Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
13.30, Thursday 11 May 2023
Bluecoat Room, Gloucester Guildhall
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			13.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 9 March 2023**	Approval	Enc 1	13.35
5	**Matters arising from Board meeting held on 9 March 2023**	Assurance		
6	**Staff Story** *Katherine Holland, Patient Experience Manager*	Information	Presentation	13.40
7	**Chief Executive's Briefing** *Deborah Lee, Chief Executive Officer*	Information	Enc 2	14.00
8	**Board Assurance Framework** *Kat Cleverley, Trust Secretary*	Review	Enc 3	14.15
9	**Trust Risk Register** *Mark Pietroni, Medical Director*	Assurance	Enc 4	14.25
10	**Operational Plan 2023-24** *Karen Johnson, Director of Finance, and Qadar Zada, Chief Operating Officer*	Assurance	Enc 5	14.35
11	**Finance and Resources Committee Report** *Jaki Meekings-Davis, Non-Executive Director, Karen Johnson, Director of Finance*	Assurance	Enc 6	14.45
12	**People and Organisational Development Committee Report** *Balvinder Heran, Non-Executive Director*	Assurance	Enc 7	15.15
	Break (15.30-15.40)			
13	**Quality and Performance Committee Report** *Alison Moon, Non-Executive Director, Matt Holdaway, Chief Nurse and Director of Quality, and Qadar Zada, Chief Operating Officer*	Assurance	Enc 8	15.40
14	**Audit and Assurance Committee Report** *Claire Feehily, Non-Executive Director*	Assurance	Enc 9	16.10
15	**Any other business**		None	16.20
16	**Governor Observations**			
	Close by 16.45			

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 9 March 2023, 10.15, Lecture Hall Redwood Education Centre			
Chair	Deborah Evans	DE	Chair
Present	Vareta Bryan	VB	Non-Executive Director
	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
	Kaye Law-Fox	KLF	Associate Non-Executive Director/Chair of GMS
	Deborah Lee	DL	Chief Executive Officer
	Alison Moon	AM	Non-Executive Director
	Sally Moyle	SM	Associate Non-Executive Director
	Mike Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Director of Safety
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director for People and Organisational Development
	Qadar Zada	QZ	Chief Operating Officer
Attending	Karen Bradshaw	KB	Parent (item 6 only)
	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Suzie Cro	SC	Deputy Director of Quality (item 6 only)
	Micky Griffith	MG	Programme Director (item 14 only)
	Henry Harrison	HH	NHS Graduate Management Trainee
	Katherine Holland	KH	Patient Experience Manager (item 6 only)
	Karen Tomisino	KT	Matron, Neonatal and Paediatric Special Nursing (item 6 only)
	Becky Wood	BW	Paediatric Nurse (item 6 only)
Observers	Four governors, two members of staff, and two CQC representatives observed the meeting in person.		

Ref	Item
1	**Chair's welcome and introduction** DE welcomed everyone to the meeting. DE advised the Board that she continued to jointly visit services with the Chair of Gloucestershire Health and Care NHS Foundation Trust; recent visits had included eating disorders services, acute stroke services and stroke rehabilitation. DE would visit the surgical admissions unit next week and would be walked through the action plan, which demonstrated a great amount of work that was underway following the CQC report.
2	**Apologies for absence** Jaki Meekings-Davis, Non-Executive Director
3	**Declarations of interest** There were no new declarations.
4	**Minutes of Board meeting held on 12 January 2023** The minutes were approved as a true and accurate record.
5	**Matters arising from Board meeting held on 12 January 2023**

	All matters arising were updated.
6	**Patient Story** KB presented the story of her son, who was a patient of the Trust's paediatric oncology services. KB focused on parents' feelings and experiences of looking after their child in hospital and noted some key suggestions, including: somewhere to sleep when in hospital for a longer period of time; sustenance; ability to talk, ask questions and raise concerns; and confidence that those providing care were trained, skilled and knowledgeable. Open communication was particularly important, and parents would benefit from understanding the correct procedure for raising concerns and complaints, and a dedicated platform for parents to raise thoughts and ideas for improvement. The Board was advised of achievements that had been made so far, including: implementation of a parent representation group that met monthly with senior staff to provide feedback and ideas; folding beds had been located within the hospital and utilised on the ward; a new fridge freezer had been installed in the parents' kitchen; tea and coffee had been made available; additional storage had been created for parents to use; and emergency toiletry and comfort packs had been provided by the Charity. These improvements would be extended to the main ward to increase positive patient and family experience. Further improvements were suggested; appropriate in-house psychological support for patients, parents and siblings; and staff improvements including robust plans around skills training, knowledge transfer, covering staff absence, consistency and retention, and filling vacancies at the earliest opportunity. BW noted that the team was involved in the Paediatric Early Warning System (PEWS) project; one of the aspects of the project was for nurses to speak to the child and families to ask how the child was different from the last time they were observed. The Board was advised that a Worries and Concern project had been established which aimed to improve patient and family experience. The Board thanked KB for attending and sharing her and her son's story. The Board was impressed by the patient-led activity that was in progress to improve the experience of all patients and families using the Trust's services.
7	**Chief Executive's Briefing** DL briefed the Board as follows: • Although the Trust continued to experience a very challenging operational environment, encouraging improvements in performance had been seen and a positive upward trajectory continued. • Pre-empting and boarding continued, however processes and policies continued to be monitored on a regular basis to ensure the best care possible for patients who met boarding criteria. The commitment remained to cease boarding as soon as operational conditions permitted. • The Trust continued to focus on delayed discharge, and the Board noted particular improvements with regards to patients with No Criteria to Reside (NCTR) and improving patient experience; the Board was advised of two young people who had been in hospital for over 180 days but had now been discharged. Continued focused work would support the decongestion of Emergency Departments, with an improvement programme in place that had identified a number of themes and trends to identify appropriate packages of care to enable patients to go home sooner. • Cancer performance was progressing well, with 264 patients now waiting over 62 days, down from 420 patients. DL commended the Chief Operating Officer's leadership for this significant improvement. • The organisation was busy preparing for industrial action that was planned for the following week, with learning points incorporated from previous planning. The Board was advised that the Trust would not be able to open all services over the three-day strike period, but focus on ward-based care and emergency care would be prioritised. • Staff survey results had been published today, which were very disappointing. The Trust had held staff webinars in advance of the publication; over 300 staff had attended.

	• The Trust had celebrated Overseas Workers' Day. • Four workshops had been arranged to discuss the Equality Diversity System which would focus on the organisation's assessment of its impact of discrimination on patients and staff, which provided an opportunity for the Trust to support a healthier and happier workforce, which in turn would increase quality of patient care. • DL had taken part in Bristol Medical School's annual review of the Undergraduate Academy, and feedback had been very positive. • The Board noted that, in recognition of how much staff valued the subsidised food offer at the Trust, this would continue through to next year. In collaboration with the Trust's Green Council, free drinks would be provided to staff only if a reusable cup was used and plastic bottled water would no longer be available.
8	**Board Assurance Framework** The BAF was presented for assurance. A new set of strategic risks had been developed which reflected the current position of the Trust. The risks would be discussed at relevant Committees for further refinement and updates at each meeting, and would be regularly reviewed by executive leads. The corporate governance team would now begin to look at aligning committee agendas to the strategic risks set out in the BAF to provide greater focus on the key strategic issues and to continue to refine reporting. KC advised that the People and Organisational Development Committee had discussed the new People risks on 28 February, and the agenda had been aligned to the two risks; reports and discussions would be aligned accordingly to develop a clear link between key concerns and issues, the Board Assurance Framework, and discussions held at committee and Board meetings.
9	**Scheme of Delegation, Standing Financial Instructions and Standing Orders** The documents were presented for ratification, as they had been approved at Finance and Resources Committee in January. Communication to staff on the key changes would be included as part of the usual staff briefings. The Board **ratified** the Scheme of Delegation, Standing Financial Instructions and Standing Orders.
10	**Trust Risk Register** The Board received the report for information, noting that two new risks had been added to the register. MP advised that the risk related to water safety would be discussed at Quality and Performance Committee to provide a fuller update.
11	**People and Organisational Development Committee Report** BH advised the Board that the Committee met formally every other month, with development sessions in between to focus on key priorities of retention, recruitment and staff wellbeing and morale. Additional staff, including divisional leads, were invited to the development sessions to monitor the impact of the work of the Committee. BH noted that February's meeting had been strong, with a focus on the staff survey results and plans to address the key themes. There was a lot of work to do, however there was also a lot of enthusiasm to make real, positive change for staff. ***Staff Survey Results*** Staff survey results had been published at 9.30am this morning. Webinars had been held with staff yesterday, with comments, questions and reflections captured. The Board noted that 50% of the Trust's staff had responded to the survey, and bank colleagues had been included for the first time. The Trust's engagement score was 6.3, which had deteriorated from last year and was below the national average of 6.6. In relation to People Promises scores, the Trust was the worst-performing trust across the following areas: Compassionate and Inclusive; A Voice that Counts; Working Flexibly; and We Are a Team. CR advised the Board that a lot of work had already started to address the feedback reflected in the survey, with culture work focusing on addressing poor behaviours, confronting discrimination, building psychological safety,

	and increasing involvement of colleagues on matters and decisions that affect them. Focus would also be needed to improve health and wellbeing, including flexible working, maintaining an effective work/life balance, and improving team and line manager relationships and effectiveness. CR advised that Board of the change principles that would be utilised, with three key priorities: Teamwork and Leadership; Discrimination; and Raising Concerns and Speaking Up. CF acknowledged that the results were difficult, but commended the candid approach and the programme that would support significant improvement. CF noted that the Trust would need to ensure facilitators, trainers and developers who helped the organisation with this work were able to engage with the most challenged teams to really make a difference. MN reflected his disappointment at the results, and challenged the sufficiency of the action plans in place; the overall programme would take three years, but what was the plan to address some of the challenges in the immediate term. RP noted that she had joined one of the staff webinars and had also reflected on the three-year timeframe, noting that some staff may feel frustrated at the length of time and wondered what the Trust was going to do now. VB reflected that the work would feel disruptive and uncertain to the organisation, and queried how this would be anchored within the Trust so that staff would not feel overwhelmed. MAG felt that bridging the gap between initiatives that the Trust had implemented in the past and the new culture programme, as there may have been successes in previous years. MAG also noted that race discrimination would require intercultural understanding and communication. DL noted that the senior team wanted to signal this as a watershed moment for the Trust, where there would be recognition of the issues and a collaborative effort to make real, positive change for all staff members. The Board was also advised that the culture programme work had been underway for some time, with a lot of work already taken place. The Trust had extended the food subsidy offer as a result of staff feedback and to show staff how much they were valued; a letter would also be sent from the CEO to each member of staff to ask them for the one key thing that would make a difference to their response to recommend the Trust as a place to work and receive care. DL recognised that the immediate here and now was just as important as the longer-term culture programme and felt that there were a number of quick wins that would signal the Trust's intent and provide staff with a sense of change. MH also reflected on the need for a cultural education programme for wards in the Trust who were welcoming international workers. KLF felt that the three-year culture programme was positive, and indicated that the issues were being carefully considered and planned, rather than a reactive solution. BH noted her support for the programme and timeframe for delivery. CR advised the Board that pace would be key, and the team would review staff experience around ward moves, with clinicians and ward staff deciding the timings to ensure greater involvement and a better overall process. The Board supported the culture work, noting that they would take part in development workshops and receive regular updates on the programme.
12	**Quality and Performance Committee Report** AM updated the Board on key issues from February and January meetings. The Committee continued to see a pressured system. Comprehensive maternity reports had been received in February, including the Safer Staffing report. Planned care and cancer performance had been noted, with some assurance taken on the plans in place and the recent improvements in cancer noted. The Committee had been advised of a new emerging risk related to end-of-life care reflecting delays in discharge meaning many patients did not get to die at home despite this being their preference, which the Committee was monitoring. The red rated area on the report related to urgent and emergency care, which continued to be driven by the pre-empting and boarding of patients. ***Quality and Performance Report***

	Other key points were highlighted as follows: • There had been an increase in PALS contacts and complaints, related to boarding. Themes were identified around experience of boarding, and privacy and dignity issues. The Board was advised that the boarding policy continued to be reviewed three times per week, with thematic analysis reviewed. Themes were consistent around safe staffing and criteria of patients receiving corridor care. Teams continued to hold safety huddles, which monitored the impact of boarding. The Trust had initiated a quality improvement project around handover procedures, and an audit into adherence to the National Early Warning Score (NEWS) would be undertaken. • The Board was advised that a Quality Summit had been organised to discuss boarding, its associated issues and risks, and consider the trajectory needed to stop boarding practices. The Summit would include emergency department congestion issues. MH noted that it was important to involve staff in this summit. RP queried some data within the report that suggested emergency department attendances had halved; QZ thanked RP for flagging this and responded that this was due to a data error which would be rectified.
13	**Maternity Safer Staffing Report** The Board received the report for information, noting that it had been reviewed by Quality and Performance Committee in February. The report provided assurance on the workforce planning tools utilised to review midwifery staff establishments, and actions taken to address staff shortages and increased pressures. The Board particularly noted the number of red flag incidents related to induction of labour, which the CQC had reported as an issue for the service in the section 29a warning notice. The Board was advised that a quality improvement project was underway to support learning and improvement in this area. The percentage of incidents related to red flags would be included in future reports, for increased clarity. CF queried if there was adequate resource in place to manage quality governance processes. MH reflected that this was challenging, as staff also had clinical roles to fulfil, however streamlining of reporting mechanisms was underway with the Trust's Maternity Advisor, and was expected to support with capacity. MH also advised that four new matrons had recently been recruited and would significantly increase capacity to support the quality governance programme. DL asked when the Trust could expect to be at full midwifery establishment to enable the Aveta unit to reopen. MH noted that midwifery recruitment tended to fall at the end of summer, at which point there would be greater clarity around timescales for the reopening of the unit; a new model of care was in development which would reduce reliance on midwifery staff.
14	**Fit for the Future 2 Business Case** The business case set out the case for change for the reconfiguration of five specialist hospital services as part of the continued implementation of the Trust's Centres of Excellence clinical strategy; Benign Gynaecology; Diabetes and Endocrinology; Non-Interventional Cardiology; Respiratory; and Stroke. SL advised the Board that there had been a great level of clinical engagement in the programme, and that there would be no changes to outpatient clinics. Some ward moves may need to take place as part of the plan; however, assurance was provided that these would be managed well and with full staff involvement. The Board **approved** the following recommendations: • To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital • To centralise the dedicated Diabetes and Endocrinology inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology consult service at Cheltenham General Hospital • To centralise Non-Interventional Cardiology inpatient beds at Gloucestershire Royal Hospital and provide a Cardiology consult service at Cheltenham General Hospital • To centralise Respiratory inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory consult service at Cheltenham General Hospital

	• To establish a Respiratory High Care unit at Gloucestershire Royal Hospital • To locate the Hyper Acute Stroke Unit and Acute Stroke Unit at Cheltenham General Hospital
15	**Finance and Resources Committee Report** MN advised the Board of key discussions held during January and February, noting that financial performance was incredibly concerning and had been for some time, however the Trust was on plan to contribute to a breakeven position as a system. Other key concerns related to the achievement of the capital programme, financial sustainability, cyber security plans, and high levels of vacancies within GMS. ***Finance Report*** Other key points were highlighted as follows: • The Trust had reported a year-to-date deficit of £8.4m, which was £7m adverse to plan. The material underlying financial deficit was being supported by non-recurrent benefits. • A balanced position would be reported in Month 11 due to the positive outcome of the HMRC legal case. • The Board was advised that some improvements had been seen in divisional performance, although nothing that made a material difference to the financial position. • The system was required to breakeven at year-end, and all organisations with the ICB were forecasting breakeven positions. • The financial sustainability programme had a current £3.2m gap, which was an overall positive position, however a number of schemes that supported the position were non-recurrent. The Trust was looking to utilise a number of recurrent opportunities for the next financial year. • In relation to the capital programme, the Trust had goods delivered, works done or services received to the value of £38.5m, leaving £26.2m to be delivered in the final eight weeks of the year. ***Digital Transformation Report*** The Board set out updates on the four key work areas: Electronic Patient Record; Clinical Systems Optimisation; Infrastructure and Cyber; and Business Intelligence. The work plan continued to deliver 57 projects alongside business-as-usual operations. Delivery continued although a high rate of vacancies was impacting on optimal service. The programme of work for 2023-24 was currently being finalised. The Board discussed the need to ensure basic IT was in place and working, including wifi. SH noted that the service was aware of key problem areas, and continuous improvement plans were in place. AM reflected that it would be beneficial to review what the team had enabled and celebrate successful implementation of new systems. ***Capital Plan 2023-24*** The Board noted that the plan had been reviewed at Finance and Resources Committee, and had been scrutinised by capital lead colleagues and the Executive team. KJ advised that notional figures for 2024-25 had also been set out, however these figures required further work. KJ confirmed that a level of contingency would be included. The Board supported the draft plan. ***Finance Strategy*** The Board received the strategy, and commended its easy to read, approachable format. DE asked that the Trust's net zero target and approach be included, and DL reflected that the transformational element of the strategy should be strengthened. MN noted that the BAF risk around financial sustainability should also be taken into account, particularly regarding the significant underlying deficit which needed to be balanced against what the Trust hoped to achieve. The Board **approved** the strategy, noting that the transformational approach and net zero targets would be strengthened.

Unconfirmed

16	**Audit and Assurance Committee Report** The Committee had met in January. MN highlighted the Risk Assurance Report which had been rated red in relation to achievement of key performance indicators; the Risk Management Group was undertaking a review into a streamlined approach to KPI reporting, which would be reported back through the Committee. KJ advised that responsiveness to internal audit reviews had improved. DL and CF would discuss the best approach to risk assurance reporting at Audit and Assurance Committee. **Action**
17	**Any other business** None.
18	**Governor observations** AH provided the following feedback: • AH asked when the improvements noted in the patient story would be rolled out to other areas, and that the presentation should be shared with paediatric staff. • AH commended the Board Assurance Framework, and the corporate governance team for the work that had gone into its revision. • AH shared the disappointment with the staff survey results, and noted the potential impact on staff who may already be struggling and unable to wait for the conclusion of the three-year culture change programme.
Close	

Actions/Decisions			
Item	**Action**	**Owner/ Due Date**	**Update**
Scheme of Delegation, Standing Financial Instructions and Standing Orders	The Board ratified the Scheme of Delegation, Standing Financial Instructions and Standing Orders.		
Fit for the Future 2 Business Case	The Board approved the following: • To locate the majority of Benign Gynaecology Day Cases at Cheltenham General Hospital • To centralise the dedicated Diabetes and Endocrinology inpatient beds at Gloucestershire Royal Hospital and provide a Diabetes and Endocrinology consult service at Cheltenham General Hospital • To centralise Non-Interventional Cardiology inpatient beds at Gloucestershire Royal Hospital and provide a Cardiology consult service at Cheltenham General Hospital • To centralise Respiratory inpatient beds at Gloucestershire Royal Hospital and provide a Respiratory consult service at Cheltenham General Hospital • To establish a Respiratory High Care unit at Gloucestershire Royal Hospital • To locate the Hyper Acute Stroke Unit and Acute Stroke Unit at Cheltenham General Hospital		
Finance Strategy	The Board approved the strategy, noting that the transformational approach and net zero target would be strengthened within the document.		
Audit and Assurance Committee Report	DL and CF would discuss the best approach to risk assurance reporting.	DL/CF	In progress

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

1 Operational Context

1.1 The Trust continues on a broadly positive trajectory in respect of operational performance however the situation in respect of urgent and emergency care (UEC)remains fragile. Inevitably, recent industrial action by junior doctors and nursing in colleagues has introduced a number of operational challenges but our teams and leaders have worked incredibly effectively to maintain safe care.

1.2 We continue to progress make 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 183 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 upon 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. This week we will be holding our Clinical Summit where we will work with clinical colleagues to develop a plan for reducing and, ultimately. eliminating the need to board patients on our wards and care for patients in areas not intended for this purpose including day surgery and Emergency Department cohort areas.

1.3 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 are now well placed to achieve the 65-week standard. Of particular note, is was achieved despite the total number patients waiting for planned care being the highest in the SW; this 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 in 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 activity to enable us reduce the total number of patients waiting.

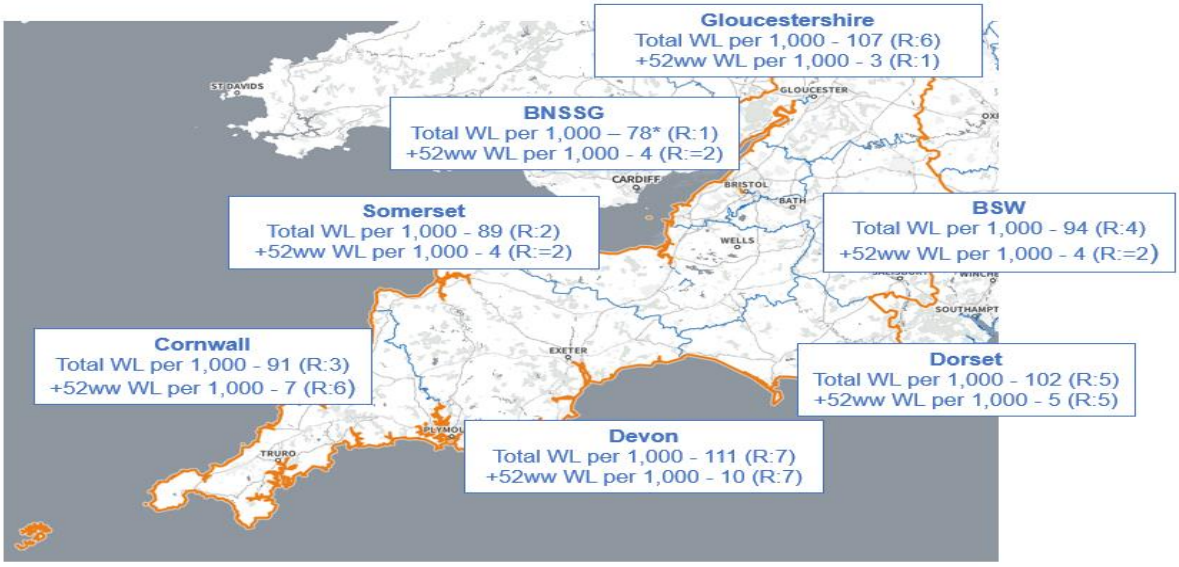

Figure 1 Patients on a hospital waiting list per 1,000 patients – admitted and non-admitted

1.4 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.

1.5 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 197 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 our operational plan submission proposes that we will achieve the standard by the end of June 2023. 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 Key Highlights

2.1 Following the publication of the staff survey in March, work has progressed to establish the Staff Engagement Taskforce. Following a call for Expressions of Interest, over 30 people have been appointed to the Taskforce. An induction was held from 24th – 26th April comprising: team profiling and development; an introduction to project management; input from Library Services about evidence-based practice; an overview of QI approaches and support; and a structured review of staff survey feedback and the responses to the QR code. Members of the Taskforce have self-organised into four groups focussing on policy; management behaviours; reward and recognition (feeling valued); and patient experience. They have continued to meet since the induction to develop project plans and actions and are being supported by a dedicated Project Manager who has met with each group to refine their plans and ensure milestones and deliverables are captured. The Taskforce has requested monthly whole-group sessions to ensure learning, progress and duplication are considered.

2.2Members of the Executive Team and the Chair attended the launch of the One Gloucestershire Reciprocal Mentoring Programme on 25th April. All members of the Executive Team have an allocated partner that they will meet with on at least four occasions over the next six months, with the overall aim of achieving greater insight and understanding of the experiences of staff with protected characteristics.

2.3 Tracie Jolliff, Head of Inclusive System Development for NHSE, is working with the Director for People to consider opportunities and support for progressing our Equality, Diversity and Inclusion agenda. She has made a number of suggestions that we are continuing to explore, including building skill in anti-racist practice alongside a 12 to18 month Board Development Programme.

2.3 Building on our commitment to diversity and inclusion, I was delighted to see that Muslim colleagues hosted two Iftar events during the period of Ramadan, with catering providing by our

GMS colleagues, staff from across the Trust were joined by partners from many organisations across Gloucestershire including the fire service. These events attracted attention regionally and nationally and hopefully pave the way for more celebrations that reflect our diverse workforce. Members of the Diversity Network are planning on joining colleagues in the Pride Parade on September 9th and Board members are invited to join the march.

2.4 Last week, the Care Quality Commission visited the Trust to assess progress against the actions arising out of the Section 29a Warning Notice served last year. They visited maternity and surgical services on both sites and met staff from many different services, observed their practice, spoke to patients and their families and reviewed numerous sources of data. Attached is their letter capturing the verbal feedback given on the day pending their final report. We are still in the process of fulfilling their data requests including providing evidence with respect to their observations regarding Executive visibility which has increased significantly since their visit following the introduction of the *Back To The Floor Programme.* This most recent visit was not a core service inspection and as such will not result in a re-assessment of the inadequate safety rating in the two services, however, paves the way for an improved rating when the CQC undertakes the full core service re-assessment which we believe is likely to be in Q3 of this year (October to December).

2.5 Today, we joined midwives from around the world to celebrate International Day of the Midwife. A number of initiatives took place across the Trust and attached is the message of thanks sent to our midwifery colleagues by Matt Holdaway, Chief Nurse and Lisa Stephens, Director of Midwifery.

2.6 Finally, for colleagues working this weekend who would like the opportunity to mark the coronation of King Charles lll our restaurants will be providing a themed menu to mark the occasion with TVs available for staff, patients and visitors to watch the ceremony.

Deborah Lee
Chief Executive Officer
5th May 2023

Celebrating International Day of the Midwife 2023

Today is International Day of The Midwife when we celebrate our midwives and give heartfelt thanks for everything they do for the people of Gloucestershire.

We join the worldwide midwifery community in marking International Day of the Midwife and appreciating the hard work, dedication and commitment of our midwifery team who provide such fantastic care for women and birthing people, babies and their families here in Gloucestershire.

Working across our units and in our community, whether over months, weeks or hours, our midwifery team develop trusting relationships with people through a life-changing experience, using their professional skills and knowledge to support families on this journey.

While midwives' work often brings great joy to families, it can also be very challenging with a consequent impact on their emotional and physical wellbeing. We not only recognise this but also pledge to find more ways to support them with this in the coming year.

To our midwives, thank you for everything you do in caring for our patients, which empowers them to bring new babies into the world with confidence. The fantastic feedback that we receive every day confirms that our local community hugely appreciates your time, care, professionalism and expertise. Enjoy your special day!

Lisa Stephens
Director of Midwifery (Interim)

Matt Holdaway
Director of Quality and Chief Nurse

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Date: 03/05/2023

CQC Reference Number: INS2-14498088151

Dear Ms Lee

Re: CQC inspection of Gloucestershire Hospitals NHS Foundation Trust

Following your feedback meetings with Neil Powell, Sharon Hayward-Wright, Claire Babbage, Corine Koppenol and Ann Goodwin. I thought it would be helpful to give you written feedback as highlighted at the inspection and given to you and your colleagues Matt Holdaway, Suzi Cro and Alan Dyke at the feedback meeting.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on the 26 and 27 April and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

Maternity -

Staff told us they felt staffing levels had improved since the last inspection.

Staff all felt supported by their immediate line managers.

The band 5 nurse role on the maternity ward was described as ‘invalualbe’ and staff wanted it to stay.

We had positive feedback from patients.

On the birth unit the safety net for the birth pool had been sent to be cleaned and staff were not aware of when it would be returned. Staff told us there was not another one available. The birth pool was being used on the 27 April 2023 as this was mentioned at the 08.30 safety briefing.

On the birth unit anti-emetics of stemetil and cyclizine were being stored in the CD cupboard with controlled drugs.

On the birth unit we also saw in the drugs fridge decanted ampules of oxytocin and syntocinon into other containers ready to be used by staff. This was not how your pharmacy had not delivered the medication to the unit.

Staff on the ward felt as they didn’t have an acurity tool for their staffing levels when other areas on the maternity unit were short staff, their staff were moved to cover.

Surgery-

Staff told us that they felt there had been an improvement in staffing since last inspection and we note that vacancies across the Directorate and been reduced.

Staff informed us that they had a positive relationship with their Directorate managers who were visible on the units at Gloucester and Cheltenham sites.

Staff told us that they did not see members of the executive team on the units, across both sites.

Cheltenham Hospital

We visited the Chedworth unit and found that multiple oxygen bottles were stored in the discharge unit which is currently not in service.

On the day of the visit the temperature of the unit was very warm in places and we were told by staff that thermometers had been requested. The room temperature were medications are stored were not recorded.

We were informed that children undergo non-specialist emergency surgery at the hospital and that the standard operating procedure may not meet the standards for non-specialist emergency surgical care of children produced by the Royal College of Surgeons in the provision of specialist paediatric anathestic care.

