND ASSURANCE REPORT **Finance and Resources Committee, 25 May 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**
GMS Key Issues and Assurance Report	The continuing failure to achieve the Fire Risk Assessment KPI and the lack of resource to deliver was raised as a key concern.	The Committee noted the continued high vacancy rates within the GMS, and the impact on compliance. Recruitment continued to address the staffing gap.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
CGH Electrical Incident Update	The Committee received assurance on the proposed actions in response to the incident concerning the electrical outage at CGH in January which affected a number of critical services.	Actions were agreed at the Trust's Electrical Safety Group, the Digital / EPRR Post Incident Review and an EPRR pan-Trust Post Incident Review. A full report would be brought to the meeting in June.
Financial Performance Report	The Committee noted that at M1, the Trust was reporting a deficit of £3,265k which was £639k adverse to plan. The drivers of this position were outlined and the Committee noted that the position would have been overspent by £2,060k in M1 (including £760k in ED) if reserves had not been released and corporate areas were not underspent. The Committee noted that temporary staffing was a key concern.	A deep dive into the pay position would be undertaken. The Committee agreed that benchmarking of issues common throughout the NHS would take place and would be included in the next report.
Financial Sustainability Report	In Month 1, £1.2M was planned, of which £1.1M was achieved, the Financial Sustainability Programme plan submitted to NHS England in May was valued at £34.7M. In addition to the £34.7M FSP plan, GHFT now had a stretch target of £1.4M in order to achieve a system balanced plan and a technical adjustment of £6.7M for Covid, where spend was already removed from the plan, before efficiency targets were applied. Within the £13.2M of red-rated schemes were £7.7M of schemes still requiring a detailed delivery plan. Agency and locum spend remained high in areas where there were staffing vacancies.	Schemes still requiring a detailed delivery plan had been discussed at Programme Delivery Board. Actions were now being taken to ensure the schemes underwent a Project Initiation Document (PID) and QIA process. A 'deep dive' into agency and bank schemes was planned.
Estates Risk Register	There were 72 risks currently on the Risk Register. The age of the estate, coupled with other factors created a number of challenging issues. The report set out the link between backlog maintenance and risk.	A Board Strategy session on the broader risk issues was planned. Clarity around the purpose of that session would be sought.
Capital Programme Report	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. There had been no additional capital approved since the plan submission.	Subgroup meetings were in place to provide accountability and assurance.
Procurement Bi-Annual Assurance Report	The Committee received assurance that the Procurement Service met national performance targets and operated in accordance with national standards. The service also supported the delivery of the Trust's Financial Sustainability Programme and represented value for money.	The current market situation continued to put pressure on input costs, commodities and inflation; procurement challenges and risk mitigation actions taken were noted.

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.

	Quarters 3 and 4 continued to be a period of pressure for the team with a number of vacancies balanced with continued support for the various programmes and supporting the Trust in its delivery of activity.	
NHS England Productivity Tool	2022/23 GHFT productivity was 22% lower than in 2019/20, driven by inflation-adjusted increase in costs of 16% versus 2019/20, combined with cost weighted activity reduction of 9% driven in part by changes to activity points of delivery in 2022/23.	A further report would be received in July, and would include commentary and implications.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
None		

Items not Rated

Commercial and Innovations Review Group KIAR	Contract Management Group Overview Report	Business Case Process

Business Cases and Investments

Case	Comments	Approval	Actions
Pay Award for GMS Staff	NHS England had announced a 5% non-consolidated resilience payment in relation to 2022-2023 and a 5% consolidated pay rise for AfC from 1 April 2023. This was payable to AfC staff employed by qualifying organisations of which GHNFT was one. GMS did not qualify. The gap of £177,650 was noted.	Approved	The Committee approved the uplift and non-recurrent payment for both groups of GMS staff and recognised this was a cost GMS had not budgeted for. The Committee supported approaching the ICB for funding.
GMS Business Plan 2023-24	The proposed GMS 23/24 business plan was received by FRC.	Approved	None
Renal HD Contract Recommendation Report	The Procurement Tender undertaken for the Renal HD Contract was robust, and the outcome demonstrated best value to the Trust for the delivery of the proposed contract. Bidder 3 was recommended. A challenge to the evaluation panels impartiality was received and a residual risk of challenge was noted. Mitigating actions were taken in response, following advice from DAC Beechcroft.	Approved	None
TIFF Orthopaedic Theatre Procurement	The Committee supported engagement with Kier Construction on the TIFF Orthopaedic Theatre. External funding was already approved; the exi Design Team had been appointed and were currently working towards RIBA Stage 3 Design and issuance of tender documents.	Approved	None

Impact on Board Assurance Framework (BAF)

BAF risks had been agreed and would now be aligned to agendas to drive forward key strategic work.
The Committee recommended a reduced risk score for *SR9: Financial Sustainability*, from 20 to 16.

Report to Board of Directors			
Agenda item:	11	Enclosure Number:	6

Date	July 2023
Title	M2 Financial Performance Report
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 2.

Revenue

The Trust is reporting a year to date (YTD) deficit of £5,165k which is £747k adverse to plan. This is the position after adjusting for donated assets impact and Salix grant.

The ICS YTD deficit position of £5.112m which is £0.745m adverse to plan. This is the result of a £0.747m adverse to plan position from GHFT, a £0.02m YTD surplus position at GHC and a nil variance at GICB.

Capital

The Trust is reporting a YTD position of £7.3m against a planned spend of £10.1m which is a variance of £2.8m. This excludes IFRS 16 capital. This leaves £48.5m of non-IFRS 16 capital to deliver in the remainder of 23-24.

The Trust is reporting a breakeven forecast outturn in line with the plan. This has been reported to NHSE in the M2 Provider Financial Return (PFR).

Recommendation

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

Enclosures

Financial Performance Report

Report to Trust Board

Financial Performance Report
Month Ended 31st May 2023

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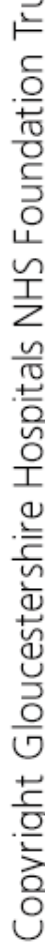
Revenue & Balance Sheet



NHS
Gloucestershire Hospitals
NHS Foundation Trust

Director of Finance Summary

System Overview

The ICS is required to breakeven for the year. At month 2, 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 £5.112m which is £0.745m adverse to plan. This is the result of a £0.747m adverse to plan position from GHFT, a £0.02m YTD surplus position at GHC and a nil variance at GICB.

Month 2

M2 YTD Financial position is reporting a deficit of £5,165k which is £747k adverse to plan.

The position includes :

- Industrial Action costs £747k
- Unscheduled Care pay pressures, including ED £1,760k
- Frailty Unit pay pressures £500k
- Theatres and T&O pay pressures £455k
- Theatres and ophthalmology equipment £259k
- Radiology & Pathology pressures £382k
- Drugs £318k
- Interest receivable and payable lower than plan £738k benefit
- Reserves (planned release) £1,347k benefit
- Reserves (supporting YTD position) £703k benefit
- Corporate underspends £1,037k benefit

The position would have been overspent by £2,487k in Month 2 if unplanned reserves of £703k had not been released and corporate areas were not underspent by £1,037k.

The Financial Sustainability Plan (FSP) target for the Trust is £34.7M in 23/24 and year-to-date the programme has delivered £4.5M of savings (£4.2M recurrent; £0.3M non-recurrent). The programme overall is slightly behind of plan by £0.1M. It is too early to say yet how the programme will perform over the year however there remains a significant level of risk within the programme, with all divisions are engaged in ensuring that risks are mitigated.

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Month 2 headlines

Headline	Compared to plan	Narrative
I&E Position YTD is £5.165m deficit which is £0.747m adverse to plan	↓ (red)	I&E Position YTD is £5.165m deficit which is £0.747m adverse against the plan of £4.418m deficit.
Income is £121m YTD which is £2.2m favourable to plan	↑ (green)	M2 income position is £121m YTD which is £2.2m favourable to plan. Most of the Trust income is covered by block contracts. The month 2 position is £2.2m favourable due to private patient income, CDC income (matched by costs) and HEE income (matched by costs).
Pay costs are £77.5m YTD which is £4.4m adverse to plan	↓ (red)	Pay costs are £77.5m YTD which is £4.4m adverse to plan. Pressures include Industrial Action costs and covering vacancies within ED, theatres and trauma.
Non Pay costs are £45.9m YTD which is £1.5m favourable to plan.	↑ (green)	Non Pay costs (included non-operating costs) are £45.9m YTD which is £1.5m favourable to plan. This position includes overspends which are consistent with last month although the rate of overspend is reducing. These include clinical supplies, pathology and radiology which are offset by the release of reserves and underspends in corporate areas.
Delivery against Financial Sustainability Schemes	↓ (red)	The Financial Sustainability Plan (FSP) target for the Trust is £34.7M. In Month 2, the Trust had planned efficiencies of £4.6M and achieved £4.5M.
The cash balance is £54m	↑ (green)	Cash has increased by £4.5m

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Oversight Framework – Financial Matrix

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 2 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	4,599	4,495	(104)
Financial stability – variance from breakeven*	(4,418)	(5,164)	(747)
Agency spending against ledger budget	(1,505)	(3,531)	(2,026)
adjusted position			

The Trust is adverse to plan across all metrics in Month 2.

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M2 Group Position versus Plan

The financial position as at the end of May 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 May the Group's consolidated position shows a deficit of £5.2m deficit which is £0.75m adverse to plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 2 Financial Position	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	107,505	107,513	8			0	107,505	107,513	8
PP, Overseas and RTA Income	688	1,261	574			0	688	1,261	574
Other Income from Patient Activities	1,875	1,963	89			0	1,875	1,963	89
Operating Income	8,909	9,388	479	11,892	11,076	(816)	8,669	10,206	1,537
Total Income	**118,977**	**120,126**	**1,149**	**11,892**	**11,076**	**(816)**	**118,737**	**120,944**	**2,207**
Pay	(70,026)	(73,355)	(3,329)	(4,096)	(4,160)	(64)	(73,096)	(77,516)	(4,420)
Non-Pay	(48,875)	(48,158)	717	(7,427)	(6,912)	515	(45,551)	(44,812)	739
Total Expenditure	**(118,900)**	**(121,513)**	**(2,613)**	**(11,523)**	**(11,072)**	**450**	**(118,647)**	**(122,328)**	**(3,680)**
EBITDA	**76**	**(1,387)**	**(1,463)**	**369**	**3**	**(366)**	**90**	**(1,384)**	**(1,473)**
EBITDA %age	**0.1%**	**(1.2%)**	**(1.2%)**	**3.1%**	**0.0%**	**(3.1%)**	**0.1%**	**(1.1%)**	**(1.2%)**
Non-Operating Costs	(1,769)	(1,051)	717	(369)	(3)	366	(1,781)	(1,055)	727
Surplus / (Deficit)	**(1,692)**	**(2,438)**	**(747)**	**(0)**	**0**	**0**	**(1,692)**	**(2,438)**	**(747)**
Dontated Asset, Impairment & Salix Grant Adjustment	(2,726)	(2,726)	0	0	0	0	(2,726)	(2,726)	0
Adjusted Surplus / (Deficit)	**(4,418)**	**(5,164)**	**(747)**	**(0)**	**0**	**0**	**(4,418)**	**(5,164)**	**(747)**

* Trust position excludes £6m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £10m of inter-company transactions, including dividends

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Balance Sheet

Gloucestershire Hospitals
NHS Foundation Trust

	Group Closing Balance 31st March 2023 £000	GROUP Balance as at M2 £000	B/S movements from 31st March 2023 £000
Non-Current Assests			
Intangible Assets	16,483	16,007	(476)
Property, Plant and Equipment	365,383	368,002	2,619
Trade and Other Receivables	3,901	3,880	(21)
Investment in GMS	0	0	0
Total Non-Current Assets	**385,767**	**387,889**	**2,122**
Current Assets			
Inventories	12,312	12,566	254
Trade and Other Receivables	44,610	41,418	(3,192)
Cash and Cash Equivalents	49,193	53,769	4,576
Total Current Assets	**106,115**	**107,753**	**1,638**
Current Liabilities			
Trade and Other Payables	(104,686)	(110,046)	(5,360)
Other Liabilities	(11,325)	(12,373)	(1,048)
Borrowings	(5,292)	(6,180)	(888)
Provisions	(141)	(141)	0
Total Current Liabilities	**(121,444)**	**(128,740)**	**(7,296)**
Net Current Assets	**(15,329)**	**(20,987)**	**(5,658)**
Non-Current Liabilities			
Other Liabilities	(5,426)	(5,381)	45
Borrowings	(51,171)	(49,784)	1,387
Provisions	(10,612)	(10,612)	0
Total Non-Current Liabilities	**(67,209)**	**(65,777)**	**1,432**
Total Assets Employed	**303,229**	**301,125**	**(2,104)**
Financed by Taxpayers Equity			
Public Dividend Capital	397,288	397,619	331
Equity	0	0	0
Reserves	28,113	28,113	0
Retained Earnings	(122,173)	(124,607)	(2,435)
Total Taxpayers' Equity	**303,229**	**301,125**	**(2,104)**

The table shows the M2 balance sheet and movements from the 2022/22 unaudited closing balance sheet.

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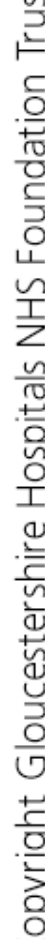
Capital



Director of Finance Summary

Funding

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m, of which £1.5m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £55.8m.

As at the end of May (M2), there has been no additional capital approved.

YTD Position

Year to date, excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £7.3m, against a planned spend of £10.1m, equating to a variance of £2.8m. This leaves £48.5m of non-IFRS 16 capital to deliver in the remainder of 23-24.

The Trust is reporting a breakeven forecast outturn in line with the plan. This has been reported to NHSI in the M2 Provider Financial Return (PFR).

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23/24 Programme Funding Overview

The Trust submitted a gross capital expenditure plan for the 23-24 financial year totalling £57.3m, of which £1.5m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £55.8m.

As at the end of May (M2), there has been no additional capital approved.

The current agreed programme can be divided into the following components; Operational System Capital (£25.9m), National Programme (£16.3m), STP Capital – GSSD (£0.6m), IFRIC 12 (£1.1m), Government Grant (£6.7m) and Donations (£1.1m)

The breakdown of secured funding is shown below.

in £000's

		Plan	Secured	Variance
DIGITAL	Digital	5,700	5,700	0
MEDICAL EQUIPMENT	Medical Equipment	5,996	5,996	0
ESTATES	Estates	14,192	14,192	0
Total Charge against Capital Allocation (excluding impact of IFRS 16)		**25,888**	**25,888**	**0**
RIGHT OF USE ASSET	Right Of Use Asset	1,478	1,478	0
Total Charge against Capital Allocation (including impact of IFRS 16)		**27,366**	**27,366**	**0**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Image Sharing	326	174	152
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	iRefer	0	152	(152)
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	Digital Pathology	115	115	0
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Equipment 22/23	451	451	0
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Enabling works	4,185	4,185	0
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	Community Diagnostic Centre Digital	2,540	2,540	0
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	5th Orthopaedic Theatre	8,703	8,703	0
NAT PROG: RIGHT OF USE ASSET: NEW	Leases: Community Diagnostic Centre	4,098	4,098	0
STP PROGRAMME: GSSD	Gloucestershire Hospitals Strategic Site Development	561	561	0
IFRIC 12	PFI Lifecycle	1,126	1,126	0
DONATIONS VIA CHARITABLE FUNDS	Gamma Camera	514	514	0
DONATIONS VIA CHARITABLE FUNDS	Jet Ventilator	61	61	0
DONATIONS VIA CHARITABLE FUNDS	Other potential charitable donations	500	0	500
GRANT	PSDS 3a Salix (Grant Funded)	6,724	6,724	0
Total Additional Capital		**29,904**	**29,404**	**500**
Gross Capital Funding Total (including IFRS 16)		**57,270**	**56,770**	**500**
Excluding IFRS16		(1,478)	(1,478)	0
Gross Capital Funding Total (excluding IFRS 16)		**55,792**	**55,292**	**500**

Gross Capital Funding Total (including IFRS 16)		**57,270**	**56,770**	**500**
Less Donations and Grants Received	Less Donations And Grants Received	(7,799)	(7,799)	0
Less PFI Capital (IFRIC12)	Less PFI Capital (IFRIC 2)	(1,126)	(1,126)	0
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
Total Capital Departmental Expenditure Limit (CDEL)		**48,680**	**48,180**	**500**

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23/24 Programme Spend Overview

As of the end of May (M2), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £7.3m, against a planned spend of £10.1m, equating to a variance of £2.8m. This leaves £48.5m of non-IFRS 16 capital to deliver in the remainder of 23-24.

In month, excluding IFRS 16, the Trust delivered £5.3m against a planned spend of £5.3m.

in £000's	In Month			Year to Date		
	Last Forecast for this Month £000's	In Month Actual £000's	Variance to Last Month Forecast £000's	Plan £000's	Actual £000's	Variance to Plan £000's
DIGITAL	235	385	(150)	470	488	(18)
MEDICAL EQUIPMENT	89	35	54	178	35	143
ESTATES	1,671	2,132	(461)	3,823	3,135	688
Total Charge against Capital Allocation (excluding impact of IFRS 16)	**1,995**	**2,552**	**(557)**	**4,470**	**3,658**	**812**
RIGHT OF USE ASSET	36	0	36	36	0	36
Total Charge against Capital Allocation (including impact of IFRS 16)	**2,031**	**2,552**	**(521)**	**4,506**	**3,658**	**848**
NAT PROG: DIAGNOSTIC DIGITAL CAPABILITY PROGRAMME	74	17	57	147	(5)	152
NAT PROG: COMMUNITY DIAGNOSTIC CENTRES	711	377	334	1,421	411	1,010
NAT PROG: ELECTIVE RECOVERY/TARGETED INVESTMENT FUND	519	153	366	1,038	178	860
NAT PROG: RIGHT OF USE ASSET: NEW	0	0	0	0	0	0
STP PROGRAMME: GSSD	127	0	127	331	0	331
IFRIC 12	94	94	0	188	188	0
DONATIONS VIA CHARITABLE FUNDS	0	0	0	0	0	0
GRANT	1,757	2,102	(345)	2,434	2,872	(438)
Gross Capital Spend Total	**5,313**	**5,294**	**18**	**10,066**	**7,302**	**2,764**
Less Donations and Grants Received	(1,757)	(2,102)	345	(2,434)	(2,872)	438
Less PFI Capital (IFRIC12)	(94)	(94)	(0)	(188)	(188)	(0)
Plus PFI Capital On a UK GAAP Basis (eg. Res. Interest)	28	28	0	56	56	0
Total Capital Departmental Expenditure Limit (CDEL)	**3,490**	**3,126**	**364**	**7,500**	**4,298**	**3,202**
Excluding IFRS16	(36)	0	(36)	(36)	0	(36)
Gross Capital Spend Total (excluding IFRS 16)	**5,349**	**5,294**	**54**	**10,102**	**7,302**	**2,800**

The YTD £2.8m underspend versus plan was primarily driven by the following projects: CDC £1.0m, 5th Orthopaedic Theatre £0.9m, Fit for the Future (IGIS) £0.5m, GSSD £0.3m, and Backlog Theatres Refurbishment £0.3m, partially offset by a £0.4m overspend on Salix due to a revised milestone payment schedule.

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Recommendations

The Board is asked to:

- Note the Trust is reporting a deficit of £5.165m which is £0.747m adverse to plan.
- Note the Trust balance sheet position as of the end of May 2023.
- Note the Trust capital position as of the end of May 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: **July 2023**

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Report to Board of Directors			
Agenda item:	**11**	**Enclosure Number:**	**6**
Date	13 July 2023		
Title	Digital Transformation Report		
Author / Sponsoring Director / Presenter	Helen Ainsbury, Chief Digital & Information Officer (Interim) Sarah Hammond, Associate CIO - Head of Information		

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

Summary of Report

This report provides an overview of the Digital programme for the current financial year, delivered as part of the five-year Digital Strategy 2019-24. Projects are reported under the five programmes:

- Sunrise EPR
- Clinical Systems Optimisation
- Business Intelligence and TrakCare
- Infrastructure
- Cyber Security

Updates this month include:

- Vue PACS (radiology imaging)
- BadgerNet Maternity EPR
- Blood transfusion in TCLE and results into EPR

Risks or Concerns

None

Recommendation

The Board is asked to note the report

Enclosures

Digital Transformation Report

PUBLIC BOARD OF DIRECTORS – JULY 2023

DIGITAL TRANSFORMATION REPORT

1. Purpose of Report

This report provides an overview of the Digital programme for the current financial year, delivered as part of the five-year Digital Strategy 2019-24. This includes a high-level status summary and RAG rating for major programmes. Further detail on the 2023-24 plan for Sunrise EPR is provided in a separate report, as requested by the Digital Care Delivery Group.

2. Executive Summary

The work prioritised for 2023-24 is constrained by the available budget. An ambitious, but realistic programme has been developed to balance all aspects of digital enablement for the organisation. Ongoing consultation with clinical, strategy and divisional teams, as well as ICS Exec, ensures the Digital agenda remains on-track.

There are 63 projects planned for delivery during the year divided between the five programmes of work; they are:

- Sunrise EPR (13)
- Clinical Systems Optimisation (16)
- Business Intelligence (12)
- Infrastructure (15)
- Cyber Security (7)

System implementations planned for the first quarter include:

- Vue PACS (radiology imaging improvements) (May).
- BadgerNet Maternity EPR (June).
- OnBase ongoing expansion - external docs viewer in EPR (provides clinicians with access to documents from other systems through Sunrise).
- Blood transfusion laboratory workflow to TrakCare TCLE and results viewable in Sunrise (July).
- ePMA optimisation drops in EPR (May).
- Wi-Fi expansion and infrastructure improvements (ongoing).

3. Digital Transformation 2022-23 Highlights

3.1 Clinical Systems Optimisation

Radiology Vue PACS

The Trust went live with a replacement radiology imaging system on 16 May, replacing Philips IntelliSpace PACS with the new Philips Vue PACS. This included new infrastructure built and managed by Philips.

This has been in planning for two years and was required as the previous version was end of life and had three associated high risks on the risk register. The new PACS also enables us to surface images and reports through a tab in EPR, providing a more

seamless experience for clinicians in inpatient areas. All reporters in radiology department moved to PACS-based reporting, whilst other users would continue in CRIS.

Since the implementation there have been issues in a number of areas. There have been issues with performance and stability of the system. The majority of Trust users' access PACS images through Sunrise EPR, and this has presented a few problems. However, Radiologists and the Breast Centre team access in a different way and this has been where the more profound issues have been.

In the first few days the Philips infrastructure was unable to cope with demand from the number of concurrent users and, as a result, Philips doubled the capacity in the datacentre. There have been other issues which the Philips global team has been working on, and continues to do so. There have been significant issues in the Cheltenham Breast Screening Unit (BSU) and the team is currently working at 65% of their previous capacity. There are plans in place to strengthen the infrastructure.

BadgerNet Maternity EPR went live on 6 June, first in inpatient areas, before rolling-out to ante-natal clinics on 20 June. BadgerNet is a trusted system and the most commonly used Maternity EPR in England. It provides a clinical record to support maternity services, as well as providing a patient notes app for expectant parents to access. The implementation directly responds to the CQC requirement for a digital solution. The system interfaces with TrakCare, as well as some documentation being available to view in the Sunrise EPR external documents tab. The implementation was a success.

OnBase (External Documents viewer in EPR) continues to load phases of additional documents, to bring more and more information into one place for clinicians to access and provide them with immediate information to improve patient care.

3.2 Business Intelligence & TrakCare (PAS & TCLE)

The project to bring the blood transfusion laboratory workflow to TrakCare TCLE went live on 4 July. The legacy IPS system reached its end of life and transfusion medicine has now moved off IPS to TCLE as per all other laboratory disciplines. This means that:

- The processing of samples and workflow has moved to TCLE.
- All test results are displayed in Sunrise EPR and ICE for clinicians to view.
- Send-away results are attached as a PDF and authorised in TCLE for clinicians to view directly in Sunrise EPR.
- Send-away test results no longer require printing and sending by post to clinicians; hence will reduce the need for manual transcribing of results.
- Clinical users have a read-only view of Blood 360 within Sunrise EPR to allow them to check the availability and location of blood products, reducing the need to contact the laboratory for this purpose.

The requesting of transfusion medicine tests will remain on paper forms and the process for collection of patient samples remains unchanged.

Work on delivering the mandatory commissioning data set, community services data set, and expansion of our Business Intelligence and Clinical Data reporting work, will provide an increasingly rich source of data to inform performance management, quality improvements and focus on patient safety.

3.3 Infrastructure

An extensive programme of optimisation, maintenance and improvement is planned for 2023-24. Guest Wi-Fi will be extended to all internal and external areas for the convenience of patients and their families. On the wards, laptop carts (computers on wheels) are being upgraded, replacing the PCs with iGels to improve performance and access to Sunrise EPR.

We continue to work closely with the ICB on joint infrastructure projects, including the development of the Quayside Community Diagnostic Centre, which aims to provide a new facility for patients in Gloucester.

4. Cyber Security

4.1 Cyber Projects

A vital part of protecting patients and staff is centred on our work to improve our cyber security resilience. In addition to resolving risks generated by end-of-life operating systems, we are proactively working to implement a range of security tools, introduce multi-factor authentication and security information and event management. These will improve our ability to identify, defend and respond to potential cyber threats.

4.2 Cyber Risks

A detailed cyber security report is submitted to the Digital Care Delivery Group. It provides assurance on cyber security risks and actions across the Gloucestershire ICS. Work has commenced on aligning the ICS Cyber Security Strategy with the national Cyber Security Strategy for Health and Adult Social Care, published March 2023. The national strategy gives direction and focus for our local NHS organisations based on five cyber security strategy pillars and will help the ICS develop and align our own cyber strategy.

GHFT Digital Risk Register has seven high severity and three moderate risks relating to cyber. A review of the GHFT Digital risks is currently underway with an expectation that several of these risks will be merged to facilitate action planning, risk register management in preparation for GHFT move to Datix Cloud IQ and closer alignment to the Digital programme.

A face-to-face cyber exercise was conducted on 12 May 2023. The exercise aimed to understand, review and further develop Gloucestershire NHS ICS' response to a cyber incident and to provide delegates with a wider perspective of the combined or co-ordinated county-wide response to cyber incidents, thereby enabling them to be better prepared to carry out their own roles and responsibilities.

5. Information Governance

5.1 Data Security and Protection Toolkit (DSPT) Version 5 2022/23

The final status of the GHFT version 5 submission was submitted as 'Approaching Standards' as a result of the Trust not achieving the required standards for IG training, updating of out-of-date software and security assurance of medical devices on the network. While these standards were not achieved, considerable progress has been made on them and NHSE has accepted the Trust action plan to reach compliance.

5.2 Information Governance Incidents

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

One incident has been reported to the ICO during the 2023/2024 financial year reporting period to date. A total of 15 incidents having been reported in the previous year, 2022/2023.

29 confidentiality incidents have been reported on the Trust internal Datix incident reporting system during April 2023.

A summary of the incidents, together with a description of controls in place, are included in the Trust's annual report.

6. Conclusion

The Digital Transformation Programme continues to develop the Trust's digital maturity in line with its five-year strategy and journey to HIMSS Level 6. The Trust's ability to provide safe, consistent and high-quality care has been greatly enabled by delivery so far and is continuing at pace.

-Ends-

Report to Board of Directors			
Agenda item:	**11**	**Enclosure Number:**	**7**
Date	13 July 2023		
Title	Community Diagnostics Centre – Agreements for Lease		
Author /Sponsoring Director/Presenter	Terry Hull, Strategic Asset Services Director Ian Quinell, Interim Director of Strategy and Transformation		

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

Summary of Report

Purpose

To request authorisation for GMS to sign the Agreement for Lease (AfL) x 2 with Gloucestershire County Council for the Community Diagnostics Centre (CDC) project. There are separate AfL's for the internal and external areas.

The AfL includes the arrangements for both the construction works and the lease which will be signed upon completion of the development.

Project Outline

The Community Diagnostics Centre is an externally funded redevelopment of a GCC owned property. The proposed contracting route is to sign an Agreement for Lease (AfL) with GCC.

The CDC business case has been approved by GHNHSFT boards at various meetings throughout 2022 and was agreed for submission to NHSE by TLT, F&R Committee and Trust Board. Additionally, the business case was approved by the ICS as the strategic direction for diagnostics by both Strategic Executives and ICS Board. The business case was signed off by NHSE in September 2022 and the Letter of Agreement and Memorandum of Understanding has been received

Furthermore, a previous approval was agreed by GMS Board and Trust Finance and Resources Committee in March 23 for the advanced payment of £1,201k to GCC for works completed in 22/23 ahead of the AfL being completed, this being supported by a MOU and agreed Heads of Terms between the parties.

Previous Procurement Comments

The scope is for GCC to provide specific works requirements for a building owned and operated by them. This activity is associated with the lease agreement and any payment to GCC for this requirement is not part of the Public Procurement Regulations.

Finance

Construction costs for the internal and external areas is specified at £3.904m with a current capital project forecast outturn of £4.882m against a capital budgetary allowance of £5.772m within the funding envelope.

Revenue costs related to the AfL are £230,200 pa for internal and external rents and car parking allocation. Operational estates and facilities revenue costs are c. £322,000 pa.

CCG Programme lead Kerry O'Hara notes – '*All capital elements are covered by the programme but revenue remains a risk. The revenue for the programme is covered by tariff plus central costs for 23/24 and 24/25. To date PDC and depreciation have been funded separately. Clarity is being sought on arrangements beyond 24/25 and the risk has been agreed as a system risk and not an organisation risk to GHNHSFT at the ICS Board.'*

Management of risk will be through the CDC Programme Board, with reporting as part of Capital updates to GMS Board and Strategy and Transformation Committee.

Summary of DAC Beachcroft Review

1) There are two separate agreements, one for Quayside House and a second for the modular scanning unit;
2) Quayside House:
    a. AFL:
        i. The Landlord is to carry out the works;
        ii. On practical completion of the works the tenant pays to the landlord a fixed sum for the works;
        iii. On practical completion of the works the landlord grants the lease of the premises;
        iv. The target date, long stop date and rectification period in the draft AFL are currently blank but the AFL, once complete, will provide for termination if the works are not completed by a certain date.
    b. Lease:
        i. Term: 20 years from completion within the 1954 Act;
        ii. Annual Rent: £175,000;
        iii. Rent Reviews: every 5 years by reference to CPI (subject to a 7% per annum aggregate cap);
        iv. Break Dates: Every 5 years, tenant only on 12 months notice;
        v. Permitted Use: use as a community diagnostic centre, community based health and social care including ancillary offices;
        vi. Demise: Internal with a full repairing covenant, a service charge and the landlord insuring at the tenant's cost;
        vii. Other costs: all related rates and utilities;
        viii. Alienation: Assignment, underletting and sharing permitted with consent.
3) Modular Scanning Unit:
    a. AFL:
        i. The AFL will be based on the Quayside House AFL but will include a planning condition for the landlord to obtain planning for the works.
    b. Lease:
        i. Term: 20 years from completion within the 1954 Act;
        ii. Annual Rent: £25,800;

iii. Rent Reviews: every 5 years by reference to CPI (subject to a 7% per annum aggregate cap); iv. Break Dates: Every 5 years, tenant only on 12 months notice; v. Permitted Use: use as a modular community diagnostic centre for community based health and social care including ancillary offices; vi. Demise: ground lease subject to repair covenant – insurance position to be confirmed; vii. Other costs: all related rates and utilities; viii. Alienation: Assignment, underletting and sharing permitted with consent. GMS Board (27/06/23) and Trust Finance and Resources Committee (29/06/23) have reviewed and approved this paper.
Recommendation
The Board is asked to: • Give approval for GMS to sign the 2Nr. Agreement for Leases. • Give approval for GMS to raise the Purchase Orders for both capital and revenue elements as identified in the report.
Enclosures
• None

Report to Board of Directors			
Agenda item:	**11**	**Enclosure Number:**	**8**
Date	13 July 2023		
Title	Energy Performance Contract		
Author /Sponsoring Director/Presenter	Terry Hull, Strategic Asset Services Director Ian Quinell, Interim Director of Strategy and Transformation		

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

Summary of Report

Following the formation of GMS, the Trust novated the original Energy Performance Contract (EPC) with Vital Energi to GMS as part of GMS being able to provide a full Managed Services Contract for energy supply to the Trust. This contract expires 2033.

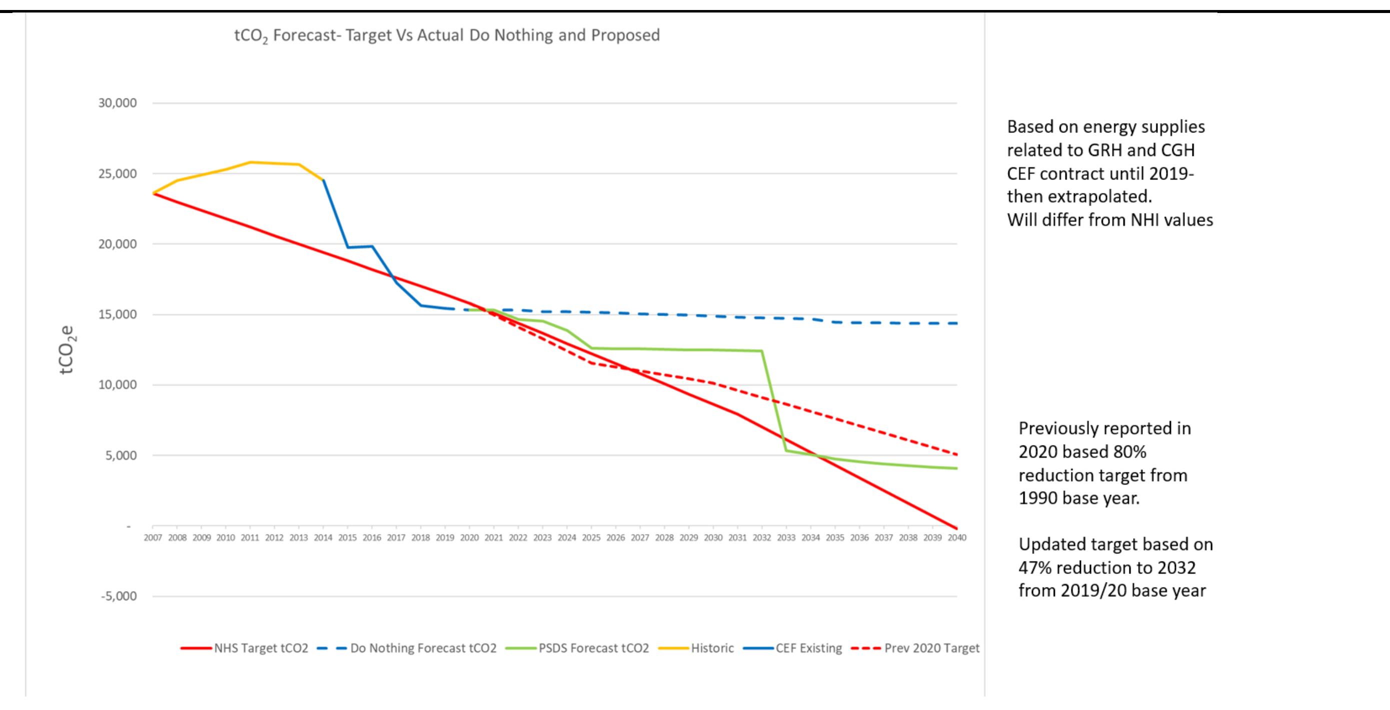
An Energy Performance Contract is designed to allow a 3rd party to design, install, operate, maintain and if needed fund a series of sustainability measures providing a guaranteed saving from the original energy expenditure baseline.

This original contract has successfully installed a Combined Heat and Power engine on each site funded through the EPC agreement and implemented the majority of the additional measures funded through the Public Sector Decarbonisation Scheme phase 1 (PSDS1) successfully reducing the Trust's carbon footprint and reducing the overall Trust energy expenditure below the original baseline.

It is no longer possible to instruct additional variations to this original contract due to procurement regulations therefore we are unable to deliver the works identified as part of the funding successfully obtained under PSDS 3a (c. £10.96m)

Accordingly, GMS have procured a second EPC contract. This was tendered with Procurement's support and both GMS and the Trust approved the granting of a Preferred Bidder letter to Vital Energi to commence the works whilst the contract was being drafted.

This second EPC contract has been drafted not only to support the delivery of the current PSDS 3a phase of works but to allow for future decarbonisation projects to be appointed to Vital Energi as a variation up to 2040 in support of the NHS and GHFT pledge to achieve net carbon zero by that date. This is however at the explicit discretion for GMS / Trust and there is no obligation to appoint Vital Energi to any further works.



The PSDS3a works proposed as the first tranche under this agreement is for:

- The use of the grant award of £10.964m plus £1.2m of Trust internal capital funds (agree within 24/25 capital plan) to undertake the façade improvements including renewing of windows to the Tower Block, installation of an Air Source Heat Pump to the GRH site, introduction of improved zonal heating control and replacement of a number of steam traps across the GRH site.
- The works are forecast to save c. 1,366 tCO2e pa and have revenue benefit of c. £50k - £100k pa against a 2023 baseline
- The works will also reduce the Trust backlog liability by £1.2m. These relate to the condition of the existing Tower Block windows (risk GMS2030Est L1 C4 R4) and addressing the backlog condition of the roof over Fosters restaurant an nearby areas.

<u>Previous Procurement Comments</u>

GMS and Trust Board approved the placement of the Preferred Bidder letter with Vital Energi in November 2022 to allow the design works to be finalised and the construction works to commence. Procurement's comments at that time were:

Vital Energi have been selected off the Carbon Energy Fund (CEF) Framework. This selection was via a further competition exercise lead by CEF, with Vital Energi being the only bidder.

CEF ran the procurement process for GMS and Procurement supported GMS with this. The CEF framework is fully compliant with the Public Procurement Regulations and the further competition process that CEF have undertaken for GMS, is also in line with these regulations.

An initial draft contract was developed between the parties last year and the new contract will be based on this original draft.

As the route to market is compliant, we do not perceive any risk in making the award to Vital Energy, however we

do note that it will advantages for all parties to agree the final contract terms at the soonest opportunity.

Summary of DAC Beachcroft Review of EPC2 Contract

The contracts have been negotiated and agreed between Vital Energi, the Carbon Energy Fund and GMS including the legal involvement of DAC Beachcroft on behalf of GMS.

> *Appropriateness of contract*
>
> *3.5. Subject to any specific comments in this report we can confirm that our legal review of the proposed Project Agreement indicates that it is in a form that is now quite widely in use across the NHS, and subject to resolution of the outstanding issues to the satisfaction of GMS, should be acceptable for GMS to approve in relation to this Project. As noted above, GMS will need to satisfy itself on the technical aspects of the Project Agreement and the commercial numbers.*

To note, Trust Board is required to approve the form of words included in enclosure 3 'Trust board minutes approving the entry into the Project Agreement and the Trust PCG'.

Additionally, to note that Trust Board will need to approve a Parent Company Guarantee for the project.

GMS Board (26/06/23) and Trust Finance and Resources Committee (28/06/23) have reviewed and approved this paper.

GMS Board have reviewed the resourcing requirements inherent in signing this contract and are satisfied that they are able to adequately resource the contract. This is aided by the contract being managerially an extension the existing EPC contract and with the involvement of CEF in the process.

Recommendation

- This paper is provided to seek support and approval from the Board of Directors to the proposal for GMS sign the Energy Performance Contract 2 with Vital Energi
- Permission is also requested for GMS to raise the requisite purchase orders with Vital Energi in fulfilment of the contract works.

Enclosures

Provided in the Board reading pack for information:

- DAC Beachcroft Summary of Contract
- Trust Parent Company Guarantee to Vital
- Trust Board minute approving the entry into Project Agreement and the Trust PCG
- GMS Board minutes approving the Project
- Vital Holdings Limited PCG to GMS
- CEF Business Case Executive Summary

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 28 June 2023		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
None.		
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	Key points were noted: • Badgernet had been implemented for maternity services and had received positive feedback from staff users. • Maternity services governance review was underway. • An increase in Healthcare Safety Investigation Branch (HSIB) cases had been reported, with work underway to understand the reasons behind this. • Maternity staffing issues remained a concern. • Elective care was stable, despite industrial action challenges. • Diagnostics remained stable, with a recovery plan in place for cardiology. • Cancer performance continued to be good, with two-week wait delivery and faster diagnosis in its sixth month. • The Committee received an Elective Care 2023/24 Report which set out six key priorities from NHSE; work was underway to implement these, however there were some challenges on reducing health inequalities. • Improvement in urgent and emergency care standards were noted and boarding had now ceased, however there some areas continued to be used for purposes they were not designated for. The impact of Newton work not expected in the short term.	Vacancy rates within maternity was a key challenge, however ongoing recruitment and engagement plans were expected to make significant improvements from September. A monthly report on Elective Care priorities would be developed to provide assurance on evidence-based indicators. A case note review of 50 patients would be undertaken to review non-designated area data and the operational impact the process had; the Committee would receive the output.
Water Safety Briefing	A briefing was received by the Committee, noting the current theory of the root cause.	Executive lead asked to do further work on developing a clear narrative which provided assurance. An action plan had been developed and was being progressed, with regular robust monitoring. Confidence was expressed by the executive that the plan was on track. The Committee would receive further updates and more detailed quarterly Infection Prevention and Control reports for assurance.
Virtual Wards	The report outlined the Virtual Ward Programme approach to implementing technology-enabled pathways for Gloucestershire, including key activities and milestones to implement the first pathway with the Trust. The work would enable greater flow, avoiding admissions, reducing length of stay, readmission and attendance at Emergency Departments.	Some concern was raised over the ambition to increase virtual patients from 133 to 223 within one month however expectations had been clear and assurance was provided on the robust plans in place. Governance arrangements were noted and a progress update would be received at a future Committee meeting.
Serious Incidents Report	No further Never Events had been reported. Seven serious incidents had been reported. There had been three HSIB	The Committee noted that a permanent budget increase had enabled a temporary investigation

	reports, which were under review. A review of themed incidents was being undertaken.	post to be established.
PACS Go Live Update	A briefing report was received into the migration of PACS and assurance provided on the monitoring of impact to patients. Some challenges had been experienced but had been mitigated and were under control.	An update would be received in three months.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Quality Account 2022/23	Delegation for final approval and sign off had been given to the Committee.	The Committee approved the final Quality Account 2022/23.
Industrial action planning update	There was clear and well-established action planning in place.	Assurance of plans in place, although concern about potential impact for patients and staff during the 10-day period.
Regulatory Report	The process for reporting was clear, and provided assurance on the plans in place.	None.
Trust Risk Register	The Committee was assured by the process for reporting risks.	None.
Items not Rated		
System feedback		
Impact on Board Assurance Framework (BAF)		

SR1 Urgent and Emergency Care: Reflection of Newton work to be included, and ensure target risk scores were appropriately realistic. Recent improvements in urgent and emergency care, winter planning, and industrial action would be reflected.
SR2 Quality governance framework: the new CQC framework would be reflected, with progression monitored against the report from the last visit.

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

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Public Board of Directors Meeting 09.30, Thursday 13 July 2023 Bluecoat Room, Gloucester Guildhall AGENDA				
Ref	**Item**	**Purpose**	**Report type**	**Time**
1	**Chair's Welcome and Introduction**			09.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 11 May 2023**	Approval	Enc 1	09.35
5	**Matters arising from Board meeting held on 11 May 2023**	Assurance		
6	**Patient Story** *Katherine Holland, Patient Experience Manager*	Information	Presentation	09.40
7	**Chief Executive's Briefing** *Mark Pietroni, Deputy Chief Executive/Medical Director and Director of Safety*	Information	Enc 2	10.00
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	10.15
9	**Trust Risk Register** *Mark Pietroni, Deputy Chief Executive/Medical Director and Director of Safety*	Assurance	Enc 4	10.25
10	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director*	Assurance	Enc 5	10.35
11	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director, Karen Johnson, Director of Finance* • **Community Diagnostic Centre Lease Agreement** • **Energy Performance Contract**	Assurance Approval Approval	Enc 6 Enc 7 Enc 8	10.50
Break (11.15-11.25)				
12	**Quality and Performance Committee Report** *Alison Moon, Non-Executive Director, Matt Holdaway, Chief Nurse and Director of Quality, and David Coyle, Interim Chief Operating Officer*	Assurance	Enc 9	11.25
13	**Maternity Report** *Matt Holdaway, Chief Nurse and Director of Quality*	Assurance	Enc 10	11.55
14	**Annual Guardian of Safe Working Hours Report** *Mark Pietroni, Deputy Chief Executive/Medical Director and Director of Safety*	Assurance	Enc 11	12.05
15	**Annual Medical Appraisal and Revalidation Report** *Elinor Beattie, Emergency Medicine Consultant*	Assurance	Enc 12	12.15
16	**Audit and Assurance Committee Report** *Claire Feehily, Non-Executive Director*	Assurance	Enc 13	12.25
17	**NHS Provider Licence Self-Certification** *Kat Cleverley, Trust Secretary*	Approval	Enc 14	12.35
18	**CQC Statement of Purpose** *Kat Cleverley, Trust Secretary*	Approval	Enc 15	12.40
19	**Trust Seal Report** *Kat Cleverley, Trust Secretary*	Approval	Enc 16	12.45
20	**Any other business**		None	12.50
21	**Governor Observations**			
Close by 13.00				

Erratum - On page 130 of the July 2023 Board Papers it includes reference to a maternal death for May 2023. This is an error and the report should have shown no maternal deaths.

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 24 May 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**
Quality and Performance Report	The Committee was advised that an internal audit review on the Discharge Lounge had been received at Audit and Assurance Committee, with Limited Assurance ratings for both Design Opinion and Design Effectiveness.	Actions against the recommendations were agreed and reassurance provided that improvements had been put in place. Action plan implementation would be overseen by Audit and Assurance Committee.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	Key points were noted: • A deep dive review into maternity governance was due to take place in June. Increased leadership roles within the maternity service were anticipated to make a positive impact. • A recent increase in C.diff infections was being closely monitored, but was not considered to be an outbreak. • There had been a reduction in the number of pressure ulcers. • Cancer performance remained good, with the Trust delivering against the 62-day standard which was expected to be achieved in June. • The Trust remained committed to end boarding, with teams working hard to discharge high numbers of patients; there had been a significant decline in boarded patients towards the end of April, which was continuing throughout May.	The Quality Summit planned to take place in April was now taking place on 25 May to discuss plans to end boarding with colleagues.
Trust Risk Register	One new quality and performance risk was added to the Trust Risk Register, related to water safety. This remained a key concern across both hospital sites.	Water Safety meetings had been increased in frequency, with robust oversight and management. The group continued to support GMS to ensure the resource was available to manage the issue appropriately.
Serious Incidents Report	No further Never Events had been reported. Two Serious Incidents were reported. There had been no further Healthcare Safety Investigation Branch (HSIB) reports. There was continued oversight of all serious incidents, complaints and PHSO activity, and action and learning by the Safety and Experience Review Group.	The investigation team continued to feel pressured, with multiple delays and extensions in place to process within deadlines. Resource for the team continued to be monitored.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Regulatory Report	Reports from the recent CQC visits to surgery and maternity services were expected imminently. An action plan related to BBraun activity would be discussed at Quality Delivery Group, with assurance to Committee next month.	None.
Items not Rated		
System feedback		
Impact on Board Assurance Framework (BAF)		
SR1 Urgent and Emergency Care: Reflection of Newton work to be included, and ensure target risk scores were appropriately realistic.		

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period May 2023

Executive Summary

The Trust continued to make progress in May in spite of the Industrial action and three Bank holidays made progress in a number of areas:

ELECTIVE CARE
The Trust ACHIEVED ZERO 78Week and ZERO 104 week breaches in May. RTT performance has remained stable in-month. The part validated position for May is 68.3% compared to last months finalised position of 68.4%. Validation will continue until the submission until submission on the 19th. Performance remains above the national average of approx. 58%. Total incompletes are likely to increase again in month and is estimated to be around 75,000, compared to 74,058 last month. Patients waiting over 52 weeks continues to increase, which was anticipated due to 3 bank holidays, and is estimated to be just below of 2,500 (compared to 2,194 at the end of April). Teams are planning to minimise the impact of BMA IA (14th to 17th June) There are 17 (78wk breach) risks for June (@6/6/23) of which 5 are considered to be high risk and services are continuing to take steps to expedite and mitigate. There are currently 71 risks for July, and given the high volume of patients waiting 52 weeks further pressures are anticipated in Q3 and 4.

DIAGNOSTICS
DM01 performance for May has deteriorated in month, with a final submission of 14.4% breaches. Although the total waiting list remains largely unchanged, the number of breaches has increased by 455. The key contributor to this increase being Echo's, moving from 133 breaches in April to 361 in May. Steps have already been taken to recover this position with urgency. Other notable increases were seen in Neurophysiology (+46) and Colonoscopy (+86). This deterioration was caused primarily by the loss of capacity caused by Bank holidays and 2ww demand, and staff sickness.

URGENT & EMERGENCY CARE
Increase in ED attendances of 10% compared with April; Second successive month where four-hour performance has been maintained at > 60%. 12 hour performance was maintained at ~ 86% in May – expected to improve from June/July onwards when specialty referral process is introduced. There has continued to be a reduction in hours lost to ambulance handovers delays. SDEC attendances increased to 1,129 in the month, of these, 65% were direct attendances and 35% via ED 10% of these attendances resulted in an admission. In CADU, 52% of attendances came via ED; 40% of these came direct via GPAU/Cinapsis, of those attendances 29% were discharged home without admission.

CANCER PERFORMANCE
Overall delivery of 4 against the 10 national operational standards
The Trust MET the 2WW Standard with performance of 96.3% in May; Whilst not meeting the standard, LGI has shown improvements over the last 4 reported months and these improvements are forecasted to continue. The Trust MET the 2WW standard for breast symptomatic with performance of 99%. The Trust RECOVERED 28d FDS standard in May with a performance of 80% 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 May with data showing performance of 88.8%. The Trust DID NOT meet the 62d Standard at 60.5% for May while we continue to work to reduce and clear our backlog, treating our longest waiting patients. Daily validation of future 62-day breaches is now firmly in place within Cancer Services; The Trust back-log is continually reducing with an end of May reportable position of 178, and steps have been taken to minimise 'tip ins' Of the GHFT backlog, Colorectal and Urology due to complex pathways and diagnostic capacity. Cancer services are working closely with these specialties to support recovery of performance.

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Demand and Activity

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

	May-22	Jun-22	Jul-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
All electives (including day cases)	5,822	5,625	5,671	6,198	6,257	6,196	6,236	5,097	5,928	5,778	6,547	5,084	6,134
Day cases	4,736	4,626	4,710	5,235	5,214	5,178	5,317	4,284	5,129	4,932	5,648	4,346	5,236
ED attendances	12,551	12,092	12,596	11,915	11,888	12,630	12,290	12,726	10,947	10,706	12,511	11,616	12,990
FUP outpatient attendances	37,857	34,602	33,716	35,379	35,532	35,706	38,420	30,884	37,443	33,641	38,545	30,849	34,779
GP referrals	10,653	10,346	10,201	10,997	10,510	10,825	10,739	8,569	10,475	9,771	11,901	9,333	10,594
New outpatient attendances	17,536	16,403	16,451	17,042	17,376	16,892	19,160	15,008	18,295	16,877	18,768	14,811	17,163
Non elective (Incl. Assessment)	5,419	5,240	5,266	5,158	5,221	5,656	5,664	5,282	5,238	5,013	5,598	5,103	5,344
Outpatient attendances	55,393	51,005	50,167	52,421	52,908	52,598	57,580	45,892	55,738	50,518	57,313	45,660	51,942

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Guidance

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

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Access Dashboard

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%	May-23	96.0%
	Cancer - 28 day FDS (all routes)	≥ 75.0%	May-23	80.8%
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%	May-23	89.7%
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%	May-23	99.3%
	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	≥ 94.0%	May-23	95.8%
	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	≥ 94.0%	May-23	75.6%
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%	May-23	72.9%
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%	May-23	70.7%
	Cancer - 62 day referral to treatment (urgent GP referral)	≥ 85.0%	May-23	62.6%
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%	May-23	96.3%
	Number of patients waiting over 104 days with a TCI date	No Target	May-23	16
	Number of patients waiting over 104 days without a TCI date	No Target	May-23	27
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%	Apr-23	9.20%
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600	May-23	1,062
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%	May-23	96.0%
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%	May-23	21.71%
	% of ambulance handovers < 15 minutes	No Target	May-23	29.78%
	% of ambulance handovers < 30 minutes	No Target	May-23	57.35%
	% of ambulance handovers over 60 minutes	≤ 1.00%	May-23	24.84%
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%	May-23	45.2%

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation	
Emergency Department	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%	May-23	38.9%
	ED: % total time in department - under 4 hours (type 1)	≥ 95.00%	May-23	61.22%
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0	May-23	1,107
	Number of ambulance handovers 30-60 minutes	↓ Lower	May-23	707
	Number of ambulance handovers over 60 minutes	= 0	May-23	809
Maternity	% of women booked by 12 weeks gestation	> 90.0%	May-23	89.7%
Operational Efficiency	% day cases of all electives	> 80.00%	May-23	85.36%
	Average length of stay (spell)	≤ 5.06	May-23	6.96
	Cancelled operations re-admitted within 28 days	No Target	May-23	57.14%
	Intra-session theatre utilisation rate	> 85.00%	May-23	88.48%
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40	May-23	3.16
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65	May-23	7.84
	Number of patients stable for discharge	≤ 70	May-23	182
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380	May-23	577
	Urgent cancelled operations	↓ Lower	May-23	0
Outpatient	Did not attend (DNA) rates	≤ 7.60%	May-23	6.27%
	Outpatient new to follow up ratio's	≤ 1.90	May-23	1.89
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%	Apr-23	8.94%
Research	Research accruals	No Target	Feb-23	141
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower	May-23	93

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Access Dashboard

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		May-23	9,496	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target		May-23	4,817	
	Referral to treatment ongoing pathways over 52 weeks (number)	= 0	F	May-23	2,496	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%	F	May-23	68.60%	L
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	No Target		May-23	70.00%	H
	% patients receiving a swallow screen within 4 hours of arrival	No Target		May-23	76.10%	
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target		May-23	74.6%	
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%	?	Dec-22	92.7%	H
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	≥ 65.00%	?	May-23	20.00%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%	P	May-23	100.0%	

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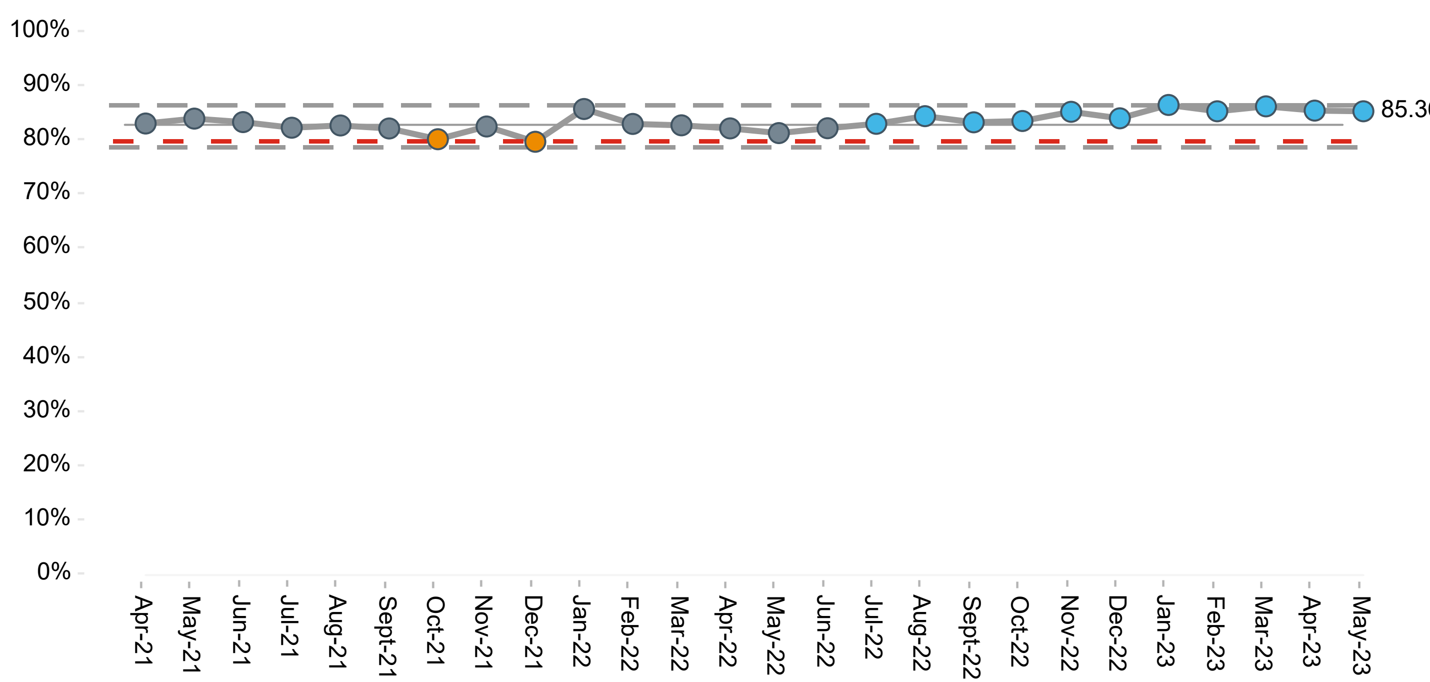
Access

SPC - Special Cause Variation

[487] % day cases of all electives

Target: > 80.00%



Data Observations

[2] SHIFT

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

[4] 2 OF 3

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

Commentary

Daycase rate of 79.2% has been achieved for April 2023.
Divisional Director - Surgery

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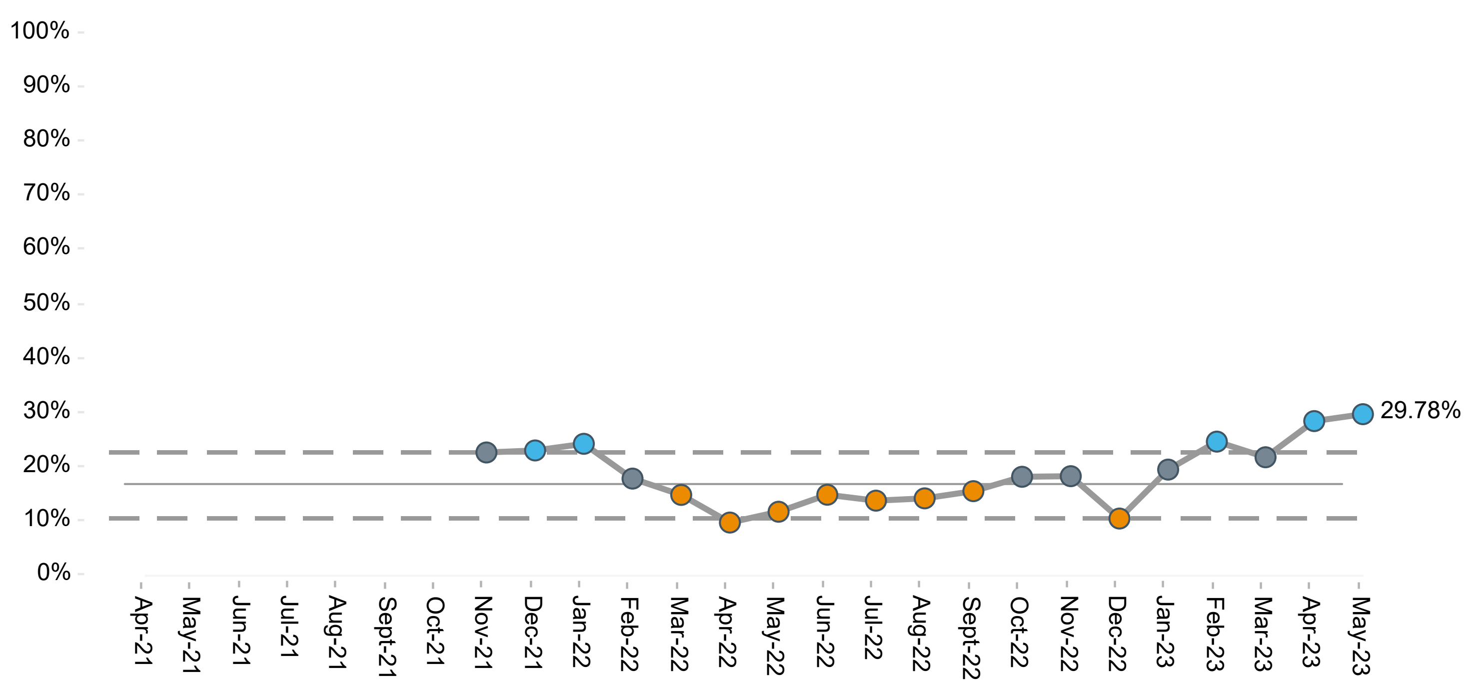
Access

SPC - Special Cause Variation

[594] % of ambulance handovers < 15 minutes

Target: No Target



Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

Commentary

Overall level of ambulance handover delays has improved between April and May.

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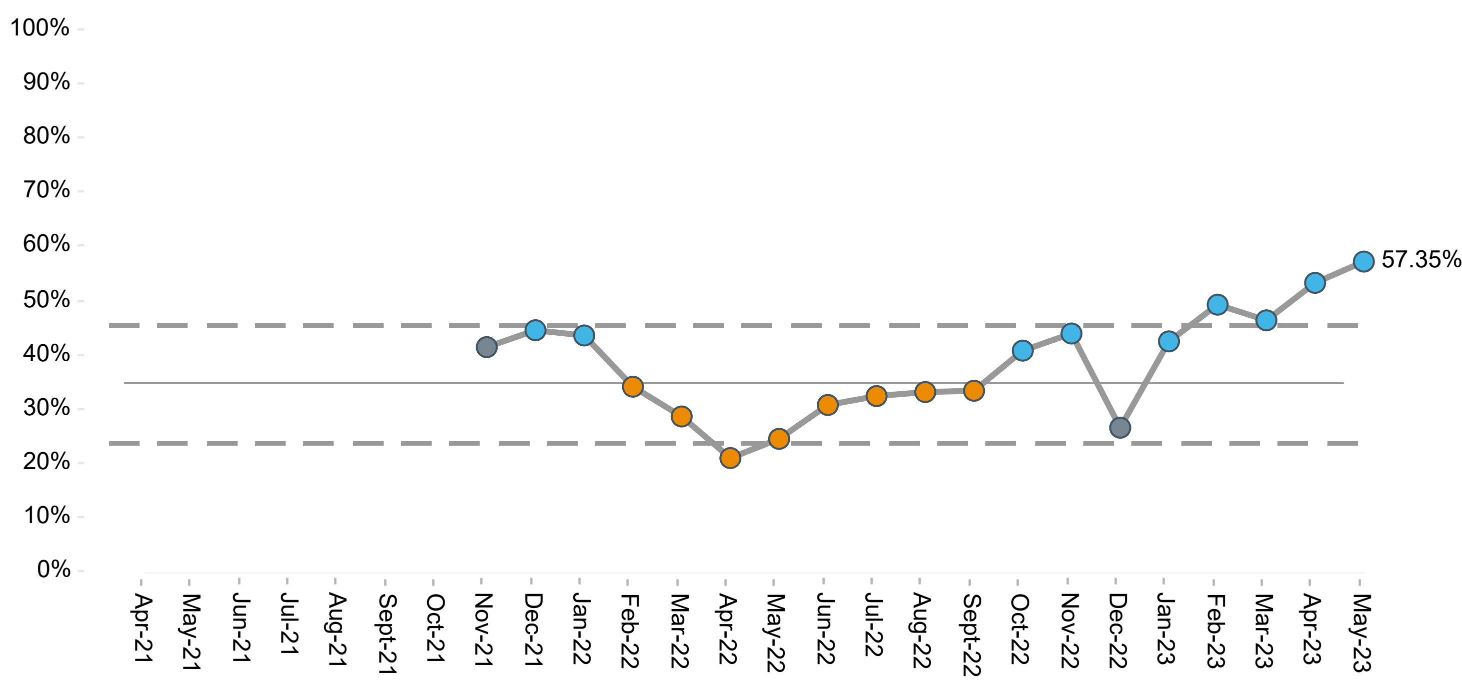
Access

SPC - Special Cause Variation

[595] % of ambulance handovers < 30 minutes

Target: No Target



Commentary

Overall level of ambulance handovers has fallen in May.

Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

[3] RUN

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

[4] 2 OF 3

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

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SPC - Special Cause Variation

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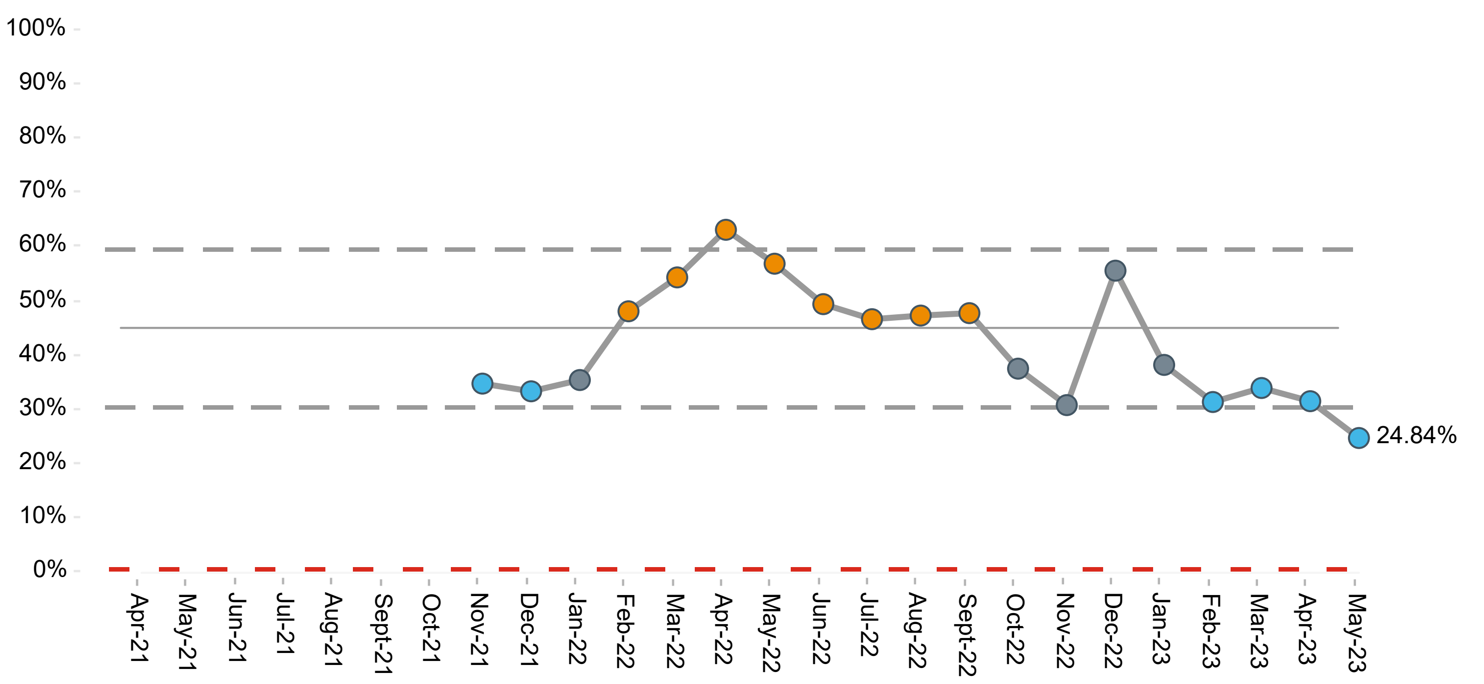
Gloucestershire Hospitals
NHS Foundation Trust

[482] % of ambulance handovers over 60 minutes

Target: ≤ 1.00%



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.

[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 number of patients experiencing an ambulance handover delay of more than one hour has fallen to 819 in May (from 957 in April). This outweighs the increase in ambulance handover delays of 30 - 60 minutes, and reflects the fact that the total level of ambulance handovers has fallen in May.

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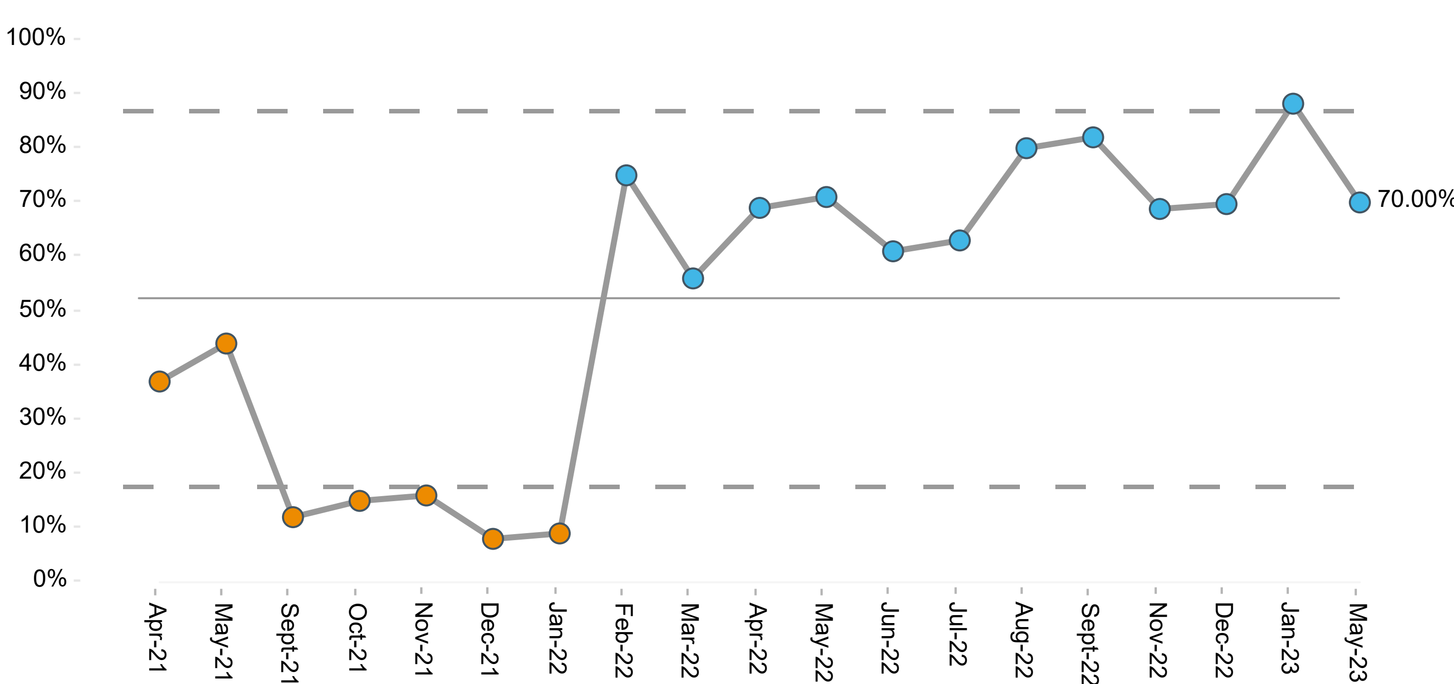
SPC - Special Cause Variation

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

- - - Target: No Target



Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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[4] 2 OF 3

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Commentary

General Manager - COTE, Neuro and Stroke

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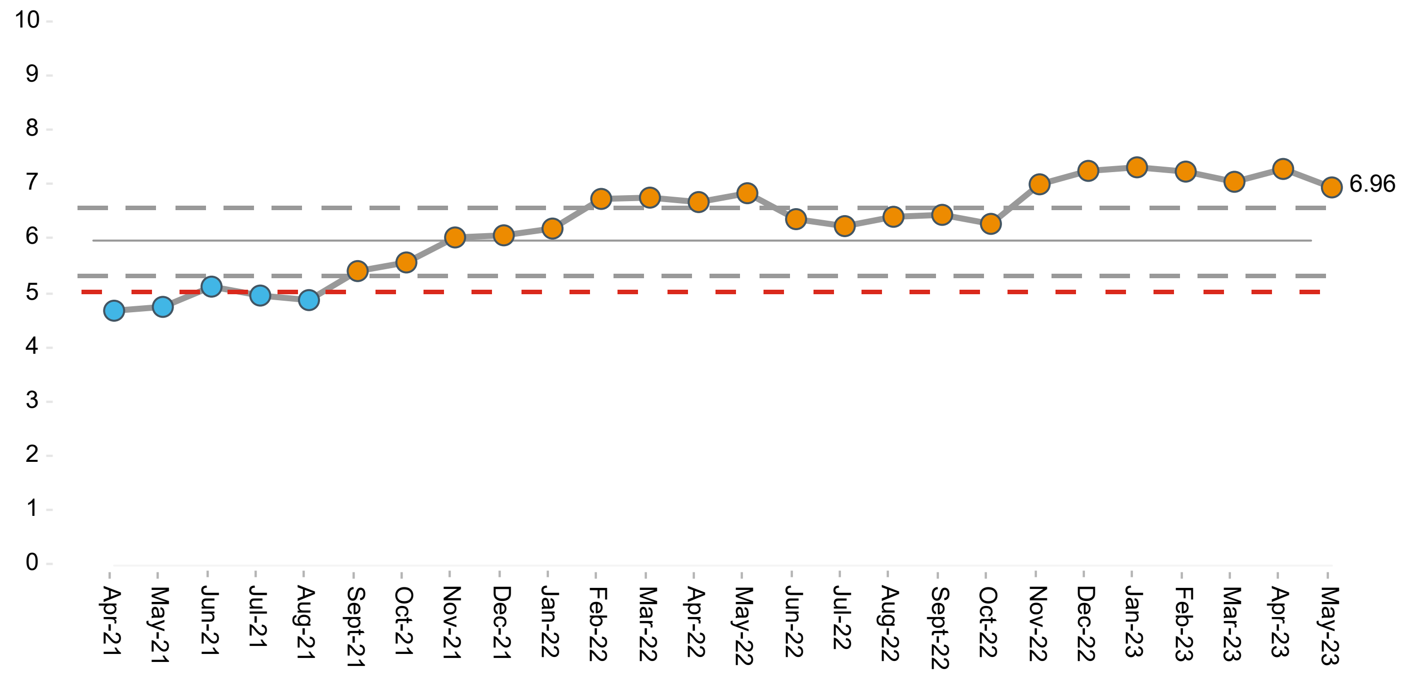
SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[188] Average length of stay (spell)

Target: ≤ 5.06



Commentary

Average LOS has spiked slightly in month. Now at 7.33 days. With the reduction in nCTR and length of delay in transfer of care, this indicates this is more related to acuity or internal decision making around emergency admissions. This is supported with the trends in 189 & 190.