Staff and patients told us that they liked the design of the Chedworth Unit

Staff told us that they had concerns about oncall staffing arrangements when staff were transferred from Cheltenham to Gloucester sites to cover staff shortage and resource demands of Gloucester Royal Hospital. Staff felt that this could leave the Cheltenham site short of staff.

Gloucester Royal Hospital

Staff told us that they felt they were not fully informed, in a timely way, of changes to the developmental plans and staff moves, and that they relied on Trust wide announcements.

We saw that there had been an improvement in the numbers of patients nursed in areas that were outside of their intended purpose.

We saw that the Surgical Assessment Unit had been extended and that the numbers of patients who required ward based care being nursed in recovery has been reduced.

Staff told us that the auditing of NEWS2 and patients notes has improved.

We found that mixed sex breeches are being recorded.

We found that there has been a reduction of never events across both sites.

We saw patient notes across both sites which showed evidence of risk assessments being undertaken

Staff informed us that they were involved in the governance process.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Sue Little at NHS England.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Odette Coveney

Operation Manager

c.c. Chair of Trust

Sue Little

CQC regional communications manager – John Scott.

April 2023

Gloucestershire Hospitals NHS Foundation Trust

Board Assurance Framework Summary

Ref	Strategic Risk	Date of Entry	Last Update	Lead	Target Risk Score	Previous Risk Score	Current Risk Score
1. We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges							
SR1	Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System	Dec 2022	Feb 2023	CNO/MD/COO	3x3=9	N/A	5x5=25
SR2	Failure to implement the quality governance framework	Dec 2022	Feb 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	April 2023	DOP	3x4=12	3x2=6	5x4=20
SR4	Failure to retain our workforce and create a positive working culture	Dec 2022	April 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	Feb 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	Jan 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	April 2023	DOF	4x3=12	4x4=16	5x4=20
8. We have developed our estate and work with our health and social care partners, to ensure services are accessible and delivered from the best possible facilities that minimise our environmental impact							
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							

Board Assurance Framework Summary

SR12	Failure to detect and control risks to cyber security	Dec 2022	Jan 2023	CDIO	3x3=9	N/A	4x3=12
SR13	Inability to maximise digital systems functionality	Dec 2022	Jan 2023	CDIO	2x3=6	N/A	3x4=12
10. We are research active, providing innovative and ground-breaking treatments; staff from all disciplines contribute to tomorrow's evidence base, enabling us to be one of the best University Hospitals in the UK							
SR14	Failure to invest in research active departments that deliver high quality care	Feb 2023	April 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.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR1: Urgent and emergency care — February 2023

REF	STRATEGIC RISK	GOAL/ENABLER	CAUSES	CONSEQUENCES	LEAD COMMITTEE	LEAD	LINKED RISKS
SR1	**Failure to effectively deliver urgent and emergency care services across the Trust and Integrated Care System**	We are recognised for the excellence of care and treatment we deliver to our patients, evidenced by our CQC Outstanding rating and delivery of all NHS Constitution standards and pledges	Reduced flow out of the Trust with high levels of Medically Optimised of Discharge patients who are unable to access community pathway Not enough discharges from the hospital, including pathway zero (Simple discharges) Increase acuity of patients being admitted which means that length of stay is extended, and therefore daily discharges lower and the opportunity to divert people away from the front door reduced.	• Extreme and considerable pressure upon staff and impact on well being • Potential for increased moderate and serious clinical incidents • Potential for delay related harm • Poor patient experience • Increased number of 12hour breaches • Longer waiting times in our ED. • Deterioration in ambulance handover times and ambulance community response times. • Higher levels of patients being cared for in temporary settings.	Quality and Performance Committee	CNO/MD/ COO	SR2 SR3 SR4 SR5 SR8 SR9

CURRENT RISK SCORE	RATIONALE	TARGET RISK SCORE	RATIONALE	RISK HISTORY
5x5=25	CCQ requires improvement rating (Dec 2019) Congestion within the ED department Impact on staff experience, attraction, recruitment and retention Failure to deliver ED performance standards System Opel Level 4	**Dec 2024** **3x3=9**	Patients are managed within the department with access times at each stage of their journey kept to an absolute minimum. Ambulances are offloaded within 15 minutes of arrival, patients triaged within 30 minutes and overall, LOS in ED is no greater than 12 hours	Dec 2022 Newly developed BAF risk

CONTROLS/MITIGATIONS	GAPS IN CONTROL
• Range of work programmes to support with managing demand internally and with system partners – including Discharge programme, Winter ward, winter plan, Newton work programme • Use of additional temporary settings on wards to provide additional capacity for pre-empting and Boarding • Weekly GOLD meeting at System level to review demand and agree actions • Additional money invested into social care to support additional domiciliary and community capacity • UEC Improvement Board chaired by CEO to review plans and monitor progress	• Additional impact of Industrial Action being noted and mitigations developed as announced, unable to plan in advance for all possible actions

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

• ED Metrics on Quality and Performance Report reviewed by Board and Quality and Performance Committee • Quality and Performance Committee Report to Board	

ACTIONS PLANNED

Action	Lead	Due date	Update
Work underway to implement recommendations from Newton review	ICB	Ongoing	Currently agreeing terms of reference, programme led by ICB and working in conjunction with Trust
Trust wide Discharge QI programme	Andrew Seaton	July 2023	Programme underway and meeting with MDT
UEC Improvement Board overseeing performance	CEO	Ongoing	Regular meetings every fortnight

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

Emergency Care Report:
• Friends and Family Test increased to 80% the highest score seen for 2 years
• Handover delays reduced from 194 delays over 4 hours w/c 2 Jan to 8 delays w/c 23 Jan
 	
Quality and Performance Report Feb 2023:
• Reduction in ED attendances from 19,175 Jan 2022 to 10,946 Jan 2023
	Emergency Care Report Feb 2023:
	• Escalation level for Jan 2023 BLACK
	• 4 hour performance at 60.11% (national target 76%)
	• Safety Checklist only 43% compliance
	  ○ NEWS2 scores recorded within 30min 54%
	  ○ NEWS2 compliance every 60 min 35%
	  ○ NEWS2 score recorded every 90 min 56%
	  ○ Refreshments offered within 2 hours 8%
	
	Quality and Performance Report Feb 2023 SPC Charts:
	• ED% of time to initial assessment under 15 min 46% (target 95%)
	• ED% total time in department – under 4 hours 60% (target 76%)
	• ED number of patients experiencing 12-hour trolley wait 1057 people (target = 0)
	
	QDG Exception Report Appendix 1 - Boarding of Patients on wards to relieve congestion
	
	Quality and Safety Risk Report: ED congestion leading to the increase in ED incidents
		• 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 — February 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 in draft. 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 score for Trust and a MUST DO action to improve governance	**2022/23 Q3** **3x4=12**	Implementation and embedding of the quality governance framework.	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 • Quality and Performance Committee oversees progress of risks, safety, experience, access/performance and outcome improvement plans in areas where significant issues/concern highlighted • Key Issues and Assurance Report (KIAR) • 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 • Executive Review process	• CQC Well-Led Report • Staff Survey Results • Quality governance processes •

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

• 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	Q1 2023/24	In progress and reviewed by Feb QDG
Work in progress for the closure of the CQC S29A warning notices	CNO	Overdue Q3 2022/23	Continue regular oversight meetings with CQC and ICS/LMNS. Regular oversight of risks and action plans.
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
Formal governance review, focusing on quality ward to Board processes	CNO/DOF/ Trust Sec	Dec 2023	Proposal agreed and start of review early March

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Learning from Deaths Report	• Cancer performance (haematology, urology and lower GI)	• 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 April 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 and 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**	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
		3x4=12		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.

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR3: Workforce - Recruitment and Attraction April 2023

ACTIONS PLANNED			
Action	**Lead**	**Due date**	**Update**
Transactional recruitment review commenced in June 2022 as part of a formal transformation change programme	DDfPOD	Ongoing	Reporting into the Workforce Sustainability Programme Board, the focussed review continues with clear benefit realisation being evidenced with time to hire and improved customer survey / experience outcomes.
Development of a marketing and strategy / plan	DDfPOD	Delayed	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 required.
Interventions and activities to deliver the workforce plan across the Trust	DDfPOD	Ongoing	Increased overseas nurse recruitment has been agreed supported by NHSE funding. The outcome of a further bid has been confirmed as successful allowing the Trust to secure a further cohort of 80 overseas nurses. A successful Trust Open Day was held in March 2023 which saw 150 attendees and 15 job offers made on the day. Fresh focus and attraction drive for UK based nurse graduates is required in 23/24. Further ICS collaborative recruitment events are being planned for 23/24.
Temporary staffing controls and compliance	DDfPOD	Ongoing	This key workstream continues under the Workforce Sustainability Programme. Focus over the last 2 months has been on recruiting to the Bank Team following successful investment to the service, ongoing efforts in improving grip and control with medical agency use, developing SoPs for temporary staffing bookings and controls, and supporting the Trust wide response to ongoing Industrial Action.
Focussed planning of a Preceptorship Academy and commencement of a master accredited module	ADED	Launched	The first cohort of Preceptees have commenced on the Level 7 accredited Preceptorship Module. This is an attraction to newly qualified clinicians to the Trust. The Preceptorship Academy has launched, with branding and a SharePoint for Preceptees to access.
NETS (National Education and Training Survey) Group created	ADED	Ongoing progress	NETS Group (consisting of key stakeholders, leads from placement areas and influential roles) 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. HEE NETS meeting postponed to allow for senior nursing/AHP/Midwifery representation to be available. Actions being collated for mid-April ready for the HEE meeting.

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

AHP HCSW Associate Educator Post created using BID funding from NHSE	ADED	Delayed	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. This post will work alongside the HCSW Associate Educator focusing on nursing HCAs. Post went to AHP leads for comment, out to recruitment, but no suitable appointment. Review of objective being undertaken with Simon Lovett, new Head of AHPs.

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 January 2023 data	▪ 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

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 April 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	See Risk update April 2023

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

CONTROLS/MITIGATIONS

- 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 - ongoing	Tender document finalised and published 31st March 2023. Scheduled start date of supplier expected 1st September 2023. The programme aims to work with 50 teams per annum, over a 3-year period, in the form of manager development to come together in an action learning set environment as well as team development. £500k from HEE has been assigned to a new budget to fund this programme.

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	TBC	The Culture and Staff Experience Project Coordinator commences in post on 17th April 2023 and will take responsibility for delivering this, working with the ESR teams and Divisions.
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"	Head of L&OD	To commence April 2023	Full scoping of the workstream to take place week commencing 17th April with Head of L&OD, and Head of Heath Inequalities and Healthy Hospitals. Metrics have been identified in order to monitor progress of the workstream. Current data will act as the baseline, which will initially focus on People Promise Element 1: We are compassionate and inclusive as well as Race related Violence and Aggression incidents data held by the Trust Risk department.
Raising Concerns and Speaking Up Develop full plan for the new workstream as identified by the 2022 Staff Survey results, including aim, deliverables, benefits and milestones	Lead FTSU Guardian	TBC	Full scoping of this workstream will commence when the new lead Freedom to Speak Up Guardian starts in post.
Taskforce 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	To commence April 2023	35 Expressions of Interest have been received for the Taskforce. It has been agreed that everyone who took time to express an interest will be included onto the taskforce. An induction programme is currently in development for week of the 24th April 2023, with the aim to commence design and delivery of projects and interventions suggested by staff from May -December 2023.
Restorative Just, 4 Steps Approach and People Policies and Processes ▪ Schedule of policy reviews for Trust people policies ▪ Supporting procedures that utilise the four-step model and tools within people processes and investigations ▪ Established resources, advice and guidance to support line management practice	ADofW&R	TBC	Full scoping of workstream will commence when the new Associate Director of Workforce & Resourcing commences in post in June 2023.
Colleague communications and Engagement ▪ Review and audit all internal communication channels completed ▪ Review and engage services on Staff Survey results ▪ Ongoing promotion of NQPS in Q4, 1, 2	DofComms	January - May 2023	Comms and Engagement plan staff survey results put into action. Webinars held 8th March sharing staff survey results with colleagues from across the Trust. Engagement events continued for a further 4-weeks thereafter. Recording of webinars shared Trust wide. NQPS took place in January 2023. Results were analysed alongside staff survey results. Further NQPS to launch in April 2023

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 April 2023

Establish a Trust wide Retention Group focussing on 2-3 core initiatives at a time, informed by expert exit data analysis	P&OD ADs	TBC	Delayed due to reduced capacity across the P&OD portfolio and ongoing operational pressures. To commence formally with the two new P&OD Associate Director appointments
Financial Wellbeing Support	Head of L&OD	April 2023 September 2023	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 investigated in partnership with Hospitals charity, for launch in autumn 2023.
Mental Health Wellbeing Support	Staff Psychology Lead	Ongoing	Long-term funding for fixed term posts within the Staff Psychology team has been approved. This allows for an assured longer-term planning of the Services offering and support to complement other health and wellbeing interventions for staff.
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	Commencing April 2023	Programme and Project Management support now identified with first scoping meeting in April 2023. The programme group will work in close partnership with ICS colleagues for a collaborative System approach, together with Staff Side colleagues.
Becoming a Real Living Wage Employer (ICS collaboration)	DDfPOD	Timescales not yet set	Early discussions being held with One Gloucestershire ICS partners. National living wage uplift has been applied with effect from 1 April 2023
Cultural Awareness Pilot site for National Programme	ADED	Ongoing	EOI was submitted to be a pilot Trust for a new Cultural Awareness training package. As a Trust we have been chosen to provide a locally delivered days workshop for leaders from an IEN background and for line managers of IENS. This will feed into a Nationally delivered programme.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
▪ Ability to offer flexible working arrangements ▪ Diversity 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 ▪ Cost of living increases ▪ Exit interview trends ▪ Inconsistent Pay T&Cs for HCSWs	▪ Culture and Staff Experience Improvement Programme ▪ Internal audit reviews 2022-25: - Cultural Maturity - Cross health economy reviews - Equalities, Diversity and Inclusion - Health and Wellbeing - Staff Engagement

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 SR5: Quality improvement methodologies — February 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 adhoc 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	• Quality governance arrangements • CQC Well-Led Report

ACTIONS PLANNED

Action	Lead	Due date	Update
Review of the Quality Governance framework (Quality Plan to deliver assurance and improvement)	CN	Q1 2023/24	In progress and reviewed by Feb QDG
Introduction of PSIRF	MD	Q3 2023/24	
Establish A3 thinking approach to establish a recognised planning and monitoring approach for improvement	CN\MD\SL	Q3 2023/24	

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Feedback from staff on safety huddles	• CQC Well-Led Report	• 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 — February 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 • Wrong 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	
		Aug 2022	Jan 2023	Jan 2024			
5x3=15	Development of an Integrated Gloucestershire system	3x3=9	3x3=9	2x3=6	Developed and embedded system working	Q2 2021/22	
						Q4 2021/22	

CONTROLS/MITIGATIONS

- System wide discussions underway and meeting of ICB Board taking place to agree priority areas
- System wide development of Operational Plan
- System GOLD meetings weekly
- Quality and Performance Committee oversees progress of improvement plans in areas of significant concern.
- Delivery Group exception reporting (Maternity, Quality, Planned Care and Cancer)
- Urgent and Emergency Care Board
- Monitoring of key performance metrics via Quality and Performance Report (QPR)
- Quality Strategy in place
- Risk Management processes
- Executive Review processes
- Trust investment plans
- Key issues and assurance reporting (KIAR)
- ICB attendance at Q&P Committee
- Triumvirates in place for the Operational/Clinical Divisions
- Close working relationships between Operational Divisions and Finance/HR proven in delivery of some priorities

GAPS IN CONTROL

- Operational Plan 2023/24 not fully compliant in all domains (Activity agreed to delivery 105%; however not all quality measures planned to be met; Financial gap identified and not fully mitigated).

ACTIONS PLANNED

Action	Lead	Due date	Update

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

Refresh of Trust Strategy to align with priorities of ICS	DST	Ongoing	
Meeting of the ICB Board	CEO	Ongoing	
Continuation of Operational Plan delivery monitoring at system level	COO	March 2023	Meeting confirmed and in diaries twice per month. Reporting being finalised

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Elective Recovery Board in place • Regular 'systemwide' planning meetings in place • KPI (Cancer performance, diagnostics etc) monitoring meetings are fully established • GIRFT Report – Urology services have made significant improvements **Quality and Performance Report** – A high performer on elective recovery - continued to make significant progress on the number of patients on the waiting list. – A winter ward plan was in development, with 24-34 additional beds for this winter. – Cancer performance. – Plans in place to improve the two-week-wait pathway, – Marginal gains against the 62-day standard.	• Operational Plan 2022/23 not fully compliant • CQC Maternity Service report (inadequate rating) • CQC S29A Warning notice for maternity and Surgery **QPR metrics** Many access, performance and quality metrics triggering "red" and not meeting their performance targets.	• Operational Plan 2022/23 to be monitored delivery on formal basis from June 2022. • CQC Well Led Inspection (report due October 2022) • 'Flow' focussed strategy and delivery group planned • Internal audit reviews 2022-25: o Outpatient Clinic Management o Discharge Processes o Cultural Maturity o Clinical Programme Group o Patient Safety: Learning from Complaints/Incidents o Patient Deterioration o Equalities, Diversity and Inclusion o 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	
3x3=9	External engagement has improved but requires a more systematic approach, including joined up working with partner organisations	**April 2023**	**Jan 2024**	• Impact mapping and metrics that show increase in public and community involvement. • Recruitment of 1000 people to Citizens Panel • 10% increase in membership, that reflects the diversity of local communities	Feb 2023	**3x3=9**
		3x2=6	**1x3**		March 2022	**3x3=9**
					Aug 2022	**3x2=6**
					Nov 2022	**3x2=6**

CONTROLS/MITIGATIONS

- 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

GAPS IN CONTROL

- 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

Membership Strategy 2023-2025	Corp Gov	April 2023	Development of refreshed Membership Strategy – engagement workshop with Governors to help influence plan and approach.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• 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	• Trust membership has reduced to below 2,000 with limited diversity • Opportunity to actively elect more divers Governors and grow membership • Friends and Family Test Scores have dipped, in particular ED and PALS calls have tripled in last 18 months from around 200+ per month to over 600.	Internal audit reviews 2022-25: • Patient Safety: Learning from Complaints/Incidents • Equalities, Diversity and Inclusion • ICS Citizens Panel

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

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

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

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

CONTROLS/MITIGATIONS

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

GAPS IN CONTROL

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

ACTIONS PLANNED

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

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE

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

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

• 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 — April 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	
5x4=20	• 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**	**5x3=15**	• Everyone in the Trust (from Board to ward) understands and owns their element of responsibility around good stewardship of public money. • On line financial training to raise awareness of the importance of good financial control. • Full review of all revenue investments made during the pandemic to determine whether they are still to be supported or if financial commitment should be removed. • Continued monthly monitoring to understand the drivers of the deficit. • Drive the financial sustainability programme 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 2023	**4x3=12**		April 21	
		June 2023	**4x3=12**		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.	

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	• Clear line of accountability with no accountability framework • Robust benefits identification, delivery and tracking across major projects • Controls on the approval of WLIs/overtime payments needs strengthening • Inability to generate ideas • Capacity issues to generate and implement ideas at pace i.e., RMN decision making thresholds

ACTIONS PLANNED

Action	Lead	Due date	Update
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/P MO	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.

POSITIVE ASSURANCES	NEGATIVE ASSURANCES	PLANNED ASSURANCE
• Achieved key annual financial targets in 2020-21. • Achieved key annual financial targets in 2021-22. • Achieved key annual financial targets in 2022-23. • Continued the monitoring of financial sustainability with a greater focus on recurrent savings • ERF performance to secure monies for the system • Improved and co-ordinated system working.	• 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	• Internal Audits planned 2022-25: ○ Cross health economy reviews ○ Shared Services reviews ○ Risk Maturity ○ Data Quality ○ Budgetary Control ○ Charitable Funds

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

• Development of productivity analysis at divisional level	• 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	○ Payroll Overpayments • NHSE/I scrutiny of Trust/system finances. • ICS accountability and assurance on system wide transformational changes.
UPDATE		
April 2023: Planned action due dates updated with a number of further actions applicable to the new financial year.		

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	RISK HISTORY	
		Jan 2023	Jan 2024			
4x4=16	One Gloucestershire CDEL results in an annual capital budget of c£24M per year for GHFT. This is split across estates, digital and equipment. This allocation is insufficient to address the scale of backlog maintenance (£72M) risk within an appropriate timescale as well as a refurbishment, equipment replacement & digital programme.	**4x4=16**	**4x3=12**	• CDEL limits constrain the level of capital investment One Gloucestershire can commit to • Estate backlog maintenance schemes compete with other strategic and operational priorities, including strategic estate schemes, digital and equipment replacement • Equipment Managed Equipment Service (MES) procurement on hold as business case did not demonstrate value for money and impact of IFRS16 was unknown in 21/22. • ICS Partners have greater awareness of risk GHFT is carrying across estates in particular, which could lead to a change in CDEL allocation from 2023/24. • GHFT have a good track record of securing capital from NHSE schemes (UEC, TIF, CDC etc) and these schemes include backlog maintenance element.	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			
3x3=9	• Scale of investment required to achieve required EPC ratings and carbon reduction across GHFT estate • Electrical infrastructure investment required to stabilise and then increase capacity to support EVs	**3x3=9**	**3x3=9**	GHFT has been successful in securing external grants	Apr 2023 Feb 2023 Dec 2022	

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

ACTIONS PLANNED

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR11: Sustainable healthcare April 2023

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

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR12: Cyber security — January 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
4x3=12	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.	**Feb 2024** **3x3=9**		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	• Lack of 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

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	CDIO		Ongoing

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

BOARD ASSURANCE FRAMEWORK RISK SUMMARY SR13: Digital systems functionality — February 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 aligning or in place to allow data sharing across system • 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

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	

ACTIONS PLANNED

Action	Lead	Due date	Update
Radiology system replacement		March 2023	
Blood Transfusion onto EPR (resulting)		April 2023	
E-referral Rollout/expansion		May 2023	
Paper-lite Outpatients - phased		Summer 2023	
NHS at Home		Summer 2023	
Clinical Documentation Expansion		Ongoing	
Pre-Assessment Clinic Process / Documentation		Autumn 2023	
Sunrise Mobile		2024	
Virtual Wards		Autumn 2023	

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 — April 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
3x4=12		**Feb 2024** **2x3=6**		Risk entered Feb 2023

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

ACTIONS PLANNED

Action	Lead	Due date	Update
Analyse results of clinical research survey for nurses	KG	April 2023	
Continuous Improvement projects in progress to streamline processes, releasing capacity	CS	Ongoing	Feb 2023: New
Review research sessions for clinical staff	CS	April 2023	
Invest to Save paper to TLT in April to address finance and resource issues (or is this an action?)	CS	April 2023	

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

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

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	9	Enclosure Number:	4
Date	11 May 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

Purpose

The Trust Risk Register (TRR) enables the Board to have oversight of, the active management of the key risks within the organisation. Following Risk Management Group on 5 April and 3 May 2023 the following changes were made to the Trust Risk Register.

Key issues to note

- 3 risks were approved onto the Trust Risk Register (TRR)
- 2 risks were approved with a TRR score to be held at divisional level
- 4 risks were downgraded from the TRR to a lower risk register following a reduction in score

Full details of the risks are below.

Recommendation

The Board is asked to note the report.

Enclosures

Trust Risk Register

Gloucestershire Hospitals NHS Foundation Trust

TRUST RISK REGISTER

BOARD REPORT

MAY 2023

1.0 NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

M2815Stroke
Operational Lead: Kate Hellier
Executive Sponsor: Mark Pietroni

Inherent Risk
The risk to patient safety due to delays in the acute stroke pathway for patients attending GRH ED.
Cause
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.
Impact & Effect
Effect: • Delays to thrombolysis and thrombectomy. • Delays to management of ICH. • Delays to swallow assessment. • Delays to timely to admission to acute stroke unit. Impact • Poor patient outcomes, including disability by failing to provide thrombolysis for infarcts or management of ICH.
Scoring
Safety C4xL3=12. Quality C3xL3=9 Reputational C3xL2=6
Evidence of scoring
• 36 Incidents • 1 linked risk • 1 linked complaint
Key Controls
• 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.
Gaps in Controls
• Improvement in communication between ED and stroke specialities needed to improve leadership and engagements. • Increased public health awareness of correct site to attend with stroke systems. • Work with GRH ED team to help support them to prioritise patients considering high pressures on department
Actions
• Reducing ED pressures to allow staff to work safely and prioritise patients appropriately • Stroke awareness training of ED triage nurses • Enhanced training for ED staff (doctors and nurses) on the stroke pathway and timelines • To work with ICB to improve patent awareness of stroke service not going to GRH

WC3845Obs

Operational Lead: Sue Maxwell
Executive Sponsor: Matt Holdaway

Inherent Risk
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.
Cause
• Insufficient Antenatal Screening Co-ordinator (ANSCO) and administrative hours within team • Increase in fetal medicine caseload • Increase in referrals from genetics department • Increase in complex pregnancies • Unable to identify, in a timely manner, eligible cohorts for antenatal screening owing to requirement to manually collect data • Lack of an electronic booking process and appropriate system of clinical prioritisation of scan requests • Lack of capacity in ultrasound to mitigate against short term list cancellation due to sonographer sickness • Delay in transfer of data from manual booking to computer system by community midwives • No funded time for Fetal Medicine Consultant to act as Screening Lead • No regular Fetal Medicine team meetings to discuss pathways
Impact & Effect
Effect: • Impact Notification from NHSE of recommendation to declare a serious incident due to failure to meet contractual requirements for screening • ANSCO unable to complete duties effectively and maintain screening standards as per Screening Quality Assurance Service Impact • Missed or delayed screening which could result in a missed diagnosis of a fetal abnormality such as T21, reducing options for women with affected pregnancies. • Potential reputational damage from failure to meet screening requirements/contract when already subject to an existing action plan regarding screening
Scoring
Quality C4xL4=16, Workforce C3xL4=12, Statutory C4 xL4=16, Reputational C3xL4=12
Evidence of scoring
• 3 new born and fetal screening incidents • Risk score increased following one declared SI • Meetings with NHSE following concerns over missed screening
Key Controls
• 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 subsequent screening opportunities (ie quad and anomaly) are offered and completed • 0.2.WTE bank hours currently being worked by ANSCO deputies • ANSCOs counselling women for Non-Invasive Prenatal Testing reducing requirement for extra Fetal Medicine appointment • Locum Consultant currently providing extra Fetal Medicine appointments (Fetal Medicine Consultants have also offered 'overtime' to help fulfil screening scans)

- Obstetric Consultants working flexibly to provide ad hoc Fetal Medicine appointments where possible
- Bookings have now been audited

Gaps in Controls

- Electronic referral process to be developed to improve efficiency and reliability of scan booking
- No Fetal Medicine meetings to discuss cases and plan service
- No Fetal Medicine Lead Consultant providing oversight of infectious diseases in pregnancy, sickle cell and thalassemia and fetal anomaly screening programmes
- Lack of IT equipment leading to delays in community midwives inputting booking data onto Trak system
- No substantive increase in ANSCO hours
- Team do not have direct access to book fetal medicine slots

Actions

- Create newsletter
- Undertake review of ANSCO hours
- Review booking system
- Review job plans
- Fetal medicine team meetings

C3941EFD
Lead: Bernie Turner
Executive Sponsor: Simon Lanceley

Comment: Risk previously agreed as Trust Risk by RMG and placed on the TRR. However, Executive withdrew risk at the main Board meeting with a view to reviewing it. Risk has since been updated by Mark Pietroni and is represented to RMG with Trust score.

Inherent Risk

The risk of severe patient harm due to an ineffective water safety programme at Cheltenham General and Gloucestershire Royal hospitals

Cause

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

Impact & Effect

Effect:

- 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

Impact

- 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

Scoring

Safety C5 x L2 = 10, Quality C3 x L3 = 9 Statutory C4 x L3 = 12

Evidence of scoring

- 1 linked serious incident

Key Controls

- 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
- SOP created for water samples typing, the management of positive results for GMS Estates and Apleona Estates teams and communication to relevant stakeholder
- SOP created for installation and management of filters, including tap replacement if tap will not take a filter
- Water risk assessments review and update in progress with pseudomonas risk assessments completed for augmented care areas.
- Compliance group in place (monthly meetings
- Bi-weekly action plan review meeting relating to all aspects of water safety (iterative as issues arise due to increased visibility and scrutiny)
- Improved communication of positive results by GMS to IPCT and Trust/ Water Safety Group through creation and implementation of reporting SOP
- Cleaning method statement for showers and bathrooms updated in line with national standards and signed off by IPC
- Training designed and implemented for all domestic staff, focussing on augmented care areas as a priority
- Process agreed regarding descaling, including tap replacement
- Augmented care areas signed off by Water Safety Group to eliminate any scope for error
  Water sampling frequency increased for augmented care areas to 3 monthly
  Funding agreed for Horne shower installations for augmented care areas
  Funding agreed for Zetasafe electronic system linked to water management which will prevent missed PPMs
- To use paraceti acid for drain cleaning in augmented care

Gaps in Controls

- Pseudomonas Written Scheme now in draft form for Water Safety Group comment
- Water Safety Plan now in draft form for comment by Water Safety Group
- Flushing records remain incomplete, relating to human factors, training needs and staff vacancies. IPC and Domestic leads improved training plan: need to review additional methods to improve
- Sampling was not being carried out to required frequency: this has been resourced by GMS but require data as evidence

- Standard risk assessment template for non-augmented care areas - this is currently in progress by IPC
- Schematic drawings to be updated. Drawings in place but not necessarily accurate. GMS team establishing costs to update.
- Dead legal / pipework survey required - this is partly underway for CGH
- Lack of assurance in reporting by GMS to Water Safety Group required.
- Water reporting template created, under second revision to provide improved assurance.