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

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[4] 2 OF 3

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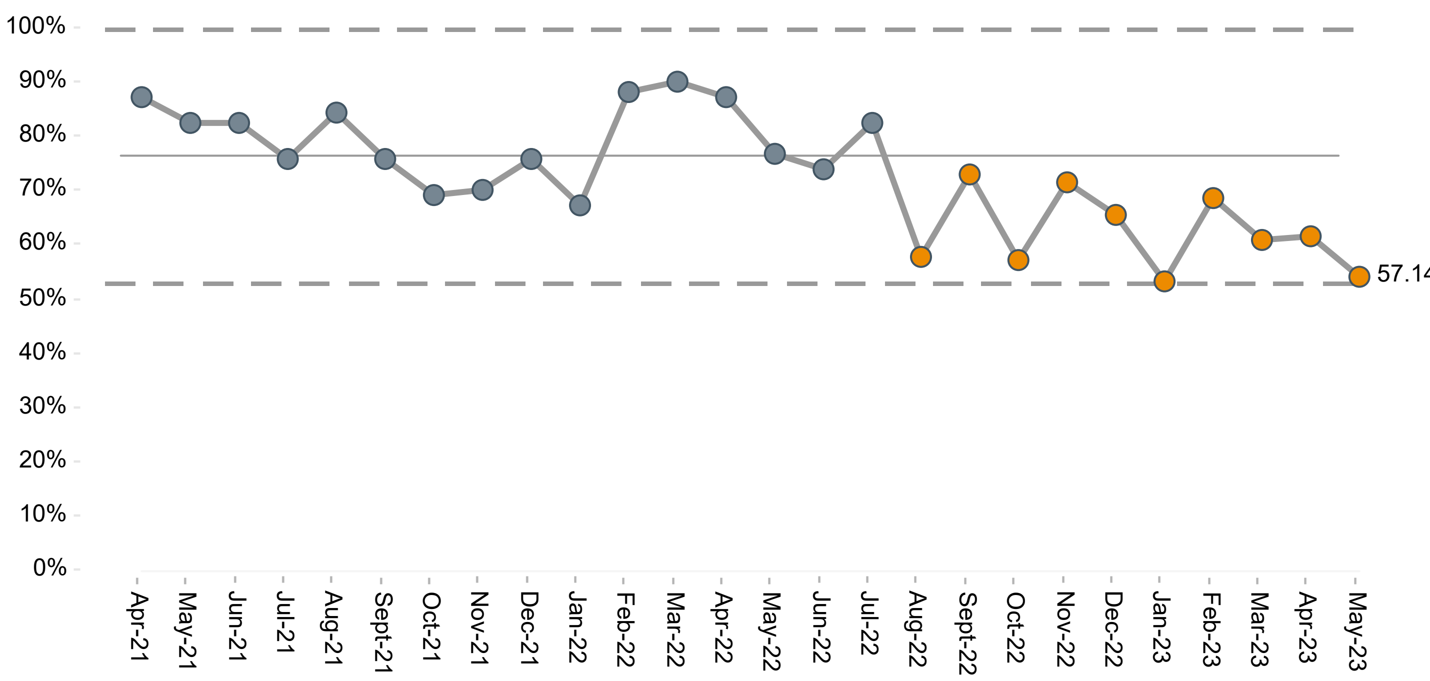
SPC - Special Cause Variation

[180] Cancelled operations re-admitted within 28 days

Target: No Target



Data Observations

[2] SHIFT

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

[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

In April there was a total of 15 patients cancelled on the day that could not be rescheduled within 28 days, which is comparable to last month. T&O accounted for approx. 50% of these, with the main reasons being trauma cases; theatre over-run; capacity and sickness.
Associate Director of Elective Care

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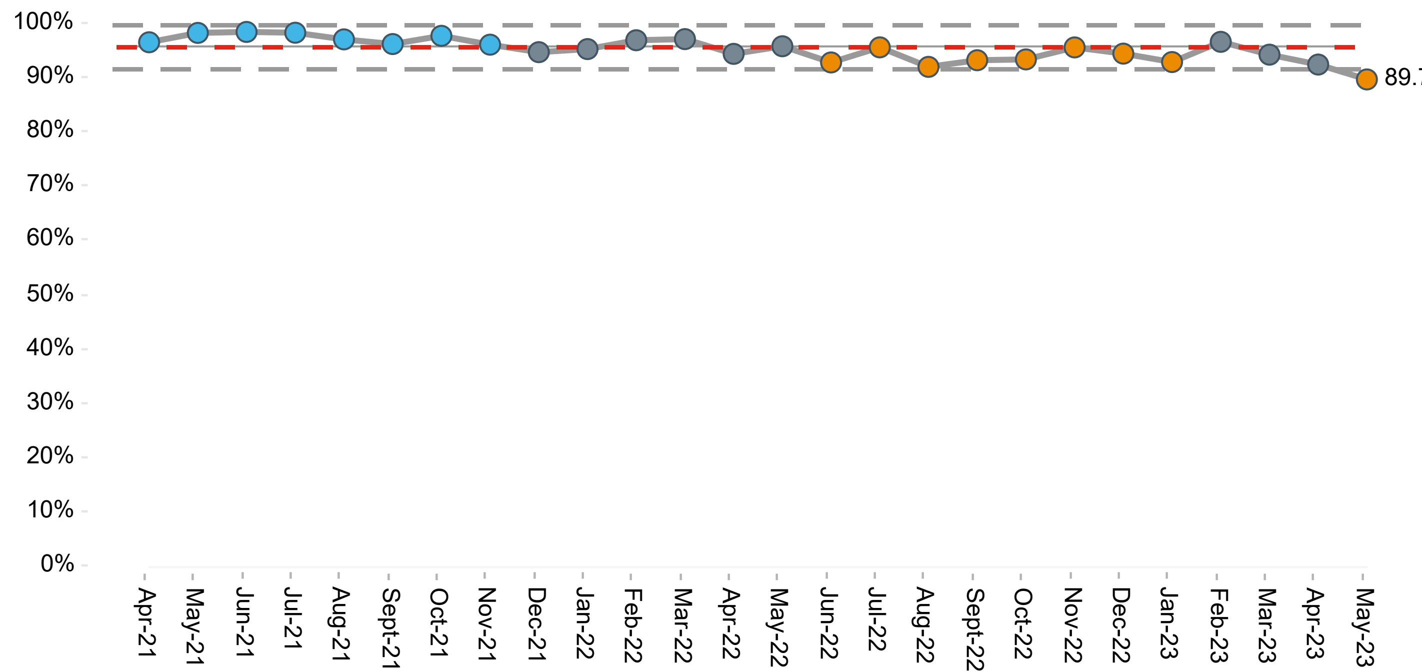
SPC - Special Cause Variation

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

Target: ≥ 96.0%



Data Observations

[1] SINGLE POINT

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Commentary

Divisional Director of Operations

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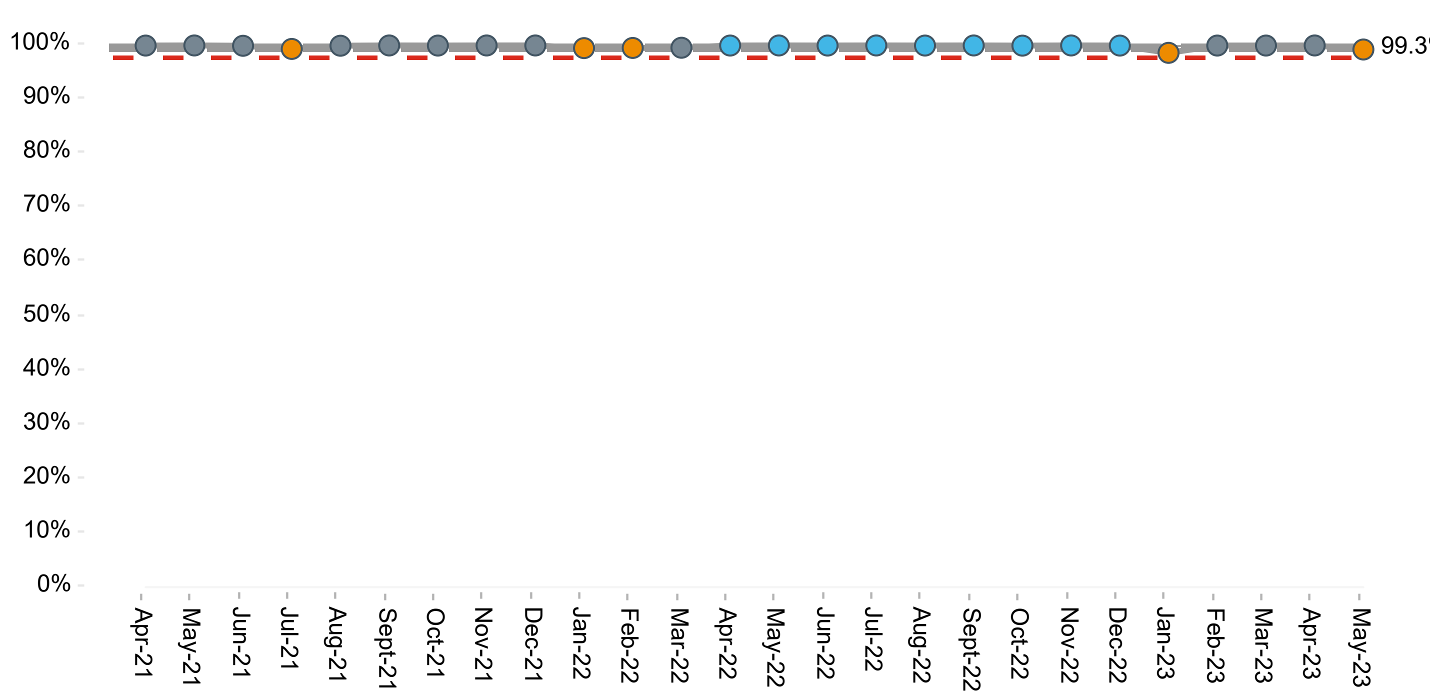
SPC - Special Cause Variation

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

Target: ≥ 98.0%



Data Observations

[1] SINGLE POINT

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Commentary

Divisional Director of Operations

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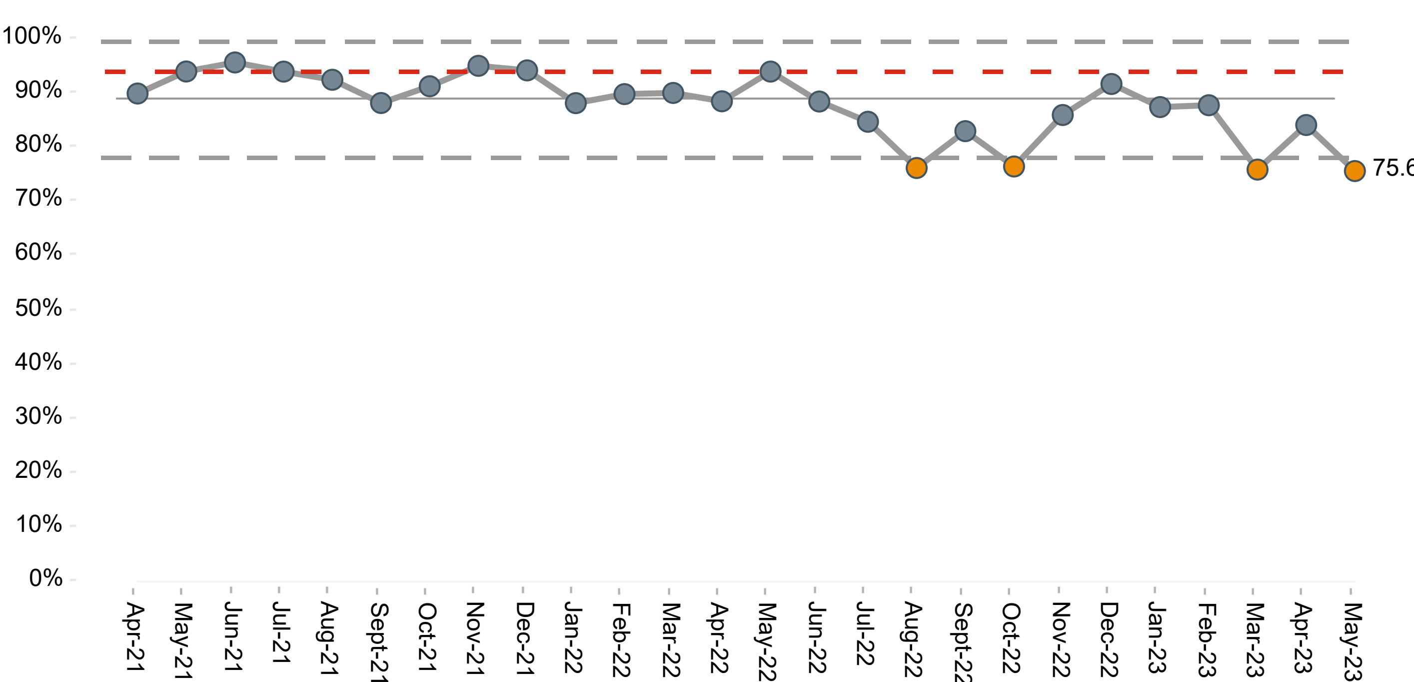
SPC - Special Cause Variation

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

Target: ≥ 94.0%



Data Observations

[1] SINGLE POINT

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

Commentary

Divisional Director of Operations

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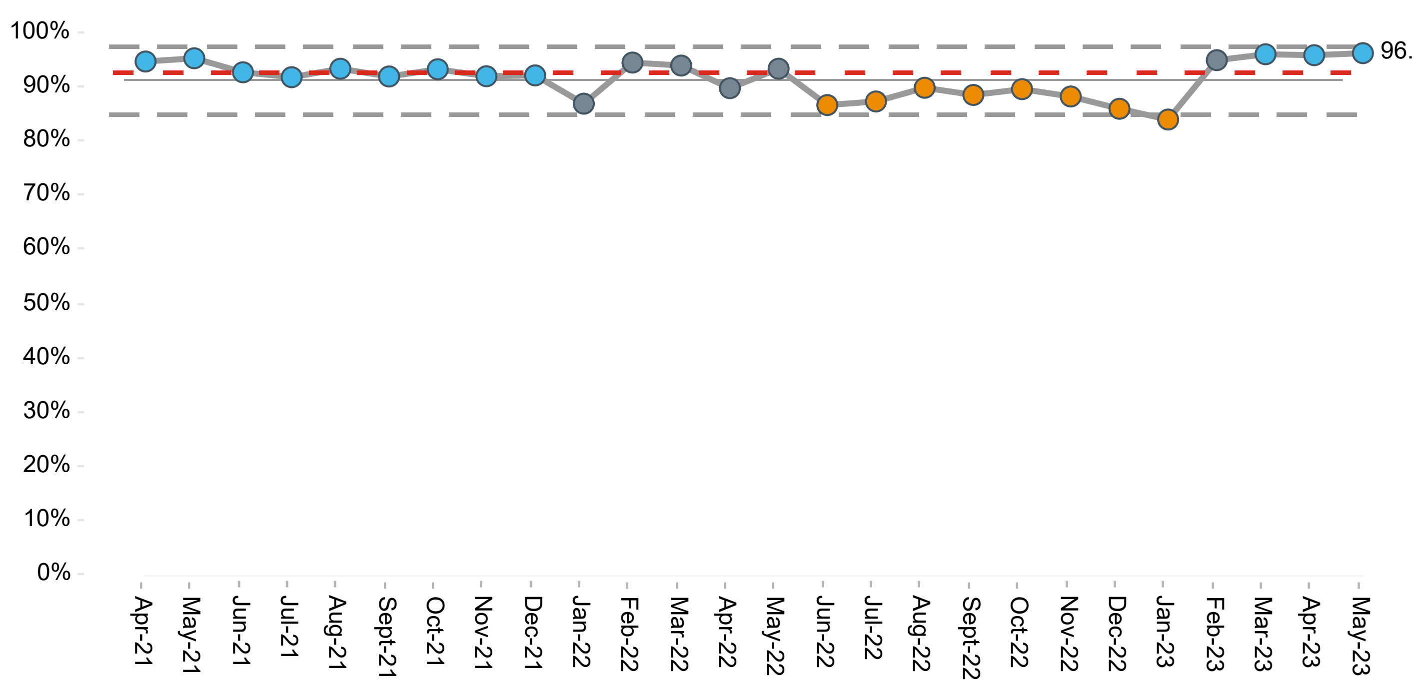
SPC - Special Cause Variation

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

Target: ≥ 93.0%



Data Observations

[1] SINGLE POINT

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Commentary

Divisional Director of Operations

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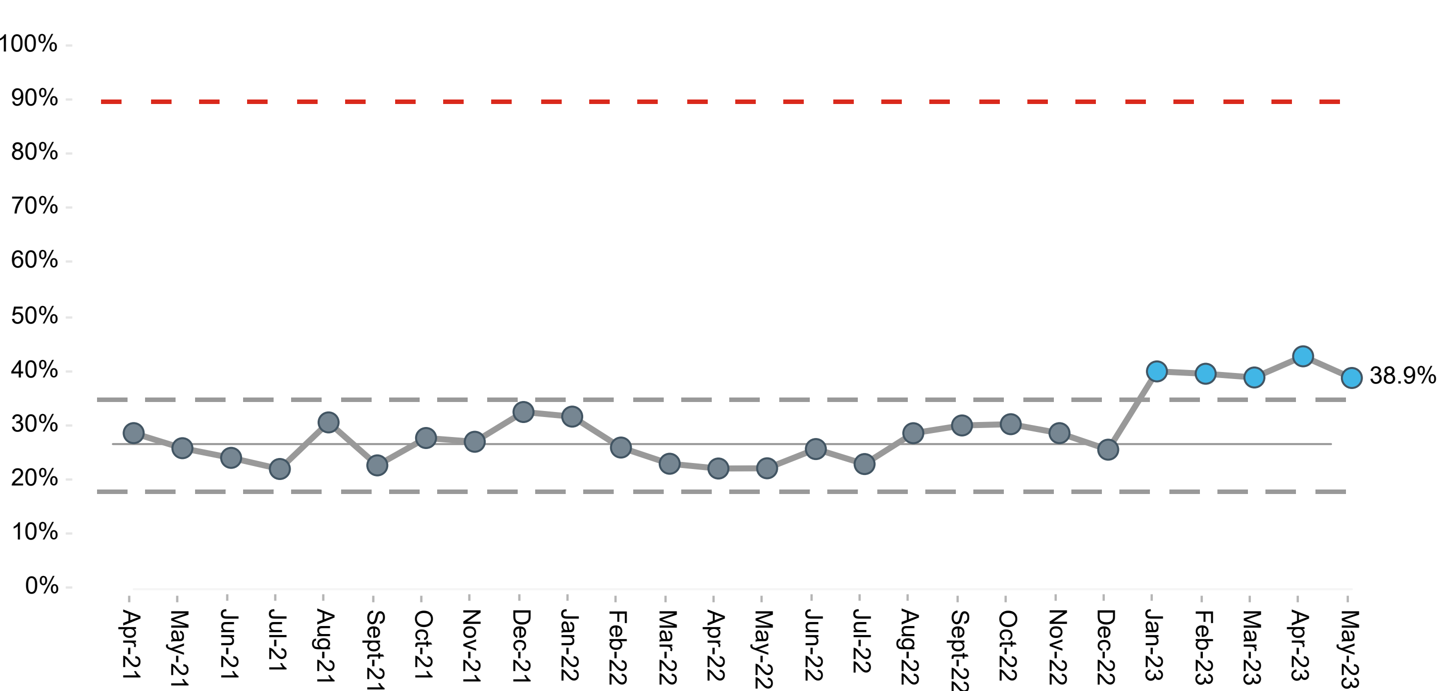
SPC - Special Cause Variation

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

Target: ≥ 90.0%



Data Observations

[1] SINGLE POINT

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Commentary

Slight deterioration in performance against this metric with average time to clinician increasing to 99 minutes (from 92 minutes in April). Note, however, this was the fifth month in succession where the Trust has achieved an average time to clinician of less than two hours.

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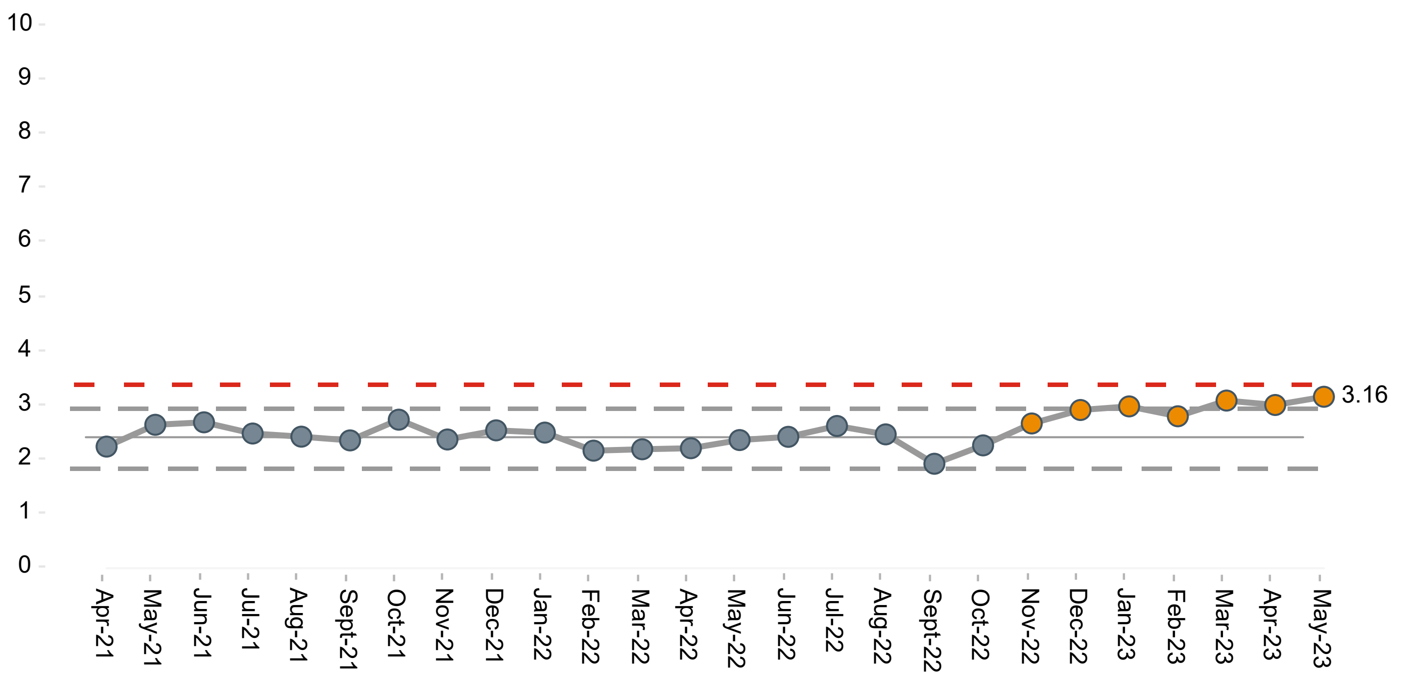
SPC - Special Cause Variation

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

Target: ≤ 3.40



Data Observations

[1] SINGLE POINT

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[4] 2 OF 3

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Commentary

This remains under the target of 3.44days, seeing a small recovery within month to now 3days.
Deputy Chief Operating Officer

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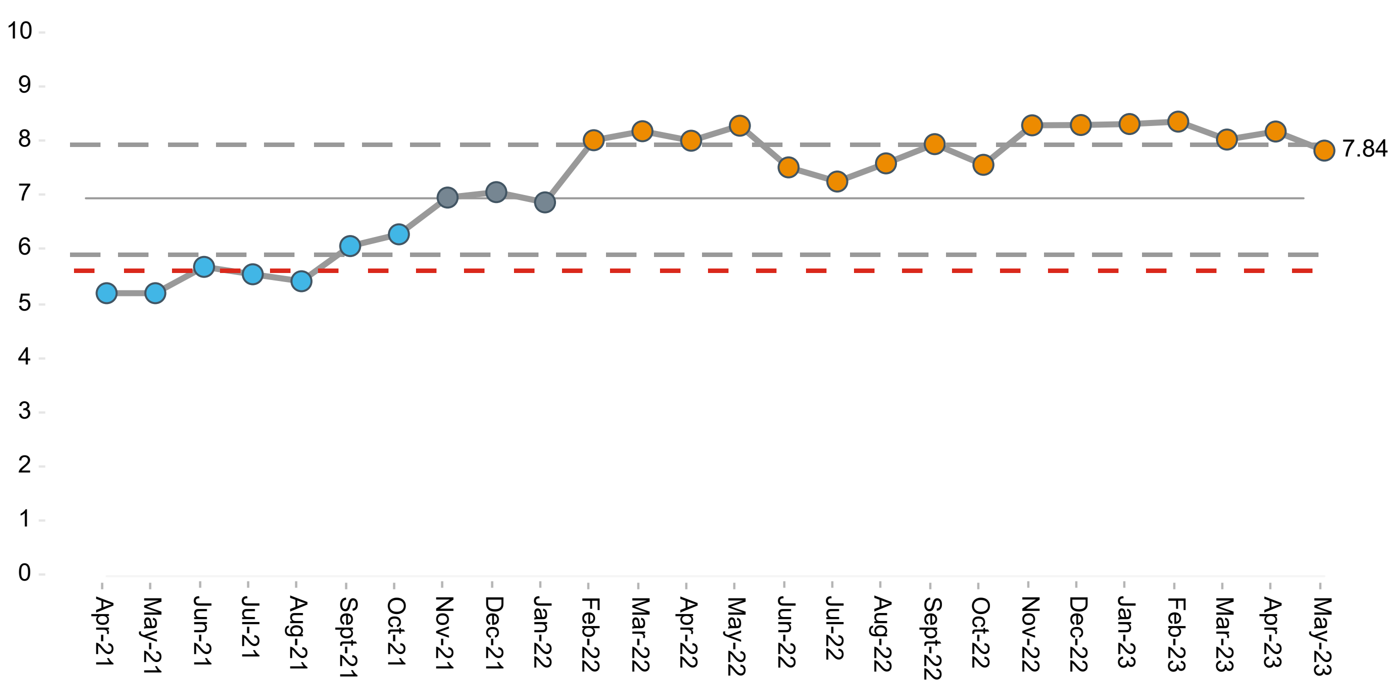
SPC - Special Cause Variation

[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

The average LOS within emergency admissions has risen in month to 8.22 days. This fits with an increase number of stroke and NOF admissions seen through the reference period. Work to understand this rise in both presentations has been initiated at an ICS level as it does not fit with normal seasonal variations. Internally work continues to drive earlier decision making and discharge processes through various workstreams.

Deputy Chief Operating Officer

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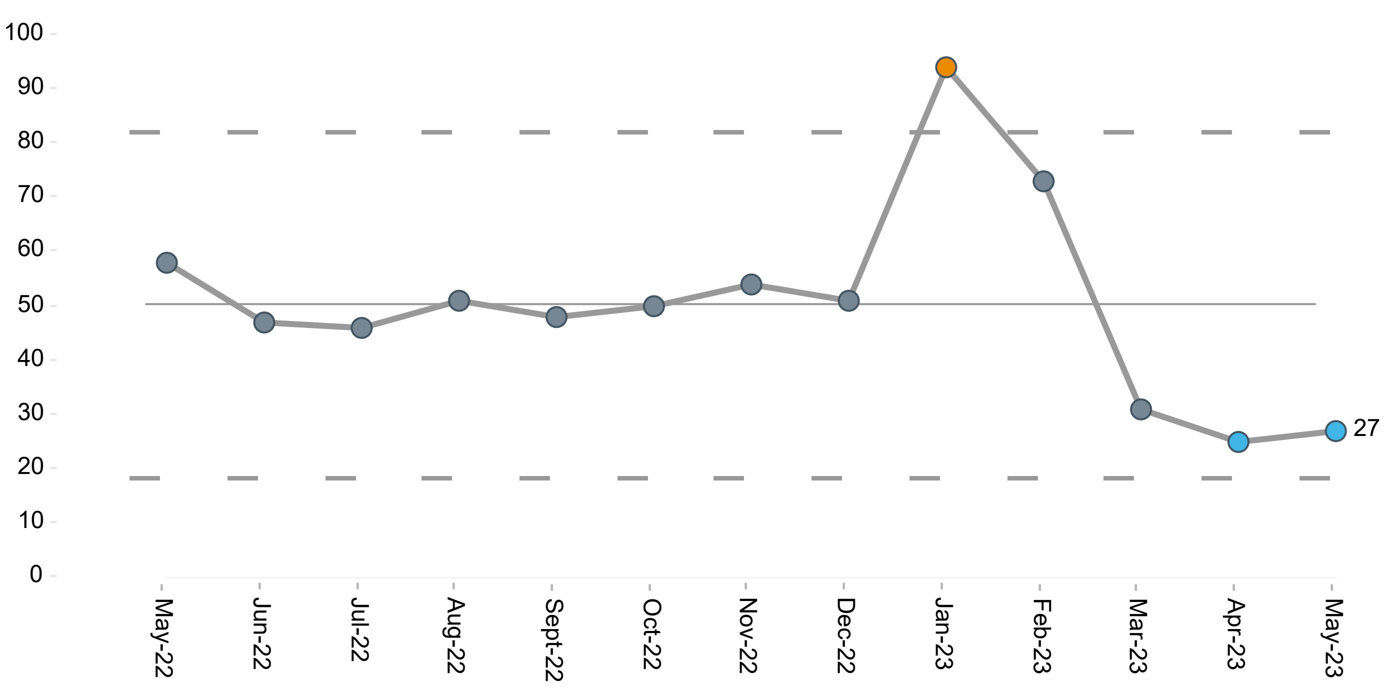
SPC - Special Cause Variation

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

Target: No Target



Data Observations

[1] SINGLE POINT

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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

General Manager - Cancer

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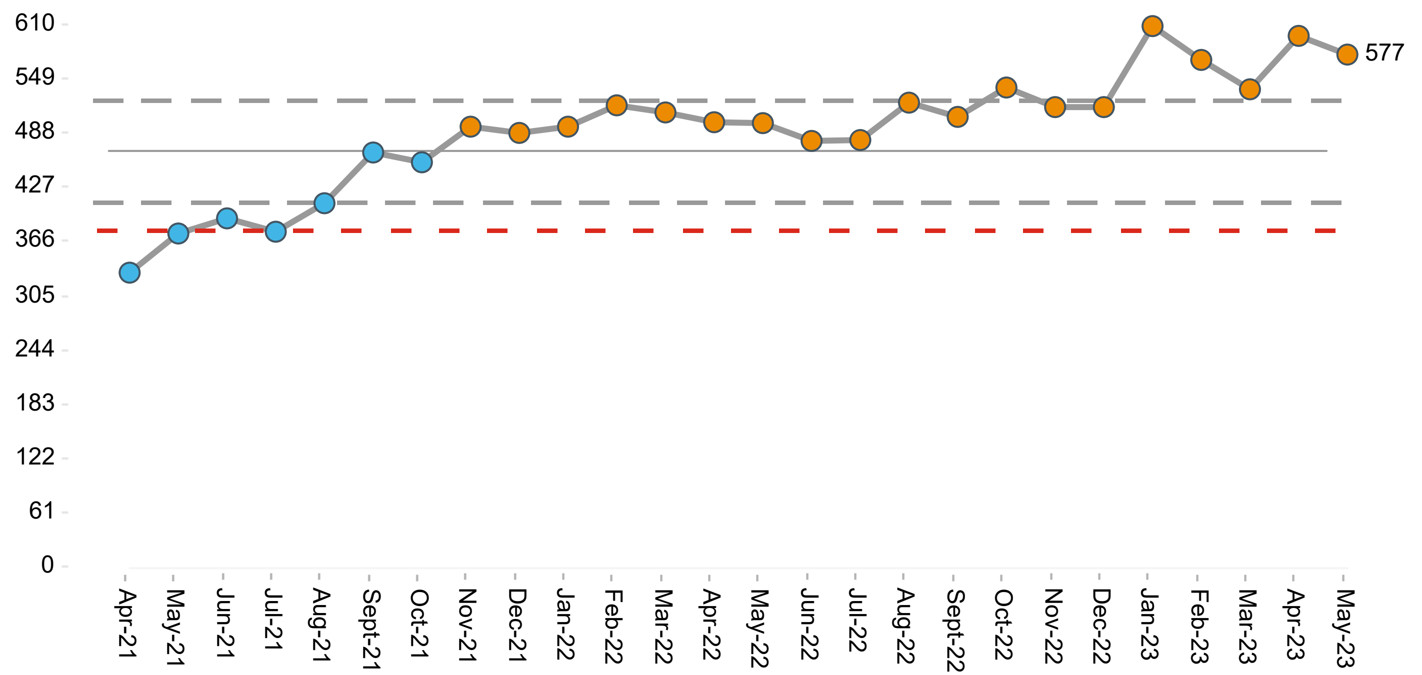
SPC - Special Cause Variation

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

Target: ≤ 380



Commentary

In line with the average LOS, this has seen an in month spike to 568. 14+ and 21+ day figures remain stable, with a slow reduction in line with system workstreams. The increase in 7+ days therefore fits with the higher level of acuity and demand seen within the reference period.

Deputy Chief Operating Officer

Data Observations

[1] SINGLE POINT

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[2] SHIFT

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[4] 2 OF 3

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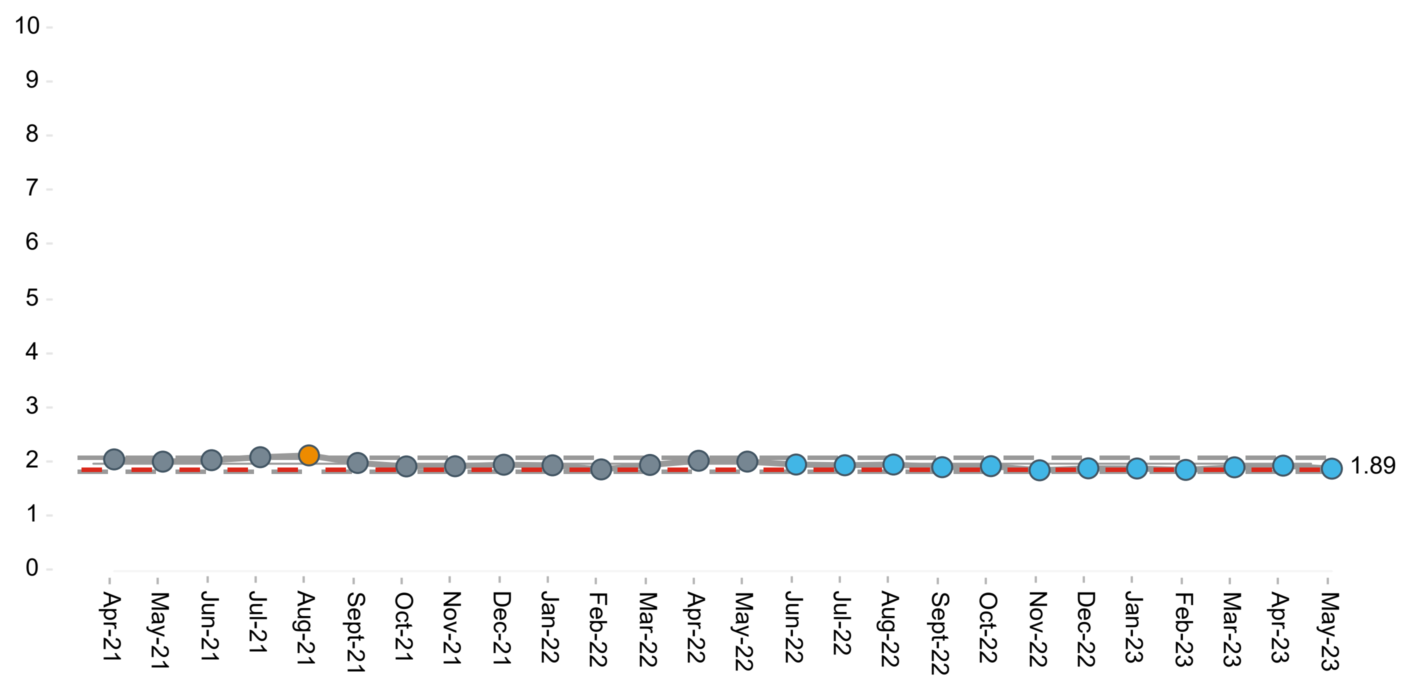
SPC - Special Cause Variation

[490] Outpatient new to follow up ratio's

- - - Target: ≤ 1.90



Data Observations

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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

Associate Director of Elective Care

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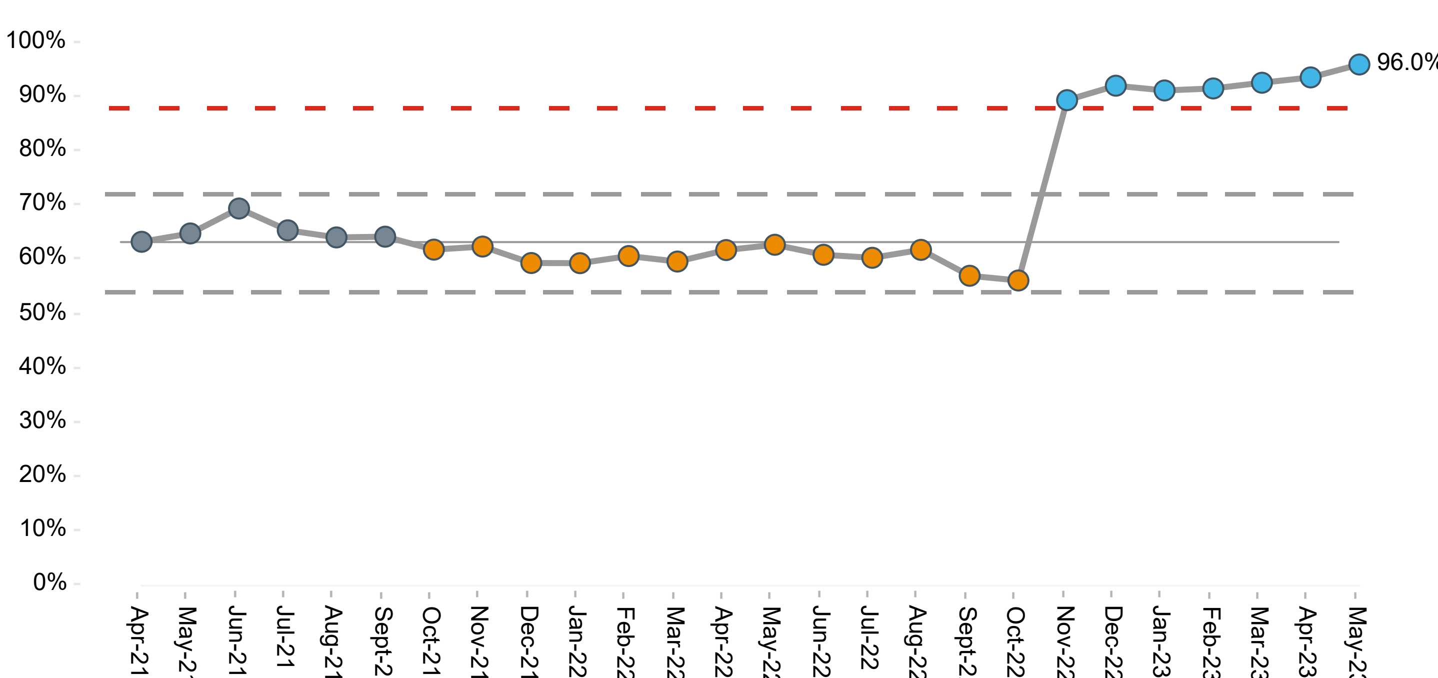
SPC - Special Cause Variation

[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

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

Medical Director

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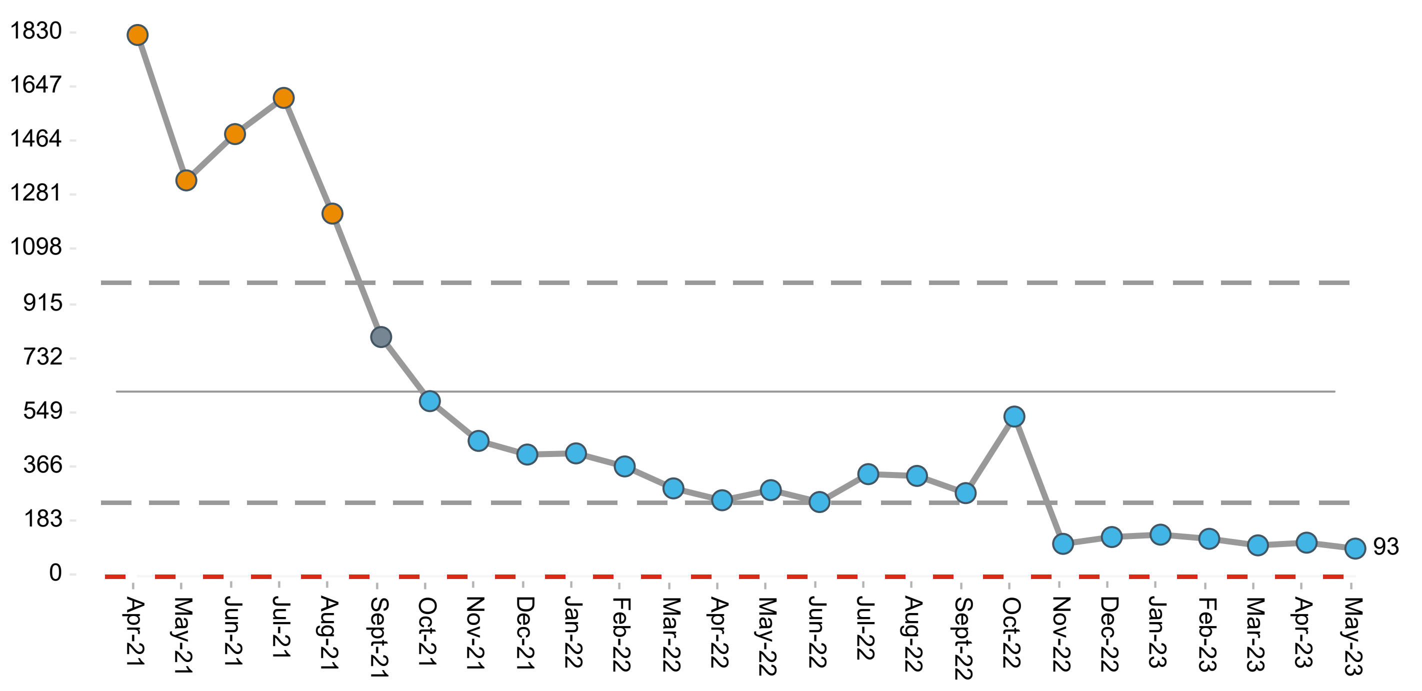
SPC - Special Cause Variation

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

Target: ↓ Lower



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

The only category where a reduction in the number of patients waiting has been observed, with a reasonable reduction made, moving from 113 last month to an a estimated 90 for May.

Associate Director of Elective Care

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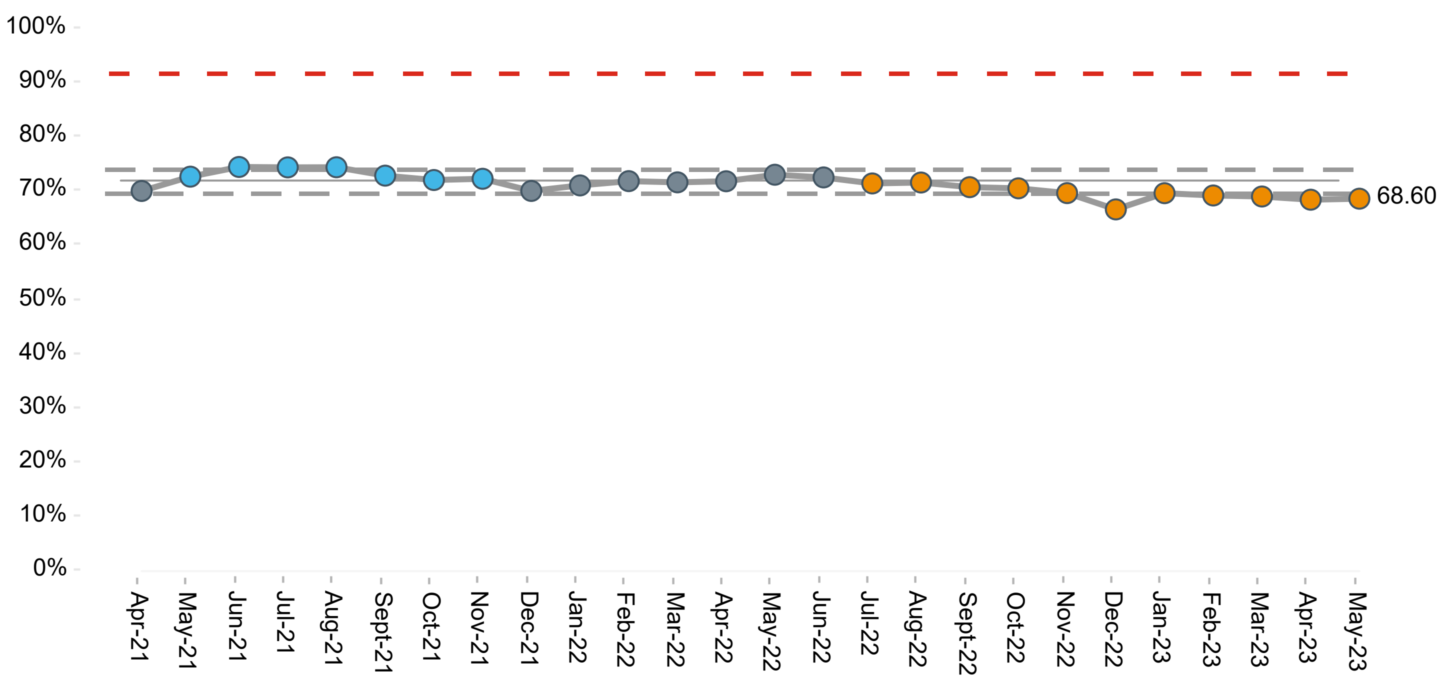
SPC - Special Cause Variation

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

Target: ≥ 92.00%



Data Observations

[1] SINGLE POINT

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[2] SHIFT

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Commentary

See Planned Care Exception report for full details. RTT performance has remained stable in month and is expected to be similar or slightly higher than last months finalised position of 68.4%. Nationally GHFT still remains in a favourable position.
Associate Director of Elective Care

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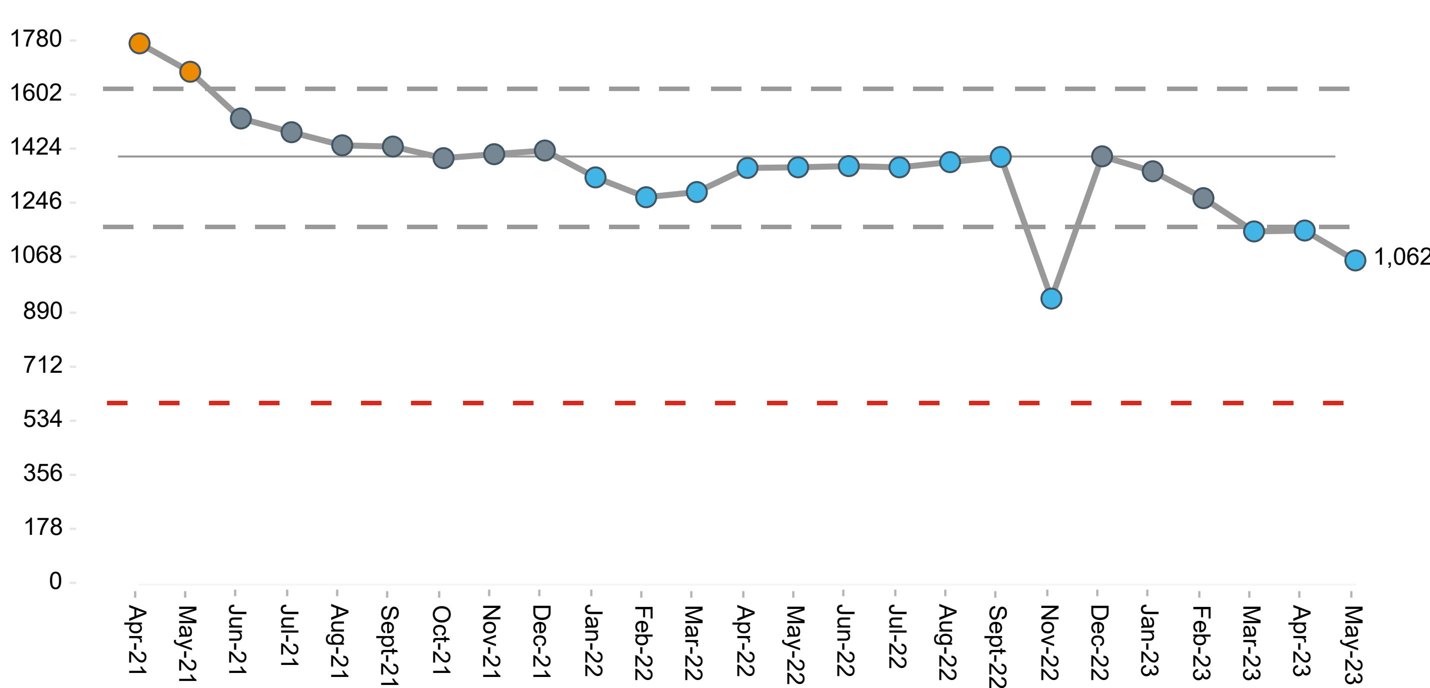
SPC - Special Cause Variation

[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

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

Commentary

General Manager of Endoscopy

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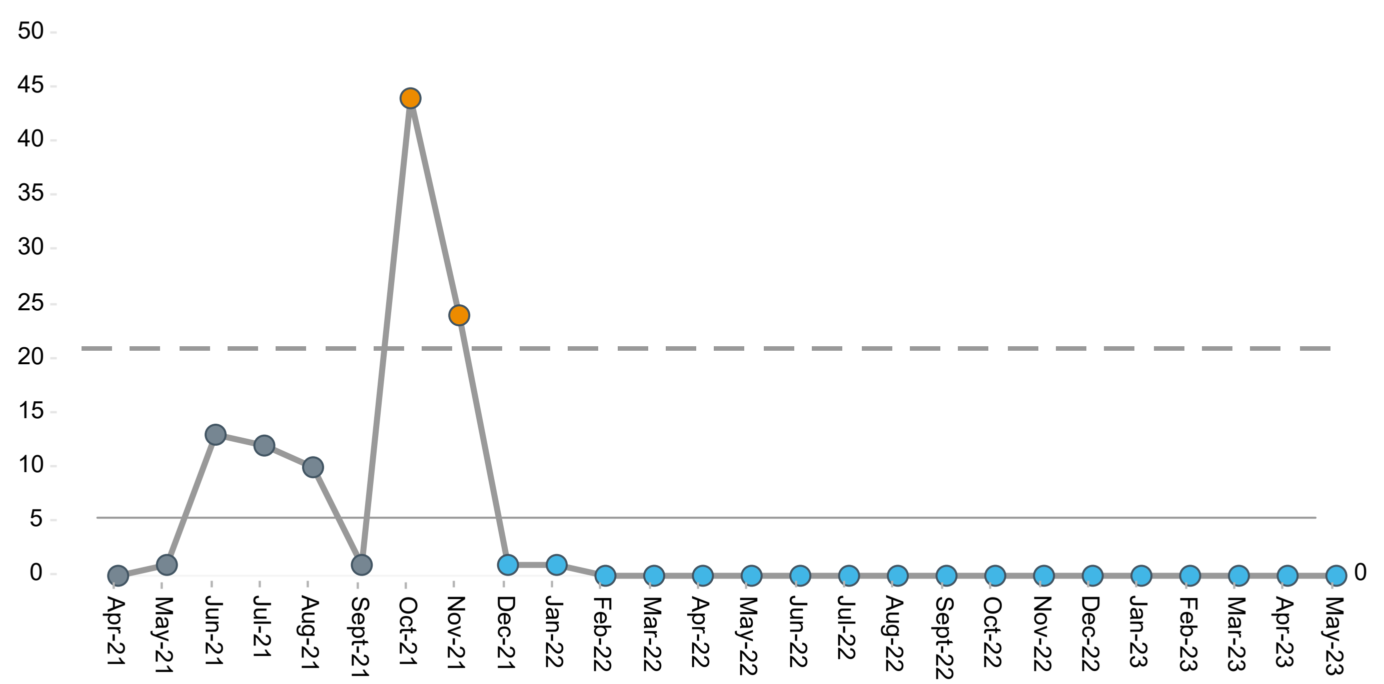
SPC - Special Cause Variation

[552] Urgent cancelled operations

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

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Commentary

Not given

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Quality Dashboard

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		May-23	81.4%	
	Inpatients % positive	No Target		May-23	93.0%	
	Maternity % positive	No Target		May-23	75.8%	
	Outpatients % positive	No Target		May-23	94.4%	
	Total % positive	No Target		May-23	92.5%	
Infection Control	C. difficile - infection rate per 100,000 bed days	↓ Lower		May-23	26.0	
	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target		May-23	88	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target		May-23	222	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target		May-23	61	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target		May-23	91	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower		May-23	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7		May-23	7.4	
	Number of E. coli bacteraemia cases	No Target		May-23	7	
	Number of Klebsiella bacteraemia cases	No Target		May-23	1	
	Number of MSSA bacteraemia cases	≤ 8	P	May-23	2	
	Number of Pseudomonas bacteraemia cases	No Target		May-23	3	
	Number of bed days lost due to infection outbreaks	↓ Lower		May-23	19	
	Number of community-onset healthcare-associated C. difficile cases per month	≤ 5		May-23	3	
	Number of hospital-onset healthcare-associated C. difficile cases per month	≤ 5		May-23	4	
	Number of trust apportioned C. difficile cases per month	< 10		May-23	7	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Infection Control	Number of trust apportioned MRSA bacteraemia	= 0		May-23	0	
Maternity	% PPH >1.5 litres	↓ Lower		May-23	4.8%	
	% breastfeeding (discharge to CMW)	= 0.0%	F	May-23	58.2%	
	% breastfeeding (initiation)	No Target		May-23	78.9%	
	% of women smoking at delivery	≤ 14.50%	P	May-23	9.60%	
	% of women that have an induced labour	≤ 30.00%		May-23	30.88%	
	% stillbirths as percentage of all pregnancies	< 0.52%		May-23	0.59%	
	Number of births less than 27 weeks	No Target		May-23	1	
	Number of births less than 34 weeks	No Target		May-23	11	
	Number of births less than 37 weeks	No Target		May-23	39	
	Number of maternal deaths	No Target		May-23	1	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target		May-23	1.8%	
	Total births	No Target		May-23	512	
Mortality	Number of deaths of patients with a learning disability	No Target		May-23	0	
	Number of inpatient deaths	No Target		May-23	160	
	Summary hospital mortality indicator (SHMI) - national data	No Target		Apr-23	1.104	
MSA	Number of breaches of mixed sex accommodation	≤ 10		May-23	33	
Operational Efficiency	Daily Average of Boarded Patients	No Target		May-23	9	
Patient Advice and Liaison Service (PA..	% of PALS concerns closed in 5 days	No Target		May-23	86%	
	Number of PALS concerns logged	↓ Lower		May-23	303	

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Quality Dashboard

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 Safety Incidents	Medication error resulting in low harm	↓ Lower		May-23	16	
	Medication error resulting in moderate harm	↓ Lower		May-23	1	
	Medication error resulting in severe harm	↓ Lower		May-23	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower		May-23	36	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower		May-23	0	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower		May-23	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower		May-23	15	
	Number of falls per 1,000 bed days	↓ Lower		May-23	6.10	
	Number of falls resulting in harm (moderate/severe)	↓ Lower		May-23	5	
	Number of patient safety incidents - severe harm (major/death)	No Target		May-23	9	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower		May-23	8	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target		Nov-22	70.74%	
	Number of DoLs applied for	No Target		May-23	87	
	Total ED attendances aged 0-18 with DSH	↓ Lower		May-23	100	
	Total admissions aged 0-17 with DSH	↓ Lower		May-23	44	
	Total admissions aged 0-17 with an eating disorder	↓ Lower		Apr-23	1	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower		Apr-23	1	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower		Apr-23	1	
	Total number of maternity social concerns forms completed	No Target		May-23	72	
Serious Incidents	Number of never events reported	= 0		May-23	0	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Serious Incidents	Number of serious incidents reported	↓ Lower		May-23	4	
	Percentage of serious incident investigations completed within contract timescale	> 80%		May-23	100%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%		May-23	100.0%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target		May-23	69.5%	

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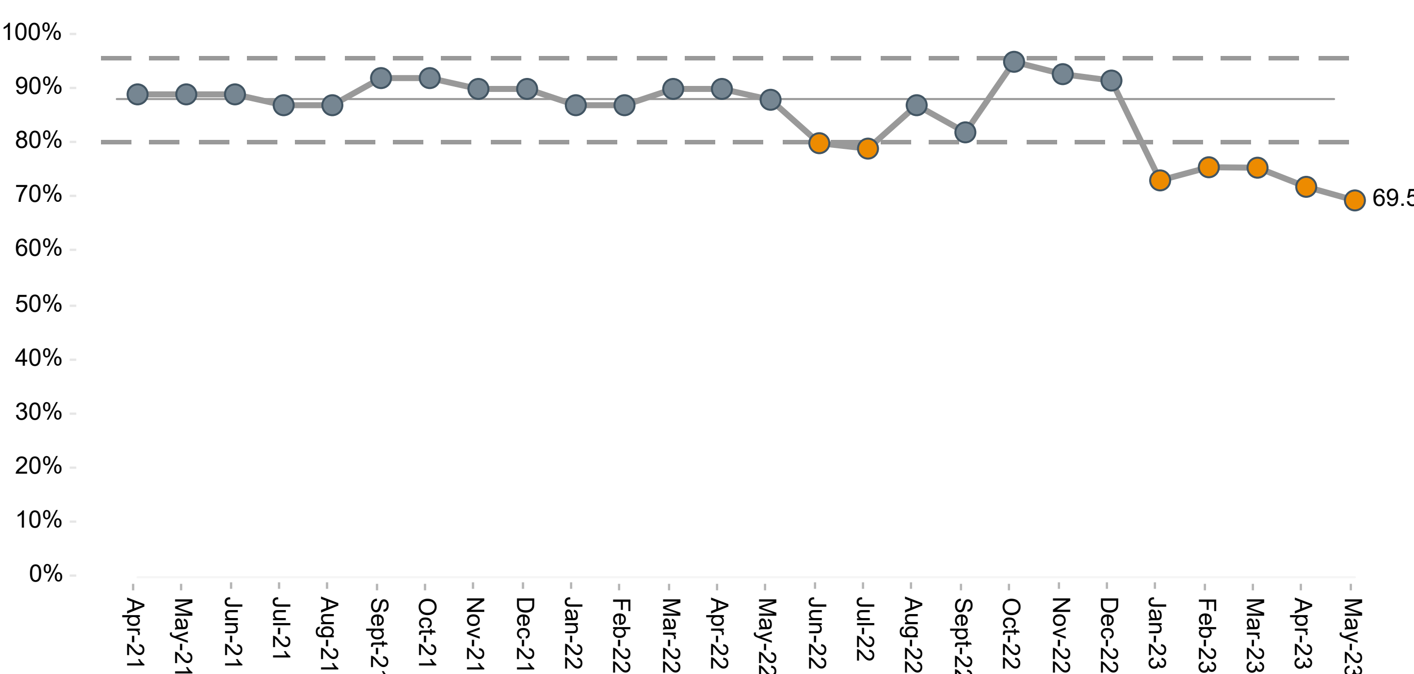
Quality

SPC - Special Cause Variation

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

Target: No Target



Data Observations

[1] SINGLE POINT

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

Commentary

Quality Improvement & Safety Director

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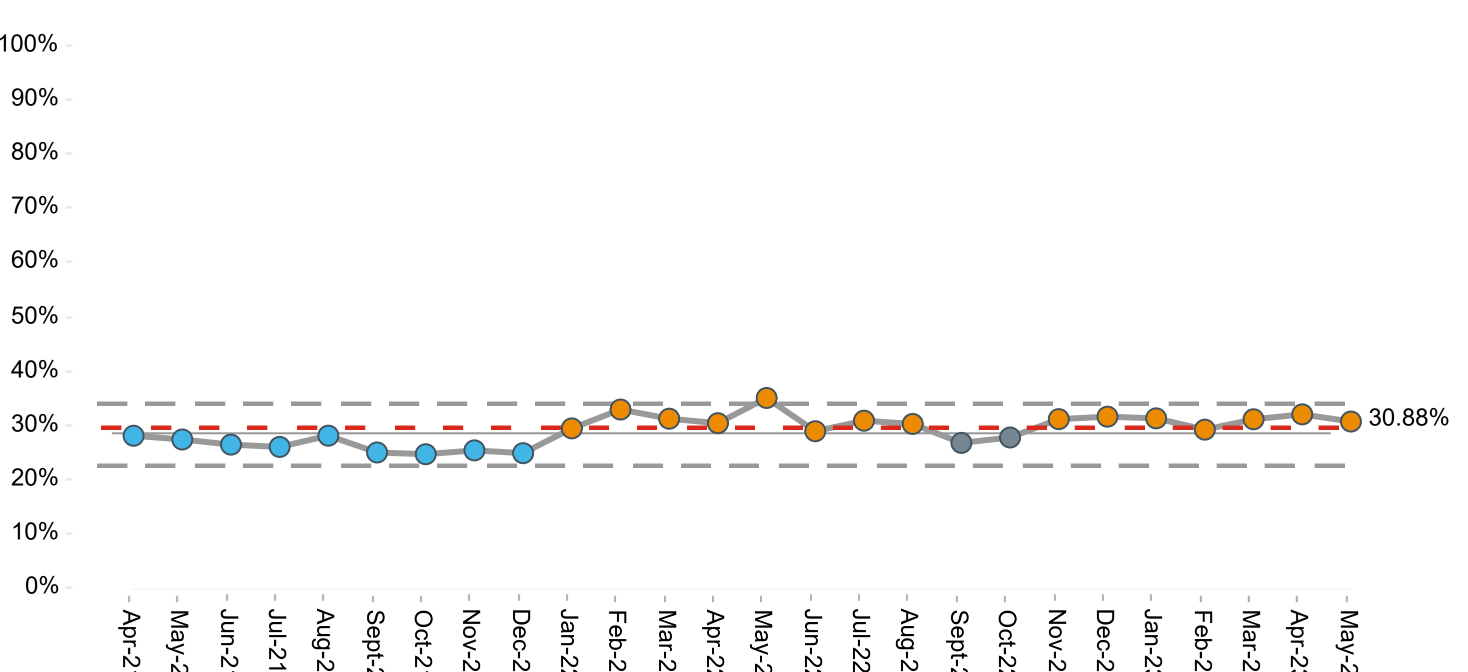
Quality

SPC - Special Cause Variation

[479] % of women that have an induced labour

Target: ≤ 30.00%



Data Observations

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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

Divisional Director of Quality and Nursing and Chief Midwife

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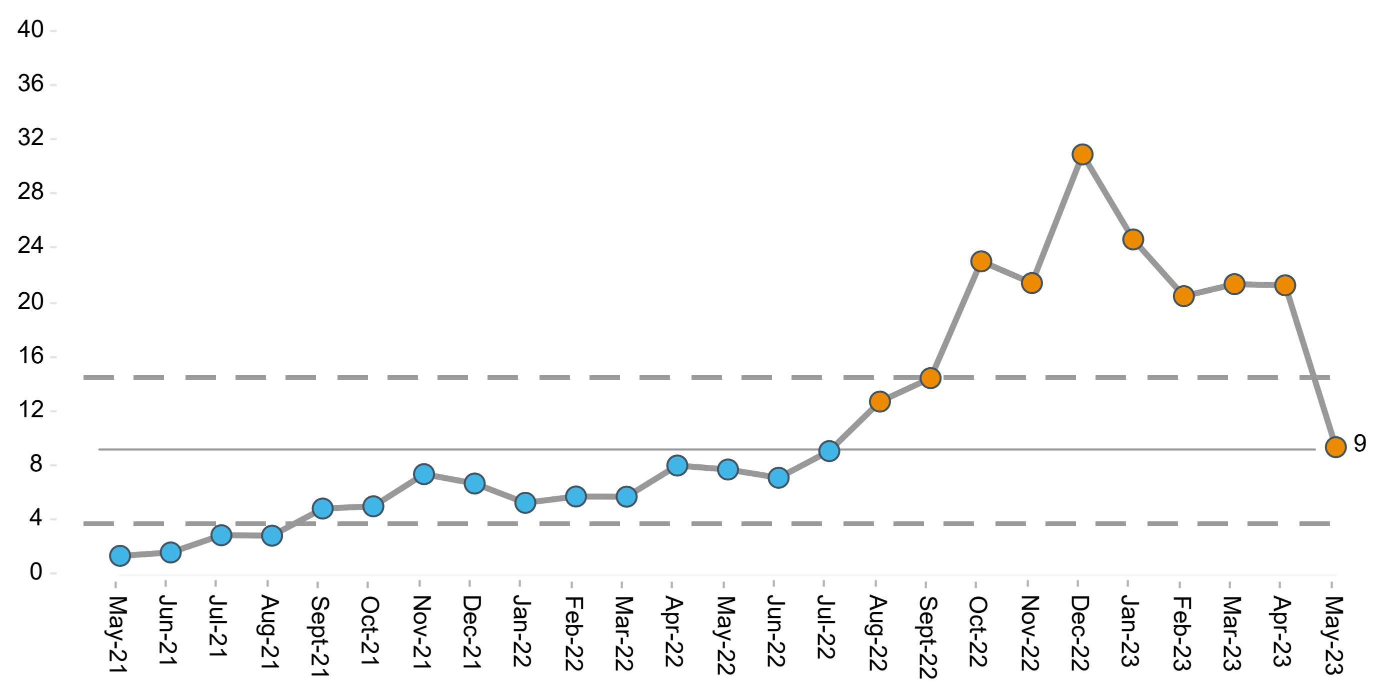
Quality

SPC - Special Cause Variation

[607] Daily Average of Boarded Patients

- - - Target: No Target



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[2] SHIFT

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[4] 2 OF 3

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

Commentary

Director of Operations for Hospital Flow

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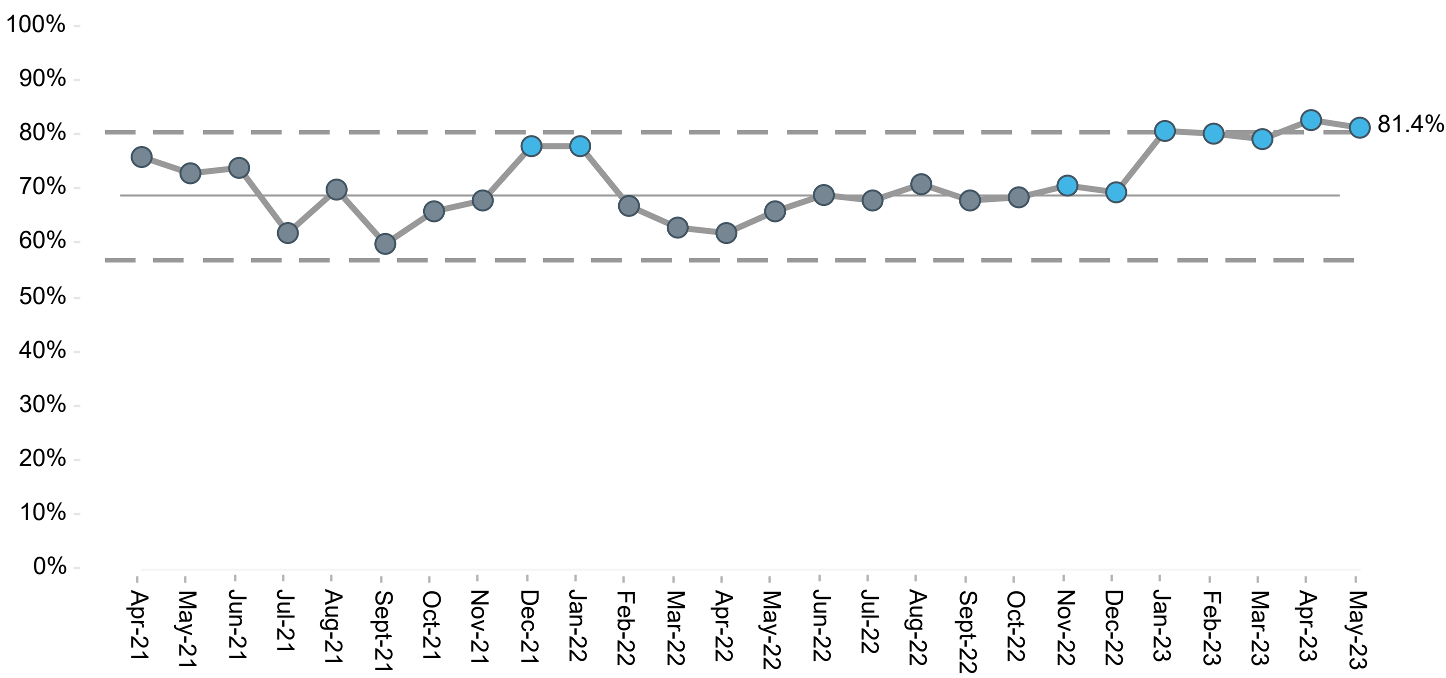
Quality

SPC - Special Cause Variation

[154] ED % 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 ED is at 81.4% across both sites, a slight decrease from 82.8% in April 2023.

Despite this decrease
the score remains above the average for the seventh month and the second month above the upper control level. The score reflects the increased operational pressure facing the department.

The main theme remains focused on wait times and the information provided while
waiting. The team receive and review reports on the feedback weekly, both FFT and PALS, and are supporting real time improvement in response to any emerging themes. This approach has seen the departments maintain above average scores .