Assurance

- Compliance reports to ICC and water compliance group
- Issues reported via action plan review meeting, Water Safety Group and Q&P
- Independent action plan assurance provided via Pseudomonas Incident Action Plan Review Group, a sub-committee of SERG and though audit by external Authorising Engineer
- Independent audit carried out on cleaning in practice by external agency
- New checklist created for domestic supervisors for cleaning regimes
- Audit completed of shower hose length to ensure compliance with standards
- Annual external AE audit
- Augmented care areas agreed and subject to annual review (Water Safety Group)
- Monthly report for all water-borne pathogens created and reviewed monthly at Water Safety Group
- Isolates will now be stored with Pathology for 6 months to allow for any future water-borne testing
- Water testing increased to 3 monthly at CGH

Actions

There is a 70-point action plan held by the Water Safety Group and IPCT

Key actions:

- Create a formal water safety plan – in draft
- Training and records for domestic services
- Ensure all sites have up to date schematic drawings of all water systems
- All Time Temp forms must be signed, dated with the temperature probe serial number noted
- Dead leg and pipework survey
- Review and update thermal flushing procedure note to ensure it is fit for purpose
- Flushing to be undertaken at required frequency and assurance provided
- Explore software that makes job assignment and record of actions taken electronic
- Explore engineering solutions to reduce risk in all augmented care areas
- Instigate a programme of proactive estates and IPC walk arounds to identify water safety issues
- Implement a programme to change u-bend and trap for outlets that have been positive as a start then all augmented care areas
- Internal audits to be undertaken monthly to check that all water related tasks have been completed on time
- SOP for ensuring decontamination of tools between estates remedial work
- Conclude water testing in Avening ward
- GMS to provide list of outlets
- Conclude risk assessment on Rendcomb
- Purchase water safety system,
- Formalise process to prioritise augmented care flushing
- Review water tanks
- Review birth pool testing
- Remove sensors (taps)
- Trustwide audit of outlets
- Create staff engagement methods for water safety

2.0 RISKS WITH AGREED TRR SCORE FOR HOLDING AT DIVISIONAL LEVEL

D&S3568
Lead: Sarah Williams
Executive Sponsor: Matt Holdaway

Comment: Sponsor has agreed the risk and score but to be linked and held at divisional level

Inherent Risk

Risk of patient harm and loss of service quality as a result of a reduced service due to staff capacity. The risk of poor health and wellbeing of the workforce within the Home Enteral Feed Team due to covering gaps in the workforce.

Cause

- Difficult to recruit skilled Dietitians and nurses, causing a significant impact on the Home Enteral Feed team.
- Small team so loss of a single post has a significant impact on service delivery.
- The team should consist of 5 Nurses but currently we have two members of staff on long-term sick.
- Of 7.8 WTE dietitians, currently we have 2.8 WTE vacancies.
- We have moved two posts to band 5-6 progression posts following several previous failed recruitment campaigns.
- National and regional issue, recent regional survey indicates all Trusts are carrying Dietetic vacancies and most for several months. National data indicates that the majority of last year's graduates did not come into the NHS.
- Service has not had an uplift of staffing establishment since 2018 despite increasing patient numbers.
- There is a national shortage of Dietetic staff in the region of 15% (report due imminently from the British Dietetic Association - now attached as of 27/07/2021), but we believe this is significantly higher for Paediatric Dietitians.

Impact & Effect

- Effect
- Loss of staff morale, as recruitment is not productive.
- Staff working overtime to cover gaps but sickness levels now rising with behaviour now indicating staff are unable to cope for a sustained period.
- Staff becoming tired/burnt out, a number struggling with mental health issues and work-related stress.
- Result of taking non skilled dietitians means these staff need more support and training which means they are less productive than skilled staff but also skilled staff need to take time out to provide the training.
- Lost time on failed recruitment for multiple staff. In the last 12 months we have been out to advert multiple time on all posts. On the first post we converted it from a Band 6 to a Band 5-6 development post.
- We have also needed to shift junior unskilled staff from the adult team in to training/development roles in paediatrics. This not only puts enormous responsibility on them, but significant responsibility on the remaining senior clinicians trying to up-skill them and maintain a challenging caseload.
- An inordinate amount of time is needing to be redirected away from clinical time to build a structured training programme.

Impact:

- KPI Heatmap report, showing significant failures in several areas.
- Delay in patient care, reduction in quality of the service offered.
- Staff sickness levels and their ability to cover the gaps for a sustained period means the service has to reduce to emergency and urgent cases, prioritising work.
- This may have an effect on admissions as patients may not be able to have issues such tube problems resolved without being admitted due to lack of capacity in the team.
- Delay in patient care due to demands on senior and junior clinicians. Increased risk of poor-quality care due to inexperience of staff and highly complex clinical cases, often with high level safeguarding concerns.
- There are also concerns about safe care being provided due to inexperienced staff managing complex cases often with very little MDT involvement due to the community-based nature of the role.

• WE are failing to meet Nice Guidance around recommended time-frames for seeing new and follow up patients. This is a daily occurrence. • Staff have rightly raised concerns regarding their registrations. • Reputational damage is also of concern as we are getting increasing levels on informal complaints regarding response time to queries and concerns from patients, families and schools
Scoring
Quality and Workforce C3 x L5= 15, Safety C2 x L2 = 5, Statutory C2 x L4 = 8, Reputational C2 x L3 = 6
Evidence of scoring
• 28 linked incidents • 7 linked risks
Key Controls
• Patient safety is being mitigated by implementation of the training programme for staff. Regular 1:1 meeting with senior staff/team lead. • Being creative with recruitment opportunities to try and increase applicant pool. • Seeking support from highly skilled staff in N&D to help with training/development programme. • Overtime is also being provided by current staff to plug gaps, but unsustainable long term. We will be requesting to recruit at risk to MAT leave positions
Gaps in Controls
• Recruitment to all vacancies, ideally with highly skilled staff. • due to current pandemic international recruitment has all but stopped and there are also long delays when applying for Visa's • HR recruiting system delays due to reduced HR staffing. • Training the current staff • Retaining staff • Quickly get in to new accommodation so the team can all be together for adequate supervision and training
Actions
• Arrange meeting with Paed Nursing lead to advise on the staff resources situation in HEFT • Undertake staff stress survey

S3709Th
Lead: Cathryn Braithwaite
Executive Lead: Matt Holdaway

Comments: Sponsor has agreed the risk and score. To be linked to overarching risk once it has been developed.

Inherent Risk
The risk of harm to patients and poor-quality care when using Day Surgery Units as an inpatient ward
Cause
During periods of pressure on medical and surgical bed capacity, Mayhill Day Surgery unit is used as an inpatient escalation ward, although this has become the normal or Mayhill. Mayhill unit is not fit for purpose for inpatients. Further, day surgery does not have the correct staff ratio and scope of practice for inpatients as well as day surgery. Insufficient infrastructure to run unit as a proper ward when being kept open. Due to current Trauma pathway, trauma patients cannot go to 2A Annexe at a weekend and therefore Mayhill is kept open to accommodate.
Impact & Effect
Effect • Often patients not appropriate for the ward - breaching SOP and action card

- Mayhill is open and staffed and therefore an 'easy' option to move patients to rather than follow escalation plan
- Receiving patients directly from ED with incidents of no clear plan for treatment
- No establishment for staff at weekends so cost implication for temporary staffing
- Normal staffing is appropriate for day case but inpatient ward is 24 hours
- 15% of staff Rota covered by bank and agency
- Patients often waiting for nurse to provide basic care as insufficient staff for the acuity, missed intentional rounding daily.
- No regular pharmacist for the ward - delays in obtaining medication
- No junior doctors based on unit
- No allocated medical consultants - patients not reviewed daily, sometimes several days before reviewed
- Enhanced care patients or wandering patients are at risk to abscond or entering theatres.
- Insufficient bedside lockers - drugs cannot be stored safely for patients without lockers
- Treatment room has insufficient storage space for inpatient ward supply and the locks are broken on the cabinets
- Fire risk assessment is only appropriate for a day surgery unit.
- Lack of facilities to support an inpatient evacuation
- Environment is not suitable for dementia patients with high level confusion and anxiety
- Patients with falls risks - uneven floor, floor surface has deteriorated, unable to 1:1 patients with high falls risk
- Male and Female patients sharing sleeping areas and have to use same access routes whilst patients not in their day clothes
- Only 1 patient bathroom, one shower room for all patients - shared by all patients and mixed sex
- When housing inpatients Mayhill day surgery is in regular breach of the mixed gender accommodation policy
- Insufficient stock levels for an inpatient ward - daily chasing of materials management for supplies
- Delays in prescribing / Broad medication storage compromised
- Patients going to theatre at risk of not having a space to come back to post operatively delaying discharge from recovery, knock on effect to the whole of theatre flow.
- Lack of clarity regarding escalation of issues
- Sharing therapy resources - delays getting patients assessed
- No allocated OCT which means there is a delay in getting patients discharged
- Electrical sockets, regularly tripping causing operational pressures
- Cleanliness substandard due to insufficient domestic cover as only funded for day surgery service.
- Cleaning of equipment not being done by bank and agency staff and due to high proportion of temporary staff unit falling below target levels
- No catering facilities
- Patients less than 2 meters apart
- No storage for mobility equipment
- No curtains on the ward which causes difficulties with patients sleeping and temperature in the summer months
- Severe pressure on staff

Impact:

- Business as usual attitude to using Mayhill over the weekend to move patients both medical and surgical - discussed as every site call as to how many they can place there rather than look to close and redeploy the temporary staff
- Patients may deteriorate without medical review
- Delay of receiving support when clinical emergency due to geographical distance from main ward areas
- Quality of care is reduced due to staffing issues
- Patients left waiting for medication
- Patient's dignity not preserved
- Risk of CQC intervention - breach of safer staffing
- Substandard nutrition levels for patients due to limited menu that is repeated daily
- Increase in falls, pressure ulcers and other general injuries
- Patients bed bathed as unable to access suitable bathroom facilities
- Potential unauthorised access to medicines. POPAM storage monitoring noticeably shows area non-compliant.
- Confirmed cases of infection
- Dirty equipment

• Impact on elective patients arriving for day surgery as this leads to increased numbers in the waiting area means breaches of privacy and dignity. • Noticeable increase in written complaints, verbal concerns from both patients, relatives and members of staff. • Friends and Family positive feedback is noticeably lower when escalation causes day surgery to be used as a ward. • Staff have left the team as a direct result of being expected to care for patients outside of their scope of practice • Sickness levels amongst staff have been elevated as a direct result of being exposed to this environment • Loss of capacity as a day surgery units effects utilisation of theatre lists, under filled, and theatre flow reduced. Patients sitting in waiting area for prolonged periods of time, up to 5 hours.
Scoring
Safety, Quality and Workforce C3 x L4= 12, Statutory C2 x L3 = 6, Business C3 x L2 = 6, Finance C2 x L5 = 10
Evidence of scoring
• 545 incidents • 5 complaints • No linked risks
Key Controls
• Bank and Agency staff are being used to cover rota gaps • The staff are escalating issues to materials management for supplies • there is an SOP that has been drafted • Agreement for 4 Trauma day case beds in Mayhill in a dedicated space aware from other surgery flow
Gaps in Controls
• 25% of staff rota covered by bank and agency • Lack of funding/establishment for appropriate staffing levels • 50% of patients not appropriate for the ward • Lack of fire safety compliance as an inpatient area • Lack of agreed doctor/junior doctor/nurse and HCA requirements when agreed to open in escalation • Failure to meet basic ward provisions • Failure to meet drug safety requirements • Failure to meet mixed gender accommodation policy • Lack of agreed provisions around therapy assessment and treatment plans • Failure to meet nutritional requirements of patients • Unable to socially distance patients
Actions
• Review current practice of admitting trauma patients via Mayhill at the weekend

3.0 RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

WC3685Obs
Operational Lead: Rachael Harris
Executive Sponsor: Mark Pietroni

Comment: The last 2 months audit of BSOTs time show a 92% compliance in achieving primary assessment within 15 minutes. CE/LS/AH attend a weekly tri meeting and have agreed to reduce the scoring. The reporting culture has improved and the trigger list is to be reviewed.

Inherent Risk
The risk of delayed review, identification and treatment for pregnant women attending triage, in addition inability to adequately meet required standards of care.

Cause

- Maternity Triage - Inability to meet 15-minute wait times on a daily basis and daily Red Flag events due to women waiting longer than 30 minutes.
- Insufficient staffing to safely staff the triage service and to implement BSOTS.
- Current staffing status already insufficient; Despite funded establishment holding a vacancy rate of 1.9 WTE, the current and continuously changing picture of significant absences (maternity leave, covid leave, delays in new starters, sickness, retirement) means staffing thresholds are difficult to achieve on a day-by-day basis.
- Ambulance Hub calls diverted to triage out of hours without uplift in staffing.
- There are no medical staff rostered to Triage which creates inefficient working and exacerbates delays.
- Inability to coordinate management of the unit due to the band 7 being pulled clinically.
- Inappropriate referrals and confusion around referral pathways.
- unable to capture and analyse digital data as IT not fit for purpose.

- **Impact & Effect**

Effect

- Risk that identification of issues and treatment for the same are delayed.
- Risk that inappropriate referrals clog triage and compound the issues listed above.
- Risk of ability to implement quality improvement measure due to poor capture and analysis of data. Impact
- An interruption in clinical and/or non-clinical support functions that impact on patient services and colleagues

Impact:

- Frequent near miss events recorded as a result of delayed treatment and lack of designated medical staff.
- Potential harm to mothers and their babies.
- Frequent delays to identification of issues and treatment.
- Inaccurate or incomplete data for compliance.

Scoring

Safety reduced from C3 x L5 = 15 to **C3 x L2 = 6**, Quality reduced from C2 x L5 = 10 to **C2 x L2 = 4**, Workforce reduced from C3 x L5 = 15 to **C3 x L2 = 6**, Statutory reduced from C3 x L5 = 15 to **C3 x L2 = 6**

Evidence of scoring

- 124 linked incidents
- 1 linked risk

Key Controls

- Daily staffing review by matrons.
- A minimum of 2 midwives for all shift. However during a nightshift, if activity allows to reduce to 1 midwife at 02:00
- Redeployment of staff where possible.
- Additional hours such as twilight shifts put out to staff as bank.
- Rolling advert for band 5/6 staffing.
- Datix reporting all adverse events.
- Mitigation and control update: 18/02/22 Staffing establishment reviewed and discussed with Deputy Chief nurse. To await results from Birth rate plus. Currently staff on CDS rota are identified on a daily basis to support Triage
- Staffing discussed daily with HoM/Matron/Band 7 flow midwife.
- BSOTs is relaunched to reduce the risk of delayed reviews
- Staffing reviewed to meet required minimal to attain BSOTS standards.

Gaps in Controls

- Designated unscheduled care lead to be appointed and rostered.
- Funding to be reviewed to for establishment of a band 2 ward clerk to man telephones and data collect.

Actions

- All completed

D&S2938RT
Risk Lead: Bridget Moore
Executive Sponsor: Matt Holdaway

Comments:
Statutory risk reduced as recruitment handshake is still in place and has been successful in securing new staff. The uplift of 7% ceased on Oct 31st and was successful in retaining remaining staff and supporting them through the challenge of the induction and training of so many new inexperienced staff. Banding review will be completed by March. Number of agency staff have been reduced from 5 to 4. Remaining agency staff to run 6 machines in March only in order to clear the remaining patients from the waiting list by end of March. The department will be able to fulfil Cancer waiting time targets of 31 Days. Mutual Aid is no longer required from Bath, Bristol and Taunton. Two unfilled B5 posts have been made into Radiotherapy apprenticeships - apprentices starting in March 2023.

Inherent Risk

The Workforce risk that the Radiotherapy Service will not be able to recruit and retain enough staff to maintain the cancer waiting times and extended working due to a National shortage of Therapeutic Radiographers and difficulty recruiting & retaining due to our lower pay scales and increased opportunities from promotion elsewhere.

Cause

There is a national shortage of therapeutic radiographers. The staff banding grades of the Therapy radiographers are lower for Band 6 Team Leads and above, compared to all other surrounding Radiotherapy centres, and to 50/56 centres Nationally. The department will lose 17 radiography staff (14.5WTE) which is 31.5% of our Radiographic workforce between Jan 2022 - Aug 2022. The Swindon Satellite unit will be opening in June/July 2022 and has launched a recruitment drive at the beginning of May, So far, they have recruited two of our B6 Team Lead staff for B7 posts. In addition, a Private centre with 2 linacs will be opening in Birmingham in 2023 and will require staffing end of 2022.

Impact & Effect

Effect:

- It is becoming increasing difficult to recruit Band 5 staff due to national shortage and difficult to retain staff due to increasing numbers of vacancies locally and nationwide. Radiotherapy Census indicates a National Vacancy rate of 8.8% in Nov 2021 which has increased from 7.7% in 2020.
- A recent departmental staff engagement survey has indicated that up to 21 staff are considering leaving for promotion, leaving the profession, or changing location in the next year.
- Appraisals have fallen from 96% or higher routinely, to 82% in 2 months.
- Falling numbers of applicants for B5 posts. Last attempt to recruit B5 staff 30.5.22, there were no UK applicants and only 4 suitable overseas applicants

Impact:

- A failure in the Service due to unsustainable staffing levels with the department unable to extend its working hours to 8pm.
- There are breaches of the 31-day CWT targets and a waiting list has now commenced with a growth rate of 3-5 patients per week.
- Phycological impact on patients on the waiting list.
- One Linear accelerator has been closed since March 14th due to not enough staff to run all 5 machines safely.

Scoring

Statutory reduced from C4 x L4 = 16 to **C4 x L3 = 12**
All other domains remain the same - Safety C2 x L3 = 6, Quality C3 x L4 =12, Workforce C4 x L3= 12, Statutory C4 x L3=12, Reputational C2 x L3 = 6, Business C3 x L2 = 6, Finance C3 x L2 = 6,

Evidence of scoring

- 4 risks

Key Controls
• New Band 5 radiographers are recruited • Recruitment handshake is still in place and has been successful in securing new staff. • The uplift of 7% ceased on Oct 31st and was successful in retaining remaining staff and supporting them through the challenge of the induction and training of so many new inexperienced staff • Bid put through Division for funding that may be required as a result of any up-banding of staff • Number of agency staff have been reduced from 5 to 4. Division have agreed to keep 4 agency staff in order to run 6 machines for the month of March only in order to clear the remaining patients from the waiting list. • Mutual Aid is no longer required from Bath, Bristol and Taunton. • Waiting list will be cleared by end of March, so the department will be able to fulfil Cancer waiting time targets of 31Days. • Two unfilled B5 posts have been made into Radiotherapy apprenticeships - apprentices starting in March 2023.
Gaps in Controls
• The supply of newly qualified staff is reducing nationally making apprenticeships a essential route for training of new radiographers. Unfortunately, apprentices must be additional to the establishment and therefore a business case has been submitted for apprentices to be included going forward. This was not approved for Capital investment this year
Actions
• Banding Review of Radiotherapy Staffing – deadline end of March

C1798COO
Risk Lead: Qadar Zada
Executive Sponsor Qadar Zada

Comments: Quality score downgraded and Business Risk. Original specialties have changed. There are now additional controls in place. However, the risk of insufficient capacity remains.

Inherent Risk
The risk of delayed follow up care due outpatient capacity constraints all specialties.
Cause
A large backlog of patients following pandemic.
Impact & Effect
Effect: • The list of follow up grew with limited risk stratification for booking patients according to the outcome of the previous appointment / clinical recommendation over an appropriate time frame. There is a significant capacity issue to processing the review of the numbers and limited capacity to undertake risk stratification of the patients on a follow up list Impact: • Patients wait for extended periods of time without follow up review and / or we do not discharge patients in a timely manner back to primary care. This can result in a poor patient experience, a detrimental affect on their recovery or long-term management and delayed diagnosis or treatment leading to avoidable harm.
Scoring
Quality reduced from C5 x L3 to **C4 x L3=12** Other domains safety C4 x L1 = 4, Reputational C2 x L3 = 6, Business C3 x L3 = 9, Finance C4 x L3 = 12
Evidence of scoring
• 6 incidents

- 12 linked risks

Key Controls

- Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation)
- Speciality specific clinical review of patients (clinical validation)
- Utilisation of existing capacity to support long waiting follow up patients
- Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties
- Do Not Breach DNB (or DNC) functionality within the report for clinical colleagues to use with 'urgent' patients.
- Use of telephone follow up for patients - where clinically appropriate
- Additional capacity (non-recurrent) for Ophthalmology to be reviewed post C-19
- Adoption of virtual approaches to mitigate risk in patient volumes in key specialties
- Review of % over breach report with validated administratively and clinically the values
- Each speciality to formulate plan and to self-determine trajectory.
- Services supporting review where possible if clinical teams are working whilst self-isolating.

Gaps in Controls

- Review at weekly Check and Challenge PTL meeting, with a focus that has demonstrated significant improvement. Focus continues of clearing the longest waiting patients.
- Some very specific speciality areas require additional capacity to see patients.
- Raised at Tri to Tri and Divisional Boards (Surgery; Medicine; W&C & D&S)

Actions

Establish a risk review meeting

C2628COO
Risk Lead: Qadar Zada
Executive Sponsor Qadar Zada

Comment: Systems are well managed to reduce the risk to the patient and organisation. Statutory score reduced.

Inherent Risk

The risk of poor patient experience and poorer outcomes where there is a breach of the 18 week wait from referral to treatment due to a backlog of patients.

Cause

During C-19 the approach has been to treat in Clinical Urgency order and to review patients who were booked as new patients and those with a pathway under review. Whilst services have been reinstated as part of recovery, each service has a significant backlog which means patients are not managed within 18 weeks.

Impact & Effect

Effect:

- Failure to offer appointments in a timely manner, poor patient experience and potential risk of deterioration.

Impact:

- Intervention by Regulator
- Impact on Patient Experience.
- Potential patient harm.
- Impact on Trust Reputation.
- Failure to meet the National Performance Standards for RTT.

Scoring

Statutory reduced from C4 x L4+ 16 to C3 x L3 = 9, Finance score C4 x L3 = 12 now not scored

Evidence of scoring
• 7 linked risks
Key Controls
• Monitoring by clinical urgency and prioritisation is in place • Additional capacity is being sought for each specialty • Weekly review of PTL by the COO • Monthly oversight by Improvement Board, led by CEO
Gaps in Controls
• Don't have sufficient capacity to reduce the backlog from the pandemic at a sufficient pace. • Reduced available of the Independent Sector. • High levels of medically optimised for discharge patients occupying bed base.
Actions
• All complete

4.0 RISKS CLOSED ON THE TRR

None

TRR report

Ref	Inherent Risk	Controls in place	Action / Mitigation	Division	Highest Scoring Domain	Consequence	Likelihood	Current Score	Current	Executive Lead title	Title of Strategic Group	Title of Operational Group	If other, please specify name of Operational Group	Title of Assurance Committee / Board	Date Risk to be reviewed by	Operational Lead for Risk	Approval status
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 ANSCD 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					31/05/2023	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	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		Divisional Board - Corporate / DOG, Divisional Board - D & S, Divisional Board - Medical, Divisional Board - Surgery, Divisional Board - W & C, Emergency Care Delivery Group, Quality Delivery Group, Risk Management Group	Clinical Safety Effectiveness and Improvement Group, Emergency Care Operational Group, Fire Safety, GMS Health and Safety Committee, Health and Wellbeing Group, Patient Experience Group, Patient Flow Steering Group, Quality and Safety Systems Group, Staff Experience and Improvement		Emergency Care Board, Executive Management Team, Quality and Performance Committee, Trust Board, Trust Leadership Team	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	Divisional Board - D & S, People and OD Delivery Group, Quality Delivery Group	OHPCLI Board		People and OD Committee, Quality and Performance Committee	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 Recruitment and Retention Actions Workforce Planning Review 2022 Person-centred career 'plans on page' Establish Task and Finish Group for Radiographer Vacancies	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Workforce	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director for People & OD	People and OD Delivery Group	Recruitment Strategy Group		People and OD Committee	31/05/2023	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	Quality Delivery Group, Screening Performance Committee, Trust Health and Safety Committee	Radiation Safety Committee		People and OD Committee, Quality and Performance Committee	06/03/2023	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	Planned preventative maintenance by GMS Outsourcing for some products in place which would reduce impact somewhat - however this is not reliable due to	Liaise with GMS AHU motors report of AHU status check on chiller at weekends	Diagnostics and Specialties, Gloucestershire Managed Services	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk		Divisional Board - D & S	Medicines Optimisation Committee		Cancer Services Management Board	02/06/2023	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	Divisional Board - Medical	Unscheduled Care Leaders Group		Quality and Performance Committee, Trust Leadership Team	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		OHPCLI Board			19/06/2023	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		Fire Safety Committee Group, Risk Management Group, Trust Health and Safety Committee	Fire Safety		Other	30/06/2023	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				Executive Management Team, Quality and Performance Committee	12/06/2023	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 trainine packaee for HCAs #Little 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	Divisional Board - Corporate / DOG, Quality Delivery Group	Other	Falls and Pressure Ulcers Group	Quality and Performance Committee, Trust Leadership Team	16/05/2023	Bradley, Craig	Trust Risk Register
C1850NSafe	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour	1. The paediatric environment has been risk assessed and adjusted to make the area safer for self harming patients with agreed protocols. 2. Relevant extra staff including RMN's	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Medical, Surgical, Women's and Children's	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Interim Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Divisional Board - W & C, Quality Delivery Group, Safeguarding Strategic Group	Safeguarding Adults Operational Group, Safeguarding Children Operational Group / Board		Quality and Performance Committee, Trust Board, Trust Leadership Team	30/06/2023	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,	Governance process Reporting structure Patient safety and H&S advisors monitoring the system daily Monthly performance reports on new, overdue risks, partially completed risks, uncontrolled risks and overdue actions etc	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis test risk module Weekly meeting and action plan for DATIX Cloud	Corporate, Diagnostics and Specialties, Gloucestershire Managed Services, Medical, Surgical, Women's and Children's	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	Divisional Board - Corporate / DOG, Finance and Digital Committee, Trust Health and Safety Committee	Quality and Safety Systems Group		Finance and Digital Committee, Quality and Performance Committee, Trust Leadership Team	06/06/2023	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 (CDTE and T&O) and dietician review	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 aars campaign Education and suppt to staff on 5b for pressure ulcer dressines	Diagnostics and Specialties, Medical, Surgical, Women's and	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, Quality Delivery Group	Clinical Safety Effectiveness and Improvement Group		Quality and Performance Committee, Trust Leadership	05/05/2023	Bradley, Craig	Trust Risk Register

	prevention controls	(SSKIN and TAIS) and detection 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.	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 Ward 7a W170891 training with HCA's to allow them to assist registered nurses with assessing patient skin and documenting on EPR	Children's									Team			
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	Divisional Board - D & S	Pathology Management Board		31/05/2023	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	Divisional Board - W & C, People and OD Delivery Group			People and OD Committee	30/06/2023	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 AMU. Upgrage risk to reflect ED corridor being used for frequently + liaise with Steve Hams so get risk back on TRR audit form fo NIC re patients suitability Fire risk assessment Risk assessment of corridor care Review of SOP and escalation policy	Medical	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse & Director of Quality	Divisional Board - Medical, Emergency Care Delivery Group, Quality Delivery Group, Trust Health and Safety Committee	Emergency Care Operational Group, Patient Experience Group, Resuscitation and Deteriorating Patient Group		Emergency Care Board, Quality and Performance Committee, Trust Leadership Team	30/06/2023	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	To review and update relevant retention policies Set up career guidance clinics for nursing staff Review and update GHT job opportunities website Support staff wellbing and staff engagment Assist with implementing RePAIR priorities for GHFT and the wider ICS Devise an action plan for NHSI Retention programme - cohort 5 Trustwide support and implementation of BAME agenda Devise a strategy for international recruitment	Medical, Surgical	Safety	Major (4)	Almost certain - Daily (5)	20	15 - 25 Extreme risk	Director of Quality and Chief Nurse	Divisional Board - Corporate / DOG, People and OD Delivery Group, Quality Delivery Group, Recruitment Strategy Group	Recruitment Strategy Group, Vacancy Control Panel		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	01/04/2023	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.	COVID T&F Group to develop Recovery Plan to minimise harm To resolve outstanding areas of concern	Corporate	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	CDO	Divisional Board - Corporate / DOG, Quality Delivery Group			Quality and Performance Committee, Trust Leadership Team	10/04/2023	Zada, Qadar	Trust Risk Register
		Follow up by staff to pursue suitable	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															

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 ward 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.	Develop a systemwide MDT to expediate EoL Discharges Obtain robust data set Flow chart for roles and responsibilities for rapid discharge process Resource checklist for rapid discharge Develop outcome spreadsheet for rapid discharge MDT Regualr meeting with CHC leads Job description review	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	Quality Delivery Group	End of Life Quality Group		Trust Board	29/05/2023	White, Samantha	Trust Risk Register
C2819N	The risk of serious harm to the deteriorating patient as a consequence of inconsistent use of NEWS2 which may result in the risk of failure to recognise, plan and deliver appropriate urgent care needs	Ongoing education on NEWS2 to nursing, medical staff, AHPs etc o E-learning package o Mandatory training o Induction training o Targeted training to specific staff groups, Band 2, Preceptorship and	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	Digital Care Board, Divisional Board - Corporate / DDG, Quality Delivery Group	Clinical Systems Safety Group, Resuscitation and Deteriorating Patient Group		Quality and Performance Committee, Trust Leadership Team	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	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	Major (4)	Possible - Monthly (3)	12	8 -12 High risk		Estates and Facilities Committee, Estates and Facilities Contract Management Group, Infection Control Committee	Water Action Group		GMS Board, Quality and Performance Committee, Trust Board	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	Divisional Board - D & S, Estates and Facilities Committee, Quality Delivery Group	Pathology Management Board		Finance and Digital Committee, Quality and Performance Committee	12/04/2023	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	Create Dashboard to underpin SPEIG work priority workstreams feeding into SPEIG Review Staff Survey results EDI/Cultural Improvement plans being devised in light of DWC and staff survey results Short, medium and long-term interventions being proposed to address health-wellbeing concerns 2 x OD Specialists (fixed term) being recruited to offer additional support to a) maternity and b) junior nurse leadership development Staff Engagement and Internal Comms Manager being appointed to support internal communications effectiveness	Corporate, Diagnostics and Specialties, Medical, Surgical, Women's and Children's	Workforce	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director for People & OD	People and OD Delivery Group	Staff Experience and Improvement Group		People and OD Committee	02/06/2023	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	Finance and Digital Committee			Executive Management Team, Finance and Digital Committee, Trust Board, Trust Leadership Team	26/05/2023	Johnson, Karen	Trust Risk Register
S2424Th	The risk to business interruption of theatres due to failure of ventilation to meet statutory required number of air changes.	Annual Verification of theatre ventilation. Maintenance programme - rolling programme of theatre closure to allow maintenance to take place External contractors Prioritisation of patients in the event of theatre closure review of infection data at T&O theatres infection control meeting	Write risk assesment Update busines case for Theatre refurb programme Agree enhanced checking and verification of Theatre ventilation and engineering meet with Luke Harris to handover risk implement quarterly theatre ventilation meetings with estates gather finance data associated with loss of theatre activity to calculate financial risk investigate business risks associated with closure of theatres to install new ventilation review performance data against HTML standards with Estates and implications for safety and statutory risk calculate finance as percente of budget Creation of an age profile of theatres ventilation list Action plan for replacement of all obsolete ventilation systems in theatres Five Year Theatre Replacement/Refurbishment Plan	Gloucestershire Managed Services, Surgical	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Estates and Strategy	Divisional Board - Surgery, Finance and Digital Committee			Quality and Performance Committee, Trust Leadership Team	30/04/2023	Dobb, Michael	Trust Risk Register

			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														
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	Infection Control Committee			Quality and Performance Committee	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 proaramme	Gloucestershire Managed Services, Medical	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	Capital Control Group, Centre of Excellence Delivery Group, Divisional Board - Medical	Medical Devices Group, Medical Equipment Fund		Service Review Meetings	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		Divisional Board - Medical, Emergency Care Delivery Group, Quality Delivery Group				31/05/2023	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		Divisional Board - Surgery	Theatres Collaborative			03/07/2023	Ball, Natalie	Trust Risk Register
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)10.0wte DSN funding in place to cover inpatient, outpatient, pump clinic and GDM. 3)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. 5) Honorary contract for a diabetes nurse trainer in post, offering 0.2wte to the DSN team. This will add extra	Business case draft 2 to be submitted Business case to be submitted Demand and Capacity model for diabetes Liaise with Steve Hams to raise this diabetes risk onto TRR New Elearning module in progress to complete bimonthly audit into inpatient care for diabetes Recruitment events and Staff development opurtunity to be a DSN	Medical	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Chief Nurse and Director of Quality	Divisional Board - Medical, People and OD Delivery Group, Quality Delivery Group	Medical Workforce Productivity Board, Medicines Optimisation Committee, Patient Experience Group		People and OD Committee, Quality and Performance Committee, Trust Leadership Team	17/04/2023	Mani, Vinod	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	Divisional Board - Surgery, Estates and Facilities Committee, Quality Delivery Group			Quality and Performance Committee	06/06/2023	Jones, Lisa	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 performance.	1. Board approved, risk assessed capital plan including backlog maintenance items; 2. Prioritisation and allocation of cyclical capital (and contingency capital) via MEF and Capital Control Group; 3. Capital funding issue and	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Corporate, 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	Capital Control Group, Digital Care Board, Divisional Board - Corporate / DOG, Estates and Facilities Contract Management Group, Infrastructure Project Board	Capital Replacement Group, Medical Equipment Fund		Executive Management Team, Trust Leadership Team	30/06/2023	Johnson, Karen	Trust Risk Register

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NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Finance and Resources Committee, 27 April 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
Financial Performance Report	The M12 financial position was a surplus of £51k which was £51k favourable to plan. This was the position after adjusting for donated assets.	The Committee received the report as a source of assurance that the financial position was understood.
Annual Finance Plan	All ICS systems were required to resubmit 2023/24 operational plans on 4 May. Activity and trajectory plans for 30 March submission were approved previously by FRC. Four Metrics were being considered for revision from the submission completed in March.	The Committee supported the proposed changes to virtual ward capacity and patients with no criteria to reside (NCTR). Further consideration would be given to potential changes in the planned Referral to Treatment (RTT) waiting list and echo activity. The Committee supported virtual approval of any changes from the previously agreed position, due to the submission deadline of 4 May. The report would be received at Board of Directors to approve amendments.
Year end position and proposal for risk share approach	The pre-audit M12 position for the ICS was a £102k revenue surplus and a small surplus of £27k on Capital. This was in line with expectations and included potential costs of the band 2 – 3 pay review across the system	The Committee noted the year end position and the progress around the approach to risk share for 23/24. The Committee supported the approach to risk share within the system during 23/24.
Financial Sustainability Report	The Financial Sustainability Programme gap, before addition of recovery actions, was £2.8m. In month, the gap to the full year target of £13.2m had reduced by £0.1m. Progress had been made in identifying savings for 23-24. Work continued to drive forward and stretch the identified divisional and cross-cutting workstreams.	A system away day with ICB colleagues was due to take place and the Committee agreed that it would receive the ICS Savings Plan. A separate productivity update was being developed, which would be presented to the Committee.
Capital Programme Report	Key points were noted as follows: • The Trust had submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m. • There had been £14.6m of additional capital approved and a reduction in expected in-year donations of £0.6m, bringing this up to £65.7m. • At the end of March (M12), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £66.1m and the Trust delivered £17.5m of non-IFRS 16 capital in month. • The Trust finished £3k under the agreed position and the Committee congratulated colleagues on this achievement.	The Committee noted the M12 capital position.
Digital Transformation Report	The Committee received a review of the Digital Transformation Programme projects that had been delivered during 2022-23, broken down by projects within the four main work areas. An assessment of the Trusts position against HIMMS was being undertaken.	The update was noted.

Items Rated Green

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.

Item	Rationale for rating	Actions/Outcome	
None			
Items not Rated			
Digital Risk Register	Terms of Reference	Commercial and Innovation Review Group	
ICS Forward Plan – Draft			
Investments			
Case	**Comments**	**Approval**	**Actions**
Philips PACS system renewal	The Committee approved the renewal of the Philips PACS managed service agreement at a total cost of £2,968,431 for a four-year term commencing 1st June 2023. This represents a saving compared to the current charge of £869,309 over the four years (numbers exclude VAT).	Approved	None
TIFF Orthopaedic Theatre Procurement	The Committee supported the project but agreed that further clarity on defining the scope was required before moving forward.	Not approved	The report would be rescheduled for FRC and potentially the Capital Review Group.
Impact on Board Assurance Framework (BAF)			
SR12: Cyber Security The Committee discussed the high-risk areas of cyber security and considered whether the risk score should be raised. This would be reflected in the risk at May's meeting.			

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Finance and Resources Committee, 30 March 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**
Planning and Budget Setting - sign off	The Trust had worked with ICS partners to develop system and organisational level plans for 2023/24. The system was in a good place and the South West was in the best place across the country with regard to planning. The draft submission for 2023/24 showed an overall system gap of c£36m with a Trust gap of c£14m. The underlying recurrent deficit position of c£37m for 2023/24 were noted. The Committee noted that 79% of budgets had been signed off.	The committee approved the 2023/24 financial plan position for both capital and revenue for the Trust, and noted the wider system position. A further update on budget sign off would be provided in the April report.
Operational Planning	Information on activity and performance, urgent and emergency care capacity, investment, finance and workforce for 2023/24 was presented. The plan had been collaboratively developed by system partners and reflected the 2023/24 priorities for the ICS in line with the 2023/24 operational planning guidance.	The Committee approved the plan.
Financial Performance Report	The M11 financial position was a surplus of £1.5m which was £2.7m adverse to plan (£1.5m after adjusting for donated assets). The in-month position was £9.9m surplus which was £9.7m favourable to plan. Productivity remained challenged.	The Committee received the report as a source of assurance that the financial position was understood.
Financial Sustainability Report	The Financial Sustainability Programme gap, before addition of recovery actions, was £2.9m; this was projected to reduce to £1.6m, with additional forecasted recovery actions. The gap to the full year target of £13.2m had reduced by £0.3m. Progress had been made in identifying savings for 23-24.	Work continued to drive forward and stretch the identified divisional and cross-cutting workstreams. Meetings were taking place with GHC and ICB colleagues and plans to generate new ideas with indicative savings continued to be developed.
Capital Programme Report	Key points were noted as follows: • The Trust had submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m. • There had been £14.1m of additional capital approved and a reduction in expected in-year donations of £0.9m, bringing this up to £64.9m. • At the end of February (M11), excluding IFRS 16 capital, the Trust had goods delivered, works done or services received to the value of £68.5m, leaving £16.3m of non-IFRS 16 capital to deliver in March.	The Committee noted the M11 capital position detailed within the report and asked to be provided with an update before the next meeting.
Contract Management Group Exception Report	The Committee received assurance of the robust management of the Estates and Facilities contract between GMS and GHFT, including monitoring of KPIs, particularly discussing progress against water testing and capital schemes slippage.	Availability of national funding would be investigated to enable full compliance with water safety standards. The Committee would receive an update on backlog funding prioritisation.
Corporate SLA Performance	GMS worked on a 15-year lease expiring on 31 March 2033. In addition to the provision of services by GMS to GHFT, the contract covered the provision of a number of Corporate Services to GMS. Following a review by PwC the Committee was asked to determine the preferred way forward.	The Committee agreed to pursue option two, with a two-step approach detailed within the report.
GMS Budget	The GMS Financial Budget proposal for 2023/24 was received. This was based on GMS receiving a Unitary Charge of £68,483k for	The committee approved the GMS Financial Budget for 2023-24, recognising

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.

	2023/24 and for GMS to deliver the forecast outturn Dividend of £1,926k in consideration of pay and non-pay costs of £68,784k and via the delivery of financial sustainability of £1,331k in year.	the cost and investment necessary to enable GMS to continue to deliver on the requirements of the OHFA (Operated Healthcare Facilities Agreement) for the Trust.
GMS Dividend Approval	In relation to FY22/23 GMS recommended a dividend of £1,100,000, based on projected performance, allowing for risk, this needed to be added to the dividend payment, which totalled £1,409,000. SW reported that should the dividend fund vary adjustments would be required.	The Committee approved the dividend payment of £1,409,000.
National Cleaning Standards	A third-party report, along with internal analysis of productivity concluded an increase of 49 WTE Band A, and 8 WTE Band B1 (AfC Band 2 and 3 respectively) staff would be required to meet the standards. GMS Domestic services had implemented the new standards across 18 areas/wards and intended to complete a minimum of a further 130 in the next 12 months.	GMS had developed an implementation plan with the objective of achieving NSC, by the end of financial year 2023/24.
GMS KIAR	Safety inspections had highlighted known issues across the organisation, including damaged fire doors. Violence and aggression incidents were discussed and the Committee noted that the position was declining.	An update would be taken to the next Risk Management Group, with an update to the next Committee meeting. The CEO would discuss with GMS colleagues and a Task and Finish group would be convened.
GMS Recruitment and Retention	The Committee received a report which identified the challenges, barriers, opportunities and tracked progress against these GMS Board was fully sighted on the work being undertaken.	None.

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

Items not Rated		
Finance Systems Upgrade	Annual Review of Estates Return Information Collection (ERIC)	Estates Risk Register

Investments			
Case	**Comments**	**Approval**	**Actions**
GMS Food Approval: Frozen ready meals	Apetito Ltd (contract value circa. £1,023,823.60 Ex.VAT for the primary term two (2) years).	Approved	None
GMS Food Approval: Fresh Food (Meat)	Midland Foods Limited (Registered Company No. 02958742) as the best value provider for the contract with the indicative contract value circa. £84,173.96 Ex.VAT for the primary term six (6) months.	Approved	None
GMS Food Approval: Fresh Food – (Milk, Dairy and Bread)	West Country Milk Ltd (Registered Company No. 04032869) as the best price provider for the contract with the indicative contract value circa. £93,611.64 for the primary term six (6) months	Approved	None
GMS Food Approval: Fresh Food – (Fruit & Vegetables)	Total Produce (Registered Company No. 05953208) as the best price provider for the contract with the indicative contract value circa. £348,816.08 Ex.VAT for the primary term (two years).	Approved	None
Business Mail Contract	Approval was sought to extend the current contract with Royal Mail for Business Mail Advance Services by 12months, in order to conduct a suitable market exercise (is a rolling contract). The GMS Board had approved the contract at its Board meeting earlier in the week.	Approved	None
Community Diagnostic Centres	System partners had agreed to work together on the	Supported	The Committee noted that

Mobile CT Procurement	Community Diagnostic Centre (CDC) programme. Since the report was shared the position with the Community Diagnostic Centres – Mobile CT Procurement had changed. The NHSE regional team had advised that they did not have assurance that the plan was providing value for money for Gloucestershire. The contract was due to be signed off the following day and there was no funding guaranteed. Temporary funding would be put in place, but there was a 12-week period where funding was not agreed.	in principle.	the risk to the Trust amounted to £634k pa. reduced to £317k if cancelled after 6m. The Committee supported 'in principle' the mobile CT contract with GHNHSFT as the lead contractor and Cobalt as the provider via a sub-contracting arrangement with InHealth.
Health and Wellbeing Days	As part of supporting and recognising the hard work of colleagues in the Trust, the Executive team recommended that the Committee support the health and wellbeing of colleagues through the award of two additional health and wellbeing annual leave days. The cost was c£3.3m.	Approved	The Committee ratified the virtual agreement (23/3/23) to providing staff with two additional health and wellbeing days in 2022/23 which will be allowed to be carried forward into 2023/24 if not utilised.
Impact on Board Assurance Framework (BAF)			
BAF risks had been agreed and would now be aligned to agendas to drive forward key strategic work.			

Gloucestershire Hospitals NHS Foundation Trust

Report to Board of Directors

Agenda item:	11	Enclosure Number:	6c
Date	11 May 2023		
Title	M12 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 12.

Revenue

The Trust is reporting a surplus of £0.05m which is £0.05m favourable to plan. This is the position after adjusting for donated assets impact, Salix grant and impairments. This position is subject to audit.
The ICS financial position is £0.1m surplus against a breakeven plan. This is the result of a £0.05m surplus from GHFT, a £0.04m surplus at GHC and a £0.01m surplus at GICB.

Capital

The provisionally reported capital outturn position excluding IFRS 16 capital, is £66.1m, representing an overspend position of £0.4m. This overspending was pre-agreed with the region and the associated spending was only incurred on that basis. The Trust, therefore, finished £3k under our agreed position.

Recommendation

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

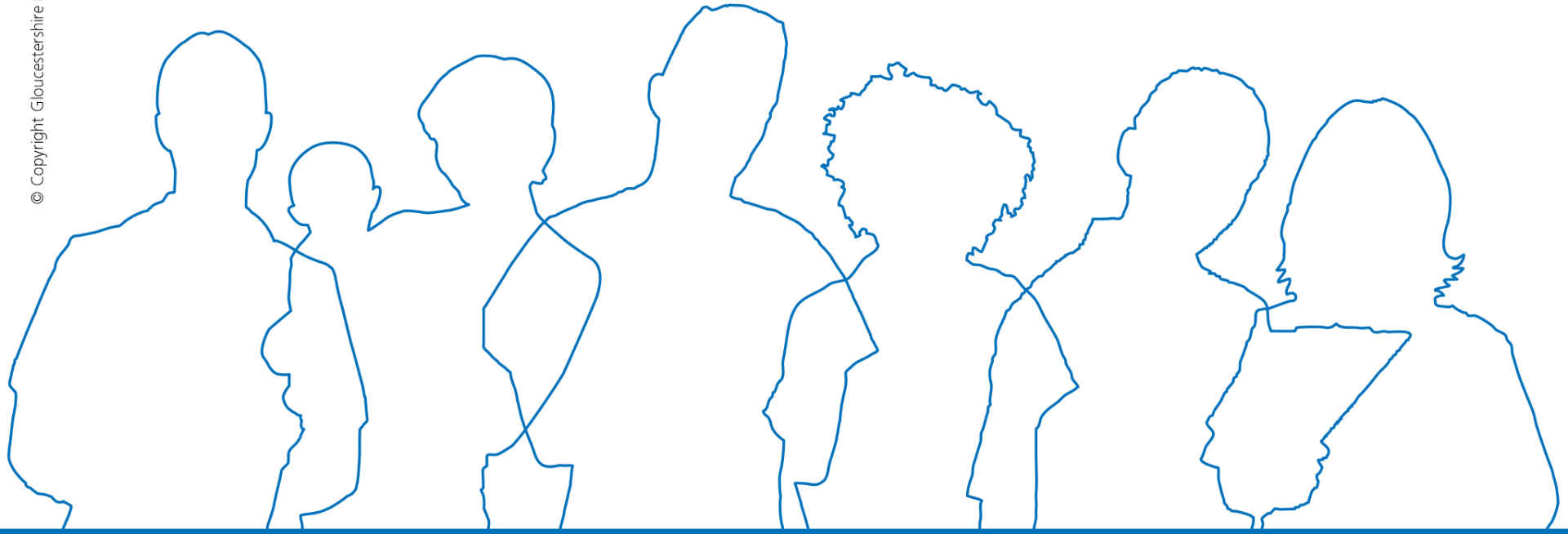
Enclosures

Finance Report Month 12

Gloucestershire Hospitals
NHS Foundation Trust

Report to Trust Board

Financial Performance Report
Month Ended 31st March 2023



Gloucestershire Hospitals
NHS Foundation Trust

Revenue & Balance Sheet

Director of Finance Summary

System Overview

The ICS is required to breakeven for the year. At month 12, the overall system financial position is £0.1m surplus against a breakeven plan.

This is the result of a £0.05m surplus from GHFT, a £0.04m surplus at GHC and a £0.01m surplus at GICB.

Month 12

M12 YTD Financial position is reporting a surplus of £0.05m which is £0.05m favourable to plan. This is the position after adjusting for donated assets impact, Salix grant and impairments. This position is subject to audit.

The position includes :

- Underperformance on out of county contracts of £2.2m and income shortfall in plan £1.7m
- Underperformance on pass-through drugs & devices overhead income £2.5m (net)
- Financial Sustainability pressure of £2.8m
- GMS costs including inflation pressure of £2.1m and food & drink subsidy £0.3m
- Divisional pay pressures of £10m pay overspend due to use of temporary staff to cover vacancies, provide RMN support and meet unscheduled care demands. This also includes £0.3m strike costs and £0.3m annualised hours accrual.
- Non pay pressures within divisions of £7.1m net due to clinical supplies, outsourcing and laboratory reagent costs.
- The divisional pay and non pay pressures are partially offset by additional £5m income.
- Corporate net underspends of £6m.
- Non recurrent benefits of £32m including additional income for IFRS 16 and Demand & Capacity / Winter) £4.7m, release of Gen Med VAT provision release of £13.1m plus a further £4.4m for service and capital. Also includes 100% release of the health & well being day accrual £2.8m and release of Spec Comm ESRF costs £3.2m.
- Year end accruals & provisions totalling £10m are in the M12 position and include £4.2m made for repayment of NHSE loan relating to Gen Med VAT provision, £1.4m annual leave accrual, £3.2m Wellbeing days (2) for GHFT and GMS staff and unfunded pay award pressure for GMS staff £0.6m.

The Financial Sustainability Plan (FSP) target for the Trust is £19m, of which £2.8m remained unidentified as at Month 12. Of the £16.2m delivery, £9.2m is recurrent, with £7.0m non-recurrent.

The M12 final position represents an improvement over the M11 full year forecast of £0.1m, driven primarily by procurement and medicines optimisation workstreams.

Director of Finance Summary

Total activity in M12 was 97% of the same period in 19/20. Activity across all Points of Delivery has increased from February.

The 2022/23 surplus position of £0.05m is slightly better than the plan of breakeven and is a significant improvement from the deficit position that had been forecast in month 9. This has been achieved through the delivery of robust actions identified as part of the financial recovery plan and non recurrent benefits that have supported the position.

Month 12 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £0.05m surplus (after Dontated Asset impact, Impairment & Salix Grants adj)		M12 Financial position is reporting a surplus of £0.05m which is £0.05m favourable to plan.
Income is £734m YTD which is £50m favourable to plan		M12 overall income position is reporting £734m income which is £50m favourable to plan. The Trust income position includes £7.5m HCSW funding, £13.4m 22/23 pay award funding and £17.9m pension funding, all of which matched by pay provisions and accruals. The GMS position contains income for Trust capital work which is matched by non pay costs.
Pay costs are £475m YTD which is £48m adverse to plan		Pay costs are £475m YTD which is £48m adverse to plan. The position includes accruals & provisions of £7.5m HCSW funding, £13.4m 22/23 pay award funding and £17.9m pension funding, all of which are matched by income. The position also includes annual leave accrual of £1.4m and the cost of 2 Wellbeing days for GMS and Trust staff £3.2m.
Non Pay costs are £264m YTD which is £7m adverse to plan.		Non Pay costs (including non-operating costs) are £264m YTD which is £7m adverse to plan. The Trust position is includes the release of Gen Med VAT Provision of £13.1m, accrual for repaying NHSE loan relating to Gen Med VAT £4.2m and release of accruals £1.8m. It also includes impairments of £8.2m and impact of donated assets £0.7m, both of which are adjusted below the line. The GMS position includes costs of capital work which is matched by income.
Delivery against Financial Sustainability Schemes		The Financial Sustainability Plan (FSP) target for the Trust is £19m, of which £2.8m remained unidentified as at Month 12. Of the £16.2m delivery, £9.2m is recurrent, with £7.0m non-recurrent.
The cash balance is £49.2m		Cash has reduced by £28m due to spend on capital projects.

Oversight Framework – Financial Matrix

Gloucestershire Hospitals
NHS Foundation Trust

The Framework is built around five national themes that reflect the ambitions of the NHS Long Term Plan and apply across trusts and ICBs:

- quality of care, access and outcomes
- preventing ill-health and reducing inequalities
- people
- finance and use of resources
- leadership and capability

The Financial Matrix used by the Trust to monitor the Finance and Use of Resources for Month 12 YTD position is below. The System is also required to monitor against these metrics plus achievement of Mental Health Standard.

Group Position	YTD Plan £000s	YTD Actual £000s	YTD Variance £000s
Financial efficiency – variance from efficiency plan	19,000	16,200	(2,800)
Financial stability – variance from breakeven*	(0)	51	51
Agency spending	(5,321)	(24,603)	(19,282)
**adjusted position*			

The Trust is favourable to plan for Financial Stability, although remains adverse to plan for Financial Efficiency and Agency Spending.

M12 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of March 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 March the Group's consolidated position shows a surplus of £0.05m which is £0.05m favourable to plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 12 Financial Position	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s	Plan £000s	Actuals £000s	Variance £000s
SLA & Commissioning Income	632,053	654,542	22,488			0	632,053	654,542	22,488
PP, Overseas and RTA Income	6,403	4,985	(1,417)			0	6,403	4,985	(1,417)
Other Income from Patient Activities	17,018	19,807	2,788			0	17,018	19,807	2,788
Operating Income	39,770	48,853	9,083	62,333	79,087	16,754	28,635	54,473	25,837
Total Income	**695,244**	**728,187**	**32,942**	**62,333**	**79,087**	**16,754**	**684,110**	**733,806**	**49,696**
Pay	(405,964)	(451,643)	(45,679)	(21,824)	(23,815)	(1,992)	(427,512)	(475,182)	(47,671)
Non-Pay	(279,647)	(277,844)	1,803	(37,909)	(53,774)	(15,864)	(244,364)	(258,426)	(14,061)
Total Expenditure	**(685,611)**	**(729,487)**	**(43,876)**	**(59,733)**	**(77,589)**	**(17,856)**	**(671,876)**	**(733,608)**	**(61,732)**
EBITDA	**9,633**	**(1,300)**	**(10,933)**	**2,601**	**1,498**	**(1,102)**	**12,234**	**198**	**(12,036)**
EBITDA %age	**1.4%**	**(0.2%)**	**(1.6%)**	**4.2%**	**1.9%**	**(2.3%)**	**1.8%**	**0.0%**	**(1.8%)**
Non-Operating Costs	(9,634)	(3,692)	5,942	(2,601)	(1,498)	1,102	(12,234)	(5,190)	7,044
Surplus / (Deficit)	**(0)**	**(4,992)**	**(4,991)**	**0**	**0**	**0**	**(0)**	**(4,992)**	**(4,991)**
Dontated Asset, Impairment & Salix Grant Adjustment	0	5,043	5,043				0	5,043	5,043
Adjusted Surplus / (Deficit)	**(0)**	**51**	**51**	**0**	**0**	**0**	**(0)**	**51**	**51**

* Trust position excludes £40m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £73m of inter-company transactions, including dividends

Balance Sheet

	Group Closing Balance 31st March 2022 £000	GROUP Balance as at M12 £000	B/S movements from 31st March 2022 £000
Non-Current Assests			
Intangible Assets	13,760	16,692	2,932
Property, Plant and Equipment	304,585	365,164	60,579
Trade and Other Receivables	4,414	3,901	(513)
Investment in GMS	0	0	0
Total Non-Current Assets	**322,759**	**385,757**	**62,998**
Current Assets			
Inventories	9,370	12,312	2,942
Trade and Other Receivables	26,360	51,883	25,523
Cash and Cash Equivalents	71,530	49,193	(22,337)
Total Current Assets	**107,260**	**113,388**	**6,128**
Current Liabilities			
Trade and Other Payables	(80,104)	(104,493)	(24,389)
Other Liabilities	(14,401)	(18,604)	(4,203)
Borrowings	(3,626)	(3,626)	0
Provisions	(24,089)	0	24,089
Total Current Liabilities	**(122,220)**	**(126,723)**	**(4,503)**
Net Current Assets	**(14,960)**	**(13,335)**	**1,625**
Non-Current Liabilities			
Other Liabilities	(5,971)	(5,426)	545
Borrowings	(34,064)	(52,837)	(18,773)
Provisions	(3,600)	(10,753)	(7,153)
Total Non-Current Liabilities	**(43,635)**	**(69,016)**	**(25,381)**
Total Assets Employed	**264,164**	**303,406**	**39,242**
Financed by Taxpayers Equity			
Public Dividend Capital	361,345	397,288	35,943
Equity	0	0	0
Reserves	19,823	28,113	8,290
Retained Earnings	(117,004)	(121,995)	(4,991)
Total Taxpayers' Equity	**264,164**	**303,406**	**39,242**

Gloucestershire Hospitals
NHS Foundation Trust

The table shows the M12 balance sheet and movements from the 2021-22 closing balance sheet.

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals
NHS Foundation Trust

Funding

Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m, of which £15.4m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £51.7m.

To date, there has been £14.6m of additional capital approved and a reduction in expected in-year donations of £0.6m, bringing the programme up to £65.7m.