Updates are provided through
to QDG.
Head of Quality

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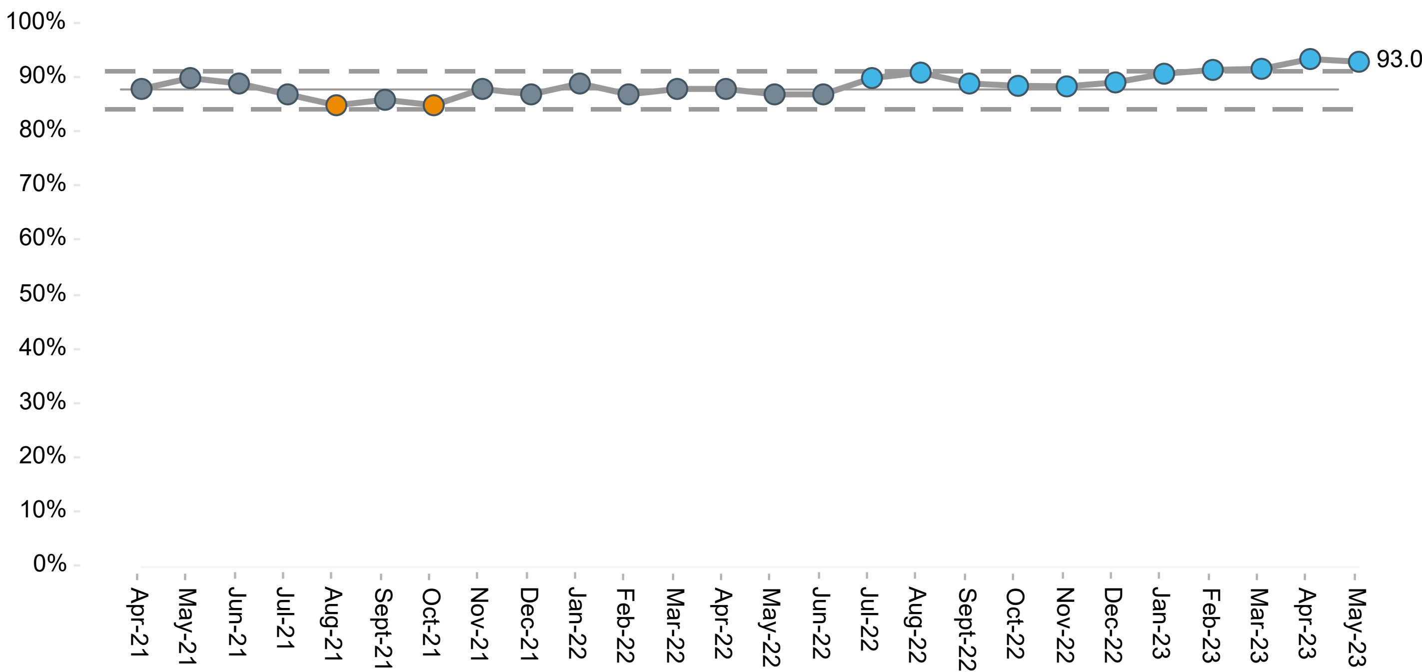
Quality

SPC - Special Cause Variation

[153] Inpatients % positive

- - - 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

Inpatient % positive 93.0%

The current positive FFT score for Inpatient and Daycase is at 93.0%, a slight decrease from 93.5% in April.
The eleventh month of the score above the average of 87% and the fourth month above the upper control limit.

There is not one
initiative that will have driven this score, however, patients are reporting less positive experiences around the discharge process. We are working with divisional teams to further understand the potential factors influencing this score. There are a large number of comments that reference staff working really hard and providing good care but that there are just not enough of them. The main themes in the comments from patients however, remain focused on lack of staff to be able to provide basic care, communication and the ward environment.

Updates will be reported through Quality Delivery Group via divisional reports and the Patient Experience Report.
Head of Quality

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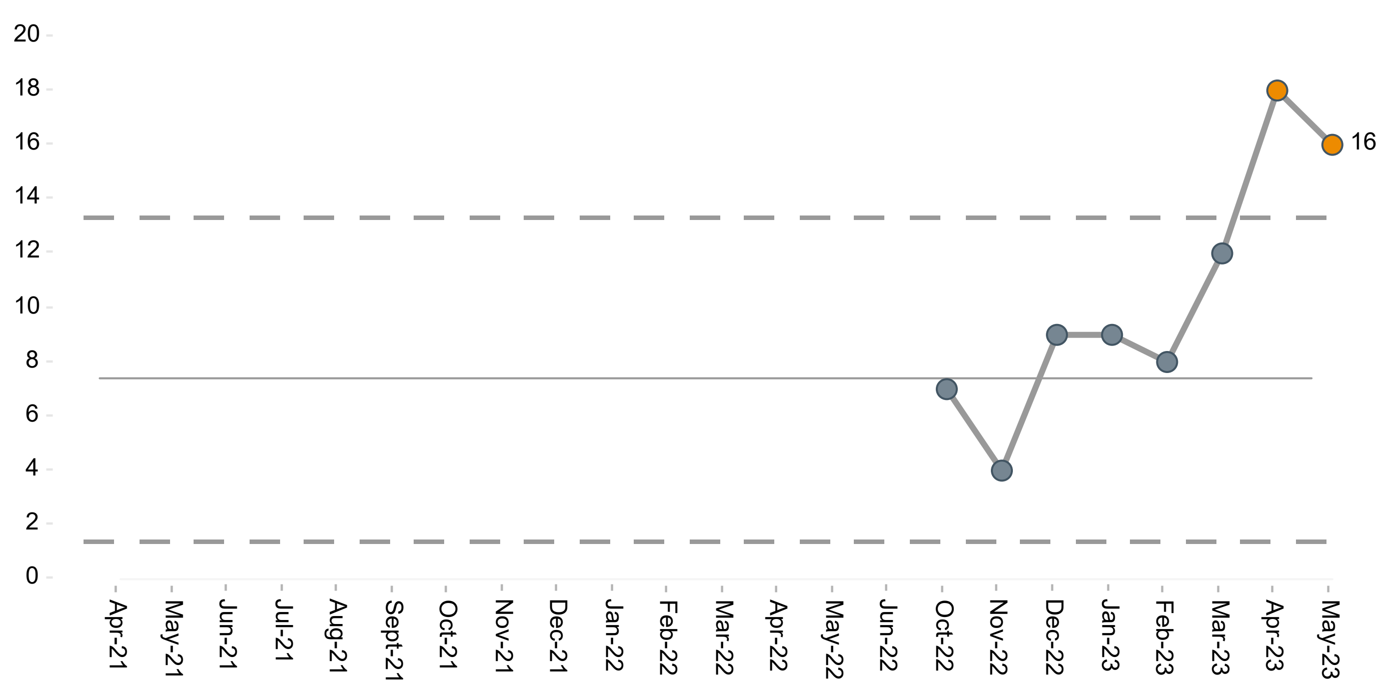
Quality

SPC - Special Cause Variation

[460] Medication error resulting in low harm

Target: ↓ Lower



Data Observations

[1] SINGLE POINT

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Commentary

Quality Improvement & Safety Director

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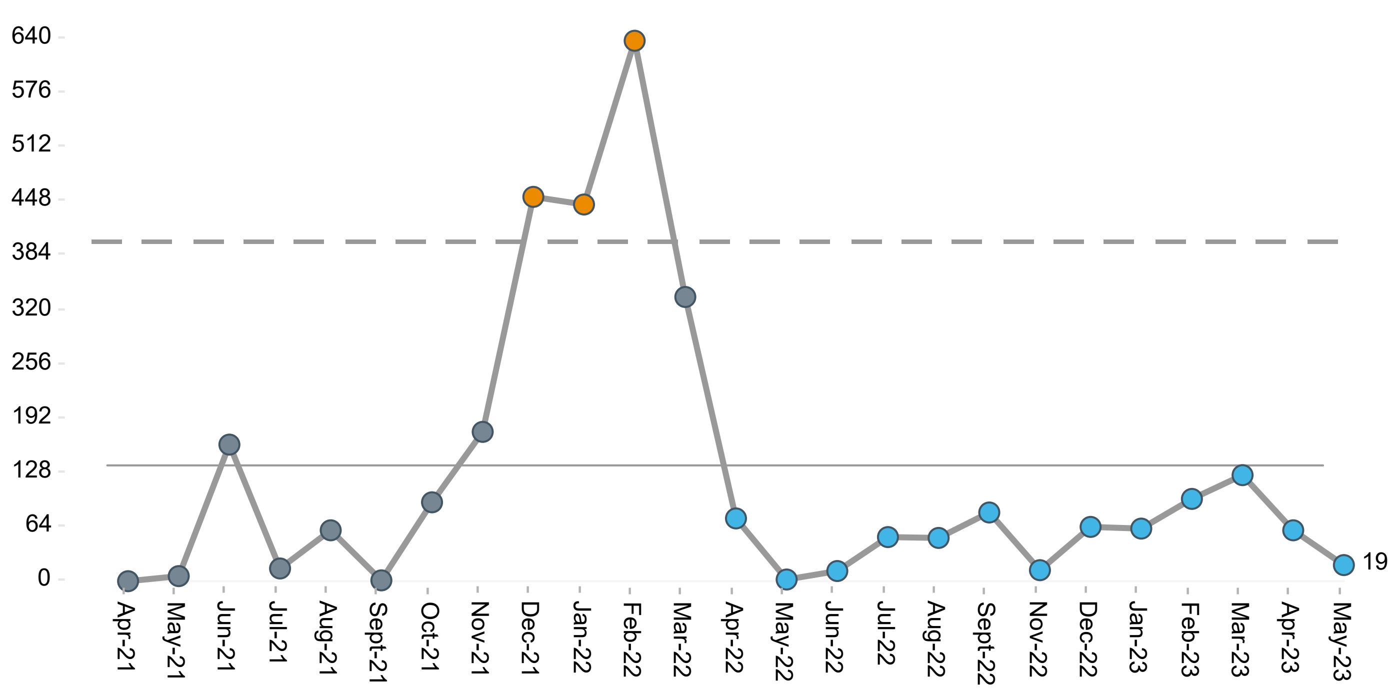
Quality

SPC - Special Cause Variation

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

- - - Target: ↓ Lower



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

During May 2023 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. With COVID-19 testing changes as per national guidance the number of outbreaks associated with COVID-19 is likely to reduce further.
Director of Infection Prevention & Control

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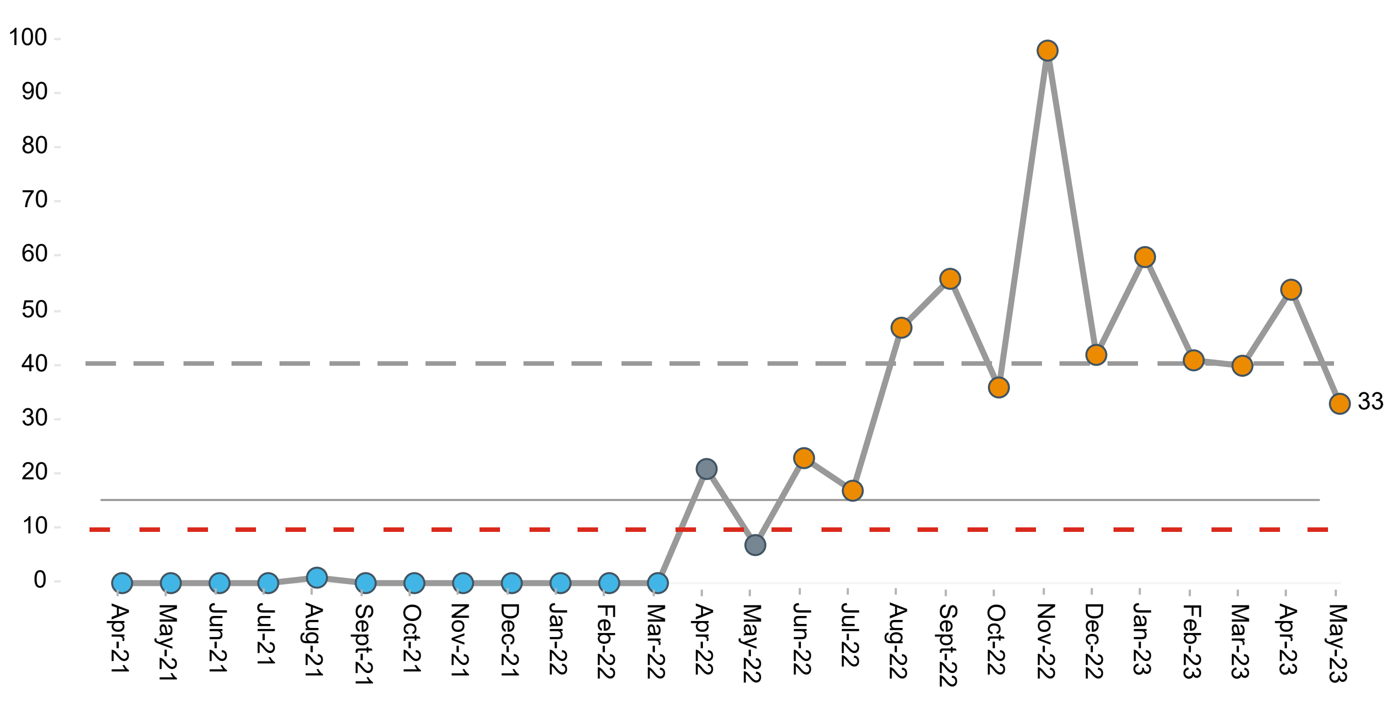
Quality

SPC - Special Cause Variation

[148] Number of breaches of mixed sex accommodation

Target: ≤ 10



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[4] 2 OF 3

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

Commentary

Mixed-sex accommodation breaches are recorded manually each day. These are due to operational pressures when patients can be placed into wards from assessment areas and recovery within a 4-hour window. Breaches for clinical reasons are reported to the Gold director on-call and action is taken to resolve the issue as soon as possible.
Deputy Chief Nurse

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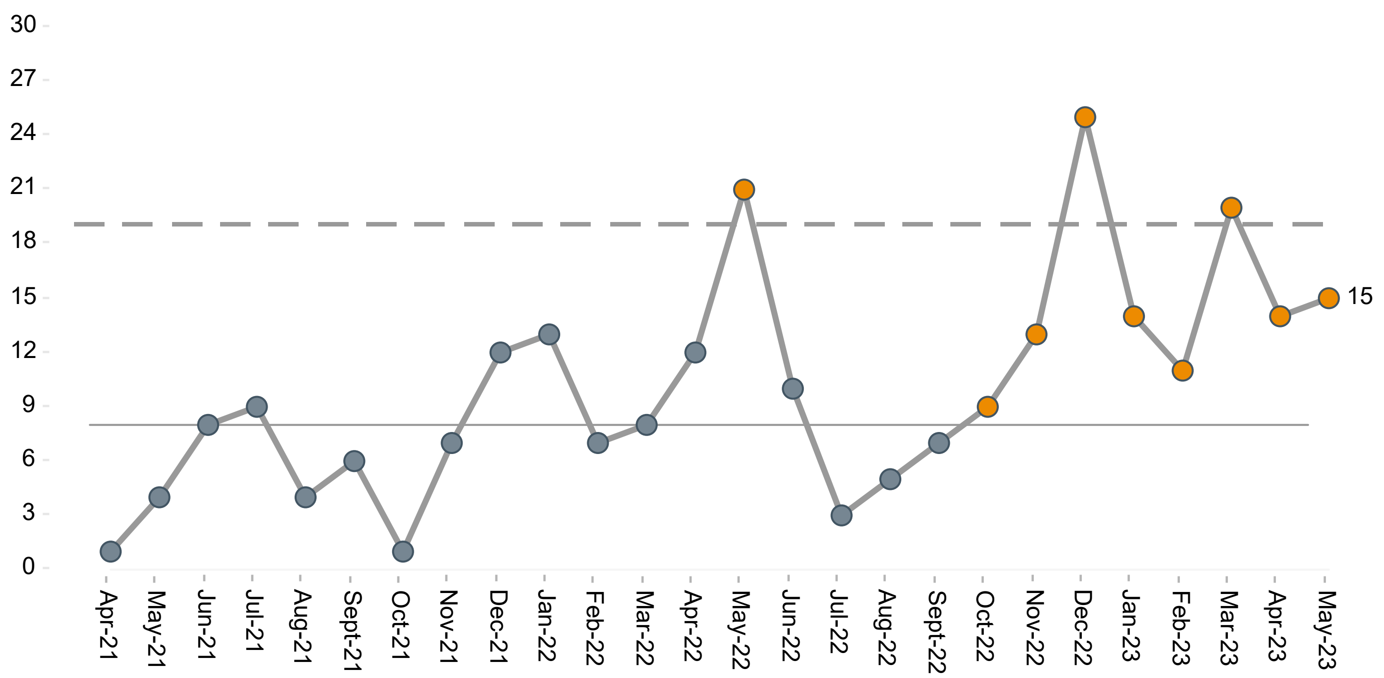
Quality

SPC - Special Cause Variation

[462] Number of deep tissue injury pressure ulcers acquired as in-patient

- - - Target: ↓ Lower



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[2] SHIFT

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Commentary

There were 15 deep tissue injuries recorded in May. Pressure ulcers, including deep tissue injuries, are very sensitive to nursing time available, there has been an increase since additional patients were placed into wards, above the numbers wards are staffed for. Pressure ulcers are reviewed each week at the Preventing Harm Hub where the ward leader meet with a patient safety officer and the tissue viability team to identift and share learning.
Deputy Chief Nurse

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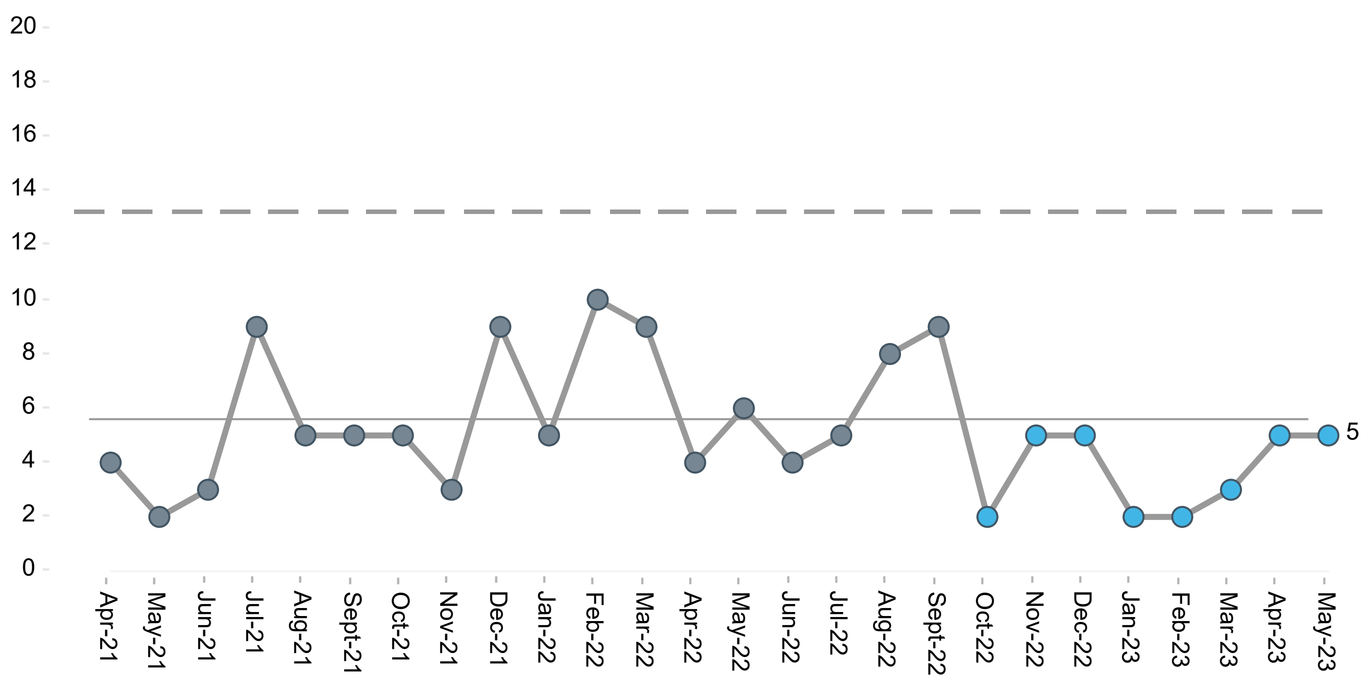
Quality

SPC - Special Cause Variation

[113] Number of falls resulting in harm (moderate/severe)

Target: ↓ Lower



Data Observations

[2] SHIFT

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

Commentary

There were 5 falls resulting in harm during May. These cases are reviewed each week at the Preventing Harm Hub where a ward leader, a patient safety officer and the falls team identify and share learning. These reviews result in a number of actions including a trial of bed exit alarms in stroke and an increased uptake in falls education provided by the falls team.

Deputy Chief Nurse

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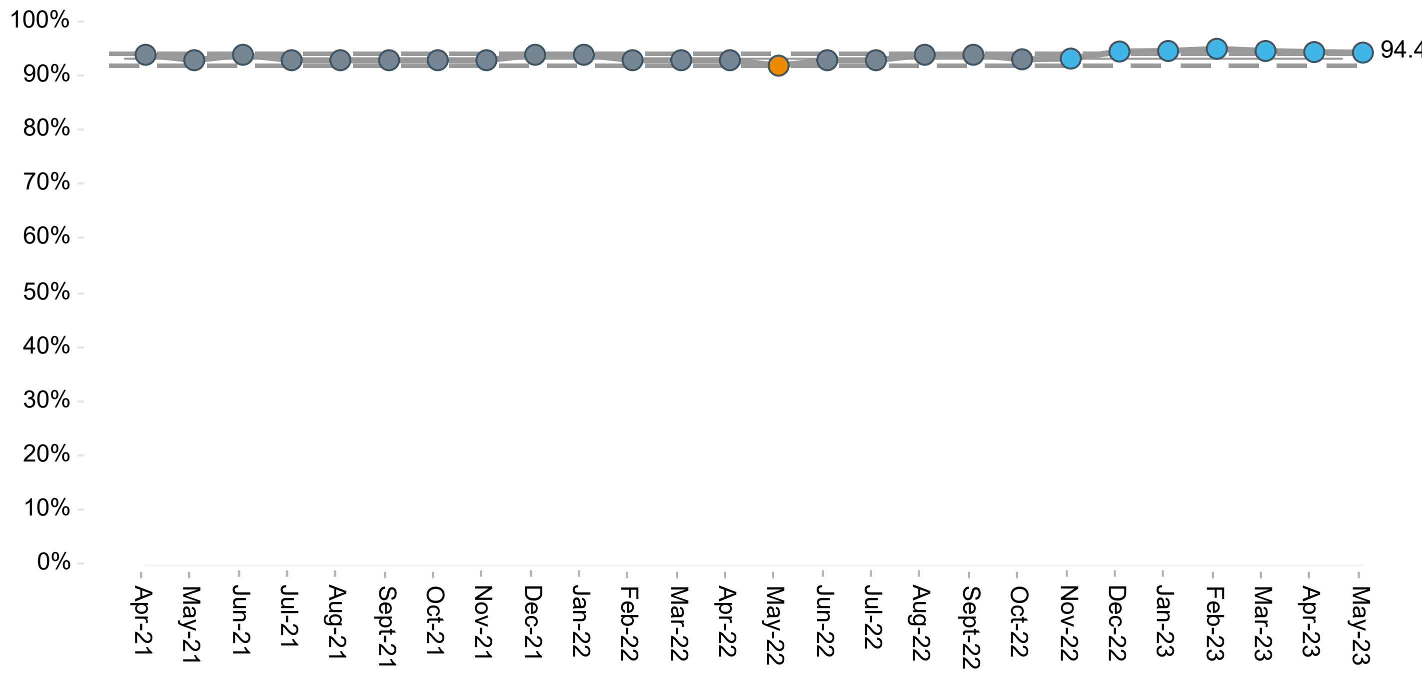
Quality

SPC - Special Cause Variation

[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

Outpatient % positive 94.4%

The current positive FFT score for Outpatients is 94.4%, a slight decrease from 94.5% in April. This is the sixth month of the positive score being above the upper control limit and seventh above average, however, this is the third month we have seen a decline albeit slight.

Comments remain overall positive with many saying 'thank you'. The main themes on areas for improvement continue to be on waits for appointments, waits in the outpatient departments, the quality of appointment letters, signage and wayfinding and appointments feeling rushed.

Head of Quality

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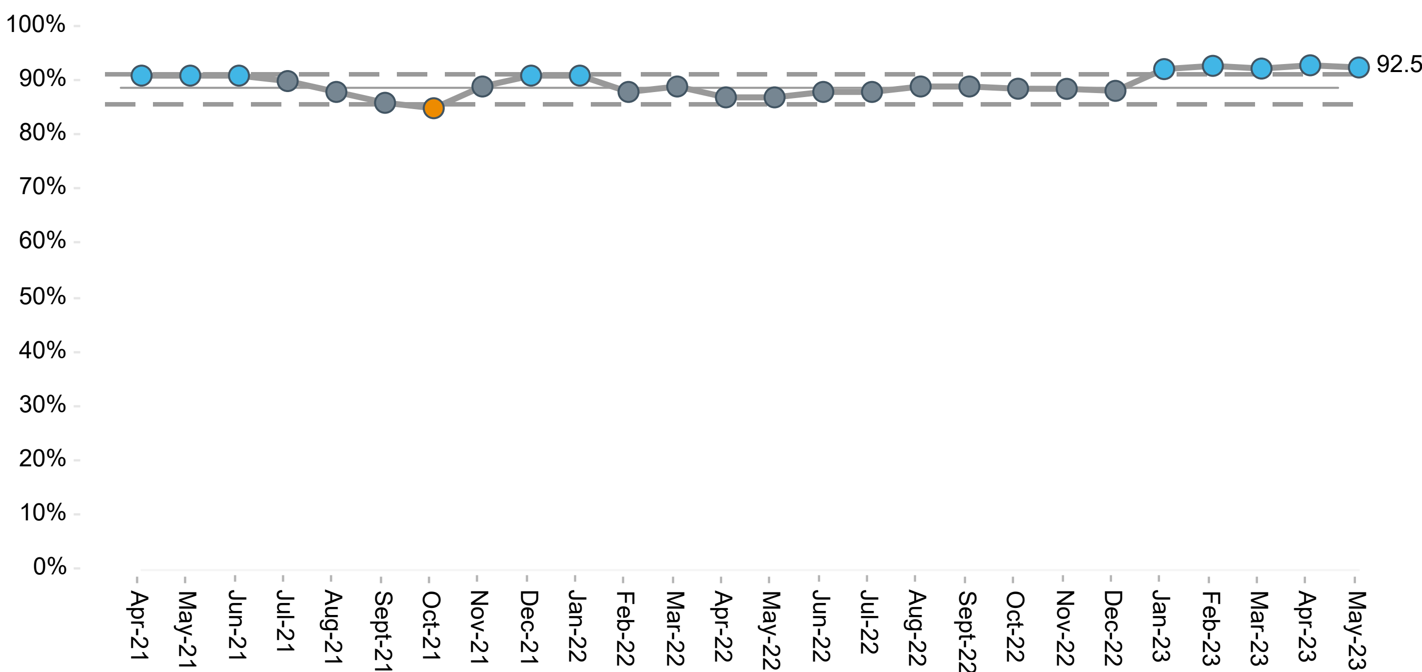
Quality

SPC - Special Cause Variation

[156] Total % positive

- - - Target: No Target



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Commentary

The overall Trust FFT positive score has seen a slight decrease this month to 92.5% compared to 92.9% in April.

Our overall score sees
us maintain our position above the upper control limit for the fifth month running. This is largely due to most care types maintaining scores above their upper control limits. ED and Inpatients and daycase scores contribute a significant number of responses to our overall score and both are above their upper controls despite seeing a slight decrease in their score in May

Divisions provide updates through
QDG each quarter on improvement plans happening within divisions, and the patient experience team have amended the current reporting offer to improve the way that FFT and PALS data is triangulated to support improvement plans. Further improvements will continue to be identified.

Head of Quality

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Report to Board of Directors			
Agenda item:	13	Enclosure Number:	10
Date	13 July 2023		
Title	Perinatal Quality Surveillance and Safety Report (PQSSR) Quarter 4 (1 January - 30 March 2022/23)		
Author /Sponsoring Director/Presenter	Patient Safety Lead Midwife – Lisa Baldwin Director of Midwifery – Lisa Stephens Director of Quality and Chief Nurse – Matt Holdaway		

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

In response to the need to proactively identify trusts that require support before serious issues arise NHSE/I (2020) developed a new perinatal quality surveillance model to provide consistent and methodological review of maternity services. The purpose of this report is to provide assurance to the Trust Board that there is an effective system of clinical governance monitoring the safety of our maternity service with clear strategies for learning and improvement. This report covers the period of 01st January 2023 – 31st March 2023

This report also contains key additional information to support meeting the Maternity Incentive Scheme requirements, working to Year 4 requirements (new scheme to be published May 2023).

Key issues to note

Perinatal Quality Surveillance Q4 highlights

CQC Ratings	CQC Inadequate rating and section 29a warning notice – significant progress has been made on the improvement plan and there are 3 areas flagging as actions were not completed within the timeframe of December 2022. Progress of those issues continues to be monitored with the ICS and CQC attending update meetings every 6 weeks (it is likely that these oversight meetings will conclude in Q1).
Maternity Safety Improvement Programme	We remain on the NHSE Maternity Service Safety Improvement Programme and are being supported by a Maternity Improvement Advisor.
Perinatal Mortality Review Tool (PMRT) (safety action 1)	All deaths were reviewed and compliance with all MIS safety action 1 standards achieved at 100%.
Digital and data (safety action 2)	Maternity Digital Strategy is being delivered 9/11 Clinical Quality Improvement Metrics (CQIMS) digital standards met
Transitional care and avoiding term admissions to the neonatal unit (ATAIN) (safety action 3)	Transitional care and avoiding term admissions to the neonatal unit (ATAIN). Our ATAIN rate over the three months is compliant as is less than the 5% national target. Transitional care audits are being reviewed. **This safety action was not compliant with the MIS scheme requirements**

		and an action plan for improvement was submitted to NHSR.
	Training compliance (safety action 8)	By 31st March 2023 73% of eligible staff have attended local multi-professional training annually. This is presented monthly at Divisional Quality Board.
	Maternity Workforce (safety action 4&5)	• Staffing is reviewed monthly at the Maternity Delivery Group and the plan is for the 6 monthly Workforce Report to be presented at Board in September 2023 (January 2023 to June 2023). • There were minimal Obstetric rota gaps and all gaps were covered by internal staff or known locums. • The Midwifery Vacancy rate remains high and has increased to 13.73% in March 2023 • Fill rate percentage average during Q4 is 88% • Our position with the RCOG document is unchanged. Compliance of consultant attendance monitored when a consultant was required to attend in person and episodes where attendance was not possible have been reviewed at unit level as an opportunity for departmental learning with an agreed strategy and action plans implemented to prevent further non-attendance. • BirthRate+ summary report received by service in December 2022 (our external workforce review provider report). • Midwife to birth ratios is green (compliant as below 1:24) at average ratio of 1 midwife for every 23 women - 1:23 for Q4. • % Specialist midwives/managers employed is compliant to Birth Rate Plus (BR+) establishment at 11%. • We have 100% compliance with supernumerary labour ward coordinator status. • 1:1 care in labour not yet complaint at the 100% target as Q4 figure 96% and so there is an improvement action plan in place which has been reviewed by the Board in November 2022.
	Saving Babies Lives Care Bundle Version 2	This standard is currently non-compliant and work is ongoing to make improvements. An advert is out to recruit an additional patient safety midwife with focus on Saving Babies Lives Care Bundle under the leadership of the Patient Safety Lead Midwife and Consultant Midwife.
	Patient experience (Safety action 7)	The service continues to engage, support and deliver the Maternity Voices Partnership work plan. The average overview of Friends and Family feedback in Q4 positive score was 90.9%. The area with the lowest scores is the Maternity Ward. This is the focus for the maternity team around improvement work. For this quarter, the focus has been on getting the leadership right and diagnosing the key issues to resolve. Improvement projects will be delivered in Q1.

Safety Champions (safety action 9)	Patient Safety Champions are the important conduit between leadership and clinical team and during Quarter 4 there were two clinical midwives employed in this role to complement the Safety Champion team including; Non-Executive Director, Director of Midwifery, Chief of Service, Executive Director (Chief Nurse). Safety champion walkabouts commenced this Quarter with Highlight reports submitted to the Patient Safety Champion meeting. The focus for the clinical safety champions was around 1:1 care in labour and engaging staff with safety issue. **This remains non-compliant**
Safety – HSIB and EN reporting (safety action 10)	There were no cases referred to HSIB during Q4. There were no Coroner regulation 28 cases and we are NHS Resolution Early Notification Reporting compliant Family involvement invited in each case identified with duty of candour.

Conclusion

The Maternity Workforce Report and the Perinatal Quality Surveillance Report have kept the Board appraised of the MIS standards throughout the year.

The Maternity service have improved their reporting and have enhanced the report you see today.

Recommendations

The Board are asked to note the following position for each safety action

Safety action	Recommendation to Board
1. PMRT	The Trust Board are asked to note that for the Maternity Incentive scheme the PQSSR provides the required data that the toolkits are being reviewed.
2. MSDS	The Trust Board are asked to note this it was confirmed by NHS Digital that the service had passed the associated data quality criteria in the “CNST Maternity Incentive Scheme Year 4 Specific Data Quality Criteria” data file in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in October 2022 for 9/11 metrics.
3. Transitional care and avoiding term admissions to the neonatal unit (ATAIN)	The Board is asked to note that compliance for this standard was not achieved and an action plan has been prepared that will be submitted to NHSR on 2 February 2023. Progress on completion of the action plan will be monitored by the Executive Led Maternity Delivery Group and this will be reported to Quality and Performance Committee for Assurance.
4. Maternity Workforce	A 6-monthly Maternity Staffing Report was received at Board in March 2022 and November 2022 and the next report is due in September 2023. For the Obstetric medical workforce our Trust Board signed off their engagement with the principles outlined in the Royal College of Obstetricians and Gynaecologists (RCOG) workforce

	document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service: https://www.rcog.org.uk/en/careers-training/workplace-workforce-issues/roles-responsibilities-consultant-report/.
5. Midwifery Workforce	The Board are asked to note that it can evidence that a Maternity Workforce Report has been received every 6 months and that within the report it was noted that the midwifery staffing budget reflects establishment as calculated by BirthratePlus in 2019 and the Ockendon requirements.
6. SBLCBv2	The Board is asked to note that compliance for this standard was not achieved and an action plan has been prepared that was submitted to NHSR on 2 February 2023. Improvement work is ongoing on SBLV and will be resourced once funding from NHSR is agreed.
7. Patient experience	The Board are asked to note that the service can demonstrate that it has mechanisms for gathering service user feedback, and that they work with service users through your Maternity Voices Partnership (MVP) to coproduce services.
8. Maternity training	The Trust Board are asked to note that it has specifically confirmed that within our organisation 73% of eligible staff have attended local multi-professional training annually and this is reported monthly to MDG. This is non-compliant. Position with compliance planned for Q2. The Go Live of a digital maternity system (Badgernet) has impacted upon the ability to release staff for MDT training compliance in Q4.
9. Safety champions and ward to board reporting	The Board is asked to note that compliance for this standard was not achieved and an action plan has been prepared that will be submitted to NHSR on 2 February 2023. Progress on completion of the action plan will be monitored by the Executive Led Maternity Delivery Group and this will be reported to Quality and Performance Committee for Assurance.
10. Safety reporting	The Board are asked to note that the service have reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) and to NHS Resolution's Early Notification (EN) Scheme from 1 April 2021 to 31st March 2023. There were no qualifying cases during the period 1 January to 31 March 2023 however, the Trust Board are assured that when this does occur families receive information on the role of HSIB and NHS Resolution's EN scheme and 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.

Enclosures
Perinatal Quality Surveillance and Safety Report

Maternity Service

Perinatal Quality Surveillance and Safety Report

Quarter 4

1 January - 30 March 2022/23

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 updated 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 Maternity was rated as inadequate.						