Outturn

The provisionally reported capital outturn position excluding IFRS 16 capital, is £66.1m, representing an overspend position of £0.4m. This overspending was pre-agreed with the region and the associated spending was only incurred on that basis. The Trust, therefore, finished £3k under our agreed position.

22/23 Programme Funding Overview

Gloucestershire Hospitals
NHS Foundation Trust

The Trust submitted a gross capital expenditure plan for the 22-23 financial year totalling £67.1m, of which £15.4m was in relation to IFRS Right of Use CDEL, leaving a remaining programme of £51.7m. To date, there has been £14.6m of additional capital approved and a reduction in expected in-year donations of £0.6m, bringing the programme up to £65.7m.

The programme can be divided into the following components; Operational System Capital (£25.0m), STP Capital – GSSD (£21.3m), National Programme (£14.6m), IFRIC 12 (£0.8m), Government Grant (£3.2m), Donations (£0.6m) and NBV from the sale of assets (£0.1m)

The breakdown of additional funding that has been secured since the plan is shown to the right.

		Plan	Secured	Variance
DIGITAL	Digital	5,634	5,634	0
MEDICAL EQUIPMENT	Medical Equipment	2,223	2,223	0
ESTATES	Estates	16,548	16,548	0
IDG CONTINGENCY	IDG Contingency	609	609	0
RIGHT OF USE ASSET	Right Of Use Asset	15,355	2,583	12,772
Total Charge against Capital Allocation (including impact of IFRS 16)		**40,369**	**27,597**	**12,772**
NATIONAL PROGRAMME - DIGITAL	Front Line Digitisation	3,300	3,300.00	0
NATIONAL PROGRAMME - DIGITAL	MRI Acceleration Software Upgrade		165.00	(165)
NATIONAL PROGRAMME - DIGITAL	Image Sharing		30.00	(30)
NATIONAL PROGRAMME - DIGITAL	Refer		487.00	(487)
NATIONAL PROGRAMME - DIGITAL	Home Reporting - Radiology Workstations		300.00	(300)
NATIONAL PROGRAMME - DIGITAL	Digital Pathology		262.00	(262)
NATIONAL PROGRAMME - DIGITAL	Lims & Interoperability - Sample Tracking Zebra Printers		126.00	(126)
NATIONAL PROGRAMME - DIGITAL	Cyber 22/23 – Firewalls	50	99.00	(49)
NATIONAL PROGRAMME - DIGITAL	Front Line Digitisation - 2nd Tranche 2223		2,200.00	(2,200)
NATIONAL PROGRAMME - DIGITAL	Endoscopy digital capital		166.00	(166)
NATIONAL PROGRAMME - NON DIGITAL	Paediatric MH UEC		362.00	(362)
NATIONAL PROGRAMME - NON DIGITAL	Discharge waiting area GRH		1,500.00	(1,500)
NATIONAL PROGRAMME - NON DIGITAL	Avening & Prescott wards refurb CGH		1,572.00	(1,572)
NATIONAL PROGRAMME - NON DIGITAL	TIF 5th Orthopaedic Theatre		1,465.00	(1,465)
NATIONAL PROGRAMME - NON DIGITAL	1 x Siemens Stereo to improve image reading outcomes and activity		84.00	(84)
NATIONAL PROGRAMME - NON DIGITAL	Endoscopy Early Drawdown		173.00	(173)
NATIONAL PROGRAMME - NON DIGITAL	Buyout of		431	(431)
NATIONAL PROGRAMME - CDC	Community Diagnostic Equipment 22/23		462.81	(463)
NATIONAL PROGRAMME - CDC	Community Diagnostic Centre Enabling works		1,261.00	(1,261)
NATIONAL PROGRAMME - CDC	Community Diagnostic Centre Digital		217.00	(217)
STP PROGRAMME - GSSD	STP Programme - GSSD	21,280	21,280	0
IFRIC 12	IFRIC 12	817	816	1
DONATIONS VIA CHARITABLE FUNDS	Donations Via Charitable Funds	1,281	635	646
GRANT	Grant		3,241	(3,241)
Total Additional Capital		**26,728**	**40,635**	**(13,907)**
Gross Capital Funding Total		**67,097**	**68,232**	**(1,135)**
Excluding IFRS16		(15,355)	(2,583)	(12,772)
Gross Capital Funding Total excluding IFRS 16		**51,742**	**65,649**	**(13,907)**

22/23 Programme Spend Overview

Gloucestershire Hospitals
NHS Foundation Trust

The provisionally reported capital outturn position excluding IFRS 16 capital, is £66.1m, representing an overspend position of £0.4m. This overspending was pre-agreed with the region and the associated spending was only incurred on that basis. The Trust, therefore, finished £3k under our agreed position.

Excluding IFRS 16, the Trust delivered £17.5m in the month. The key variances were;

Medical Equipment

This finished £0.7m over which is driven by;

- £0.4m agreed overspend with the region to fund cystoscopes and ENT equipment.
- £0.1m endoscopy stack which was delivered in 22/23, although the funding was in 23/24.
- £0.3m due to an additional backdated uplift in the Genmed charge from 3% to 6%.
- Offset by, £0.1m of Defibrillators that were needing to be moved to I&E as the cost ended up being under the capitalisation threshold.

Estates and National Programme (Non-Digital)

- The respective £0.5m variances are driven by a presentational offset between the winter demand and capacity funding and the Trust spend on generators. As part of this project to deliver the stepped change in our capacity investment in our electrical resilience was required.

There were controlled offsetting variances within the programme following the reduction in the in-year IGIS forecast spend delivery earlier in the year of £1.2m. These were;

- £0.4m of high priority, deliverable, backlog maintenance schemes
- £0.4m of Trust-funded energy efficiency works linked to the Salix energy efficiency project.
- £0.3m of accelerated works on the SSD programme.
- £0.1m of accelerated works on the Theatres refurbishment scheme

in £000's	Forecast		
	Funding	Forecast	Variance
DIGITAL	5,634	5,557	77
MEDICAL EQUIPMENT	2,523	3,182	(659)
ESTATES	16,857	17,416	(559)
IDG CONTINGENCY	0	0	0
RIGHT OF USE ASSET	2,806	2,583	223
Total Charge against Capital Allocation	**27,820**	**28,738**	**(918)**
NATIONAL PROGRAMME - DIGITAL	7,135	7,115	20
NATIONAL PROGRAMME - NON DIGITAL	5,587	5,033	554
NATIONAL PROGRAMME - CDC	1,941	1,860	81
STP PROGRAMME - GSSD	21,280	21,280	(0)
IFRIC 12	816	816	0
DONATIONS VIA CHARITABLE FUNDS	635	635	0
GRANT	3,241	3,241	(0)
Gross Capital Spend Total	**68,455**	**68,718**	**(264)**
Excluding IFRS16	(2,806)	(2,583)	(223)
Gross Capital Spend Total excluding IFRS 16	**65,649**	**66,136**	**(487)**
NBV of Write Offs/Disposals	54	0	54
Balance	**65,702**	**66,136**	**(433)**
Permissable Overspend as agreed by Region	0	(436)	436
Balance	**65,702**	**65,700**	**3**

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date surplus of £0.05m which is £0.05m favourable to plan. This position is subject to audit.
- Note the Trust balance sheet position as of the end of March 2023.
- Note the Trust capital position as of the end of March 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:	**May 2023**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

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

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

Summary of Report

This paper provides a review of the Digital Transformation Programme projects that have been delivered during 2022-23, broken down by projects within the four main work areas:

- Electronic Patient Record (EPR)
- Clinical Systems Optimisation
- Business Intelligence and TrakCare
- Cyber Security, Infrastructure and Information Governance (IG)

This paper also sets out the Digital Transformation Programme for 2023-24, as agreed at the Trust Leadership Team meeting on 21 March 2023.

The Digital Transformation Programme continues to develop the Trust's digital maturity in line with our five-year Digital Strategy. The Trust's ability to provide safe, consistent and high-quality care has been greatly enabled by our delivery so far, but needs to continue at pace.

Risks or Concerns

None

Recommendation

The Board is asked to note the report

Enclosures

Digital Transformation Report

PUBLIC BOARD OF DIRECTORS – MAY 2023

DIGITAL TRANSFORMATION REPORT

1. Executive Summary

This report provides an update on the delivery of the Digital Transformation Programme during 2022-23 and reports on planned programmes for 2023-24.

An ambitious yet realistic programme - acknowledging this year's constrained budget - has been developed to balance all aspects of digital enablement for the organisation, which includes a focus on optimising solutions already implemented. The plan has had divisional and clinical input and will continue to be monitored through existing governance structures. A new Clinical Design Authority (CDA) is now meeting weekly to consider new requests and optimisations to Sunrise EPR, as part of a programme of improvement and ongoing engagement.

2. Digital Transformation 2022-23 Highlights

This section provides a review of the 2022-23 Digital Transformation Programme and pulls out key highlights.

2.1 Sunrise EPR

Development of Sunrise EPR continued apace during 2022/23 to take us ever nearer our goal of achieving HIMSS level 6 by 2024 (international standard for EPR maturity).

The 2022-23 focus was on the delivery of Electronic Prescribing and Medicines Administration (ePMA), alongside Inpatient Discharge Summaries. This implemented successfully in November in a phased approach, working closely with Pharmacy and clinical colleagues, first in Cheltenham followed by Gloucester. Earlier in the year, (February 2022) had seen the addition of clinical documentation (take-lists, clerking, post-take and ward rounds), which saw a large surge in clinicians using the system in earnest for the first time since its launch in 2019. Optimisations and improvements to those documents continued throughout the year, which benefited levels of clinical engagement in the development and implementation of ePMA in November.

2022 also saw the EPR team transition into a function which can sustain delivery of an ambitious programme of work, whilst maintaining existing elements of functionality already deployed in the Trust. This included the update of our Emergency Care Data Set in the Emergency Department, a much-improved solution for enrolling agency staff into EPR and clinical systems, as well as the roll-out of our second and third virtual wards. This followed an initial pilot in Respiratory during the first COVID outbreak.

The EPR team will look to sustain this momentum going into 2023-24 and build on the successes realised in adult inpatient areas, by expanding development into paediatrics, surgical and theatre areas, as well as outpatient settings. The Trust is ramping up its realisation of what EPR can offer to support staff in the care of their patients and the team will continue to listen and act on suggestions and requests. The new EPR Clinical Design Authority will ensure that clinicians and patients are always placed at the heart of EPR developments.

2.2 Clinical Systems Optimisation

The Clinical Systems Optimisation Programme has delivered a number of projects across the organisation in order to advance digital maturity and support the journey to HIMMS level 6.

Implementations this year include improving access to JUYI through Sunrise EPR. By adding JUYI as a viewable tab, clinicians are able to look at records without requiring a smartcard. This is even more important following the implementation of ePMA.

The migration and upgrade to a new highly resilient Integration Engine (known as the TIE), which now manages over 40 million messages between Trust IT systems every month. The last year has seen a significant number of new integration developments:

- implementing ePMA between EPR and EMIS (Pharmacy system);
- migrating to Gov.Notify to send letters, e:mails and texts automatically;
- making e:Refer forms more reliable;
- enabling more appointment reminders and notifications to our patients.

Clinical systems upgrades include DAWN in Rheumatology, CVIS in Cardiology and upgrading Auditbase in Audiology. The team built bespoke Pre-Assessment and Industrial Action systems and widened collaboration by implementing ICE OpenNet to Hereford, Bath, UHB, NBT and Swindon for sharing of results across Pathology and Radiology.

Work is ongoing to migrate off legacy platforms, migrating old SharePoint sites into NHSmail Office 365 and consolidating over 50 SQL server databases into our main database cluster. This will save significant amounts of administration and costs by consolidating our licence requirements.

External documents in EPR (OnBase)

As part of our promise to make Sunrise EPR the one place to go for all clinical documentation, the delivery of the OnBase documentation management system is a key enabler for our clinicians. Working seamlessly in the background, it provides clinicians with access to documents from other systems, surfaced in EPR through the external documents tab. This reduces the number of times clinicians will spend logging on to different systems to access patient information.

The viewer now has over 6 million documents available and is being extended during 2023-24. Documents currently available through the External Docs tab include:

- Infoflex Documents (incl letters from clinics/general correspondence previously in External Docs tab)
- Sunrise EPR Discharge Summaries as PDFs (Post-November 22)
- TrakCare Discharge Summaries as PDFs (Pre-November 2019)
  Note: Discharge summaries between 2019 and 2022 are currently in the documents tab as text
- Rapid Access Chest Pain Clinic System Docs
- Chemotherapy OPMAS Notes (PreChemoCare)
- eTrauma (Trauma & Ortho)
- DAWN (Rheumatology)
- Medisoft (Ophthalmology)
- MacMillan eHNA (Cancer)

Documents from the following systems are planned for 2023:

- Medilogik (endoscopy, including pictures)
- CVIS (pacing documentation)
- Cinapsis
- MediCUs (ITU)
- VitalData (renal documentation)
- Badger Net maternity and neonates
- TCLE send away lab tests
- Audiology Auditbase
- Lung function results
- Opthalsuite letters

2023-24

The PACS Upgrade and BadgerNet Maternity system projects are ongoing with planned go-live dates of May 2023 and June 2023 respectively.

Other projects planned for 2023-24 include an upgrade of the ICE order comms system and collaboration with ICS colleagues on version 2 of the JUYI shared care record.

2.3 Business Intelligence and TrakCare

2022-23 has seen the successful delivery of the TrakCare upgrade - impacting both our PAS (patient administration system) and TCLE (lab system). This planned upgrade has provided increased stability for Pathology teams, who were operationally feeling the pressure of inconsistent performance impacting service delivery. The upgrade has brought with it several improvements where both product development and greater efficiencies have delivered an improved service to the labs.

The new Business Intelligence Hub launched and has enabled 350 reports to be re-platformed, many of which moved to Tableau dashboards to make surfacing intelligence more accessible for users. User feedback is overwhelmingly positive and the challenge now is to manage (and prioritise) the number of dashboard requests we receive. Access to clinical and operational data has increased engagement with our data teams and is driving service and operational improvements across the Trust. This also enabled the creation of a System Flow Dashboard, used across the ICS to monitor patient flow, reducing time spent on e:mails, telephone calls and improving partnership working across the system.

The new Data Warehouse is now operational. The warehouse brings together data flows from across the Trust, which currently includes EPR, TrakCare (PAS and TCLE), Pharmacy, Radiology, Maternity and other smaller data sets. It currently processes and surfaces 4TB (terabytes) of data. To support this, we have an advanced analytical unit, which includes two data scientists. The team looks at how taking a different approach to analyse data can directly improve patient care.

The delivery of the Data Warehouse provides a ‘data lake’ for all business intelligence reporting, as well as a high-performance server platform with exceptional stability and improved data ingestion. This allows the Trust data strategy to move forward towards our aim of having ‘one version of the truth’ - which in future will include finance, activity, clinical and workforce data.

Working closely with the quality team and clinical quality leads, work has continued to improve the Quality Performance Report (QPR). The tool provides an interactive report to be used at 'Board through to ward/specialty level' and helps to provide accountability for key deliverables within the Trust.

Further Data Warehouse developments are planned for 2023-24 and additional functionality is due to be implemented on TrakCare, including Transfusion Medicine.

2.4 Cyber Security, IT Infrastructure and Information Governance

Cyber Security

Since 2021, the global cyber security risk has increased and governments worldwide report an increase in sophisticated, high-impact ransomware incidents against critical infrastructure organisations. The NHS itself issued advice to Non-Executives and Boards during 2022 on addressing security vulnerabilities.

In November 2021, an internal audit of our cyber security position was carried out. The aim was to provide assurance and help identify gaps in our existing protection, as well as risks to our service. What the report highlighted is that the cyber threat is ever changing and cyber security measures that seemed effective just two years ago, are no longer so. This is an ever-changing beast, and the Trust as a whole needs to begin to understand the threat across the organisation.

Following the development of a Cyber Security Action plan in response to the audit, during 2022-23 we have delivered a significant programme of work to increase the resilience of our IT infrastructure, mitigate the risk of cyber-attacks and provide a safer IT environment in line with the HIMMS level 6 digital maturity standard. These include:

- removal of legacy physical servers and HyperV virtual server environments;
- upgrade of unsupported Windows 7 desktop and Windows Server 2003 and 2008 operating systems;
- deployment of a state-of-the-art immutable storage solution, enhancing our ability to restore any data compromised by attack by preventing amendment or deletion of our back-ups;
- introduction of a Security Information Event Management (SIEM) system that enables monitoring for security threats across acute, ICB and primary care IT systems;
- improvements to harden our network infrastructure against cyber attacks and introduce network access controls (to 802.1x industry best practice standard).

New systems and those under the Digital team, receive regular security updates and patches. However, there are still legacy systems within departmental areas (not managed by Digital) that are more vulnerable to malware attacks due to out-of-date software no longer receiving security patches.

Cyber security assurance is currently monitored through reports to Digital Care Delivery Group and Finance & Resources Committee, providing the latest information on cyber alerts within the Trust. This update also includes high severity cyber alerts sent from NHS Digital's Data Security Centre (DSC).

IT Infrastructure

IT Infrastructure projects in 2022-23 included the deployment of Mindray patient monitoring to improve patient care, upgrading the Cheltenham Data Centre air

conditioning to help safeguard the Trust's digital assets; wi-fi improvements across the estate and IT infrastructure for strategic site developments, including ED, Gallery Wing and the new discharge lounge. Following the implementation of further clinical documentation in EPR during 2022, demand for follow me desktop (tap and go) increased and was rolled-out across adult inpatient areas with great success. Clinicians regularly highlight this as one of the most time-saving initiatives implemented in the last year.

The Infrastructure team has also supported the ICB and Primary Care. This includes IT provision for new GP surgeries (Wilson Health Centre and Five Valleys Health Centre) and the refresh of GP IT cabinets across Gloucestershire, to address space, power and safety concerns, as well as creating additional capacity.

Further investment in cyber security, IG and IT infrastructure is planned for 2023-24, including two factor authentication to protect NHSmail accounts, additional cyber security controls for the Trust and the ICS, desktop refresh and the provision of a shared IT infrastructure across the ICS.

The Countywide IT Service (CITS) continues to provide service desk and 24-hour IT support to GHT, as well as support to the ICB and GHC - providing value for money services across the county. The service supports business as usual IT issues, but is also key to supporting major system go-lives and estate improvements across the organisation, as well as the county.

CITS key performance indicators are reported through Digital Care Delivery Group and Finance & Resources Committee.

Information Governance

Information Governance incidents are reviewed and investigated throughout the year and reported internally. Any incidents which meet the criteria set out in NHS Digital Guidance on notification, based on the legal requirements of the UK General Data Protection Regulation (UK GDPR) and guidance from the Information Commissioner's Office (ICO), are reported to the ICO through the DSP Toolkit where they may also be monitored by NHS England. 15 incidents have been reported to the ICO during the 2022/2023 financial year reporting period to date. A summary of the incidents, together with a description of controls in place, are included in the Trust's annual report.

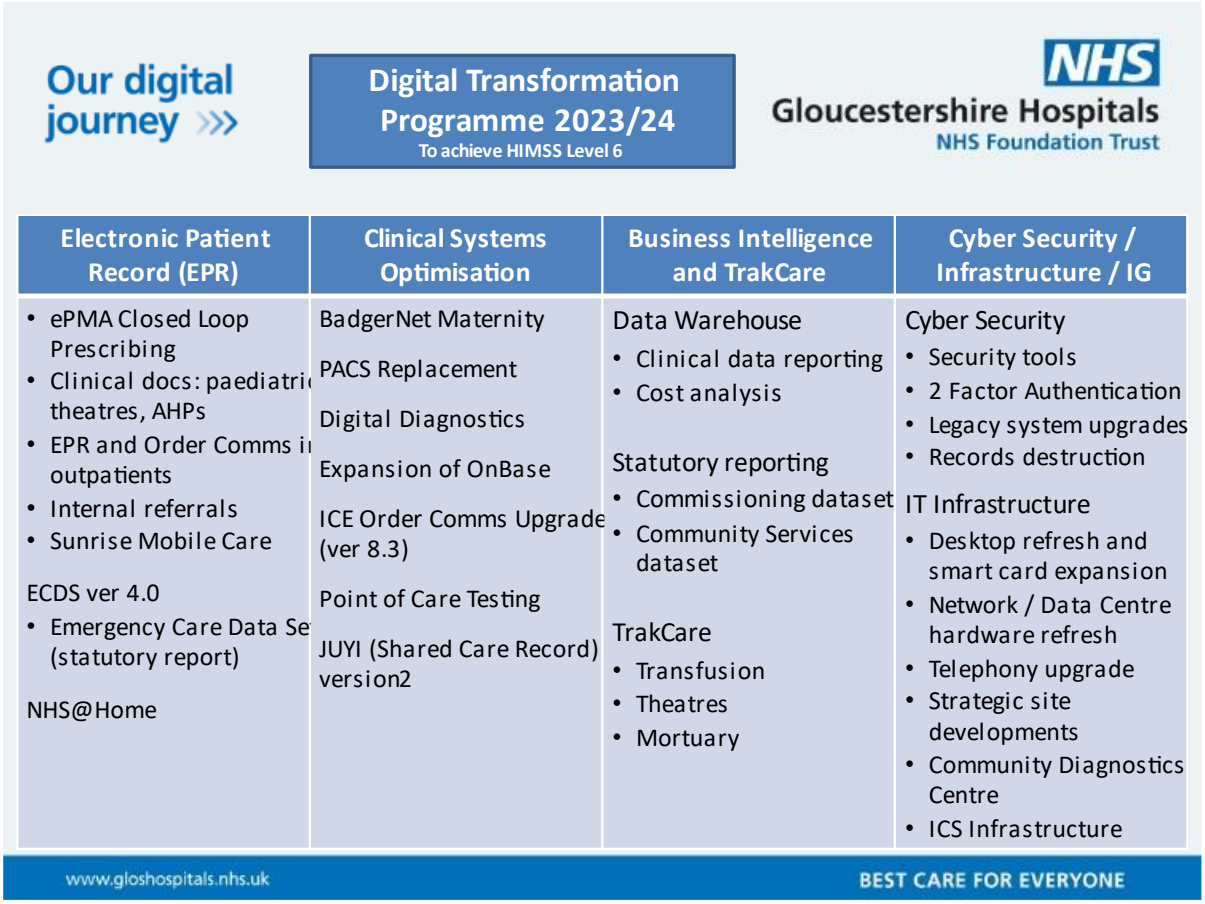
Data Security and Protection Toolkit (DSPT) version 4 submission remains as *Approaching Standards* as a result of the Trust not yet achieving 95% of staff having completed their IG refresher training. Preparations to ensure evidence of compliance for version 5 are in progress, as in previous versions the format sets out requirements against the National Data Guardians 10 standards.

3. Digital Transformation Programme 2023-24

The Digital Transformation Programme for 2023-24 has been constrained by the available budget. During this financial year there will also be a focus on optimising the solutions we already have and ensuring the benefits are fully realised.

An ambitious, but realistic programme, has been developed in order to deliver against our five-year Digital Strategy and reach the HIMMS level 6 digital maturity standard.

The 2023-24 Digital Transformation Programme (below) has been agreed by the Trust Leadership Team meeting on 21 March 2023. Work is now underway with digital senior responsible owners (SROs), project sponsors (the business leads) and project managers to develop and deliver these projects.



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KEY ISSUES AND ASSURANCE REPORT
People and Organisational Development Committee, 25 April 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
Performance Dashboard	Key points were highlighted as follows: • Agency and bank staff usage remained high and was subsequently red-rated; this was related to ongoing vacancies and industrial action and therefore reflected a worsened position. • Targeted work into long covid and work-related stress was required to support high numbers of sickness absence in these areas. • Turnover was reducing, however targeted interventions into specific staff groups would take place to support and identify any issues. Leavers' data would feed into retention plans. • Information Governance mandatory training was a particular concern, with non-compliance seen across a number of areas; some improvements had been reported however the target was not achieved, mainly due to operational pressures. • Further targeted work would take place to support divisions in completion of appraisals. • A tender exercise was underway for the Staff Engagement and Experience Programme. • The Trust had successfully bid for funding to welcome a further 80 international nurses to the organisation. • Funding to implement a marketing strategy to increase advertising the Trust as a local employer of choice had not been supported; other avenues would be explored. • Good progress had been made in relation to time to hire; as part of a wider recruitment transformation programme, a survey had been undertaken with recent candidates that highlighted positive improvements.	The dashboard continued to evolve, with increased focus on programmes of work. Key metrics and key performance indicators, particularly related to Freedom to Speak Up and Equality, Diversity and Inclusion would be further developed. Additional analysis would be carried out in relation to the ethnic minority application to appointment data, which was flagged as a particular concern.
Workforce Sustainability Review	The review outlined the programme structure required to demonstrate grip and control on workforce sustainability. The team had made positive improvements on reducing the length of time to hire, with the next phase to focus on efficiencies and targeted detail on candidates (for example, who they are, where they are from, where had they seen adverts). This would inform the overall recruitment and retention strategies with a view to embed a sustainable recruitment system.	The Committee supported the programme structure. Targeted detail into the reasons the Trust loses people during the time to hire process, and demographics of candidates, would be developed in order to increase efficiency.
Equality Delivery System 22	An overview of the requirements of the Equality Delivery System was received, with two out of three domains already completed. The EDS22 workshops (attended by 92 staff) had collated a number of suggestions for equality objectives, which would be reviewed and incorporated into planning. A new reporting template and four-year equality objectives would be developed and reported through the governance structure as evidence of the Trust's continued commitment and consideration of EDI.	Divisional attendance to support the implementation of the strategies would be requested. The Committee would consider receiving regular divisional feedback on good practice in their teams.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
None.		

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

Items not Rated		
Risk Register	ICS Update	
Impact on Board Assurance Framework (BAF)		
SR3: continue to reflect actions and progress, including options for the marketing strategy. 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.		

KEY ISSUES AND ASSURANCE REPORT Quality and Performance Committee, 26 April 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 Trust was committed to end boarding by the end of the summer; the Quality Summit that had been arranged to take place earlier in April had been postponed due to operational pressures and staff capacity related to industrial action. The purpose of the Summit was to discuss the process to end boarding with a number of colleagues from across the Trust. It was noted that boarding was part of a plan to stop caring for patients in all non-designated areas and would need internal and external support and actions; there were risks associated with this.	The Committee was concerned about the postponement of the Quality Summit, however noted that it would now take place on 28 April. Updates would be provided to the Committee on progress made.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
Quality and Performance Report	Key points were highlighted as follows: • There continued to be stable performance in Cancer, with some exceptional areas noted. • 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. • Good progress was being made against the maternity and surgery action plans; the CQC was revisiting the services to review progress made against the Section 29a warning notices. • Successful recruitment had been made into leadership positions within maternity.	Improved digital patient appointment systems were being implemented, with additional support from primary care.
Serious Incidents Report	There had been no further Never Events reported, and no further Healthcare Safety Investigation Branch (HSIB) reports. Three new serious incidents had been reported. Resources in the investigation team were challenged, with delays and extensions requested to manage current activity.	None.
Trust Risk Register	Two new risks had been added to the register, with one risk downgraded from Trust to divisional level. An improvement programme had been established to coordinate all discharge improvement activity, with an aim to support congestion in Emergency Departments. Additional governance arrangements had been put in place to monitor completion of the water safety action plan. A gap analysis for the Patient Safety Incident Response Framework had identified cost pressures.	A revised pathway for Patient Safety Alerts has been issued requiring involvement of the Patient Safety Specialist and Executive approval.
Nursing Safer Staffing Report	The report provided the Committee with an overview of nurse staffing in relation to safety as required by national guidance. A series of recommendations were made to ensure safer nurse staffing across Inpatient departments. National Registered Nurse ratio noted to be 65/35; currently 67/33 in the Trust. Required care hours per day calculated at 10.1 hours, actual provided 7.9 hours; pressure was due to staffing non-designated areas.	Additional issues related to un-resourced care hours and banding benchmarking were under discussion. Feedback from Committee to strengthen levels of assurance for next reporting period.
Internal Audit Review: Outpatient Clinic Management	The review had been rated as giving moderate assurance for both Design Opinion and Design Effectiveness. Some areas of good practice had been identified, along with opportunities for improvement.	Oversight and monitoring of recommendations would take place at Audit and Assurance Committee.
Learning from Deaths	Assurance on the governance systems in place for reviewing deaths	A detailed report into special

Report	and demonstrating compliance with national guidance was provided.	cause variation SHMI data would be reviewed at the Hospital Mortality Group.
Quality Account 2023-24	An iteration of the Account was provided; there were some challenges in obtaining necessary data, which meant that the Account would not be finalised in time for May's Board of Directors meeting.	Any additional comments to be sent to the Deputy Director of Quality. Delegated authority for committee to approve the Quality Account would be requested at Board.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
None.		
Items not Rated		
System feedback	Regulatory Update	
Impact on Board Assurance Framework (BAF)		
Work continued to ensure appropriate gaps in control were reflected and actioned.		

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

KEY ISSUES AND ASSURANCE REPORT
Quality and Performance Committee, 29 March 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	***Pre-Empting and Boarding*** Handover delays were reducing, although continued trend analysis identified the same themes related to delays as previously reported. A project was underway to manage this, and was showing early positive results. There had been an overall reduction in length of stay from January to February.	The Quality Summit would include focus on Emergency Department congestion and plans to reduce. Safety huddles continued and were having a positive impact.

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Quality and Performance Report	Key points were highlighted as follows: • Performance was stable in urgent care. • There were just over 2500 patients reported on the elective care over 52-week list, however no breaches were reported. • Diagnostic performance was good, although echocardiography continued to be challenged. • There had been significant improvement made in cancer care performance; the Trust was delivering faster diagnosis of 28 days. • Maternity governance was under review, with the team working closely with maternity improvement advisors. • The National Patient Survey data for maternity services placed the Trust in the top seven trusts in the country. ***Patient Property Policy*** The policy had been implemented and overall, there had been good progress in relation to recommendations. Some challenges remained, particularly for boarded patients.	An update on domestic abuse alert backlogs would be brought to the next meeting. Adherence to the policy would need to be audited to provide assurance on effectiveness.
Serious Incidents Report	There had been no further Never Events, and no further HSIB reports. Six serious incidents had been reported. Vacancy rates and sickness absence remained a key challenge, with a recovery plan in place to address.	An emerging theme related to results acknowledgement was noted.
Trust Risk Register	One new risk had been identified since the last report. An improvement programme was in place to address simple discharges, with a new programme board established to coordinate all discharge improvement activity. The new Patient Safety Incident Response Framework was in place, with a full gap analysis completed.	The water safety serious incident report and plan would be shared with the Chair of the Committee.

Items Rated Green

Item	Rationale for rating	Actions/Outcome
Operational Plan 2023-24	The plan now showed an improvement in activity, which had reached the compliant target of 105%.	Finance and Resources Committee had delegated authority to approve the plan this month.
Quality Account	The Account outlined the proposed quality priorities for 2023-24; comments were awaited from HOSC, Healthwatch and the ICB, with submission required by 30 June.	The Quality Account would be presented at Board in May. The Council of Governors would also receive a presentation on the priorities.

Items not Rated

System feedback	Regulatory Update

Impact on Board Assurance Framework (BAF)
SR1: consider a more detailed report to the Committee on the Newton work. The Board would require more assurance on systemwide work, including key actions and an internal trajectory, alongside system deliverables. A key reflection throughout the risk would be a trajectory to stop boarding. SR2: consider the gaps in control, and whether the risk score was sufficiently ambitious. SR5: review the gaps in control in more detail. SR6: additional wording on partnership working required.

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

Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report
Statistical Process Control Reporting

Reporting Period March 2023

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. We are ensuring that we are focussed to support the safety and care of our patients to enable them to access care as needed.

UEC: March was another very challenging month for the ED. Four-hour performance deteriorated – very slightly – from 59.7% to 58.9%, but, twelve-hour performance improved very marginally from 84.6% to 85.3%. Four-hour performance is likely to reflect an increase – across the two sites – of ~20 patient attendances per day across our EDs in the month of March. The opening of CADU, at the beginning of February, continues to have a positive impact on flow. Whilst the impact of IAs has been absorbed to date; the escalating impact of these actions continue to represent a risk to both quality and performance within the department.

Elective Care: RTT performance did not meet the national standard, with performance in March remaining similar to recent months. Currently performance is reported as 68.9% but with ongoing validation would anticipate this being around 69.2% or above. Performance still remains above the national average of approx 60%. The Total Incompletes also increased in month with the March position anticipated to be around 73,400 (compared to 71,435 last month). The number of patients waiting over 52 weeks has increased in month, moving from 1,679 in February to an anticipated 1,940 in March. This has been influenced by continued operational pressures and industrial action. Given recent RCN and BMA industrial action there is a strong correlation between increased cancellations / lost capacity and the increase in long waiting patients. Oral Surgery and ENT for the third consecutive month have seen the largest increase in 52 week breaches and now account for a 55% share of the total 52 week breaches. Scrutiny and focus continues to be placed on reducing the number of patients over 78 week which has resulted in the achievement of zero patients waiting 78+ weeks at financial year end. Every effort will be made to sustain no patients exceeding 78 weeks, noting three significant risks, namely (1) an increasing 52 week position caused over recent months for the reasons referenced previously; (2) ongoing Industrial Action in April and potentially beyond; and (3) two months of reduced working days due to bank holidays, (2 in April and a further 3 in May). As at 13 April the forecast position is 20 risks at month-end. Only 4 of these are considered high risk, with 2 scheduled in the final week of the month, and 2 requiring further intervention to create capacity. Oral Surgery and ENT continue to carry the greatest risk.

Diagnostics: The DM01 diagnostics performance still requires final validation and upon completion it is anticipated performance will be around 7% breach rate (compared to last months low of 6.23%). Overall the number of breaches has increased by approximately 120, with the main increases being +56 for Gastroscopy +23 for Colonoscopy and +20 for Echo.

Cancer: February 2023 validated and submitted cancer performance data shows that the Trust met 3 out of the 10 operational standards (2WW, 2WW breast symptomatic, 31d subsequent Chemotherapy), the insight data for February shows the Trust meeting 5 of the 10 standards so there is scope to improve final position at the quarter end.

The Trust met the 2WW Standard with performance of 95.0% In January there were 8 services not meeting the 2WW operational standard in February this had reduced to 1. Whilst not meeting the standard, LGI has shown improvements over the last 2 reported month and these improvements are forecasted to continue into the March submission. In February the Trust also met the 2WW standard for breast symptomatic with performance of 99.2%. The Trust did not meet the 28d FDS standard with performance of 69.5% however the metric was delivered according to the insight data which showed 75.3% there will be further validation and the expected submitted position is expected to improve at the quarter end resubmission. The Trust did not meet the 31d FDT standard in February with data showing performance of 95.9%, the insight data showed a position of compliance at 96.6% the expectation is that following further validation that the Trust will be compliant against this metric for February. The Trust did not meet the 62d Standard at 48.8% against the insight data showing 52.5%, the Trusts 62d performance will be impacted up until May as the Trust works to reduce and clear its back-log. The Trust back-log is reducing and the 104d position is at a 52 week low. For February and March over 50% (112/221) of the GHFT 62d FDT breaches (planned/delivered) were legacy (104+) patients this fits with the narrative of back-log reduction.

Quality: The Quality Delivery Group monitors the quality exception reports and the commentary provides the narrative.

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

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

	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sept-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
All electives (including day cases)	6,021	5,020	5,822	5,625	5,671	6,198	6,257	6,196	6,235	5,096	5,925	5,776	6,537
Day cases	4,984	4,127	4,736	4,626	4,710	5,235	5,214	5,178	5,316	4,284	5,127	4,928	5,629
ED attendances	12,305	11,616	12,551	12,092	12,596	11,915	11,888	12,630	12,290	12,726	10,946	10,706	12,510
FUP outpatient attendances	38,535	32,481	37,851	34,593	33,708	35,363	35,526	35,690	38,398	30,863	37,416	33,571	38,429
GP referrals	10,555	9,385	10,629	10,315	10,186	10,983	10,492	10,801	10,729	8,572	10,482	9,749	11,899
New outpatient attendances	18,598	14,806	17,531	16,401	16,451	17,041	17,376	16,890	19,157	15,002	18,285	16,865	18,736
Non elective (Incl. Assessment)	5,257	4,801	5,419	5,241	5,266	5,158	5,221	5,656	5,663	5,282	5,233	5,000	5,459
Outpatient attendances	57,133	47,287	55,382	50,994	50,159	52,404	52,902	52,580	57,555	45,865	55,701	50,436	57,165

Guidance

Gloucestershire Hospitals
NHS Foundation Trust

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

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Cancer	Cancer - 2 week wait breast symptomatic referrals	≥ 93.0%	?	Mar-23	99.3%	H
	Cancer - 28 day FDS (all routes)	≥ 75.0%	?	Mar-23	78.0%	
	Cancer - 31 day diagnosis to treatment (first treatments)	≥ 96.0%	?	Mar-23	94.2%	
	Cancer - 31 day diagnosis to treatment (subsequent – drug)	≥ 98.0%	P	Mar-23	100.0%	
	Cancer - 31 day diagnosis to treatment (subsequent – radiotherapy)	≥ 94.0%	?	Mar-23	94.4%	
	Cancer - 31 day diagnosis to treatment (subsequent – surgery)	≥ 94.0%	?	Mar-23	76.9%	L
	Cancer - 62 day referral to treatment (screenings)	≥ 90.0%	?	Mar-23	93.4%	
	Cancer - 62 day referral to treatment (upgrades)	≥ 90.0%	?	Mar-23	56.0%	
	Cancer - 62 day referral to treatment (urgent GP referral)	≥ 85.0%	F	Mar-23	58.9%	L
	Cancer - urgent referrals seen in under 2 weeks from GP	≥ 93.0%	?	Mar-23	96.1%	
	Number of patients waiting over 104 days with a TCI date	= 0	?	Mar-23	22	
	Number of patients waiting over 104 days without a TCI date	≤ 24	?	Mar-23	83	
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	≤ 1.00%	F	Feb-23	6.23%	L
	The number of planned/surveillance endoscopy patients waiting at month end	≤ 600	F	Mar-23	1,157	L
Discharge	Patient discharge summaries sent to GP within 24 hours	≥ 88.0%	F	Feb-23	15.0%	L
Emergency Department	% of ambulance handovers 30-60 minutes	≤ 2.96%	F	Mar-23	23.21%	
	% of ambulance handovers < 15 minutes	No Target		Mar-23	21.84%	
	% of ambulance handovers < 30 minutes	No Target		Mar-23	46.52%	H
	% of ambulance handovers over 60 minutes	≤ 1.00%	F	Mar-23	34.06%	L
	ED: % of time to initial assessment - under 15 minutes	≥ 95.0%	F	Mar-23	40.3%	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Emergency Department	ED: % of time to start of treatment - under 60 minutes	≥ 90.0%	F	Mar-23	39.0%	H
	ED: % total time in department - under 4 hours (type 1)	≥ 95.00%	F	Mar-23	58.67%	
	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to adm..	= 0	F	Mar-23	1,055	
	Number of ambulance handovers 30-60 minutes	↓ Lower		Mar-23	728	
	Number of ambulance handovers over 60 minutes	= 0	F	Mar-23	1,068	
Maternity	% of women booked by 12 weeks gestation	> 90.0%	?	Mar-23	90.7%	
Operational Efficiency	% day cases of all electives	> 80.00%	?	Mar-23	86.11%	H
	Average length of stay (spell)	≤ 5.06	F	Mar-23	7.15	H
	Cancelled operations re-admitted within 28 days	No Target		Mar-23	64.29%	L
	Intra-session theatre utilisation rate	> 85.00%	?	Mar-23	90.46%	
	Length of stay for general and acute elective spells (occupied bed days)	≤ 3.40	P	Mar-23	3.22	H
	Length of stay for general and acute non-elective (occupied bed days) spells	≤ 5.65	F	Mar-23	8.13	H
	Number of patients stable for discharge	≤ 70	F	Mar-23	208	H
	Number of stranded patients with a length of stay of greater than 7 days	≤ 380	F	Mar-23	506	H
	Urgent cancelled operations	↓ Lower		Mar-23	0	L
Outpatient	Did not attend (DNA) rates	≤ 7.60%	P	Mar-23	5.87%	L
	Outpatient new to follow up ratio's	≤ 1.90	?	Mar-23	1.91	L
Readmissio..	Emergency re-admissions within 30 days following an elective or emergency spell	< 8.25%	?	Feb-23	7.19%	L
Research	Research accruals	No Target		Feb-23	141	
RTT	Referral to treatment ongoing pathway over 70 Weeks (number)	↓ Lower	F	Mar-23	108	L

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No Target		Mar-23	8,666	
	Referral to treatment ongoing pathways 45+ Weeks (number)	No Target		Mar-23	3,885	
	Referral to treatment ongoing pathways over 52 weeks (number)	= 0		Mar-23	1,937	
	Referral to treatment ongoing pathways under 18 weeks (%)	≥ 92.00%		Mar-23	66.14%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	No Target		Jan-23	88.20%	
	% patients receiving a swallow screen within 4 hours of arrival	No Target		Jan-23	90.20%	
	Stroke care: percentage of patients receiving brain imaging within 1 hour	No Target		Jan-23	88.2%	
	Stroke care: percentage of patients spending 90%+ time on stroke unit	≥ 85.0%		Dec-22	92.7%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	≥ 65.00%		Jan-23	0.00%	
	% of fracture neck of femur patients treated within 36 hours	≥ 90.0%		Jan-23	100.0%	

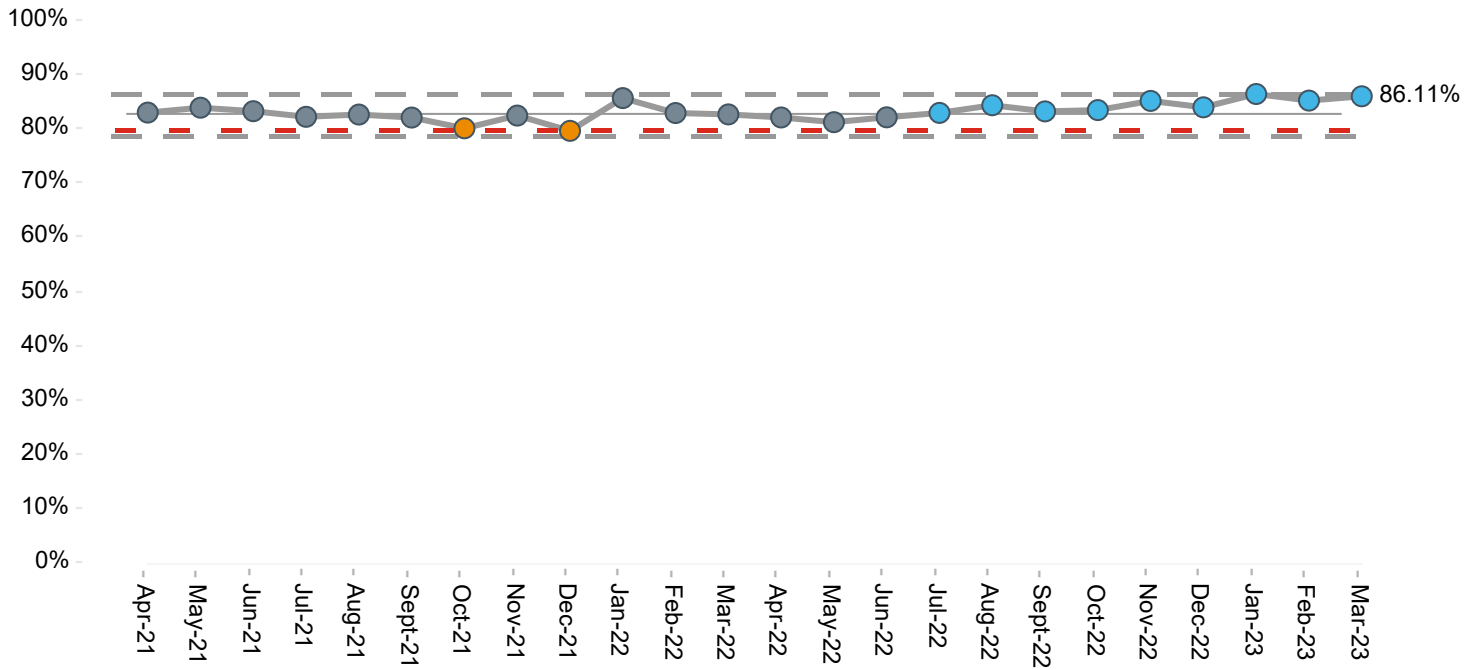
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[487] % day cases of all electives

Target: > 80.00%



Data Observations

[2] SHIFT

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

[4] 2 OF 3

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

Commentary

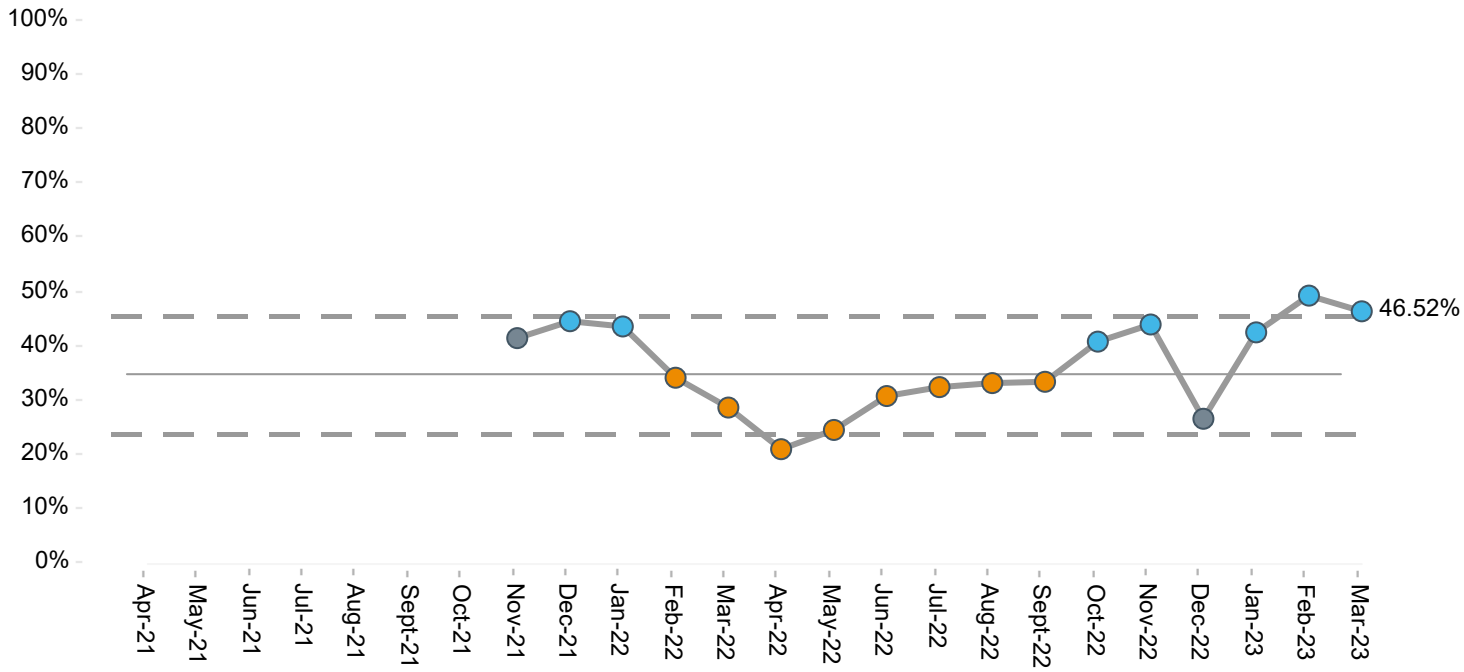
Daycase rate of 79.4% has been achieved for February 2023.
Divisional Director - Surgery

Access

SPC - Special Cause Variation

[595] % of ambulance handovers < 30 minutes

- - - Target: No Target



Commentary

Significant growth in total hours lost to ambulance handovers continues to reflect pressure on this metric. Actions proposed to improve flow at the back door, including more responsive flow co-ordinators and getting patients to the discharge lounge earlier.

Data Observations

[1] SINGLE POINT

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[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.

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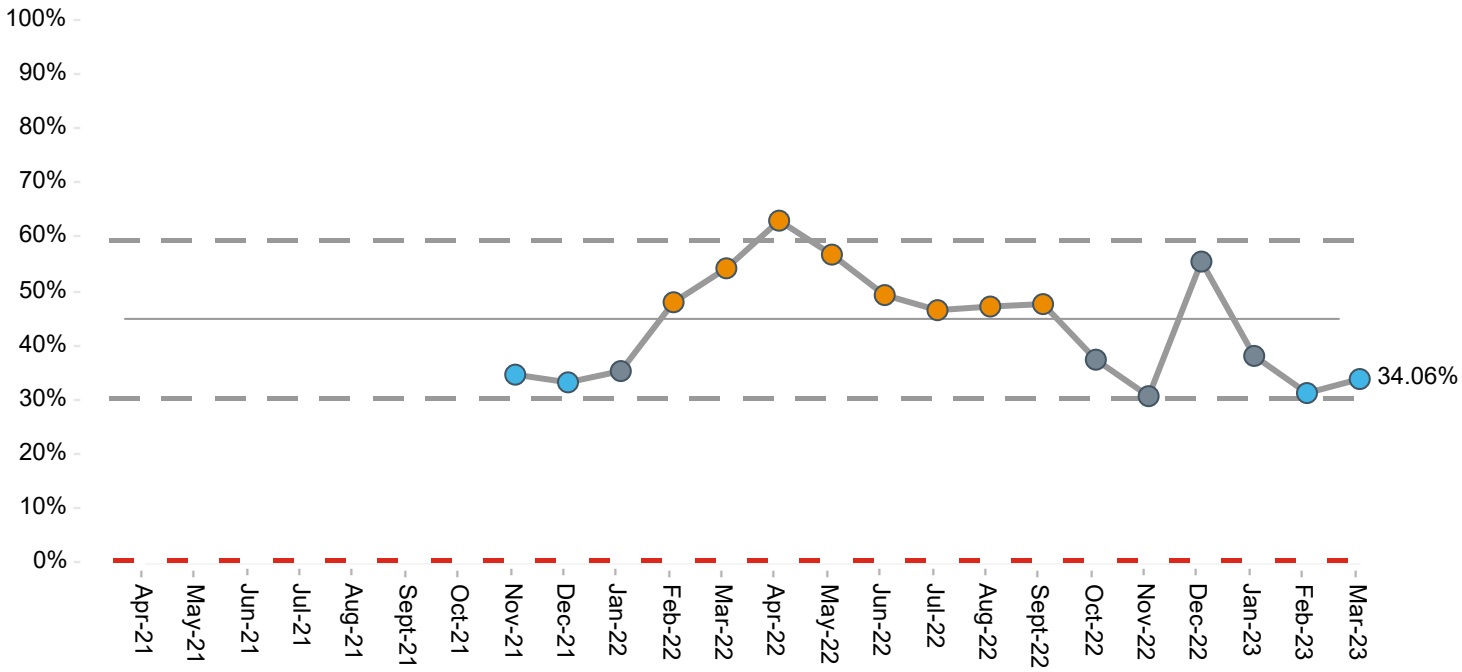
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[482] % of ambulance handovers over 60 minutes

Target: ≤ 1.00%



Data Observations

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Commentary

The number of handover delays over an hour, and the total number of hours lost to ambulance delays have increased significantly in March. This may reflect the higher footfall in the department and, anecdotally, the level of acuity of our patients.

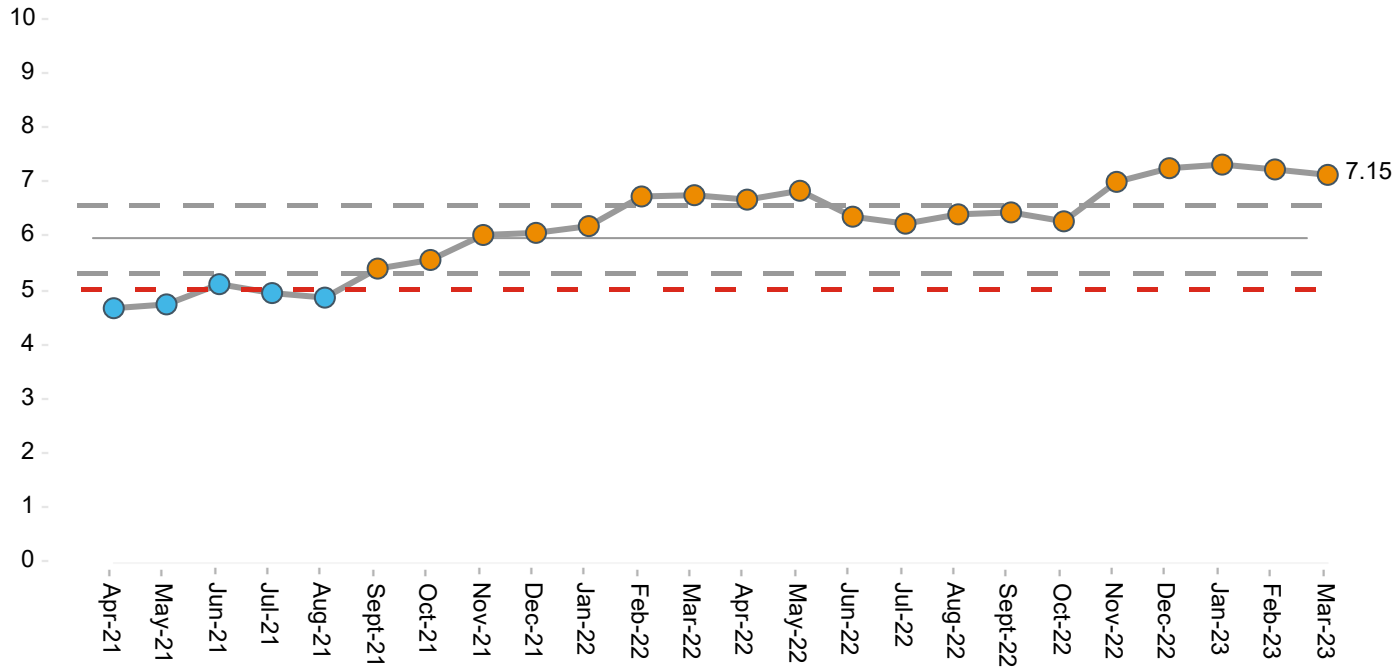
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[188] Average length of stay (spell)

Target: ≤ 5.06



Data Observations

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[4] 2 OF 3

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Commentary

Average length of stay now stabilised at 7.3. Work underway through 21 day reviews and system SBAR work to drive down the number of super stranded patients, which will drive down the overall average LOS. Consideration to the target may be needed as with the ongoing work around admission avoidance and short stay, average LOS may go up as the patients which remain in the acute would be the complex or acutely unwell patients. This has been recognised within the national 23/24 planning process.

Deputy Chief Operating Officer

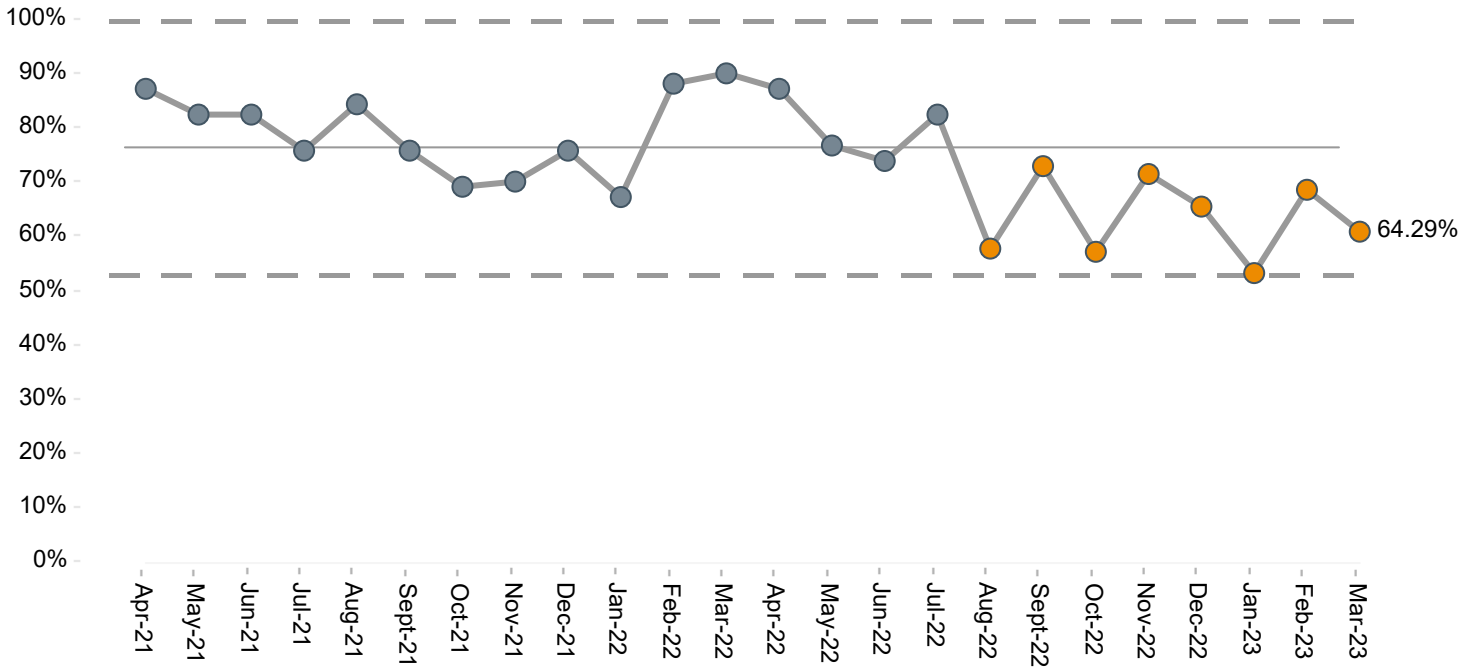
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[180] Cancelled operations re-admitted within 28 days

- - - Target: No Target



Data Observations

[2] SHIFT

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[4] 2 OF 3

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Commentary

In February there was a total of 10 patients cancelled on the day that could not be rescheduled within 28 days, which demonstrates a continued downward trend in actual numbers (with 26 and 35 in previous months). The reasons for these typically being sickness, equipment failure or theatre over-run.