	2022/23												
	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
1. Direct Maternal Deaths	0												0
2. Incidents graded moderate Harm or above	0	2	0	0	0	0	3	0	2	1	1	0	1
3. Cases eligible for referral to HSIB ***(** denotes rejected)***	0	1	0	1**	1	2 (1=**)	2	0	0	1 **	0	0	0
4. Maternity Incidents													
- **Reported**	NA	110	92	104	141	122	146	124	128	126	136	126	100
- **Overdue** *(incidents open> 30 days) (scorecard)*	0			22	80	26	44	69		158	139	192	215
5. Risk Register													
- **Risks on register**	NA		20	21	21	26	26	26	24	25	21	20	18
- **Overdue actions on risk register**	0												2
6. Periprem Births <27 wks *(based on all babies recorded in MSDS from 20-26+6 weeks: babies born in the right place)*	85%	3	0	3	0	1	2	0	3	4	3	4	100%
7. Term Admissions to Neonatal Unit (ATAIN) percentage	5%	4.5%	2.1%	3.6%	4.7%	4.5%	3.9%	3.9%	2.5%	3.6%	3.4%	6.4%	4.9%

	2022/23												
	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
8. Scorecard completion	100%												100%
National Assurance Programmes													
9. Ockenden													
- **Ockenden 1**													
- **Ockenden 2**													
10. Saving Babies Lives													
- **Element 1: Reducing Smoking** *Smoking status at time of delivery (SATOD)*	2022 <8.0												9.4%
- **Element 2: Fetal Growth Restriction**													
- **Element 3: Awareness of Reduced Fetal Movements (RFM)**													
- **Element 4: Effective Fetal Monitoring**													
- **Element 5: Reducing Pre-Term Births**													
11. CQC Section 29a													
12. Maternity Incentive Scheme Y4													
- **Action 1: National Perinatal Mortality Review Tool**													
Stillbirths rate per 1000 live & stillbirths	Nat. Av.21 4.1	0.0	0.0	0.0	2.1	2.1	3.9	2.1	0.0	2.2	2.2	5.2	0.0
Neonatal mortality rate per 1000 live births	Nat Av, 21 2.7	2.3	0.0	8.5	2.1	2.1	3.9	0.0	4.4	4.4	4.5	5.2	0.0
- **Action 2: Maternity Service Data Set (MSDS)**													

	2022/23												
	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
- **Action 4: Medical Workforce Planning** *gaps in rota*													
Mid Staff Grade		33	28	31	22	14	16	15	17	18	44	39	35
Obstetric Consultants		7	2	4	6	5	0	0	0	0	3	1	17
- **Action 5: Midwifery Workforce Planning** *vacancy rate % (midwives)*		7.45	6.21	7.45	10.26	11.59	11.61	7.22	7.37	8.26	7.62	11.68	13.73
- **Action 6: Saving Babies Lives Care Bundle v2**													
- **Action 7: Patient Feedback (service user voice feedback) %**		78.20	85.20	88.90	91.80	79.50	93.00	66.70	89.60	86.80			
- **Action 8: In-House Training**													
Obstetrics Training Compliance:													
PROMPT Parts 1&2 *MDT*													73%
- **Action 9: Safety Champions**													
- **Action 10: ENS**										100%	100%	100%	100%
13. Coroner Reg 28 made directly to Trust	0	0	0	0	0	0	0	0	0	0	0	0	0
14. NICE Guidance Number action plans overdue	0											1	2
15. POPAM Storage												75%	95%
16. Audit Programme													
17a. Proportion of midwives* responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work– reported annually (* includes Cons & Admin)													33.5 %
17b. Proportion of midwives* responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust to receive treatment – reported annually (* includes Cons & Admin)													40.3%
18. 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

REPORT ON THE SAFETY OF MATERNITY SERVICES

Perinatal Quality and Safety Report – Quarter 4 2022/23

REPORT OVERVIEW

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 Local Maternity and Neontal System (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 LMNS via the clinical quality assurance group.

1. Direct Maternal Deaths

As a consequence of a disorder specific to pregnancy, e.g. haemorrhage, pre-eclampsia, genital tract sepsis and maternal suicide

There were 0 direct maternal deaths reported during the month

2. Incidents Graded Moderate Harm or Above

Moderate Harm: Harm that requires a moderate increase in treatment and significant but not permanent harm.

Jan: No cases

Feb: No cases

Mar:

Datix	Summary	Harm Level	Immediate Safety actions
W206531	36+5- CAT 1 LSCS for fetal compromise and placental abruption. HIE confirmed on head MRI day 7. Does not meet HSIB/NHSR referral criteria as <37/40.	Serious incident	Lack of risk assessment antenatally. Gaps and delays in ante/intrapartum care with communication, assessment, escalation and documentation Action: Individualised learning plans with community and intrapartum midwives

3. Cases Eligible for HSIB Referral

Background:

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

Number of cases which qualified for notification to HSIB during the quarter: 0

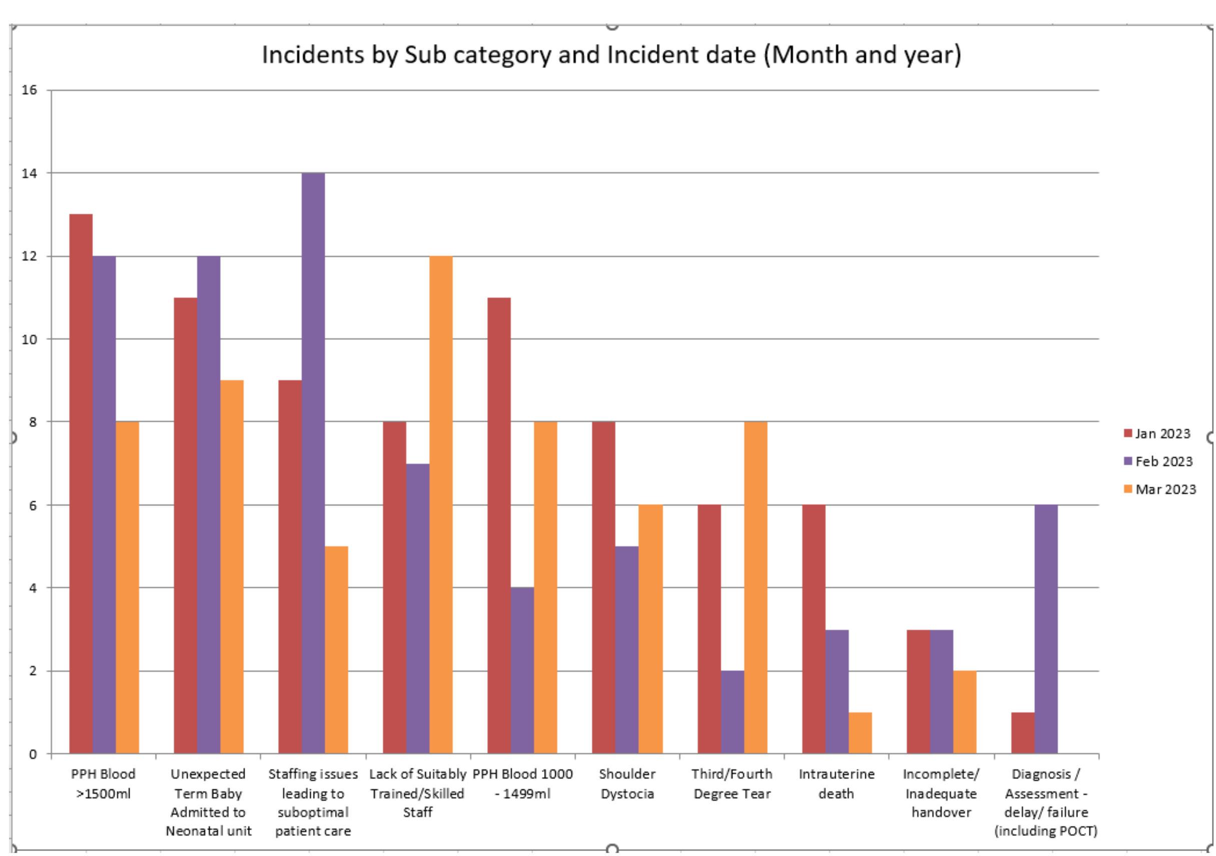
Figure 3a. Current Ongoing Investigations

HSIB Case Number: MI-011049 **Update**: Final report received: 2 safety recommendations: Action plan agreed – for three monthly review through SERG committee
HSIB Case Number: MI-013652 **Update:** Factual accuracy from 5 stakeholders sent and being reviewed by HSIB subject matter advisors and will be subject to a fresh eyes clinical advisor review**.** This investigation has breached the six-month timescale and is being exception reported to DHSC.
HSIB Case Number: MI-014046 **Update:** Awaiting final report. *(update 30.05.23 – delay in final report due to HSIB oversight – final report now received – 3 recommendations)*
HSIB Case Number: MI-015369 **Update:** Final report received. 3 safety recommendations. Action plan agreed – for three monthly review through SERG committee
HSIB Case Number: MI-017775 REJECTED as did not meet criteria for investigation **Update:** HSIB investigation offered to father via another family member & Duty of Candour (DOC) letter sent. To date no contact made by Next of Kin (NOK). Letter written to GP advising if family wish HSIB Re-referral can be made

4. Maternity Incidents Reported

- There were 362 incidents reported during the quarter

4a: The top ten incident categories



- Overdue incidents continue to be a concern, and increased from 139 at the beginning of the quarter to 215 by the end, in comparison to 158 at the end of Q3. An upward trajectory is therefore clear and action is necessary to consider ways in which this figure can be consistently reduced. A weekly meeting between the Patient Safety team and Matrons/B7's is planned in early June, where barriers to be discussed and for a long-term sustainable plan to be agreed.

5. Risk Register

5a: Risk Register Overview

Key Risk Domains	Totals
Total Number of Current Risk's Open [April 2023]	18
Top Risk Themes	**Risk Registers**
Staffing	Divisional Risk Register = 9
	Speciality Risk Register =7
	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	10
4-6 Moderate Risk	6
1-3 Low Risk	0
Highest Scoring Domain	**Risk Domains, Highest to Lowest Totals/Percentages**
Quality	9 (50%)
Safety	8 (44%)
Workforce	1 (6%)

5b: Current Risks on Register

Theme	ID	Ref	Score Breakdown	Current
Midwifery Staffing – Not having sufficient midwives to provide high quality care	3536	WC3536Obs	3x5 Safety; 3x5 Quality; 4x5 Workforce	15 - 25 Extreme Risk
Antenatal Screening – Risk of screening being missed	3845	WC3845Obs	4x4 Quality; 3x4 Workforce; 4x4 Statutory; 3x4 Reputational	8 - 12 High risk
Electronic Health Records – Staff burnout due to lack of systems/processes to support safe delivery of care	3349	WC3349Obs	3x3 Safety; 3x3 Quality; 4x2 Finance	8 - 12 High risk
Failure to achieve KPIs – Uploading booking info, accessing results, instigating further investigations	3482	WC3482Obs	2x3 Safety; 3x3 Quality; 3x3 Workforce	8 - 12 High risk
Maternity HDU – Untrained staff / Risk of closure	3591	WC3591Obs	2x3 Safety; 2x2 Workforce	8 - 12 High risk
Postnatal Ward (TC) – Lack of appropriately trained staff	3606	WC3606Neo/Obs	2x3 Safety; 3x4 Quality; 3x4 Workforce	8 - 12 High risk
Delays in Transfer – Delay in emergency ambulances	3713	WC3713Obs	4x2 Safety; 3x3 Quality; 2x3 Reputational	8 - 12 High risk
Maternity Notes – Incorrect management, storage and transportation of maternity notes	3785	WC3785Obs	3x2 Safety; 4x2 Quality; 2x2 Statutory; 2x2 Reputational; 2x2 Business	8 - 12 High risk
Incomplete Discharge – Not being adequately completed	3795	WC3795Obs	3x3 Safety; 3x3 Quality; 3x3 Workforce; 4x1 Reputational	8 - 12 High risk
Guidelines/Policies – Accessing local policies and up to date clinical guidelines / Not using permanent staff	3850	WC3850Obs	2x4 Safety; 3x3 Quality; 2x4 Workforce; 3x2 Statutory; 2x3 Reputational; 3x3 Business	8 - 12 High risk
IOL – Maternal & fetal health and wellbeing through delay in initiating or continuing the process	3952	WC3952Obs	3x3 Safety; 3x3 Quality; 3x4 Workforce;3x4 Statutory; 3x3 Reputational	8 - 12 High risk
Twin and Triplet Pregnancy – Non compliant with NG137 due to no specialist ultrasound clinic/midwife	3964	WC3964Obs	3x3 Safety; 3x3 Quality; 3x3 Workforce; 3x3 Statutory; 3x3 Finance	8 - 12 High risk
Obstetric Theatre – Inappropriate/inadequate staffing	2798	WC2798Obs	2x3 Safety; 2x3 Quality; 2x3 Workforce; 1x3 Business	4 - 6 Moderate risk
Breast Milk – Risk of babies receiving wrong expressed breast milk	3085	WC3085Obs	2x2 Safety; 3x2 Quality	4 - 6 Moderate risk
Baby Tagging System – Reduced function of system	3255	WC3255Obs/Neo	4x1 Safety; 1x3 Quality; 4x1 Workforce	4 - 6 Moderate risk
Antenatal Care – Compromised quality of scan reviews	3456	WC3456Obs	3x2 Safety; 3x2 Quality; 4x2 Workforce	4 - 6 Moderate risk
Centralised Maternity Booking System – Not receiving a booking appt in a timely manner	3472	WC3472Obs	3x2 Safety; 3x2 Quality; 2x2 Workforce; 3x2 Statutory; 3x2 Reputational	4 - 6 Moderate risk
Triage – Delayed review, identification, treatment	3685	WC3685Obs	3x2 Safety; 2x2 Quality; 3x2 Workforce; 3x2 Statutory	4 - 6 Moderate risk

5c: New Risks added to Register

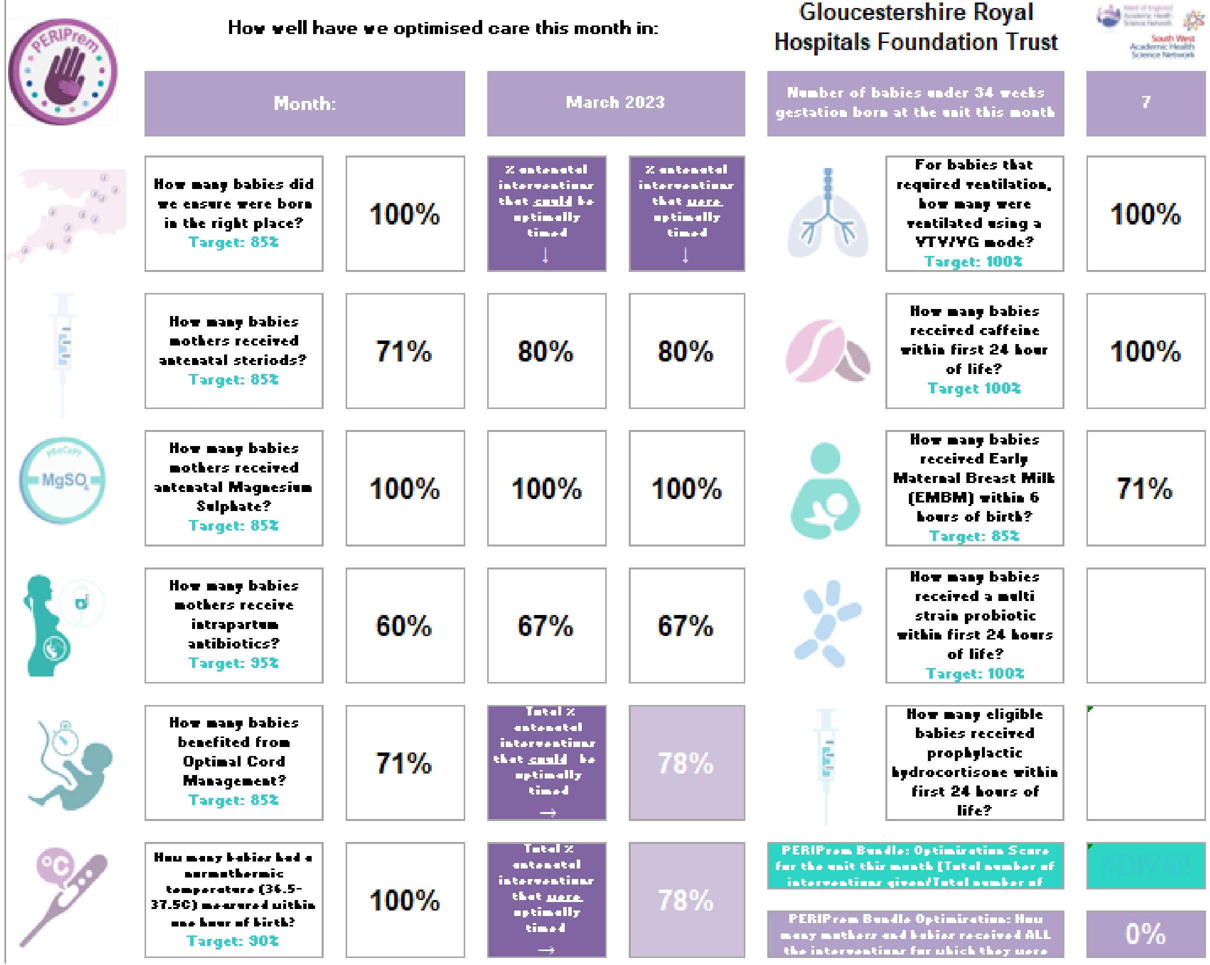
New risks added: 1			
	Risk Number	**Inherent Risk**	**Score**
Maternity	**3964**	The risk of non-compliance with NICE guideline NG137 Twin and Triplet Pregnancy due to no dedicated Multiple pregnancy clinic with a specialist ultrasound clinic or specialist midwife.	Safety = 9 Quality = 6 Workforce = 9 Statutory = 9 Finance = 9

5d: Risks Closed

Risks closed: 2			
Speciality	**Risk Number**	**Inherent Risk**	**Reason Closed**
Maternity	**3602**	The risk to safety for pregnant women when undertaking ultrasound examinations if performance and technical problems with the new viewpoint system are not resolved; due to the incorrect reporting of EFW, PI Doppler index, EDD in addition to the delayed reports due to the slow system at community sights, patient's exam not always moving over to VP6 and duplicate patients moving to VP6 from TRAK.	Viewpoint issues have now been resolved.
Maternity	**3160**	The risk of impact on safe and reliable services due to a shortage of junior medical staff within O&G.	Currently well staffed, there are short terms gaps dues to sickness which are covered.

6. Periprem

6a: Periprem overview March



The following infographic provides a Q4 update of Gloucestershire's PERIPrem dashboard. Moving forward, it is planned that academic health regional benchmarking will be reported, to ascertain if an action plan is required.

6b: Periprem overview Q4:

PERIPREM DATA SUMMARY - 2022/23 Year End

For greater detail on any of the PeriPrem measures please click on the relavant icon

Network Total	PeriPrem Target	Baseline 2019/20	2020/21	2021/22	2022/23	Change from Baseline
		Percentage Meeting PeriPrem Criteria:				
Birth in the right place*	85%	77%	69%	80%	78%	↑ 1%
Antenatal Steroids	90%	90%	91%	89%	88%	↓ -1%
Magnesium Sulphate	90%	83%	84%	87%	89%	↑ 6%
Intrapartum Antibiotics	90%	40%	33%	18%	39%	↓ -2%
Delayed Cord Clamping	85%	45%	65%	68%	74%	↑ 28%
Thermoregulation	90%	67%	63%	64%	69%	↑ 2%
Early Breast Milk	85%	81%	87%	85%	88%	↑ 7%
Caffeine Therapy	85%	75%	82%	83%	82%	↑ 7%
Probiotics	85%	45%	56%	62%	68%	↑ 24%
Prophylactic Hydrocortisone	85%	7%	38%	65%	65%	↑ 58%

*Birth in the right place is a network measure - therefore all units receive the same result

SELECT UNIT: Network Total

PERIPrem

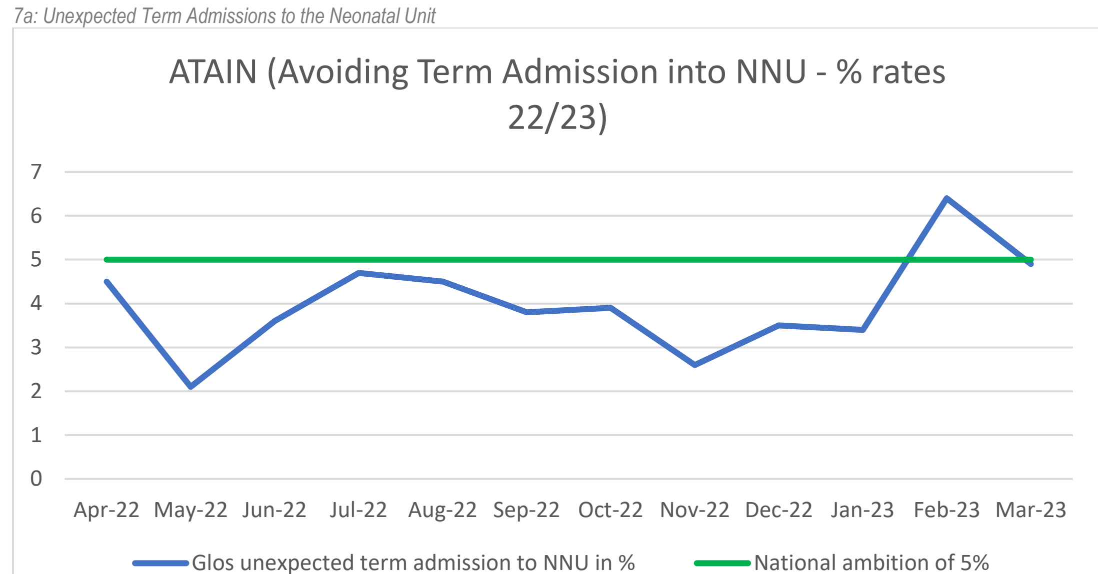
Working in Partnership with: SOUTH WEST NEONATAL NETWORK

Gloucestershire highlights

- 100% magnesium sulphate given
- 100% normothermic temperature – for 3 consecutive months
- 100% caffeine given
- 100% VTV
- 80% optimal timed antenatal steroids – highest since August 2021

7. ATAIN (Avoiding Term Admission to the Neonatal Unit)

7a: Unexpected Term Admissions to the Neonatal Unit



ATAIN admissions for the month are just within the national aim of 5% at 4.9%, this is an improvement on February 2023 which saw an admission rate of 6.4%

The unavailability of maternal hand-held notes continues to cause delays in the review of ATAIN cases by the Patient Safety Team, currently the Maternity Team are reviewing cases from December, however, we are still awaiting some notes from October and November. The neonatal team are currently evaluating cases for March. The launch of Badgernet from 6th June 2023 should improve review timescales

It should be noted that in order to maintain the current review timescales, bank payments are required, with both the Maternity and Neonatal Teams working approximately 7 extra hours each/month.

NATIONAL ASSURANCE PROGRAMMES

8. Scorecard

GHNHSFT MATERNITY SERVICES - Clinical Scorecard Year 2022/2023

MEASURE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Sparkline
MOEWS Chart Present						93%	96.3%	100%	100%	97.5%	86.0%	88.5%	
MOEWS Escalated Appropriately A/N						N/A	N/A	N/A	100%	100%	N/A	100%	
MOEWS Escalated Appropriately P/N						100%	100%	100%	86%	100%	100%	N/A	
1:1 Care in Labour	99%	98%	99%	96%	96%	98%	98%	97%	97%	97%	95%	98%	
Emergency Equipment Checks						89%	96%	99%	94%	98%	96%	99%	
Elearning Compliance	80%	79%	81%	81%	83%	82%	81%	83%	83%	82%	80%	80%	
Appraisal Compliance	60%	60%	59%	60%	69%	62%	66%	70%	75%	75%	74%	75%	
PROMPT Training - part 1									90%	53%	61%	68%	
PROMPT Training - part 2									90%	57%	66%	72%	
Overdue incidents			22	80	26	44	69	no data	158	139 inc. 1 awaiting approval	192 inc. 29 awaiting approval	215 inc. 36 awaiting approval	
Overdue Actions		19	22	17	11	10	8	no data	14	3	3	4	
CO Monitoring at 36/40								80%					
PMA RCS Sessions				6	8	12	23	26	10	21	20		
External Opinion - Requested		2	1	1	1	3	1	1	1	1	0	1	
External Opinion - Attended		0	1	0	1	3	1	1	0	1	0	1	
Covid signage - checked Maternity Ward					100%	N/A	N/A	100%	100%	Embedded in Safe to Respond			

*Data collection ongoing

- Most of the scorecard was completed on time. There has previously been some confusion around responsibility for completion of the scorecard, however the Maternity Patient Safety Lead has now taken ownership and in due course a timetable detailing data collection dates will be forwarded to data sources.
- MOEWs chart present has reduced to its lowest level in 7 months at 87%, it is hoped that with the introduction of Badgernet in June, once it is embedded, a significant increase in compliance will be seen.
- SG L3: The Trust training compliance team have advised they are unable to supply data specifically for SG L3, however this is being explored as data has been previously available.

9. Ockenden

The Ockenden 1 submission is complete, however Ockenden 2 is overdue, in the main due to the many conflicting challenges and requirements of the Maternity management team. Recruitment is underway for a project manager and it is envisaged a single delivery plan will be developed incorporating all reporting actions including SBL, Ockenden, CQC section 29a, MIS etc.

10. Saving Babies Lives SBLCBv2

Ambition: 50% reduction in stillbirths by 2020

Element 1: Reducing Smoking

The number of women smoking at delivery – 9.4%, with a target of <8.0 for 2022 (no target published for 2023). 100% of women were asked to be referred for smoking cessation. Michelle Sterry, the new Healthy Lifestyles lead is due to join the Trust in May.

Element 2: Fetal Growth Restriction

% births >= 37 weeks and <3rd percentile: 2.1%, this is the highest rate in the past 12 months (average 1.3%), (no national goal specified)

% births >= 37 weeks and <10th percentile: 7.6%, the lowest rate since October (average 8.2%) (no national goal specified)

The figures above have been extracted from the latest Perinatal dashboard. Moving forward and with the enhanced Saving Babies Lives in post, there are plans to develop a more detailed presentation and narrative to provide deeper analysis of goals and achievements sustained.

Element 3: Awareness of RFM

No data

Element 4: Effective Fetal Monitoring

Fetal monitoring training compliance has ↑ to 71% (65% in Feb)

Element 5: Reducing Pre-Term Births

Births < 37/40: 121
Births < 34/40: 25
Births < 27/40: 7

Live births < 24/40: 2
Live births < 22/40: 2

11. CQC Section 29a

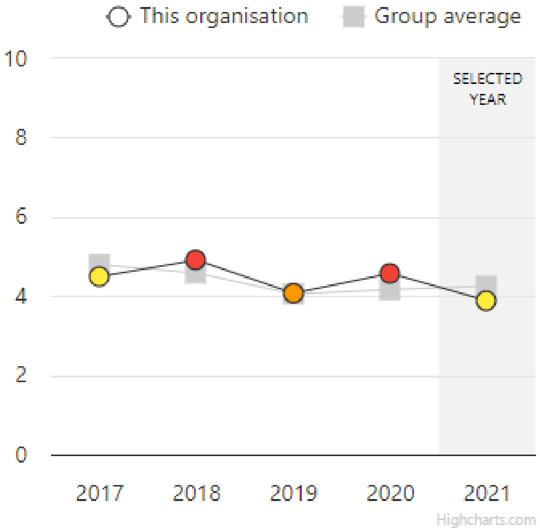
Section 29a served May 2022 and ongoing action plan being implemented.

12. Maternity Incentive Scheme Y4

The MBRRACE-UK perinatal mortality report of perinatal deaths of babies born in 2021 within this Trust is now available. This is a supplementary report exclusively about stillbirths and neonatal deaths of babies born within the Trust in 2021. It contains information in addition to that which will appear in the published national data, specific to this Trust and is only available to GHNHSFT.

The data for March 2021 is really encouraging and shows the Trust Mortality rate is 3.88, against a 'group' average of 4.25/1000 births.

12a: Mortality rates, by year
Stabilised & adjusted rate per 1,000 total births of the total number of extended perinatal deaths



<u>Action 1: Perinatal Mortality Review Tool</u>
Ambition: All perinatal deaths eligible to be notified to MBRRACE

Stillbirths reported during the quarter: 4

24+3 Presented at 24+1 having not felt movements for 4/7, confirmation that sadly baby had died, 3rd percentile

25+3 23+3 fetal medicine scan, tailing growth, increased EDF resistance. Scan findings discussed at length – fu 2/52. Attended at 25+3 for GTT & FM review – no cardiac activity. Baby on 1st percentile

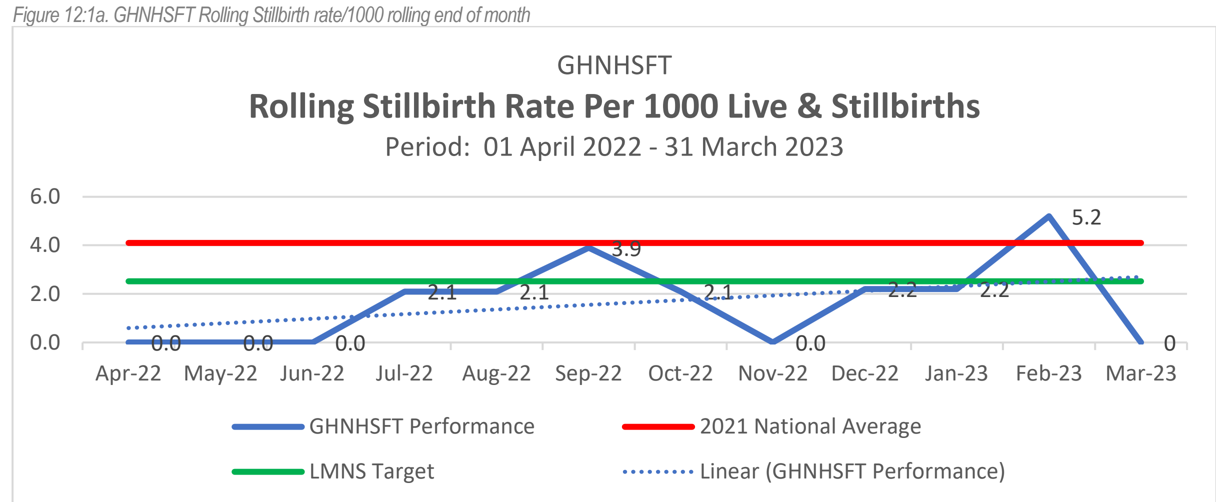
25+1 Globular placenta, tailing growth, oligohydramnios, poor dopplers, warned during antenatal period of high risk of IUD.

Neonatal deaths reported during the quarter: 4

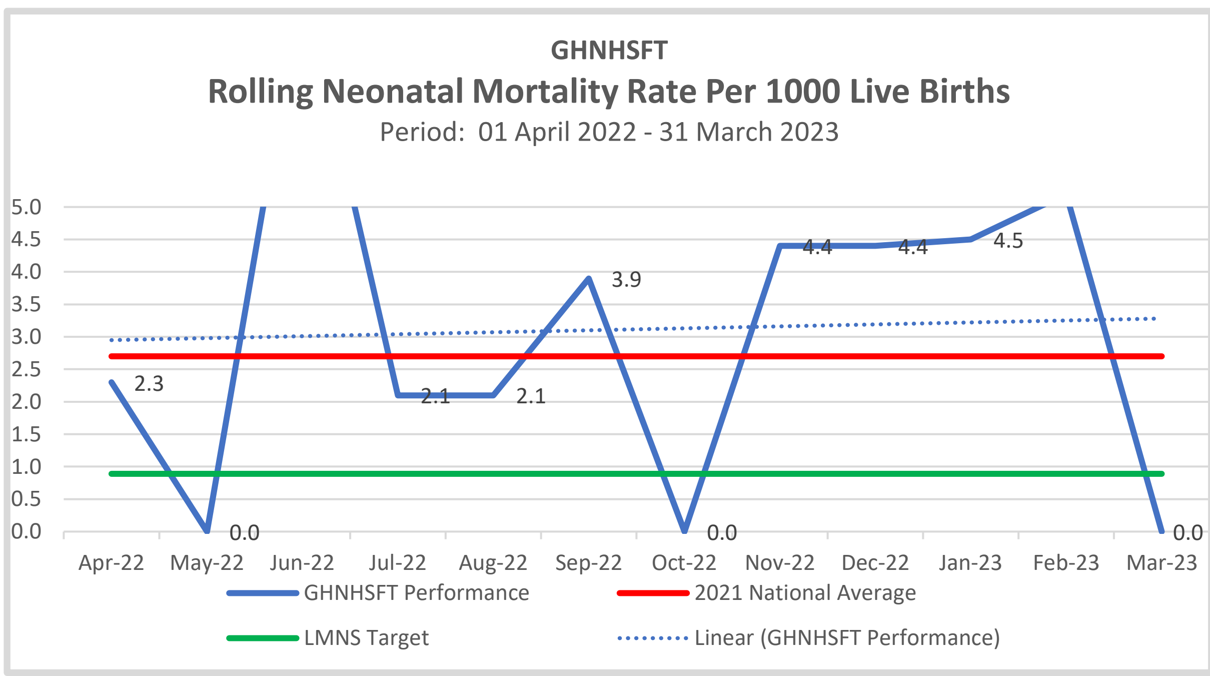
19+3 Born with signs of life
18+4 Born with signs of life
24+0 DCDA Twins, <u>transferred and died in Bristol</u>. T1 4 days of age, T2 2 days of age

The following graphs demonstrate how GHNHST is performing against the national ambition:

Figure 12:1a. GHNHSFT Rolling Stillbirth rate/1000 rolling end of month



Whilst the still birth figure is 0 – the linear value has seen a steady incline since April 22 to a high of around 2.25



The Neonatal deaths for the year are labile with a highest rate in June 22 of 8.5/1000 births, the linear rate however shows a less dramatic rate of around 3.5/1000.

Perinatal Mortality Reviews for Q4 2023 (cases reported to MBRRACE in Mar *, Aug*, Oct, Nov, Dec 2022)

PMRT Grading of Care:
A. No issues with care identified
B. Care issues that would have made no difference to the outcome
C. Care issues which may have made a different to the outcome
D. Care issues which were likely to have made a difference to the outcome

Oct

Datix Number	Incident Category	Outcome/learning/Actions
MRN0730624*	No harm	**Neonatal Death – baby born and died in St Michaels Aug – Review of antenatal care**: (delayed review as awaiting case to be referred from other Trust) The care provided to the mother and baby up to the point of the birth of the baby = A 25+4 IUGR/PET Actions: Nil
MRN0904528*	No harm	**Neonatal death – baby born and died UHBW – review of antenatal care (**delayed review as awaiting case to be referred from other Trust) 24+0 performed ileum (baby lived for 9 days) The care provided to the mother and baby up to the point of the birth of the baby = A Actions: Nil

Nov:
No cases for discussion

Dec

Datix Number	Incident Category	Outcome/learning/Actions
W198273 MRN4274621	No harm	**Stillbirth:** The care provided to the mother and baby up to the point that the baby was confirmed as having died = B Graded **'B'** for AN care provided to the mother due to: • The timings and clinical decision making appeared sound bar the rational for not administering steroids. It is unclear why this was the case. Delivery occurred within 90minutes of arrival to the hospital. • The growth scan performed at 18 weeks was performed outside of a scheduled ANC appointment and therefore reviewed by the on-call team and appropriately a referral to fetal medicine team was made at this point. • The care provided to the mother following confirmation of the death of her baby = A **Actions: nil.** 05/01/2023 Parents sent MBRRACE feedback form, letter and bereavement card to advise them on the process and ask for their perspectives/questions.
W196502 MRN4137039	No harm	**Neonatal Death:** The care provided to the mother and baby up to the point of the birth of the baby = B Graded **'B'** for AN care provided to Mother due to: • We did not contact tertiary centre when presented with significant APH at gestation <27/40. Agreed not suitable for IUT given the clinical context of ongoing bleeding but national push & gold standard would be to discuss all patients with colleagues in tertiary neonatal centres in order to make such decisions jointly and in case the window of opportunity arises.

		The care provided to the baby from birth up to the point of transfer = A The care provided to the mother following the birth of her baby = A **Actions: Nil** 20/1/2023 Parents sent MBRRACE feedback form, letter and bereavement card to advise them on the process and ask for their perspectives/questions.

Action 2: Maternity Service Data Set (MSDS)

Action 3: Transitional Care Services:
No data available

Action 4: Medical Workforce Planning – **March data**

Mid grade rota gaps: 35 – gaps covered by consultants
Obstetric consultant rota gaps: 17 – this figure is abnormally high due to consultants filling gaps in mid grade rota due to doctors strikes

Action 5: Midwifery Workforce Planning:

A monthly paper is submitted to MDG (Appendix 1). Whilst progress continues within recruitment and retention, the vacancy rate has increased to its highest level at 13.73% in March 2023. Whilst maternity leave is declining and sickness has reduced, the vacancy rate has increased. The **vacancy of 29.67 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. This has led to increased posts in Maternity Triage to support the BSOTS approach. The Birthrate plus report (Appendix 2) has been received indicating a positive variance of 4.77wte. This is based on an uplift of 21% which is low in comparison with neighbouring maternity services, but aligned with GHT nurses uplift. The national competency framework is likely to propose an increased uplift in response to an anticipated 5 day mandatory training. The recommendation to the Divisional Quad and Chief Nurse is that the establishment is not decreased in response to the Birthrate plus report in light of this.