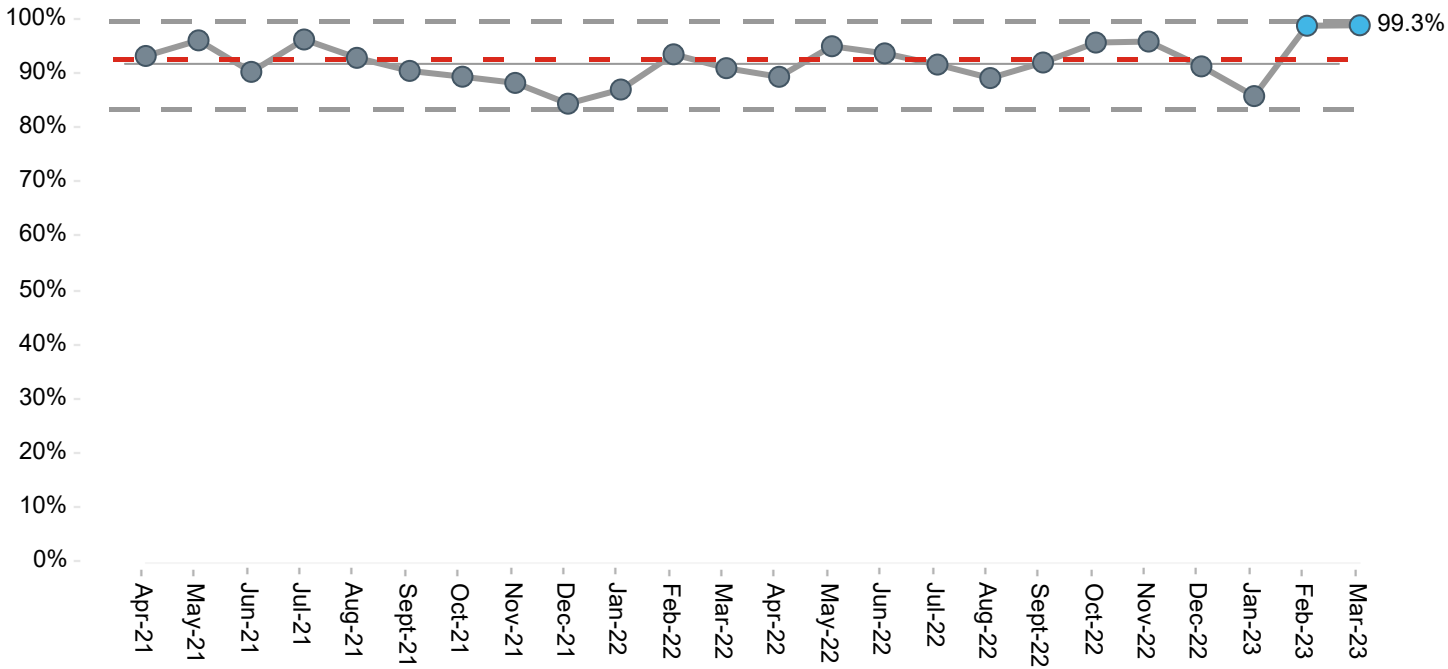
Associate Director of Elective Care

Access

SPC - Special Cause Variation

[170] Cancer - 2 week wait breast symptomatic referrals

Target: ≥ 93.0%



Data Observations

[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

Divisional Director of Operations

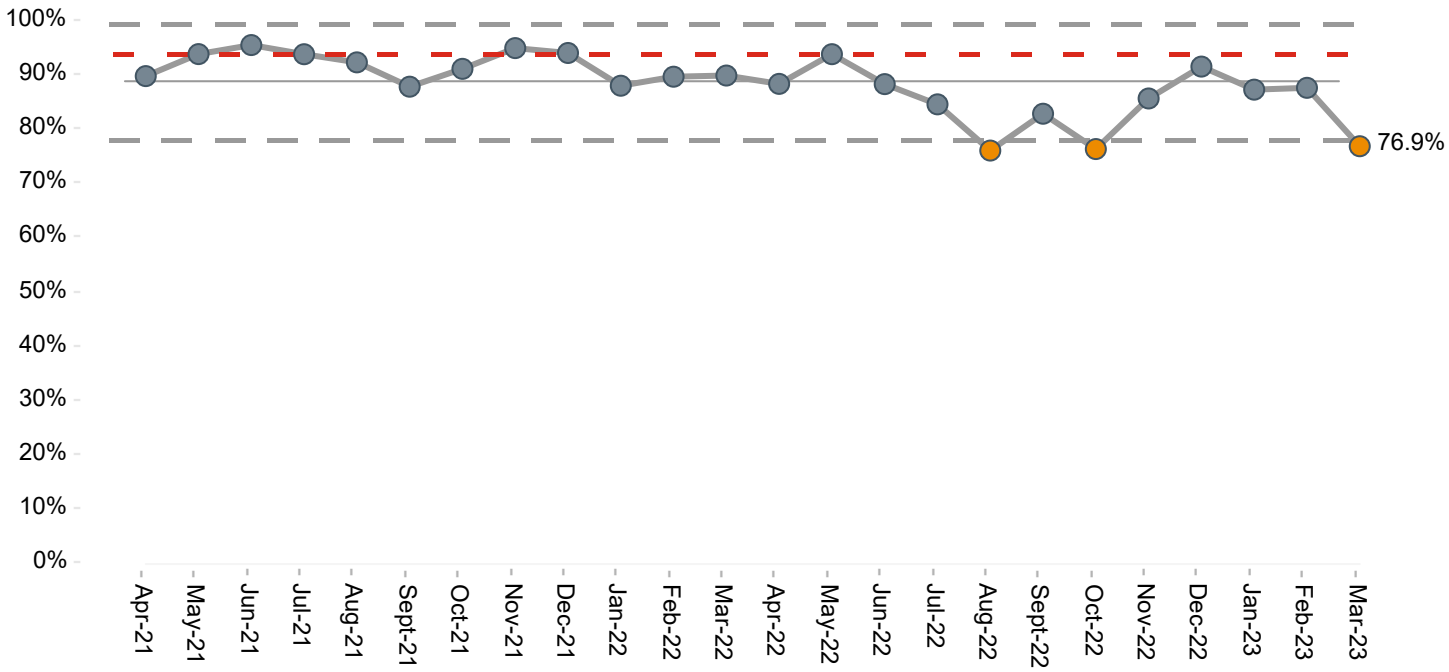
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 94.0%



Data Observations

[1] SINGLE POINT

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

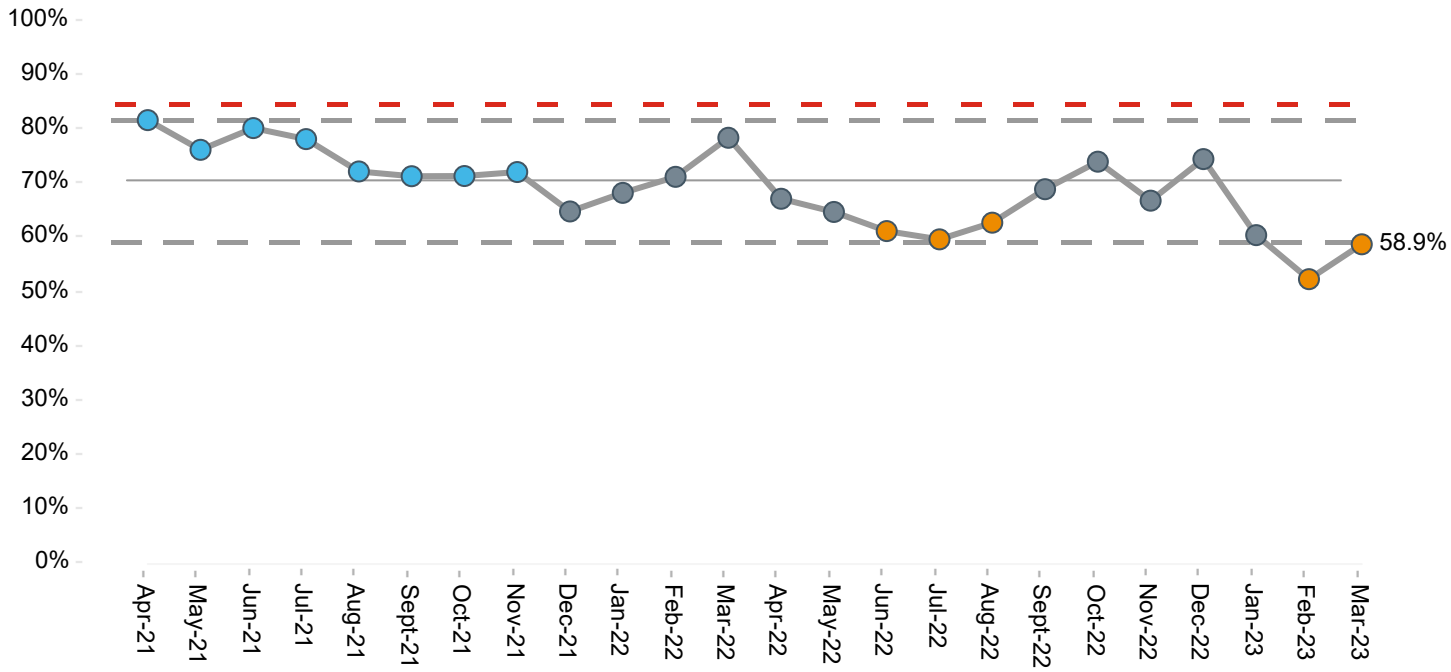
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ≥ 85.0%



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Commentary

62-day performance for February is 44.8% (unvalidated). This position is not planned to improve, due to the substantial focus on removing the backlog of patients above 62 days on the PTL before the end of April, with a view to achieving the standard in May data submission.
Divisional Director of Operations

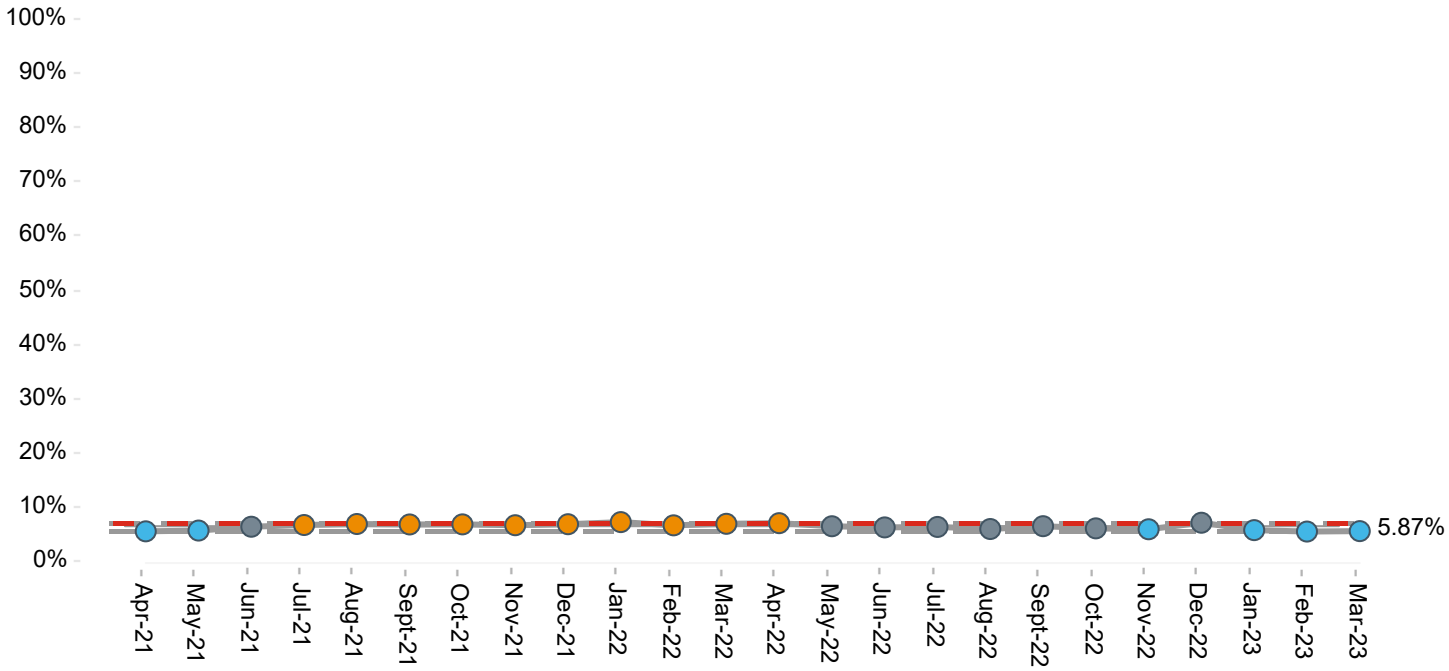
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[491] Did not attend (DNA) rates

- - - Target: ≤ 7.60%



Commentary

The DNA rate has increased marginally to 5.88% but remains within the target of 7.6%.
Associate Director of Elective Care

Data Observations

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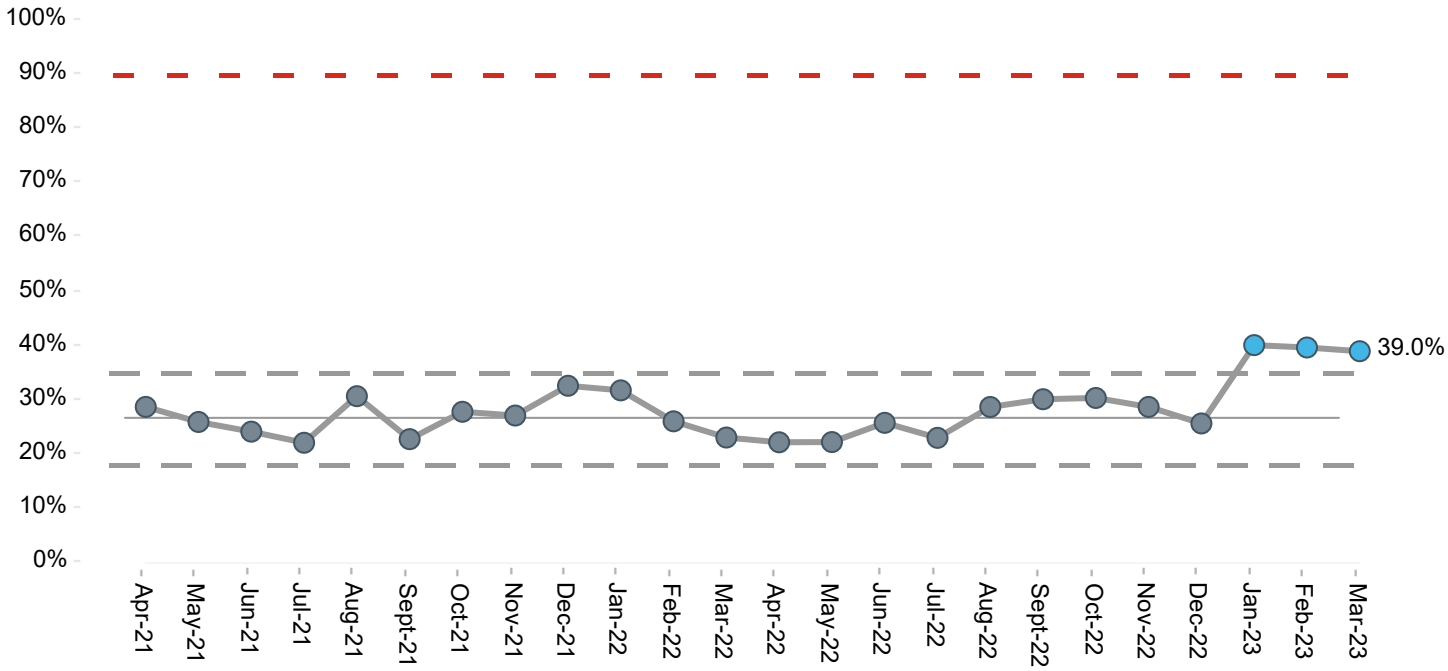
Access

SPC - Special Cause Variation

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

Target: ≥ 90.0%



Data Observations

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Commentary

Although this metric has deteriorated very slightly in March, the level has hit a plateau below 100 minutes (on average). This represents a significant improvement compared with what was being achieved in 2022.

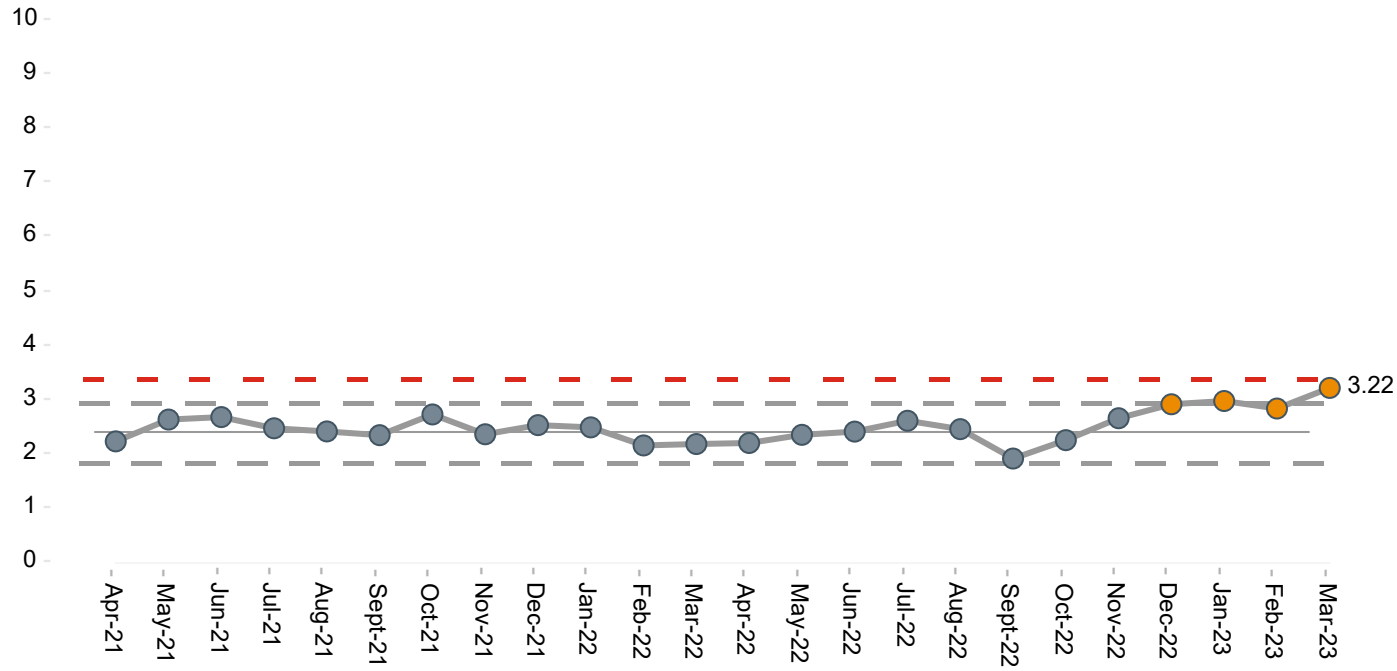
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 3.40



Data Observations

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Commentary

Continued over performance within this metric, with patients staying on average 2.9 days against the target of less than 3.4

Deputy Chief Operating Officer

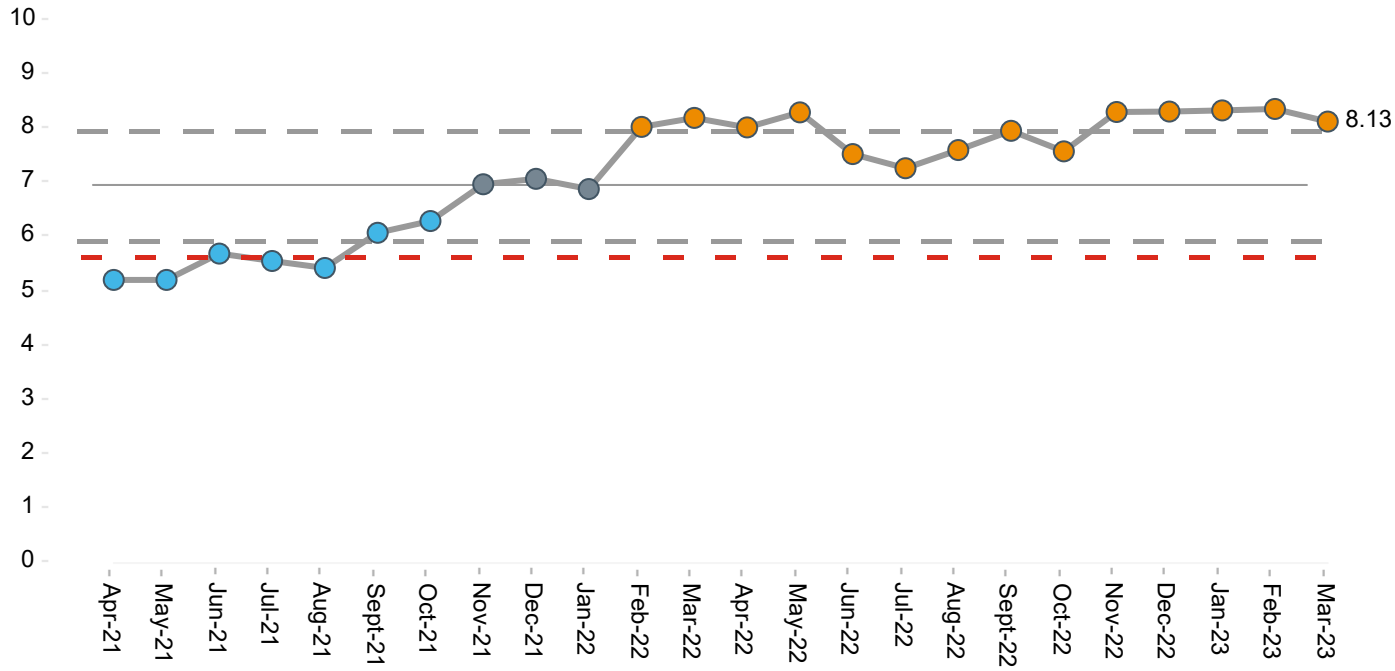
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 5.65



Data Observations

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Commentary

Clarification of our bed base and what constitutes as G&A bed as part of this years planning process. The LOS within G&A beds will subsequently reduce given the removal of GW1 as a therapy led ward. Ongoing work to drive down 21+ day patients as a % of our beds will also bring this figure towards the target.

Deputy Chief Operating Officer

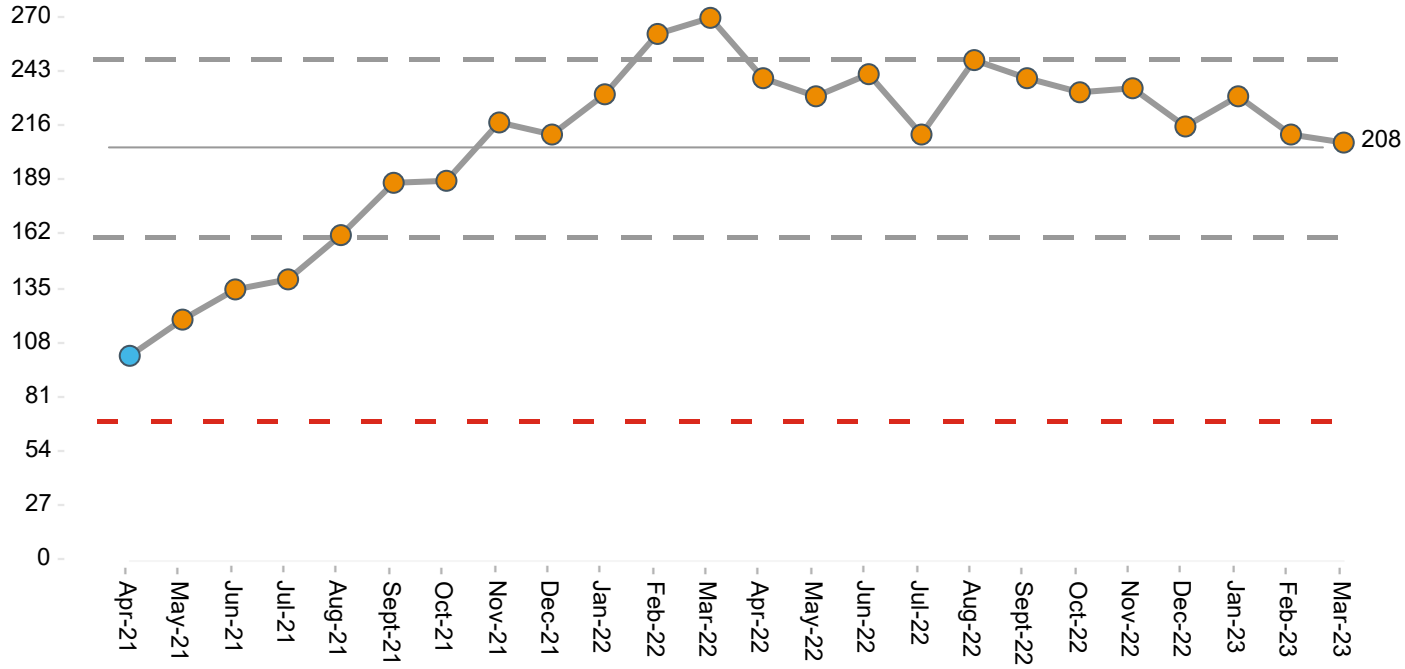
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[186] Number of patients stable for discharge

Target: ≤ 70



Commentary

Overall continued downward trajectory of our nCTR numbers. Latest figure 192, but has been as low as 184. Ongoing work with partners and internally to drive actions to ensure timely discharges

Head of Therapy & OCT

Data Observations

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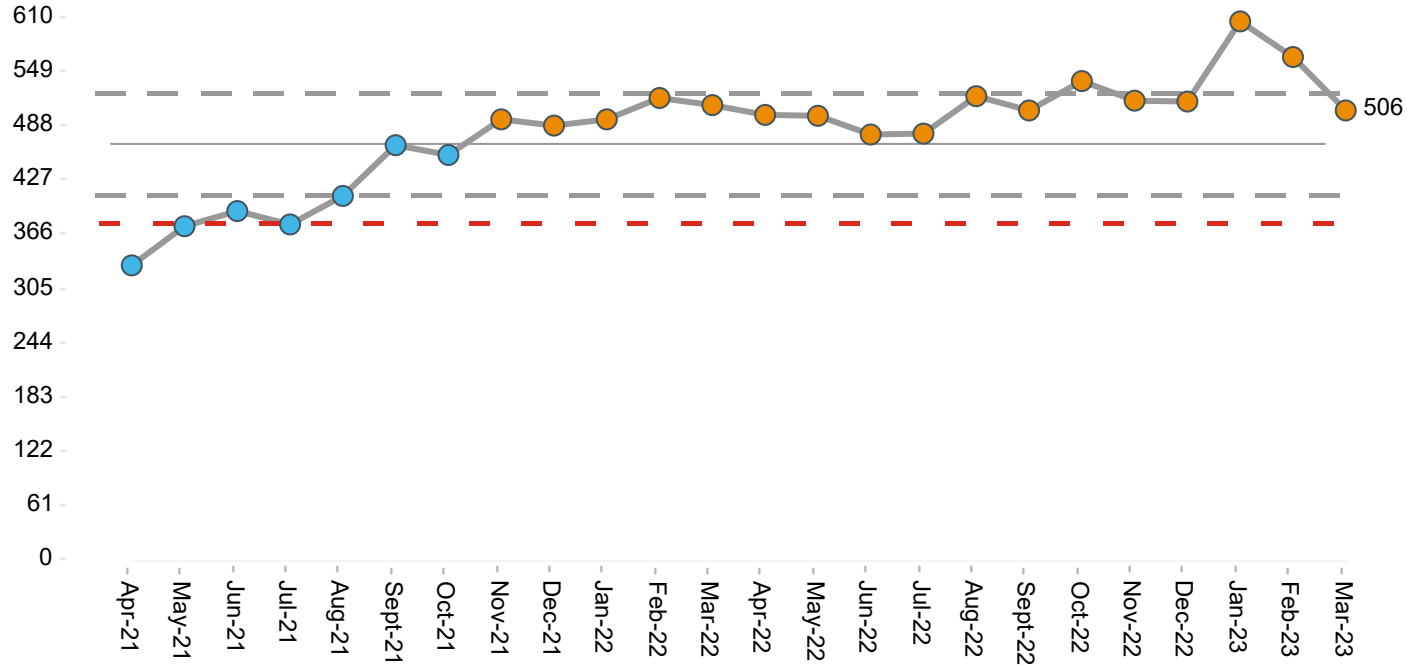
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 380