Action 6: SBL Care Bundle

Consultant midwife who has recently joined trust will be leading on the SBL care bundle due to recent, previous experience with SBL. Band 6 midwife to be recruited to Governance team to support the development of this care bundle to meet national standards.

Action 7: Patient Feedback (service user voice feedback – March data)

Figure 12:7a. Patient Complaints

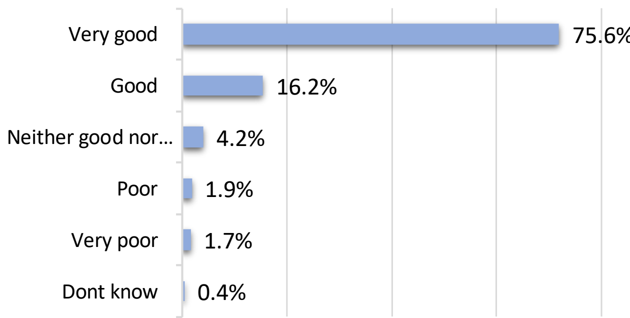
Date received	Number	Specialty	Subject	Due date
01/03/23	64242	Maternity	Poor attitude of MCA on ward	19/04/2023
01/03/23	64249	Maternity	Son has been diagnosed with Global Development delay and feels that problems during her pregnancy may have contributed to her son's current issues.	19/04/2023
06/03/23	64393	Maternity	Poor handover and communication resulting in a delayed discharge. Lack of diversity regarding discharge video.	25/04/2023
17/03/23	64530	Maternity	Poor attitude of midwife	05/05/2023

17/03/23	64616	Maternity	Patient arrived for appointment. No midwives available. Failed appointments previously	05/05/2023
31/03/23	64702	Maternity	Lack of communication and post treatment complications.	24/05/2023

Figure 12:7b. FFT Overview

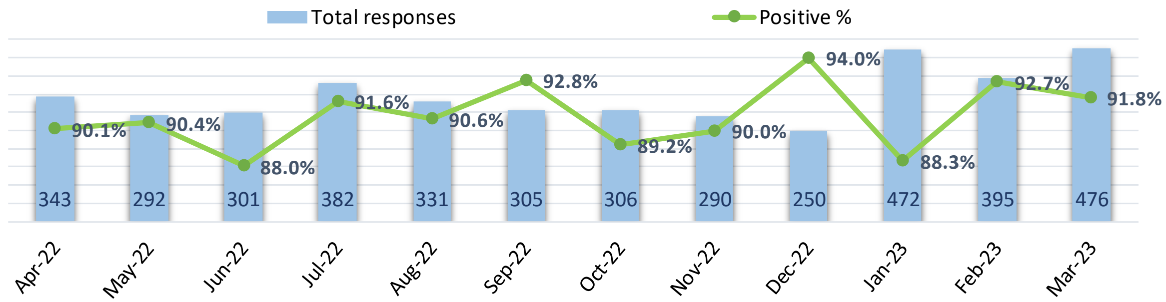
Question 1: Overall, how would you rate your experience of our service?

Answers	Responses
Very good	360
Good	77
Neither good nor poor	20
Poor	9
Very poor	8
Dont know	2
Total Responses	**476**



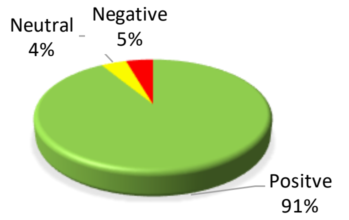
Question 1: Positive responses

The below chart shows the percentage of positive feedback (very good + good) received each month

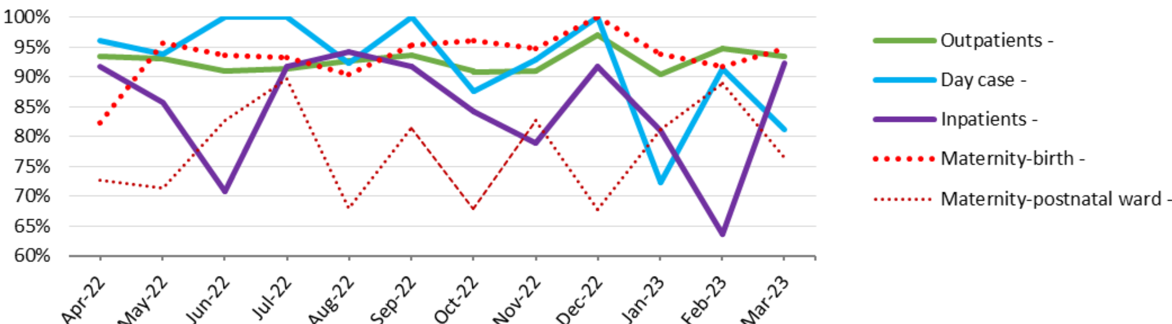


Question 2: Comments

Comments received	
Positve	346
Neutral	16
Negative	17
Grand Total	379



11:7c Percentage of Positive responses by area:


Percentage of Positive responses by Care Type (All) Women & Children
100%
95%
90%
85%
80%
75%
70%
65%
60%
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Outpatients -
Day case -
Inpatients -
Maternity-birth -
Maternity-postnatal ward -

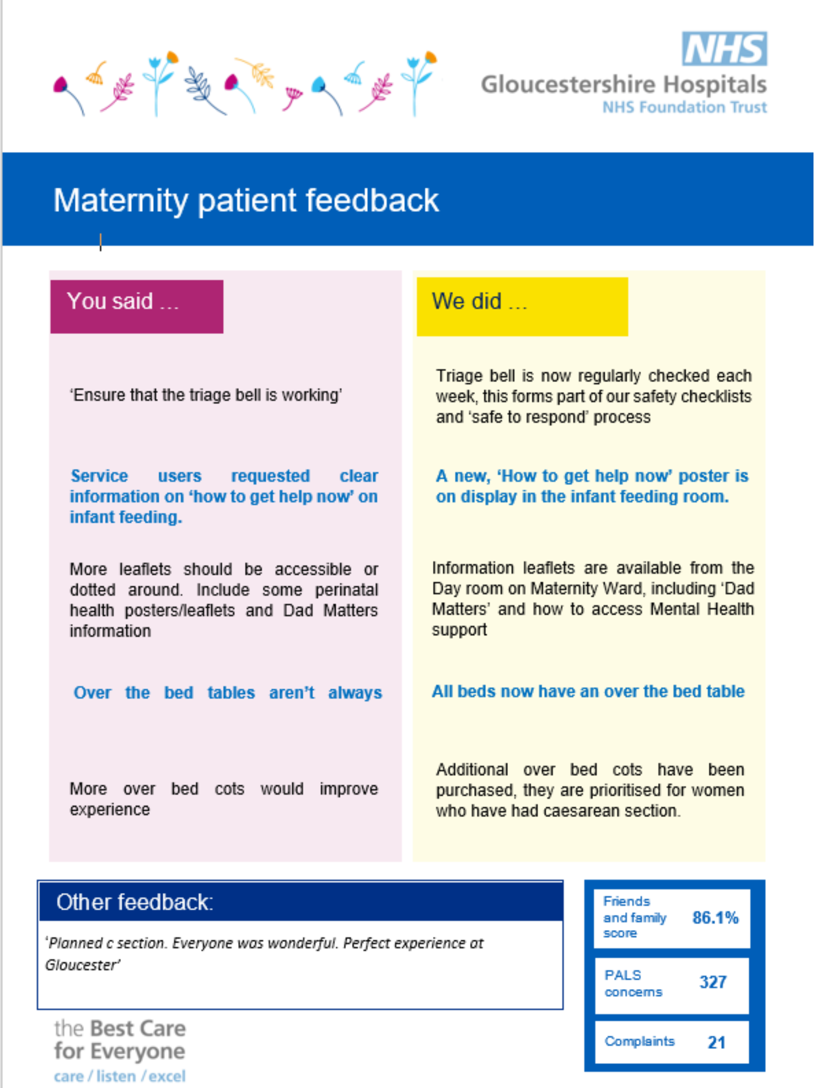
12:7c Percentage of Positive responses by area:

Ward/Unit	Very good	Good	Neither	Poor	Very poor	Dont know	Total	Positive%
Birth Unit, GRH	4						4	100.0%
Home/Other						1	1	0.0%
Delivery Suite, GRH	23	9	1				33	97.0%
Maternity Ward, GRH	18	8	4	2	2		34	76.5%
Total	**45**	**17**	**5**	**2**	**2**	**1**	**72**	86.1%

Maternity Voices Partnership

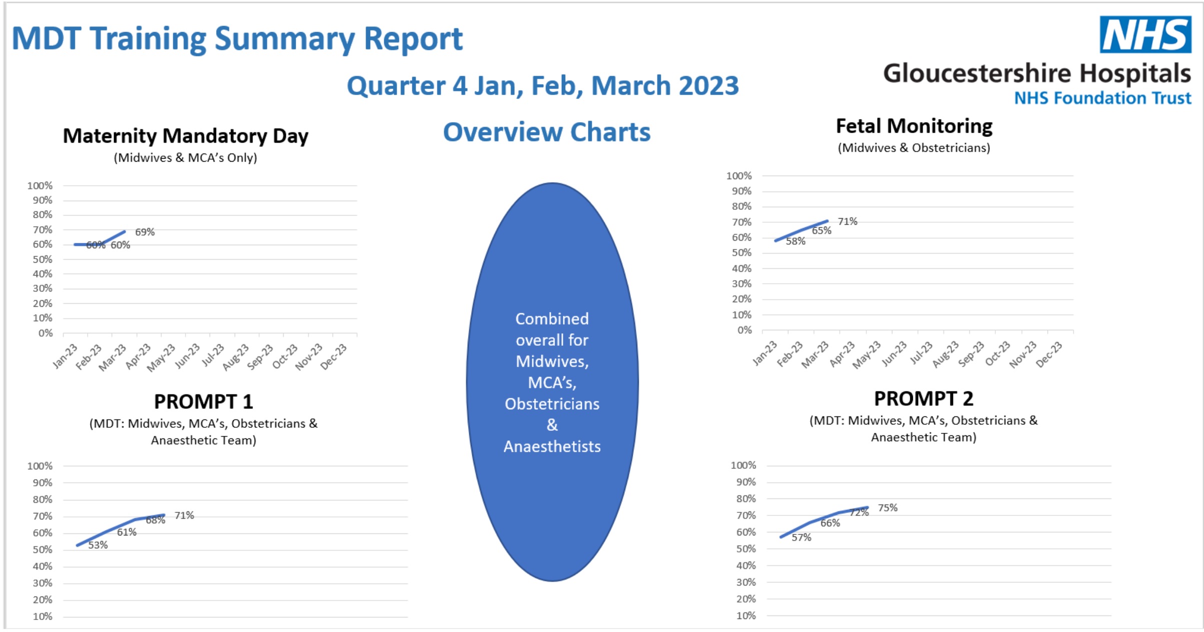
The MVP has hosted 2 MVP meetings since November 2022. These are open to women, partners, professionals and advocacy groups.

The 15 steps methodology was conducted in the summer of 2022. Feedback from that event has been shared:



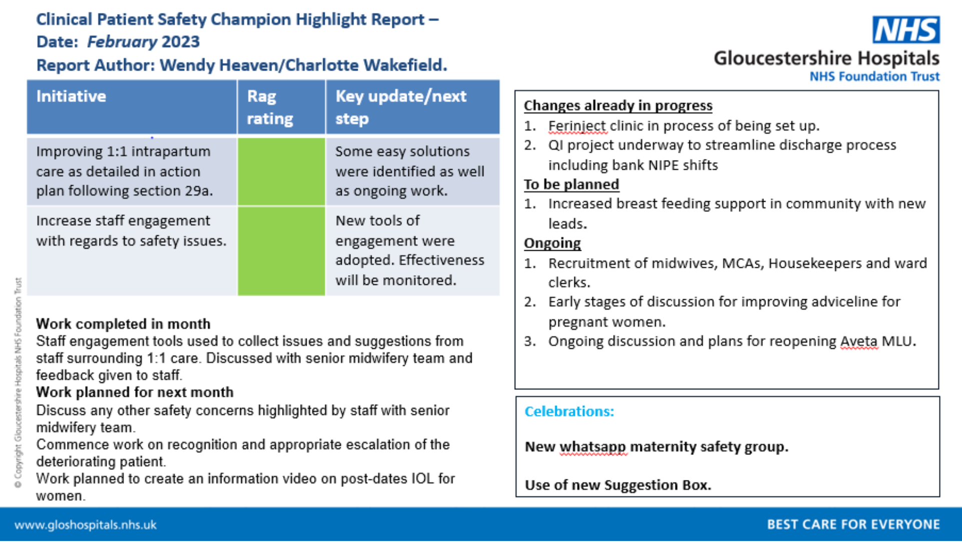
Action 8: In-House Training

Figure 12:8a. Division Training Compliance Overview



Action 9: Safety Champions

Patient Safety Champions are the important conduit between leadership and clinical team and during Quarter 4 there were two clinical midwives employed in this role to complement NED, DOM, CoS.



Clinical Patient Safety Champion Highlight Report –
Date: *February* 2023
Report Author: Wendy Heaven/Charlotte Wakefield.

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Initiative	Rag rating	Key update/next step
Improving 1:1 intrapartum care as detailed in action plan following section 29a.		Some easy solutions were identified as well as ongoing work.
Increase staff engagement with regards to safety issues.		New tools of engagement were adopted. Effectiveness will be monitored.

Work completed in month
Staff engagement tools used to collect issues and suggestions from staff surrounding 1:1 care. Discussed with senior midwifery team and feedback given to staff.
Work planned for next month
Discuss any other safety concerns highlighted by staff with senior midwifery team.
Commence work on recognition and appropriate escalation of the deteriorating patient.
Work planned to create an information video on post-dates IOL for women.

Changes already in progress
1. Ferinject clinic in process of being set up.
2. QI project underway to streamline discharge process including bank NIPE shifts

To be planned
1. Increased breast feeding support in community with new leads.

Ongoing
1. Recruitment of midwives, MCAs, Housekeepers and ward clerks.
2. Early stages of discussion for improving adviceline for pregnant women.
3. Ongoing discussion and plans for reopening Aveta MLU.

Celebrations:

New whatsapp maternity safety group.

Use of new Suggestion Box.

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Action 10: ENS

Compliance remains at 100% cases reported

13. Coroner Regulation 28 made directly to Trust

Nil not applicable

14. NICE Guidance

14a: Nice Guidance Tracker

Title	NICE ref	Specialty	Date of Publication / update	Date email sent requesting lead name	Date Lead name due or confirmed as not applicable	Date lead name supplied or confirmed as not applicable	Lead Assigned (name)	3 Month deadline date - to provide baseline assessment and action plan	Date baseline assessment and action plan received	9 Month deadline date - to confirm action plan completed and/or closed via Risk Register
Postnatal care	NG194	Maternity	20/04/2021	21/05/2021	11/06/2021	21/05/2021	S Maxwell	01/08/2021		01/02/2022
Inducing labour	NG207	Maternity	04/11/2021	06/12/2021	27/12/2021	07/12/2021	R Evans Jones	01/03/2022		01/09/2022
Tobacco: preventing uptake, promoting quitting and treating dependence	NG209	Maternity and Medicine	16/01/2023	07/02/2023	27/02/2023	27/02/2023	P Seaborn Williams	01/08/2023		01/11/2023
Obesity: identification, assessment and management	CG189	Maternity, D+S and Surgery	08/09/2022	15/09/2022	05/10/2022	15/09/2022	V Abitha	01/12/2022		01/06/2023
Intrapartum care for healthy women and babies	CG190	Maternity	14/12/2022	04/01/2023	24/01/2023	04/01/2023	A Lester	01/04/2023	29/03/2023	01/09/2023
Fetal monitoring in labour	NG229	Maternity	14/12/2022	04/01/2023	24/01/2023	04/01/2023	Leena Elbeshair	01/04/2023		01/09/2023
COVID-19 Rapid Guideline: Managing COVID-19	NG191	Maternity, Paediatrics, Neonates, Maternity & Gynaecology	29/03/2023				S Pirie			01/10/2023

Work has been undertaken by the new interim Patient Safety Leads to review the current position and compliance. The above table is an accurate representation:

NG194 Postnatal Care:	This is a significant piece of work, which has over 100 elements. SM has confirmed work will commence in June.
NG207 Inducing Labour:	MCH 17.2.23 – agreed compliant – however need e-mail from lead to confirm
CG189 Obesity:	9 month deadline 01/06/23 – has been chased – awaiting feedback

15. POPAM Storage

Overall Compliance of 95%

15a: Safe Storage Compliance

Standard	Area				Overall Compliance %
	AN	BU	CDS	MAT	
3. Drugs cupboard locked	100%	100%	100%	100%	100%
4. Drugs left out	100%	75%	100%	75%	85%
6. Fridge temp. monitored	100%	100%	100%	92%	98.6%

16. Audit Update

MAP Progress Report & Year End Evaluation

April 2023

Total number of audits underway = 73 audits and 6 QI projects

Priority 1 = 42 (Green = 66% (n27,) Amber = 15% (n6), Red = 19% (n8))

Topic (Led by)	Source/Priority	Progress
* Preterm labour and birth (OBS)	SBLCBv2 / 1	MCG Dec 22
*Women centred decision-making (MDT) - see also shared decision making	Ockenden / 1	baseline audit from 11.05.22 to ascertain if booklet in packs and being used- draft report 08.06.22
2nd swab count in theatre	Incident W169747	Details of this audit to be forwarded to Tri, L Stephens, Matrons, Obstetric Risk Lead, Obstetric Speciality Lead, Obstetric Governance Lead, W&C Lead for Quality. A further LASER will be circulated throughout the Division highlighting these findings
Antenatal CO screening (MW)	SBLCBv2 / 1	Quarterly as part of SBLv2
Antenatal screening (MW)	ANSOG	Update requested Dec
Anti D administration for Rh negative women	Incident W181887	Completed by risk team
Audit of women's plans where Dawes/Redman criteria not met	Incident	TBC post Badgernet launch
Avoiding Term Admissions into Neonatal units - ATAIN (MDT)	NHS ENG / 1	Q2 Report shared with staff via email 09.05.22 March 23- D/W EC Quarter 3 data completed, Q4 in progress therefore suggested single end of year summary report
Bladder care (MDT)	CQC / 1	Nov 22 Report of intrapartum bladder care
Breastfeeding (MW)	BFI / 1	March 23- New BF MWS in post, will locate Dec report if possible and review audits for 23-24 10.01.23 emailed ZF and SM
		17.01.23 SM fed back that audit data sent to UNICEF for BFI before Xmas.
CO 4ppm or more at booking (Audit 20 consecutive cases)	SLCBv2	10.01.23 PSW emailed re any audit data
Complex pregnancies (OBS) plan	Ockenden / 1	Actions to Matrons meeting, closed
Consultant presence at difficult births	CQC/1	10.06.22 Data requested from Information Unit. Monthly collection via WR proforma
Controlled drugs in MLU	CQC/1	10.06.22 To start 20.06.22- Completed, actions to Matrons
High risk trisomy results (MW)	ANSOG / 1	Due June 22
Interpretation services	Local	Launch in April 23
Intrapartum Care Ongoing Risk assessment-part of intrapartum care audit	W149879	Intrapartum risk assessment also in Place of Birth Risk assessment and Midwifery led care Intrapartum audit
Journey to Parenthood Personalised Maternity Care plans Shared decision making	Ockenden / 1	D/W Tracy Browning. Plan is to undertake a spot audit in ANC to ascertain if women have the booklets; if women are filling them in and if staff are reviewing them with women. As line 2. Draft report of baseline written 08.06.22
Latent & Intrapartum care (MW)	Trust / 1	Reviewed at Matrons meeting in Nov and actions closed
Maternal Medicine Pathway	Ockenden / 1	Completed, actions done
MDT handover and ward rounds (MW)	Ockenden / 1	Ongoing monthly, actions taken up at Matrons meeting Nov 22
Midwife Led	Ockenden / 1	Peer reviews are taking place. The MLU report for 2021 is drafted and this will be used for information. D/W Annie
Midwife PGD all areas audit (MW)	CQC / 1	Actions taken up at Matrons meeting Nov 22
Modified Obstetric Early Warning Score (MOEWS)	CQC/ 1	Spot audit, monthly for 12 months (Aug)
Multiple birth outcomes (OBS)	MBRACE / 1	Presented 01/07/22 Awaiting final report 10.01.23 emailed Maggie and Leena
Neonatal SBR	CQC/1	MCG Dec 22
Newborn blood spot screening	NHSP/PHE / 1	MCG Sept 22
Newborn hearing screening	NHSP/PHE / 1	Annual KPI sent to CEI Sept 22 by KM
Newborn Infant Physical Examination (NIPE)	ANSOG / 1	Annual KPI sent to CEI Sept 22 by KM
Oxytocin (? sticker) - part of intrapartum care audit	CQC/1	Part of intrapartum care audit
Patient Information leaflet	CQC/1	Closed, for PDM actions
PeriPrem Project (MDT)	SBLCBv2 / 1	Report shared at LMNS 20/09/22
Place of birth risk assessment (MW)	Ockenden / 1	D/W Annie Lester. 200 booklets were available in dec 2021 but there are 550-600 bookings per month. More have since been delivered but a complete audit will need to be undertaken in Autumn. The community team leaders are looking at 10 sets of notes per month and we will look at how we can collate this information to share with both management and the teams.
PPH over 1500ml (OBS)	Trust / 1	Monitored via PPH Project, maternity dashboard and monthly PPH risk meeting
Reduced fetal movements - computerised CTG	SLCBv2	08.06.22 Report received from RP
Safeguarding Spot Audit	J20 Mat	
SBAR audit	CQC /1	10.06.22 Data collected. To be analysed over next week and report written March 23- Report June 22, actions with MP
Scan competency	CQC/1	10.06.22 Training list requested from GS for scan review.
Sepsis screening tool (MDT)	CQC / 1	Caroline audited.
Sickle cell and Thalassaemia declines (MW)	ANSOG	
Small for gestational age (OBS)	SBLCBv2 / 1	Previous audit completed July 2021 10.06.22 Data collection in progress
TTO's	J20 mat	10.06.22 Data being collected weekly **March 23 - BN to discuss with ER re actions and re-audit**

Priority 2 = 15 (Green= 54% (n8), Amber = 6% (n1), Red = 40% (n6))

Topic (Led by)	Source/Priority	
*Hand hygiene audit (MW) (Trust)	Trust / 2	These are on SharePoint for infection control
*Infection control audit (MDT) (MAAS?)	Trust / 2	These are on SharePoint for infection control
Caesarean section births (MDT)	Trust / 2	10.01.23 emailed Ida Muslim and Leena - has there been one? 15.01.23 IM replied that no formal audit done. Handed to S Boctor.
Clinical Record Keeping	CQC/national/ Trust/2	Actions agreed MCG June 22
Complex pregnancy booking	Ockenden / 2	Reviewed at Matrons meeting in Nov, actions closed
Induction of labour (OBS)	Trust / 2	Underway
Maternity tissue viability risk assessment (MDT)	Trust / 2	10.01.23 emailed Mia 17.01.23 Audit not started due to capacity

17. Proportion of Midwives responding with 'agree' or 'strongly agree' on whether they would recommend this Trust as a place to work or receive treatment

This information is collated via the NHS staff survey. The midwifery only comments can be acquired from each individual cost centre, however are only published if the number of respondents is greater than 11. The figure reported below comprises midwives and a small proportion of obstetricians and admin. A Single, reliable data source requires a specific question in the staff survey. Significant work is underway around safety and leadership culture

17a. Proportion of midwives* responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work– reported annually (* includes Cons & Admin)	33.5 %
17b. Proportion of midwives* responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust to receive treatment – reported annually (* includes Cons & Admin)	40.3%

18. **<u>Proportion of Speciality Trainees in Obstetrics & Gynaecology responding with 'good' or 'excellent' on how they would rate the quality of clinical supervision out of hours</u>**

This data is provided by the Obstetric Clinical Training lead. The 2022 GMC Training Survey shows NTS results for trainees in each programme group within a trust/board and presents the results of the HEE SW Geographic Deanery. GHNHSFT scored 3rd across all 6 trusts at 90.97 %

Trust/Board in HEE SW	Clinical Supervision out of hours – O&G
GHNHSFT	90.97
Highest	92.71
Lowest	87.50

Appendix 1

Report to Maternity Delivery Group			
Agenda item:	-	**Enclosure Number:**	-
Date	10th May 2023		
Title	Maternity Workforce paper – Monthly Summary		
Author /Sponsoring Director/Presenter	Lisa Stephens – Director of Midwifery (DOM) / Chris Edwards (SD)		

Summary of Report

Background

Maternity Workforce continues to be subject to scrutiny associated with national reports. Locally midwifery staffing is of significant concern and remains on the risk register with a score of 20.

Purpose

The purpose of this paper to the MDG is to summarise monthly data and activity around midwifery and obstetric workforce.

Overview of Key Issues

Midwifery vacancies remain of concern, however efforts by the Recruitment and Retention team are focussed on both retention and recruitment strategies to close the gap. The vacancy rate in March has increased again due to a number of factors. January vacancy rate was 7.62% compared with 11.68% in February and **13.73% in March.** Extensive recruitment and retention is being led by the R&R team. Consideration should now be given to the commencement of consultation on Wider Unit On Call contribution and HR support has been requested again. This will require significant HR and Senior Midwife resource. Whilst there has been fragility within the senior midwifery team significant recruitment efforts in February and March has led to the successful appointment of; 3 new Midwifery Matrons (Total Matron Headcount 5 with one on LTS), Interim Head of Midwifery (18 months), Interim Maternity Governance Lead. The Consultant Midwife commenced at the end of March. Birth to actual midwife ratio fluctuates monthly and remains green. Fill rate remains Green. Clinical red flags are captured through 4 hourly Birthrate plus acuity tool. The most common red flag is Delay between admission for induction and beginning of process. Compliance of 100% in One-to-one care in labour is still not achieved. 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 tool is being reviewed to support data collection and the new version will be web based allowing higher quality data capture and extraction.

The Birthrate plus final report has been received indicating a positive variance of 4.77wte. This is based on an uplift of 21% which is low in comparison with neighbouring maternity services, but aligned with GHT nurses uplift. The national competency framework is likely to propose an increased uplift in response to an anticipated 5 day mandatory training. The recommendation to the Divisional Quad and Chief Nurse is that the establishment is not decreased in response to the Birthrate plus report in light of this.

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. Consultant Obstetricians covered Junior doctors rotas during the March Industrial Action.

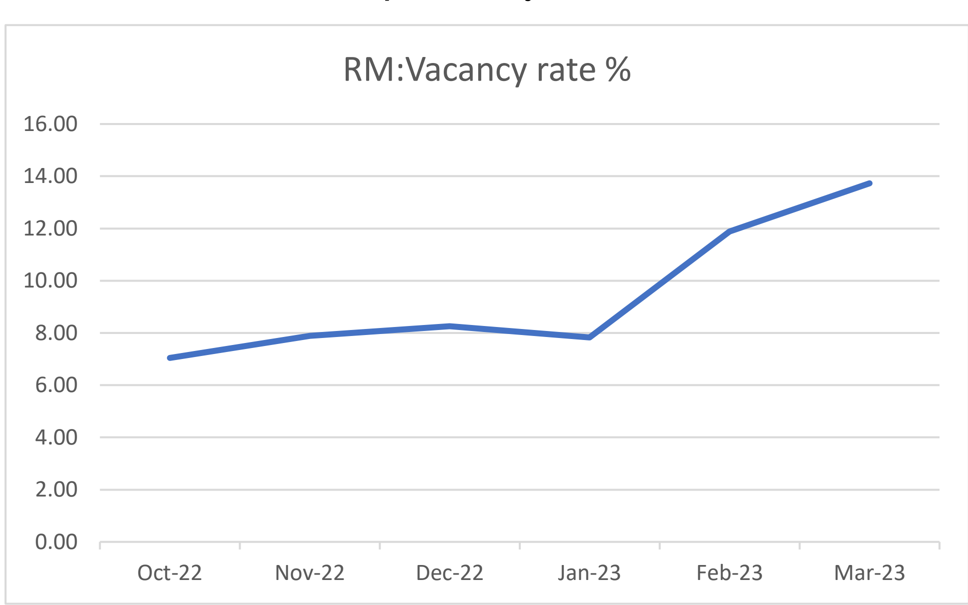
Midwifery Vacancies

The midwifery service remains under establishment at 29.67 WTE in Band 5/6 and 7, which has been an increase to rates since again since February of 25.30 WTE in last seen in September 2022**.** This is a significant concern given the extensive efforts in Recruitment and Retention in the past year.

Vacancy Rate

Whilst the vacancy rates showed a downward trajectory last seen in January, this is now upward. January vacancy rate was 7.62% compared with 11.68% in February and 13.73 in March.

Graph: Vacancy Rate %



Turnover, absence and sickness

During March 2023 there was **53.69 WTE** shortage of midwifery staff due to combined vacancies, maternity leave, and sickness absence. Whilst maternity leave is declining and sickness has reduced, the vacancy rate has increased.

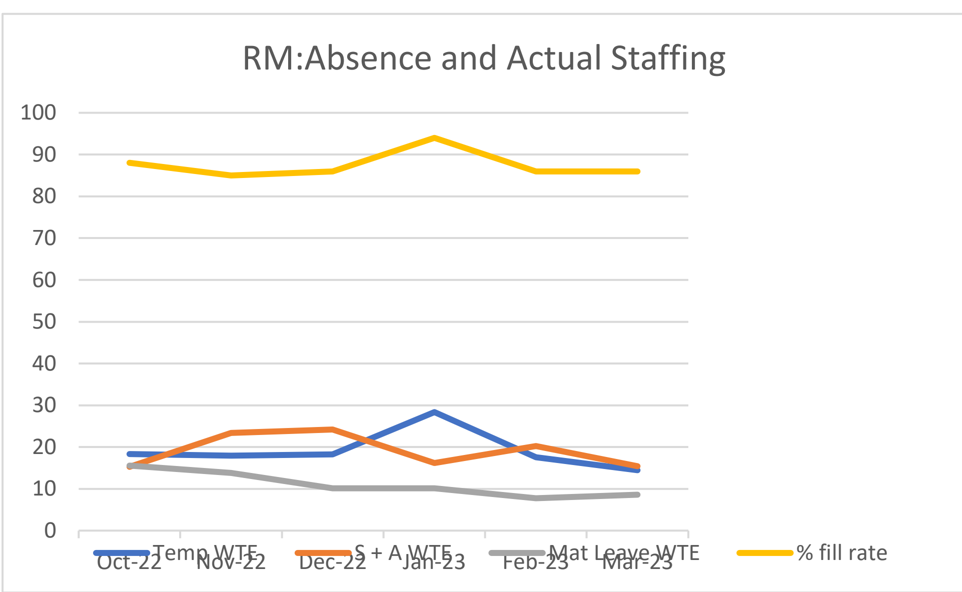
Table: Staffing leave/ absence and secondment (Source: Health-Roster)

Month/Yr	Sickness Absence WTE	Maternity Leave WTE
Jul-22	26.88	17.47
Aug-22	20.58	17.99
Sep-22	20.22	17.73
Oct-22	15.27	15.56
Nov-22	23.35	13.83
Dec-22	24.2	10.14
Jan-23	16.15	10.15
Feb-23	20.23	7.75

Mar-23	15.42	8.60

The **vacancy of 29.67 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. This has led to increased posts in Maternity Triage to support the BSOTS approach.

Graph: Absence and Actual Staffing



Planned versus actual midwifery staffing (Fill rate)

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. Fill rates have been stable since October 2022. This is monitored on a daily basis and staff are redeployed across the service based on activity and the acuity. There were a number of new starters in September and October 2022, and then again in January and February 2023, which following a period of preceptorship contributed to the improved fill rates. Incentives for; bank shifts, oncall and standby shifts have led to ongoing uptake by midwifery staff which has contributed to overall fill rate. All of the actions outlined are designed to maximise staffing into critical functions to maintain safe care for the women and their babies.

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

Month	Fill rate - percentage
Jul-22	81

Aug-22	74
Sep-22	82
Oct-22	87
Nov-22	85
Dec-22	86
Jan-23	94
Feb-23	85
Mar-23	86

Safer Staffing and Quality Indicators

National Standards on Midwifery Staffing are assoicated with NICE Safer Staffing Guideline. Additional benchmarks are presented alongside national standards.

One to One care in labour
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.

1:1 Care in labour compliance (Source: Trakcare)

Month	1:1 care in labour compliance
July 2022	96%
Aug 2022	96%
Sep 2022	98%
Oct 2022	98%
Nov 2022	98%
Dec 2022	97%
Jan 2023	96%
Feb 2023	95%
Mar 2023	96%
Average	**97%**

Midwife to Birth Ratio
Accepted midwife to birth ratio is 1:28. Midwife to birth ratio has been calculated monthly to provide actual ratio based on: Establishment – vacancies – absence (Sickness & absence + mat leave) + Temporary Staffing = Actual Midwife. The (Monthly Births x 12)/ Monthly Actual Midwife = comparative monthly figure to illustrate fluctuations in ratio as presented below. The data is presented following alignment of locally held data.

Table: Midwife to Birth Ratio (Source: ESR/Health Roster)

Month	Midwife to Birth Ratio
Jul 2022	1:29
Aug 2022	1:32
Sep 2022	1:31
Oct 2022	1:27
Nov 2022	1:27
Dec 2022	1:26
Jan 2023	1:24
Feb 2023	1:23
Mar 2023	1:22

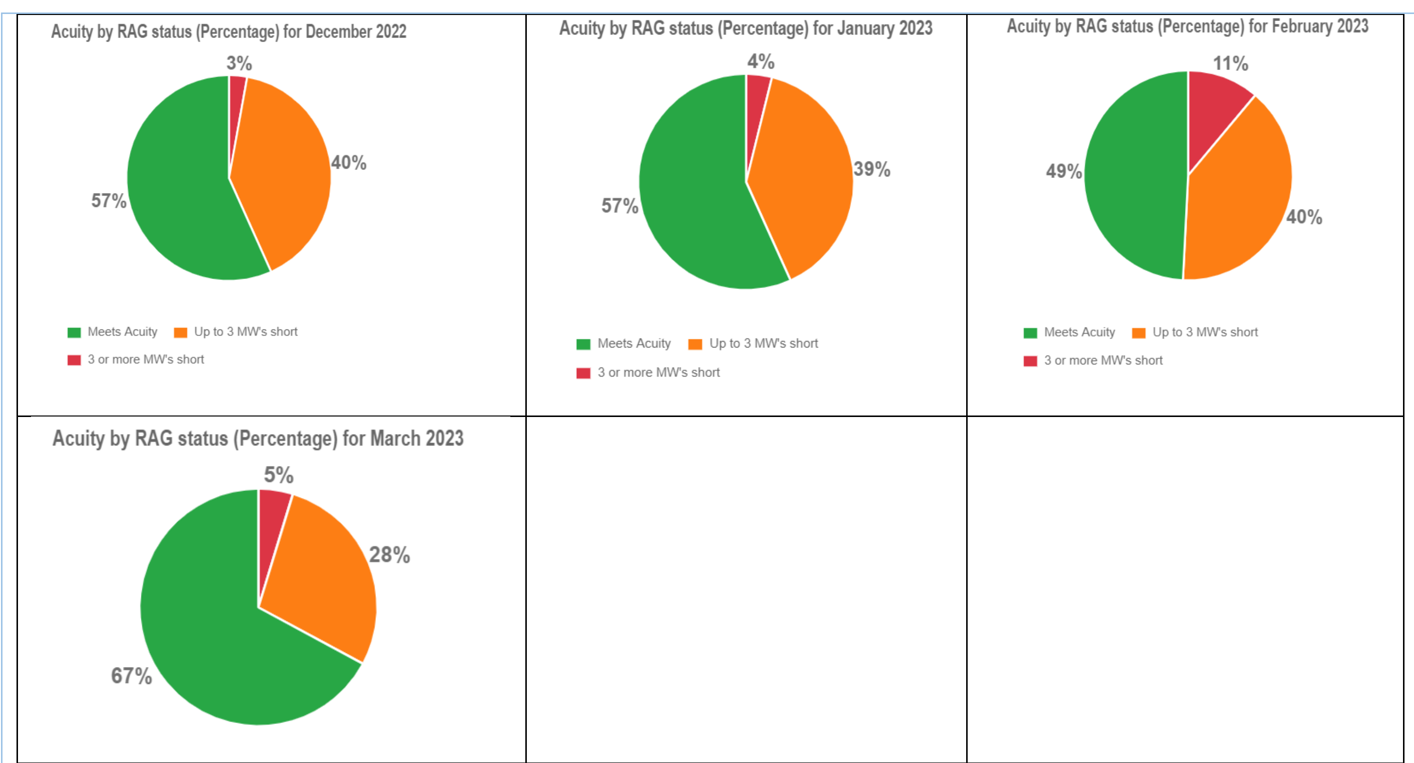
Clinical Activity and Staffing

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 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 co-ordinator.

Despite a very favourable birth to midwife ratio associated with lower than monthly average birth-rates, the incidences of acuity exceeding staffing levels illustrate an increasing trend when there are 3 or more midwives short on Central Delivery Suite during the period of December 2022 to February 2023. This illustrates the weakness of the birth to midwife ratio as an indicator of safety in the context of increasing complexity of maternity patients. There was a more favourable picture in March 2023 with an increase of periods where staffing levels met acuity.

Month	Dec 22	Jan 23	Feb 23	Mar 23
Staffing levels met acuity	57%	57%	49%	67%

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



Supernumery Status of the CDS Co-ordinator

There were no occasions when supernumery status of the co-ordinator was reported to be compromised in March 2023.

Table: Supernumery Status of Delivery Suite Co-ordinator Source: BR+ Acuity tool

Month	Co-ordinator not supernumery	
July 2022	0	88.17
Aug 2022	1	86.56
Sep 2022	1	75.56
Oct 2022	0	81.18
Nov 2022	0	83.33
Dec 2022	1	75.81
Jan 2023	0	83.33
Feb 2023	0	75.00
Mar 2023	0	80.11

The impact of the Flow midwife continues to be positive and this has now increased to weekend cover. Once all posts are recruited to, the Flow Midwife Rota will cover 24/7 enabling a helicopter view of the service.

Areas of progress

1. Consultant Midwife postholder joined the Trust in March 2023.
2. Interim Head of Midwifery appointed and likely start date May 2023
3. 4 new Matron posts appointed to with internal and external applicants commencing between March and July 2023
4. Safeguarding lead midwife hours increased with transition plan in progress
5. Ongoing engagement with MSIP Advisor and DOM on Midwifery Structure
6. Workforce Strategy finalised now with communication and design team for publication and launch at Midwifery Launch and Listen event planned for May 2023 around staffing models.
7. Workforce data calculations now being led by the Workforce Project Manager

Areas of Escalation

1. Increasing Midwifery vacancy rate

Recommendations

1. **Ongoing reporting of staffing**
2. **Further Development of Maternity OPEL tool to align with Southwest policy**
3. **Seek Support for Oncall Consultation for all midwives**
4. **Focus on Birthrate plus acuity tool compliance in GBU**

Enclosures

Nil

Appendix 2

Report to Board of Directors			
Agenda item:	**14**	**Enclosure Number:**	**11**
Date	13 July 2023		
Title	Annual Report of the Guardian of Safe Working Hours for Doctors and Dentists in Training		
Author **Director/Presenter**	Carolyne Claydon, Governance & Business Lead, Medical Directorate Prof Mark Pietroni, Director for Safety, Medical Director & Deputy CEO		

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

Summary of Report

1. A total of 475 exception reports have been raised from the beginning of April 2022 to the end of March 2023.
2. No fines have been levied during that period.
3. The overall rate of exception reports has fallen by 16.5% compared to the same reporting period the previous year. This may be a positive consequence of spending on staff members through bank and agency to support the work of existing staff and the easing of sickness due to Covid.
4. Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £2490.83 (497.25 additional hours worked.)
5. Total number of hours given as TOIL as result of exception reporting of additional hours worked: 41.25hrs.
6. The Guardian role is currently unoccupied. Efforts are underway to recruit a new Guardian.
7. In the interim, the administration associated with exception reporting is being overseen by the Medical Director's office.

Recommendation

That the Board accepts the report for assurance and information.

Enclosures

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

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

For Presentation to Public Board
Thursday 13 July 2023

1. Executive Summary

1.1 This report covers the period of 1 April 2022 to 31 March 2023.

1.2 During this period, there were 475 exception reports logged which is a 16.5% reduction on the same reporting period the previous year.

1.3 0 fines were levied.

2. Introduction

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

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

High level data

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

3. Junior Doctor Vacancies

Junior Doctor Vacancies by Department					
Department	**F1**	**F2**	**ST1-2& GPT**	**IMT & ST3-8**	**Additional training and trust grade vacancies**
ED	0	0	3	0	• 3x Trust Doctor (ST1) • (7 x Trust Doctors recruited via Remedium Agency)
Oncology	0	0	1	0	• 1x Trust Doctor ST1 grade
T&O	0	0	7	0	• 7 x Trust Doctor (ST1)
Surgery	0	0	0	1	• 1x Trust Doctor (ST6) upper GI • 1 x Urology Clinical Fellow • 1 x Trust Doctor Upper GI/Colorectal
General Medicine	0	0	0	0	• (18 x Trust Doctors recruited via Remedium Agency • 7 x Trust Doctors recruited via Mumbai recruitment drive • 11 x Trust Doctors recruited)
Paediatrics	0	0	2	3	• 2 x Trust Doctors • 3 x Trust Registrars
Cardiology	0	0	0	0	• No outstanding recruitment

(Based on data available at time of writing)

4. Medical Agency and Bank for Junior Doctors

4.1 Data supplied by Finance.

4.2 The total expenditure on agency and bank locum cover, across all divisions, including Covid related cover and hosted services, over the reporting period was: £8,303,495. This is 14% lower than the previous reporting period.

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

Division (L4CC)	Category	Junior Dr	Q1 £	Q2 £	Q3 £	Q4 £	Total £ 2022-23
CoVid-19	Medical Agency	Trainee grades	65,404	101,225	35,244	60,371	**262,244**
	Medical Bank	Trainee grades	39,577	30,497	72,535	18,764	**161,373**
CoVid-19 Total			**104,981**	**131,722**	**107,779**	**79,136**	**423,617**
Diagnostics & Specialist	Medical Agency	Trainee grades	77,484	39,077	23,771	3,160	**143,492**
	Medical Bank	Trainee grades	10,118	16,406	10,721	31,873	**69,118**
Diagnostics & Specialist Total			**87,602**	**55,483**	**34,492**	**35,033**	**212,610**
Hosted Services	Medical Bank	Trainee grades	54,400	90,440	62,470	48,637	**255,947**
Hosted Services Total			**54,400**	**90,440**	**62,470**	**48,637**	**255,947**
Medicine	Medical Agency	Trainee grades	113,191	116,612	91,869	130,130	**451,803**
	Medical Bank	Trainee grades	1,127,399	1,139,821	1,101,900	1,253,169	**4,622,288**
Medicine Total			**1,240,590**	**1,256,433**	**1,193,769**	**1,383,298**	**5,074,090**
Surgery	Medical Agency	Trainee grades	173,052	196,357	216,533	173,738	**759,680**
	Medical Bank	Trainee grades	218,852	418,092	271,472	192,357	**1,100,773**
Surgery Total			**391,904**	**614,449**	**488,005**	**366,095**	**1,860,453**
Women and Children	Medical Agency	Trainee grades	0	0	0	0	**0**
	Medical Bank	Trainee grades	145,517	107,380	74,992	148,888	**476,778**
Women and Children Total			**145,517**	**107,380**	**74,992**	**148,888**	**476,778**

5. Additional Costs

5.1 Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £2490.83 (497.25 additional hours worked.)

Total number of hours given as TOIL as result of exception reporting of additional hours worked: 41.25hrs.

6. Exception Reports

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

Exceptions Raised				
Specialty	***Working Hours***	***Educational Opportunities***	***Service Support Available***	***Of which, no. of ISCs***
A&E	8	0	0	0
Acute Medicine	7	1	0	0
Anaesthetics	0	1	0	0
Cardiology	2	1	0	0
Diabetes & Endocrinology	3	0	1	1
General Medicine	260	12	23	7
General Surgery	22	7	4	0
Geriatric Medicine	13	0	0	0
Obstetrics & Gynaecology	0	1	1	1
Otolaryngology	13	1	2	0
Paediatrics	6	0	0	0
Renal Medicine	4	0	1	1
Respiratory Medicine	19	0	0	0
Surgical Specialties	8	24	0	0
T&O Surgery	10	9	0	0
Urology	2	0	0	0
Vascular Surgery	9	0	0	0
SUB-TOTALS	**386**	**57**	**32**	**10**
TOTAL EXCEPTION REPORTS inc. ISCs = 475				

7. Fines Levied

7.1 For the period 1 April 2022 to 31 March 2023, no fines have been levied.

8. Issues Arising

8.1 There were 10 ERs listed as having an ‘immediate safety concern’. The nature of these concerns related to workload and reported lack of medical staff/ junior doctors on the ‘on-call’ medical team. This was the result of both anticipated staff shortage (i.e., known rota gaps) and unplanned / unexpected staff absence due to sickness.

Further information was obtained about the nature of these events by the Guardian of Safe Working at the time and, subsequent to this, all ERs raising immediate safety concerns have been resolved with remedial actions in place.

9. Actions Taken to Resolve Issues

9.1 Key actions taken / to be taken:

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

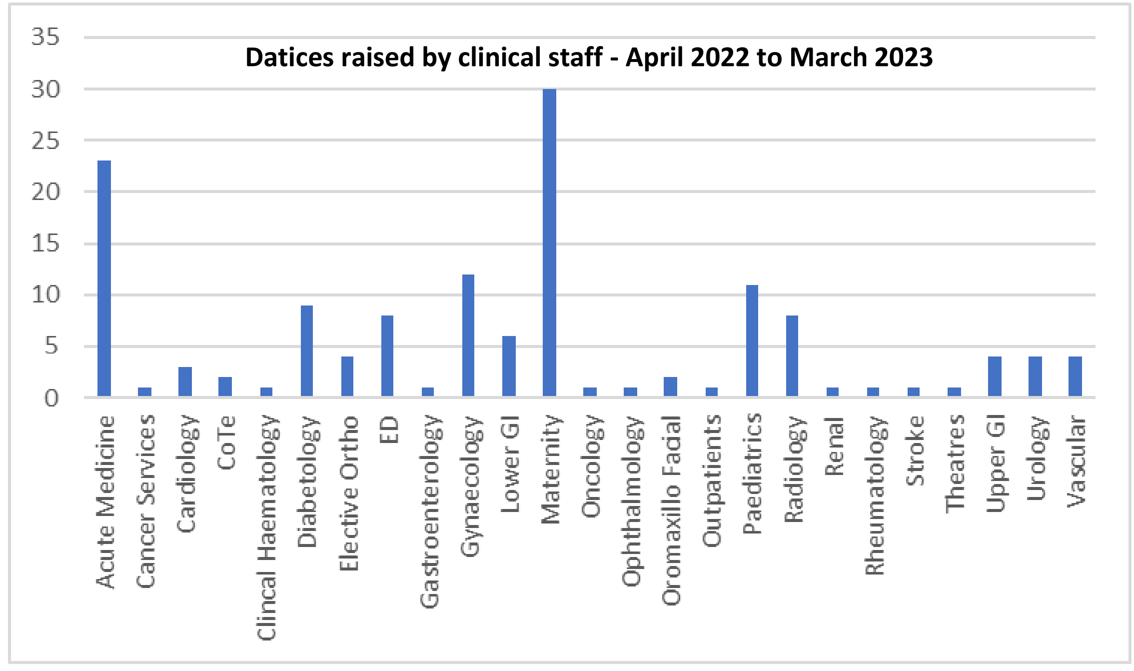
9.3 Any exception reports relating to education matters are referred to the Director of Medical Education, Dr Preetham Boddana, for oversight or follow up when necessary and any exceptions reports raising an immediate safety concern are being followed up by the Medical Director’s office and the appropriate supervising consultant, pending the recruitment of a new Guardian.

9.4 Recruiting a new Guardian of Safe Working has been a challenge with two rounds of unsuccessful recruitment. However, discussions are underway with interested parties and it is planned to re-advertise when it is known there is sufficient interest to secure a successful outcome.

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

10. Correlations to Clinical Incident Reporting

10.1 During this reporting period, there were 1,127 datices submitted relating to medical, paediatric and surgical specialties, of which 174 were submitted by doctors, consultants and surgeons. Of these 174 datices, the numbers submitted relating to each specialty can be seen in the following graph:



10.2 These datices related directly to lack of suitably trained / skilled staff, and staffing issues leading to suboptimal patient care which correlates with the themes being reported in the submitted exception reports.

10.3 92% of these datices concluded that the actual level of harm arising from these events was 'none-no harm caused' with the remaining 8% categorised as 'moderate (short term) harm'.

10.4 However, 21% of these scenarios were recognised as having a 'low' risk rating, 15.5% as having a 'moderate' risk rating, 19.5% as having a 'high' risk rating and 2% as having an 'extreme' risk rating. At the time of writing, 42% of these events did not have a risk rating ascribed to them.

10.5 Looking more closely at the two specialties which submitted the highest number of datices, Maternity and Acute Medicine, the reported cause or consequence of these staff shortages include:

<u>Maternity</u>
No SHO available
Breaches of 15 minute primary assessment target
Elective lists starting late due to no midwife

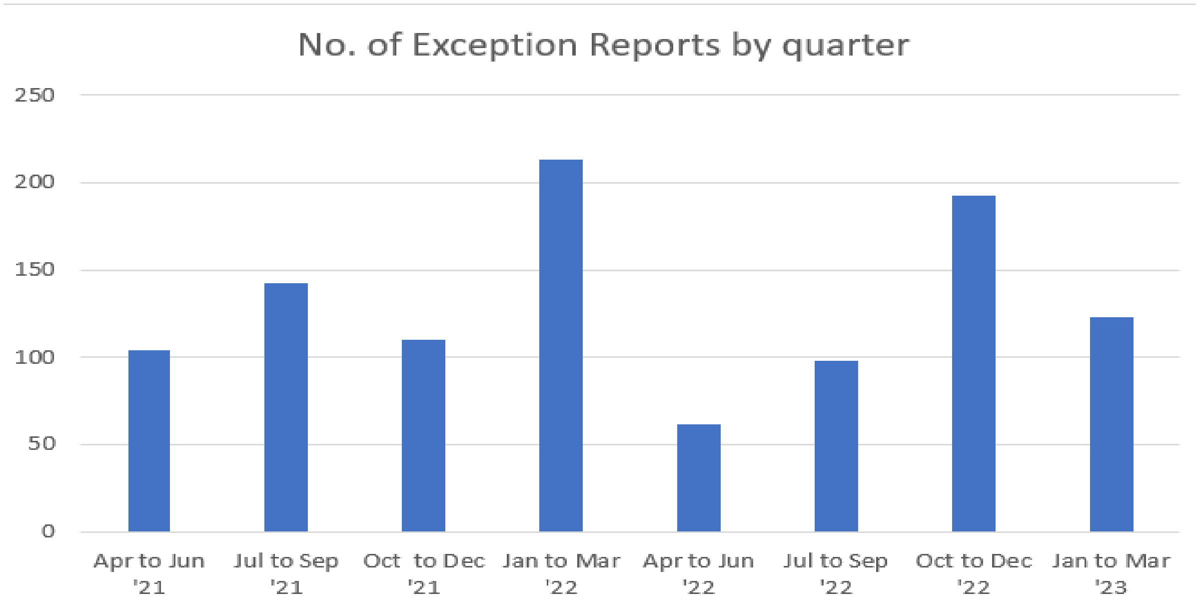
<u>Acute Medicine</u>
Crash calls with no team leader
Inappropriate staffing levels in SDEC vs volume of patients
Patient ratio to doctors very low

11. Junior Doctors Forum

11.1 The Junior Doctor's forum meets every other month and is a useful forum for juniors to raise any issue of concern and keep informed of current business issues within the Trust.

12. Trajectory of Exception Reports (quarterly from April 2021)

12.1 The trajectory of exception reports for the last two reporting periods can be seen in the table below:



1 April 2022 to 31 March 2023 Quarter	No. if ERs	Variance on previous year
April 2022 to June 2022	61	Down 41%
July 2022 to September 2022	98	Down 31%
October 2022 to December 2022	193	Up 75%
January 2023 to March 2023	123	Down 42%

12.2 There was an overall reduction in exception reports of 16.5% compared to the previous year.

12.3 It is noted that there was a significant increase in the submission of exception reports for the quarter October 2022 to December 2022. The majority of the exception reports were submitted by General Medicine, and were resolved by a combination of either overtime payments or time in lieu.

12. Guardian of Safe Working Hours

12.1 The previous Guardian of Safe Working Hours reached the end of their tenure at the end of March 2023. Since then, the post has remained unoccupied following two rounds of advertising for a replacement which proved unsuccessful, as detailed in 8.4 above. As an interim measure, the

Medical Director's office has been undertaking the collection of data to populate this annual report. This could be continued for future annual and quarterly reports which would significantly reduce the administrative burden on the incoming Guardian of Safe Working who could then focus on issues raised via exception reports and follow up liaison with junior doctors. Providing the Guardian of Safe Working Hours with additional administrative support would, in turn, allow the remuneration for this post be reduced from 2 to 1 PAs going forward.

13. Summary

13.1 A total of 475 exception reports have been raised from the beginning of April 2022 to the end of March 2023.

13.2 No fines have been levied during that period.

13.3 The overall rate of exception reports has fallen by 16.5% compared to the same reporting period the previous year. This may be a positive consequence of spending on staff members through bank and agency to support the work of existing staff and the easing of sickness due to Covid.

13.4 Total expenditure paid to junior doctors as a result of exception reporting of additional hours worked: £2490.83 (497.25 additional hours worked.)

13.5 Total number of hours given as TOIL as result of exception reporting of additional hours worked: 41.25hrs.

13.6 The Guardian role is currently unoccupied. Efforts are underway to recruit a new Guardian.

13.7 In the interim, the administration associated with exception reporting is being overseen by the Medical Director's office.

Author: **Carolyne Claydon, Governance & Business Lead, Medical Directorate**

Presenting Director: **Prof Mark Pietroni, Director for Safety, Medical Director and Deputy CEO**

Date: **23 June 2023**

Recommendation

X For assurance
☐ To approve

Appendices:
Link to rota rules factsheet:
Rota rules at a glance | NHS Employers

Link to exception reporting flow chart (safe working hours):
Safe-working-flow-chart-orange (nhsemployers.org)

Report to the Board of Directors			
Agenda item:	**15**	**Enclosure Number:**	**12**
Date	13 July 2023		
Title	Appraisal and Revalidation – Annual Board Report and Statement of Compliance 2022/3		
Author /Sponsoring Director/Presenter	Dr Elinor Beattie, Associate Medical Director		

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

Summary of Report

This report provides assurance to the board about the processes that underpin Appraisal and Revalidation of medical staff. It is a regulatory requirement, and once approved will be submitted to NHSE&I.

In summary:

An online medical appraisal system was introduced in November 2022. This supports the new Appraisal 2022 template and includes additional sections to record educational and leadership activity.

We plan to recruit and train 8 new appraisers this year

Appraiser Support and peer review of appraisal summaries have continued

Upcoming visit by the Higher Level RO and team from NHS England to review our processes and policies, and an external audit of appraisal and revalidation is underway.

Recommendation

The Board is asked to approve the report and sign the statement of compliance (Chair).

Enclosures

Appraisal and Revalidation – Annual Board Report and Statement of Compliance 2022/3

Classification: Official

Publication reference: PR1844

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1.1 Feb 2023

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

The AOA exercise has been stood down since 2020, but has been adapted so that organisations have still been able to report on their appraisal rates.

Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested in the table provided is enough information to demonstrate compliance.

The purpose of this Board Report template is to guide organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,
b) provide the necessary assurance to the higher-level responsible officer,
c) act as evidence for CQC inspections.

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of [*insert official name of DB*] can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

   Yes – Mark Pietroni

   Three trained deputy ROs – E Beattie, A Raghuram, K Hellier

   Ensure that regular meetings of the Revalidation Organisational Group continue.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

   Yes

   Action from last year: Continue to manage the appraisal budget to support timely appraisals.

   Comments: Due to a number of retirements this year, we are planning to recruit 8 more appraisers in late 2023

   The appraisal budget has now been centralised and sits within the Medical Director's portfolio

   Action for next year: Recruitment and training of additional appraisers

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

   Comments: Yes - Revalidation and Appraisal Team in place to oversee the records of all prescribed connections to us as a designated body

   Action for next year: We have now moved to an online system for storing this information for senior medical staff.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

   Action from last year: The Appraisal and Revalidation Policy has been rewritten to reflect the changes to our appraisal processes since the introduction of L2P.

Comments: This has been approved by the Revalidation Operational Group and is awaiting further review and publication.

Action for next year: Ensure that the Appraisal and Revalidation Policy is ratified and available on the trust intranet site.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year Comments: Action for next year:

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Actions from last year: Ensure that all national and regional guidelines are followed Comments: We have an inspection by the Higher Level Responsible Officer and team scheduled for August 2023, and in preparation for this all information requested has been submitted. In addition, there is an ongoing external audit of our appraisal and revalidation processes due to complete in the Autumn Action for next year: To respond to any recommendations arising from the above, and formulate an action plan as required.

Section 2a – Effective Appraisal

All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: We have introduced an online appraisal system to replace the MAG forms which are no longer supported. This template follows the national Appraisal 2022 format, which includes a mandated conversation about the wellbeing on the appraisee.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

Comments: We have chosen to include additional portfolio sections to record both educational and leadership activity for all senior medical staff. This will allow us to work with the DME to ensure effective appraisal of all educational activity undertaken Educational and Clinical supervisors with a more visible reporting system.

Action for next year: Continue to develop the L2P platform following feedback from all users. Work with the education team to ensure that reports are accurate and timely

7. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Not applicable

8. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Review and rewrite policy.

Comments: This has been completed and approved by the revalidation team. It is now going through the trust formal approval process before publication.

Action for next year: Ensure this policy is kept up to date by annual review.

9. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Ensure that the new appraisers are supported to begin appraisal activity.

Comments: Since last year there have been a number of retirements of appraisers, and therefore we are recruiting and training a further 8 in late 2023/early 2024

Action for next year: Further recruitment and training to replace a number of retiring appraisers this year.

10. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal

network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: The Trust runs an Appraisal Support Group for all appraisers twice yearly where the appraisal process is reviewed and training provided. In addition, there is peer review of appraisal summaries, and annual 1 to 1 meeting with the trust appraisal lead. Comments: The meetings have moved back to face to face/hybrid this year and have been well attended. We continue to use the EXCELLENCE scoring tool to peer review our appraisal summaries and we have moved this scoring to an online survey. All appraisers receive an individual feedback report and they are required to reflect on this before their annual meeting with the Appraisal Lead Action for next year: Ongoing review

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

11. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: The reintroduction of quarterly Revalidation Team meetings. These were held virtually due to the pandemic but have restarted and will continue. Annual Board report presented, and a quarterly review of the appraisal figures continues. Action for next year: Ensure that the ROG meetings and regular team meetings continue and develop the L2P reporting system to allow updates to be shared.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	576
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	543
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	20
Total number of agreed exceptions	13

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: None

Comments: We have an embedded process for reviewing the appraisal history of all doctors due for revalidation and timely recommendations are made by the RO or his deputy. There have been fewer deferred revalidations this year but we are seeing a small but significant increase in the number of doctors who are not engaging in the appraisal process.

Action for next year: Continue to review our processes in light of an online appraisal system and GMC/NHSE requirements

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

All revalidation recommendations are made in a timely manner, with doctors notified of their outcome. Should a deferral or non-engagement be appropriate, then contact would be made by the Medical Director

Comments: This process will remain in place

Action for next year: No further changes required

:

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Revalidation and Appraisal Team provide support to all doctors, with further access to Medical Director and Appraisal Lead if required.

Comments: The revalidation and appraisal process is fully embedded within the Trust. This includes a pre appraisal meeting with the speciality director with a focus on medical governance. This information is available to the appraiser to direct discussion at appraisal. All doctors are provided with a report detailing their involvements in complaints or Serious Incidents which is included in the supporting evidence for appraisal.

Action for next year: No further action to be taken

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Employee Relations system in place to manage conduct issues relating to all staff. Comments: This process is fully embedded within the trust Action for next year: No further action required

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Robust policies are in place within the Trust which provide adequate processes to be followed should there be concerns raised and against any licensed practitioner Comments: These remain in place and constantly reviewed to ensure they meet the necessary requirements

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Action from last year: All processes would be managed by Human Resources following strict policies that are in place and relevant notification given to appropriate people/groups within the trust Comments: Ongoing review to ensure that all necessary processes are followed. Action for next year: Further consideration of protected characteristics recording to ensure that these are reviewed as part of the annual board report

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: A review of process to ensure the transfer of information between revalidation officers via the Medical Practice Information Transfer (MPIT) form for those doctors that move to us and also where known connections to other organisations exist Comments: The review highlighted some inconsistencies with the transfer of information for new doctors connected to our Trust Action for next year: A full review of process to be undertaken to ensure that relevant information is transferred through the MPIT process for all new connected doctors to our trust

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: All staff undertake Equality and Diversity Training as part of their statutory training via the Core Skills Framework. This is also supported by the trusts Equality and Diversity policy. Comments: The Trust has taken great strides in Equality and Diversity through a Diversity Network and being active in all aspects of Equality. Action for next year: Ongoing work through the Equality and Diversity Group

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: All checks are undertaken against national NHS Pre-Employment Check Standards as per NHS Employers guidance. This meets the 6 checks that is required from identification, references through to Right to Work Comments: This is regularly reviewed and changes made to process if notice provided by NHS Employers Action for next year: No further action

Section 6 – Summary of comments, and overall conclusion

An online medical appraisal system was introduced in November 2022. This supports the new Appraisal 2022 template and includes additional sections to record educational and leadership activity. **We plan to recruit and train 8 new appraisers this year** **Appraiser Support and peer review of appraisal summaries have continued** **Upcoming visit by the Higher Level RO and team from NHS England to review our processes and policies, and an external audit of appraisal and revalidation is underway.**

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: _ _ _ _ _ _ _ _ _ _ _ _

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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KEY ISSUES AND ASSURANCE REPORT Audit and Assurance Committee, 23 May 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**
Internal Audit Progress Report	***Progress Report*** Significant delays in delivering against a number of the internal audit reviews had been identified, resulting in delays in report sign offs, receipt of evidence, and approvals. Some reviews had to be removed from the plan during the year due to a lack of engagement. Significant improvement for 2023/24 was required to avoid a "limited assurance" rating at the end of the next financial year.	The Trust accepted that improvement was required, and agreed that regular executive oversight of the internal audit plan and recommendation follow ups would be required to improve response rates. An escalation process would be established.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Internal Audit	***Discharge Processes Internal Audit Review*** A rating of Limited Assurance for both Design Opinion and Design Effectiveness had been given. Two high priority recommendations had been suggested, related to delays with discharge summaries and TTOs, and other blocks to discharge including shortage of nursing and portering staff, lack of accountability within divisions, and outlying medical patients in surgical wards. Three medium priority recommendations had been raised, related to improvements in processes for the Discharge Lounge, consistency of Board round tools, and arrangement of transport. ***Outpatient Clinic Management Internal Audit Review*** A Moderate assurance rating for both Design Opinion and Design Effectiveness had been given. Two medium priority recommendations had been suggested, related to the need for a formalised policy and performance reporting, and management and utilisation of the clinic to reduce cancellations. ***Data Security Protection Toolkit Report*** The report concluded a Moderate Assurance rating over the design and operational effectiveness of the Trust's data security and protection controls. The report rated confidence in the Trust's Toolkit return as high due to the work completed which was in line with requirements. However, further work was required to meet all mandatory sub-assertions. Further work would be required ahead of the year-end submission to address areas of non-compliance. ***Annual Report 2022/23*** A Moderate Head of Internal Audit Opinion had been given. Auditors had debated whether the delays in response to reviews and follow up recommendations would have resulted in a limited assurance rating. ***Audit Plan 2023-24*** Some changes had been made to the plan and the timetable, in collaboration with Executives.	The Trust welcomed the recommendations as an opportunity to improve patient flow. The report will be considered further by Quality and Performance Committee. The Committee approved the internal audit plan for 2023/24.

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.

Risk Assurance Report	Three new risks were included in the register. Two risks had been downgraded to be held at divisional level. Four further risks had been downgraded to a lower risk register, following a score reduction. Work was underway to refine the risk register, including reviewing risks dating back to 2005/06 and risks that had been open for more than five years.	Future iterations of the report would provide focused scrutiny on key areas, including water safety.
GMS Report	External Audit was progressing well, with no outstanding requests at the time of reporting. An internal audit report on Data Quality (ERIC) was received, with Moderate assurance given for both Design Opinion and Design Effectiveness. Two medium priority recommendations had been provided in relation to the requirement for a defined procedure and to review gaps in the validation process.	The single tender waiver report was received for assurance.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
External Audit Progress Report	There were no significant concerns with any misstatements or timetable issues, and teams were working well together with regular communication. Audit was progressing well, with no concerns. Audit work for GMS was progressing, with the aim to complete by the end of June to finalise accounts for September/October. No concerns were raised at this stage.	The Committee was assured that audit was progressing well with no concerns.
Counter Fraud Report Place this one in the green section	Key points were noted: • A memorandum of understanding was now in place with Gloucestershire Police to work together to discuss closure of cases. • Two national intelligence reports had been issued which had originated in Gloucestershire and related to email account hacking and an agency worker with several employments. • The draft annual report detailed the culmination of progress reports over the last year. In 2022/23, 22 cases had been referred to counter fraud, showing little movement from the previous year. • The draft work plan for 2023/24 was presented, with particular exercises to take place around declarations of interest and temporary staff working multiple jobs. The Committee noted that the declaration of interests process for Board was sound, however further work was required to capture interests for staff throughout the organisation, including private practice, secondary employment, and gifts and hospitality. The Trust was reviewing the utilisation of existing processes such as induction, appraisal and medical revalidation. The functionality of ESR had been reviewed and would be used to collate responses from staff, along with regular communication and guidance.	The Committee approved the Counter Fraud Annual Report 2022/23. A plan to improve the declaration of interests process for the organisation would be received in July.
Losses and Compensations Report	The Committee noted ex-gratia payments totalling £3,663.49 and approved the write off of 255 invoices. Eight ex-gratia payments had been made to patients for property lost on wards.	The Patient Property Policy was regularly reviewed at Quality and Performance Committee. Assurance on the impact of the policy would be brought to Audit and Assurance Committee.
Single Tender Actions Report	Four waivers were processed during the reporting period, with a value of £247,154.17	None.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
SR1 Urgent and Emergency Care: more detail was recommended on the work of Newton and how this would affect the target risk scores.		

Report to Board of Directors			
Agenda item:	17	Enclosure Number:	14
Date	13 July 2023		
Title	Provider Licence Self-Certification		
Author /Sponsoring Director/Presenter	Kat Cleverley, Trust Secretary		

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

Summary of Report

The Trust is required to self-certify on an annual basis the status of compliance with licensing conditions as part of the Foundation Trust Provider Licence. Foundation trusts are legally subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions:

- Condition G6: the provider has taken all precautions necessary to comply with the licence, NHS Acts and the NHS Constitution.
- Condition FT4: the provider has complied with required governance arrangements ('Corporate Governance Statement').
- Condition CoS7: the provider has a reasonable expectation that required resources will be available to deliver the designated service.

The self-certifications will be published on the Trust website, as required.

The NHS Oversight Framework has been updated following a consultation, and came into effect from 1 April 2023; compliance requirements will be different for 2023/24.

Recommendation

The Board is asked to approve the self-certifications for publishing.

Enclosures

- Self-certification FT4
- Self-certification G6 and CoS7

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Gloucestershire Hospitals NHS Foundation Trust	*Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2022-23 Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	A review of corporate governance was commissioned from the Good Governance Institute in March 2023, to conclude in July 2023.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board responds to new guidance in a timely manner through its business cycle and work of the Audit and Assurance Committee. Corporate governance practices continue to be refined to align with the new Code of Governance, and recommendations arising from the Good Governance Institute review.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	A full corporate governance review, including reporting mechanisms and meeting structures, was started in February 2022 to ensure effective and efficient systems and processes in relation to information flow and risk management. Clear effectiveness reviews and Terms of Reference reviews continue take place to ensure effective operation and will be used to inform any future changes. New processes which were put in place in 2022 continue to embed, including Key Issues and Assurance Reports to provide clear lines of reporting from Committees to Board, and a revised Board Assurance Framework which is discussed and reviewed on a monthly basis and is used a key assurance document for the organisation. Recommendations from the Good Governance Institute review will also be considered and implemented to strengthen the organisation's structures and reporting.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	The Annual Governance Statement and Annual Report document compliance with regulatory requirements.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	The Trust Appointments and Remuneration Committee and Governors' Governance and Nominations Committee meet regularly to review skill mix and succession planning. Quality and Performance is a key item on all Board agendas, with the Quality and Performance Committee maintaining oversight of quality issues and reporting key issues and assurance through to Board. The Good Governance Institute review has a key focus on quality reporting, and will make recommendations on the quality governance structure and reporting. A Quality Framework Plan is in development, and will complement the work of the Good Governance Institute.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The fit and proper persons requirements are undertaken on appointment of Board members, and annually to ensure ongoing appropriateness of the Board. Regular Board and Committee reporting on staffing, recruitment, retention, staff engagement, talent and leadership development is in place, with a new culture and organisational development framework in development. The Trust's Appointment and Remuneration Committee and Governors' Governance and Nominations Committee meet regularly to review skill mix and succession planning.	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Deborah Evans	**Name**	Deborah Lee

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates | **2022-23** | Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Deborah Evans	**Name**	Deborah Lee
Capacity	Chair	**Capacity**	Chief Executive Officer
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Gloucestershire Hospitals NHS Foundation Trust	*Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates: 2022-23

Please complete the explanatory information in cell E36

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

		Response	
1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

		Response	
3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22
	OR		
3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond
	OR		
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust reported as an individual organisation and as a system during 2022-23. The Trust delivered a year-end surplus of £0.05m, which was £0.05m favourable to plan. The overall year-end system position was a surplus of £0.1m. The Trust also delivered an overspend against its capital programme of £0.4m. A financial and operational plan had been developed to support the delivery of services. For 2023-24, the Trust will continue to work with partners in the system to plan for the next financial year and determine the system position. The Trust continues to manage any potential significant variance in plan by working closely with Divisions.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Deborah Evans	**Name**	Deborah Lee
Capacity	Chair	**Capacity**	Chief Executive Officer
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Report to Board of Directors			
Agenda item:	**18**	**Enclosure Number:**	**15**
Date	13 July 2023		
Title	CQC Statement of Purpose		
Author /Sponsoring Director/Presenter	Kat Cleverley, Trust Secretary		

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

Summary of Report

A statement of purpose is a legally required document that includes a standard set of information about a provider's service.

The Trust's Statement has been updated to include the following location: Forest Dialysis Unit.

An official notification will be submitted to the CQC for compliance.

Recommendation

The Board is asked to approve the new location added to the Statement of Purpose.

Enclosures

- CQC Statement of Purpose (reading pack)

<table>
<tr><th colspan="4">Report to Board of Directors</th></tr>
<tr><td>Agenda item:</td><td>19</td><td>Enclosure Number:</td><td>16</td></tr>
<tr><td>Date</td><td colspan="3">13 July 2023</td></tr>
<tr><td>Title</td><td colspan="3">Use of Trust Seal Report</td></tr>
<tr><td>Author /Sponsoring Director/Presenter</td><td colspan="3">Kat Cleverley, Trust Secretary</td></tr>
</table>

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 Trust's Standing Orders require that the use of the seal is authorised by the Board of Directors and entered in the Register of Sealings. The seal is used to execute deeds (e.g. conveyances of land) or where it may be required by law.

The Trust Secretary is Custodian of the Trust seal.

The seal was used on the following documents on 29 October 2022:

- Reaffirmation letter

The seal was used on the following document on 5 July 2023:

- Licence to underlet relating to shared space, St Paul's Medical Centre, 121 Swindon Road, Cheltenham, Gloucestershire GL50 4DP

Recommendation

The Board is asked to endorse the use of the Trust Seal.