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Commentary

Slight reduction in 7+ day patients within our bed base, however remains significantly over the target set. CADU now operational and driving 0-1 day length of stay. Additional improvement expected as we bring on line the LLOS predictor tool and MDT wrap around patients who did not meet the CTA at the point of admission

Deputy Chief Operating Officer

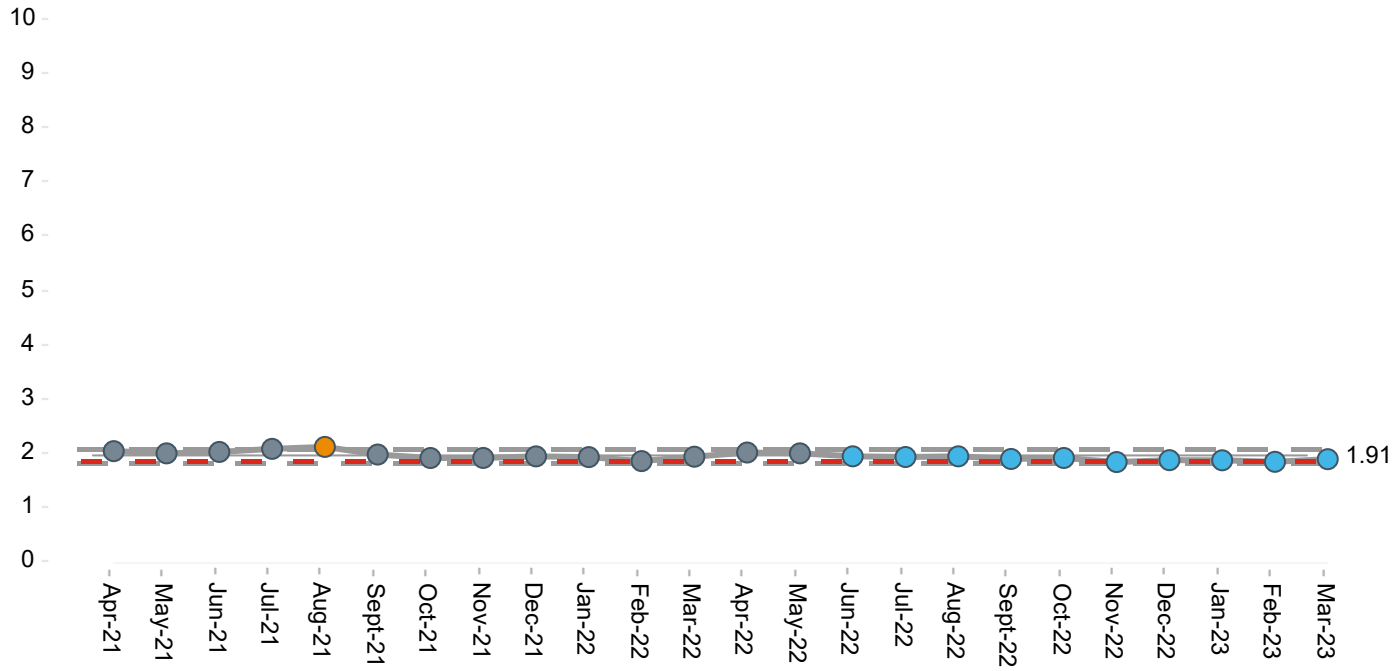
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[490] Outpatient new to follow up ratio's

Target: ≤ 1.90



Commentary

Associate Director of Elective Care

Data Observations

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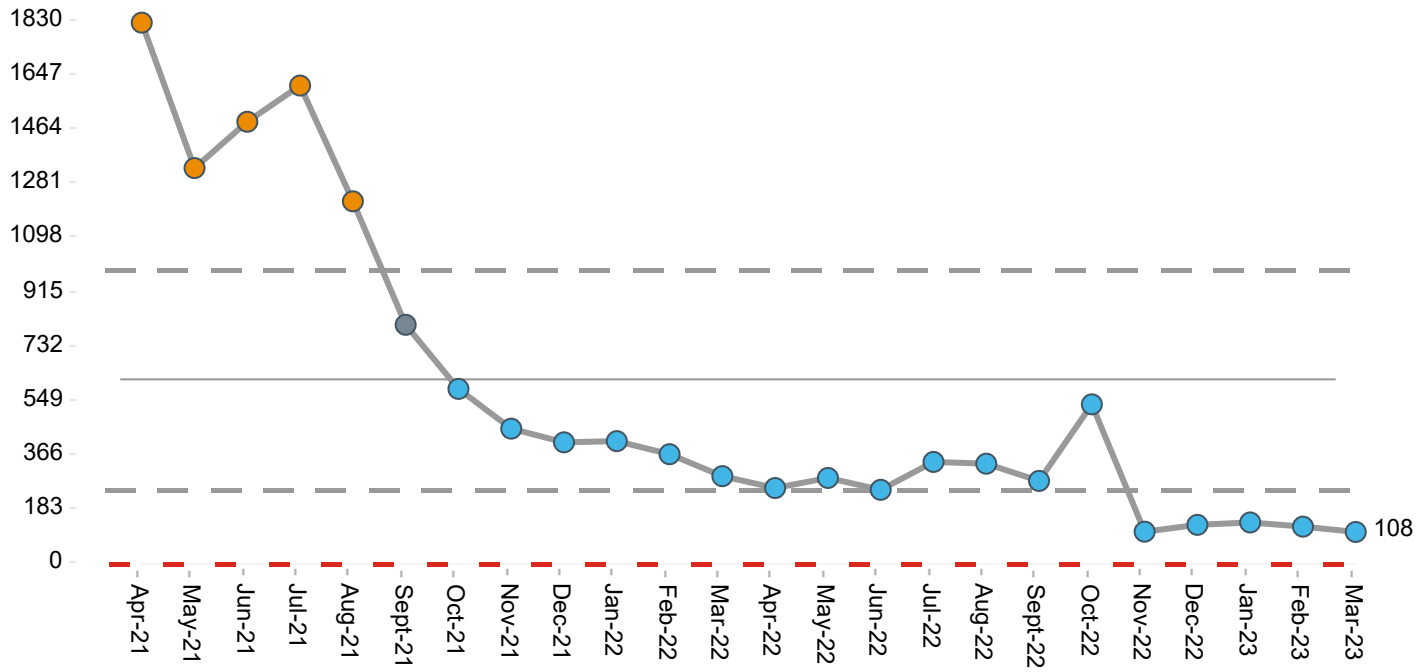
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



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Commentary

The only categories where a reduction in the number of patients waiting has been in both the 70 week and 78 week categories. For 70 weeks this has reduced to one of its lowest points of 108 patients. This has been largely influenced by the focus on those patients exceeding 78 weeks, which concluded the year with zero patients waiting over 78 weeks.

Associate Director of Elective Care

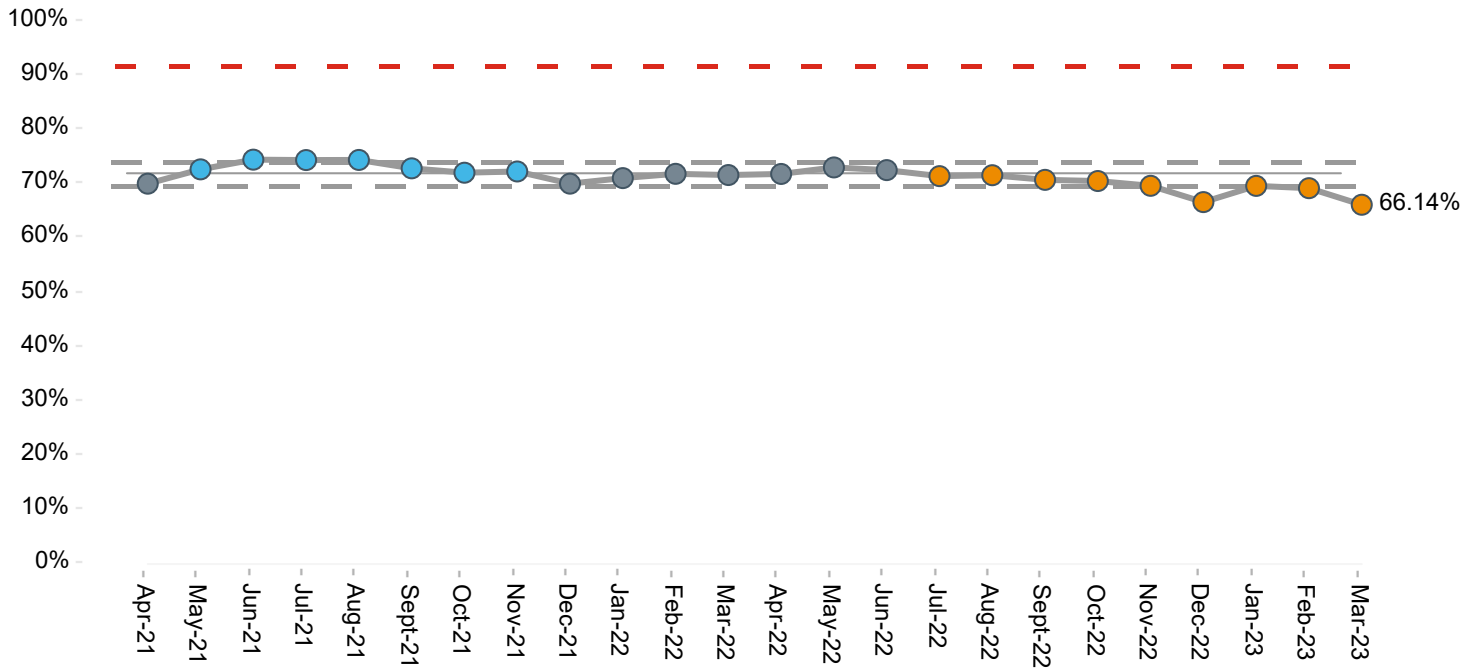
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≥ 92.00%



Data Observations

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Commentary

See Planned Care Exception report for full details. RTT performance has remained stable with an anticipated position of around 69% which remains comparable to performance over the previous 2 months.

Associate Director of Elective Care

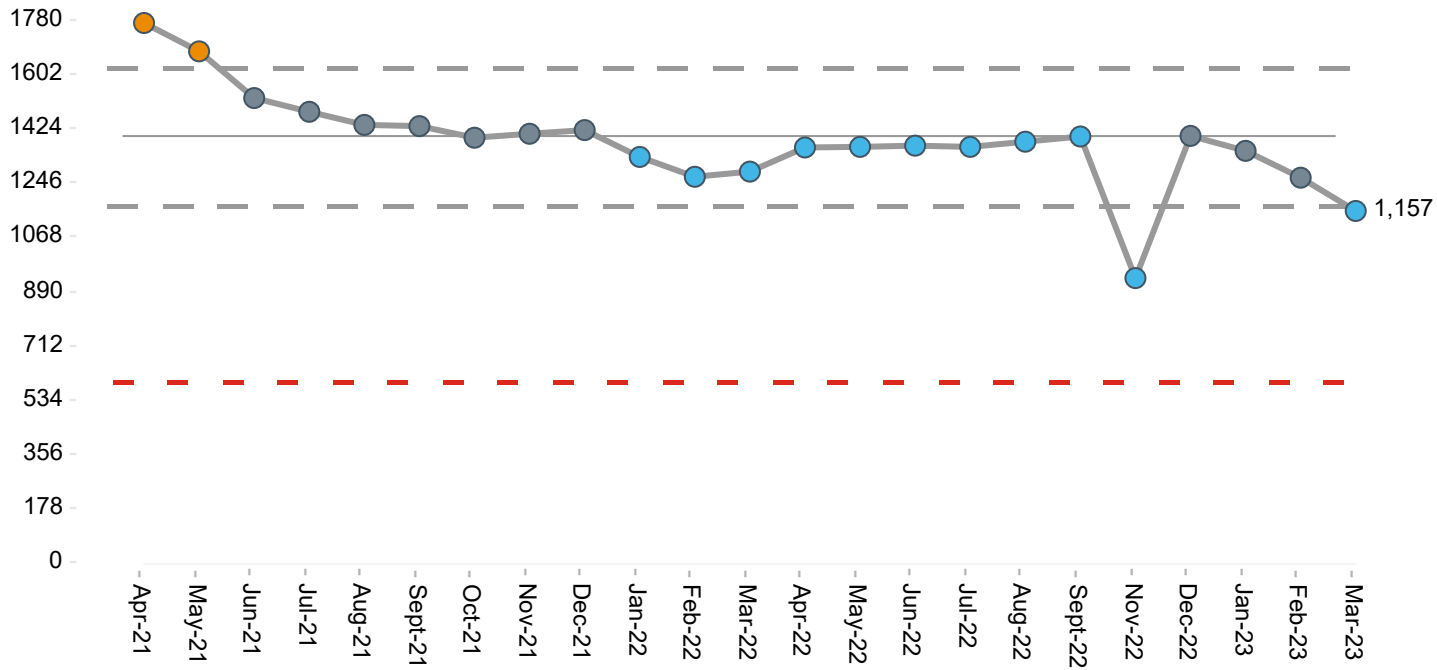
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

Target: ≤ 600



Data Observations

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Commentary

As reported before the number of patients on the waiting list are of concern. The main issue is lack of workforce. A Demand and capacity modelling exercise will be undertaken to clearly define the required workforce but delivery of this is not expected until the summer. In the meantime, 2 locum Gastroenterologists are being employed to support activity delivery. A clinical Endoscopist has also been recruited which too, will support delivery.

General Manager of Endoscopy

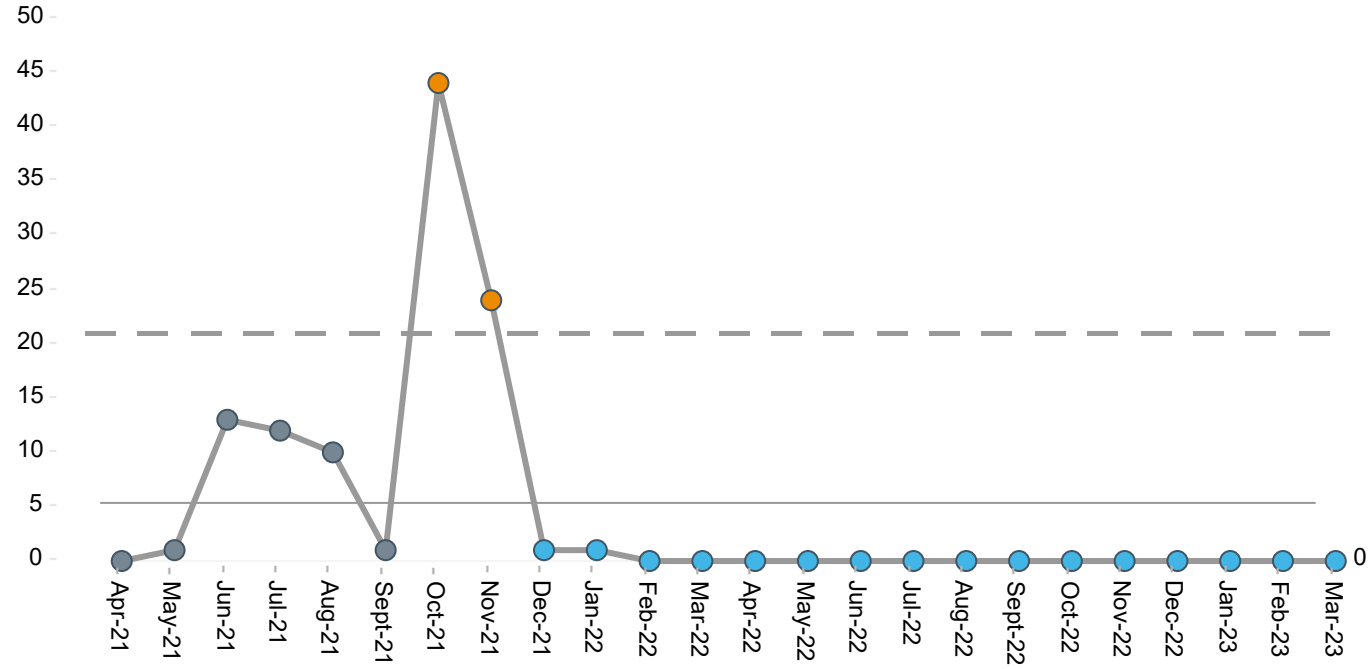
Access

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[552] Urgent cancelled operations

- - - Target: ↓ Lower



Data Observations

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Commentary

Not given

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Friends & Family Test	ED % positive	No Target		Mar-23	79.3%	H
	Inpatients % positive	No Target		Mar-23	91.7%	H
	Maternity % positive	No Target		Mar-23	86.1%	
	Outpatients % positive	No Target		Mar-23	94.7%	H
	Total % positive	No Target		Mar-23	92.3%	H
Infection Control	COVID-19 community-onset - First positive specimen <=2 days after admission	No Target		Mar-23	387	
	COVID-19 hospital-onset definite healthcare-associated - First positive specimen >=1..	No Target		Mar-23	748	
	COVID-19 hospital-onset indeterminate healthcare-associated - First positive specimen 3-7 ..	No Target		Mar-23	572	
	COVID-19 hospital-onset probably healthcare-associated - First positive specimen 8-1..	No Target		Mar-23	557	
	Clostridium difficile - infection rate per 100,000 bed days	↓ Lower		Mar-23	14.7	
	MRSA bacteraemia - infection rate per 100,000 bed days	↓ Lower		Mar-23	0.0	
	MSSA - infection rate per 100,000 bed days	≤ 12.7	?	Mar-23	14.7	
	Number of MSSA bacteraemia cases	≤ 8	P	Mar-23	4	
	Number of bed days lost due to infection control outbreaks	↓ Lower		Mar-23	125	L
	Number of community-onset healthcare-associated Clostridioides difficile cases per month	≤ 5	?	Mar-23	2	
	Number of ecoli cases	No Target		Mar-23	2	
	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	≤ 5	?	Mar-23	2	
	Number of klebsiella cases	No Target		Mar-23	0	
	Number of pseudomona cases	No Target		Mar-23	1	
	Number of trust apportioned Clostridium difficile cases per month	< 10	?	Mar-23	4	

Metric Topic	Metric	Target & Assurance		Latest Performance & Variation		
Infection Control	Number of trust apportioned MRSA bacteraemia	= 0	?	Mar-23	0	
Maternity	% PPH >1.5 litres	↓ Lower		Mar-23	2.9%	
	% breastfeeding (discharge to CMW)	= 0.0%	F	Mar-23	61.7%	
	% breastfeeding (initiation)	No Target		Mar-23	79.4%	
	% of women smoking at delivery	≤ 14.50%	P	Mar-23	9.41%	
	% of women that have an induced labour	≤ 30.00%	?	Mar-23	30.86%	
	% stillbirths as percentage of all pregnancies	< 0.52%	?	Mar-23	0.00%	
	Number of births less than 27 weeks	No Target		Feb-23	4	
	Number of births less than 34 weeks	No Target		Mar-23	7	
	Number of births less than 37 weeks	No Target		Mar-23	46	
	Number of maternal deaths	No Target		Mar-23	0	
	Percentage of babies <3rd centile born > 37+6 weeks	No Target		Mar-23	1.9%	
	Total births	No Target		Mar-23	424	
Mortality	Number of deaths of patients with a learning disability	No Target		Mar-23	2	
	Number of inpatient deaths	No Target		Mar-23	172	
	Summary hospital mortality indicator (SHMI) - national data	No Target		Sept-22	1.124	H
MSA	Number of breaches of mixed sex accommodation	≤ 10	?	Mar-23	40	H
Patient Advice and Liaison Service (PA..	% of PALS concerns closed in 5 days	No Target		Mar-23	82%	
	Number of PALS concerns logged	↓ Lower		Mar-23	337	
Patient Safety Incid..	Medication error resulting in low harm	↓ Lower		Mar-23	12	

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Patient Safety Incidents	Medication error resulting in moderate harm	↓ Lower	Mar-23	0	
	Medication error resulting in severe harm	↓ Lower	Mar-23	0	
	Number of category 2 pressure ulcers acquired as in-patient	↓ Lower	Mar-23	38	
	Number of category 3 pressure ulcers acquired as in-patient	↓ Lower	Mar-23	3	
	Number of category 4 pressure ulcers acquired as in-patient	↓ Lower	Mar-23	0	
	Number of deep tissue injury pressure ulcers acquired as in-patient	↓ Lower	Mar-23	20	
	Number of falls per 1,000 bed days	↓ Lower	Mar-23	6.50	
	Number of falls resulting in harm (moderate/severe)	↓ Lower	Mar-23	3	
	Number of patient safety incidents - severe harm (major/death)	No Target	Mar-23	6	
	Number of unstagable pressure ulcers acquired as in-patient	↓ Lower	Mar-23	19	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No Target	Nov-22	70.74%	
	Number of DoLs applied for	No Target	Mar-23	87	
	Total ED attendances aged 0-18 with DSH	↓ Lower	Mar-23	85	
	Total admissions aged 0-17 with DSH	↓ Lower	Mar-23	39	
	Total admissions aged 0-17 with an eating disorder	↓ Lower	Mar-23	2	
	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	↓ Lower	Mar-23	0	
	Total attendances for infants aged < 6 months, other serious injury	↓ Lower	Mar-23	0	
	Total number of maternity social concerns forms completed	No Target	Mar-23	86	
Serious Incidents	Number of never events reported	= 0	Mar-23	0	
	Number of serious incidents reported	↓ Lower	Mar-23	4	

Metric Topic	Metric	Target & Assurance	Latest Performance & Variation		
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	> 80%	Mar-23	10,000%	
	Serious incidents - 72 hour report completed within contract timescale	> 90.0%	Mar-23	10,000.0%	
VTE Protection	% of adult inpatients who have received a VTE risk assessment	No Target	Mar-23	53.5%	

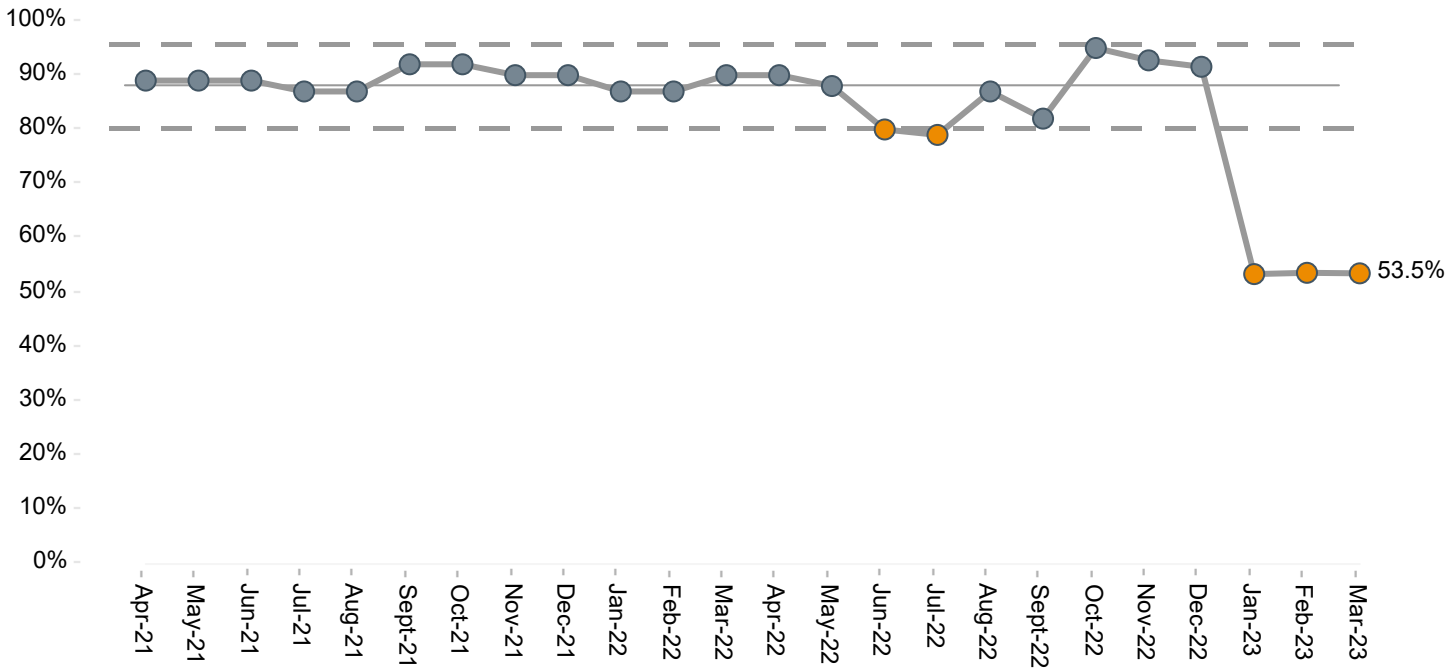
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: No Target



Data Observations

[1] SINGLE POINT

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

A review of the pathway for the electronic recording of VTE risk assessment is underway, parts of the pathway may need redesign to ensure the risk assessment is recorded accurately.

Quality Improvement & Safety Director

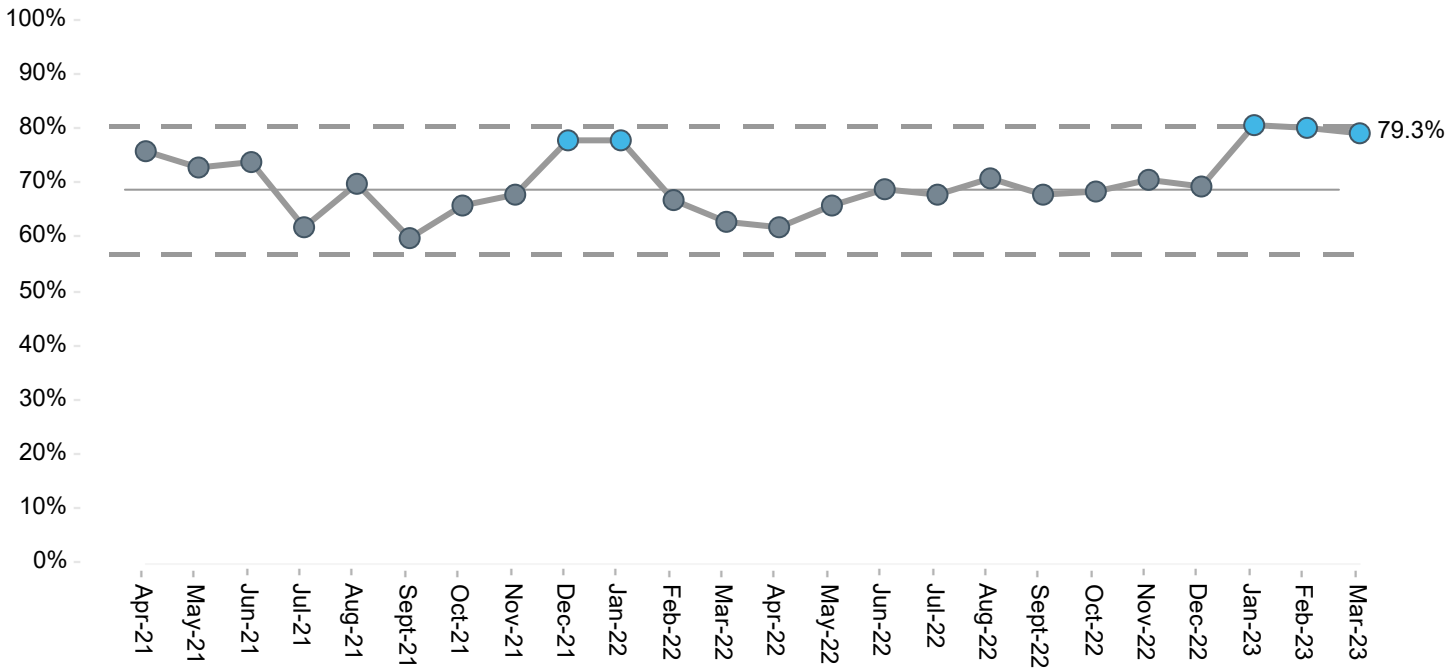
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[154] ED % positive

- - - 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.

[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 79.3% across both sites, a slight decrease from 80.3% in February 2023.

This score,
although a slight decrease is still above the average. This is the second month of a slight decrease so we will monitor this position.

The main theme remains focussed on wait times, which remains reflective of the operational pressures in the department. The team are 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 achieve above average scores for the past 5 months.

Updates are provided through to QDG.

Head of Quality

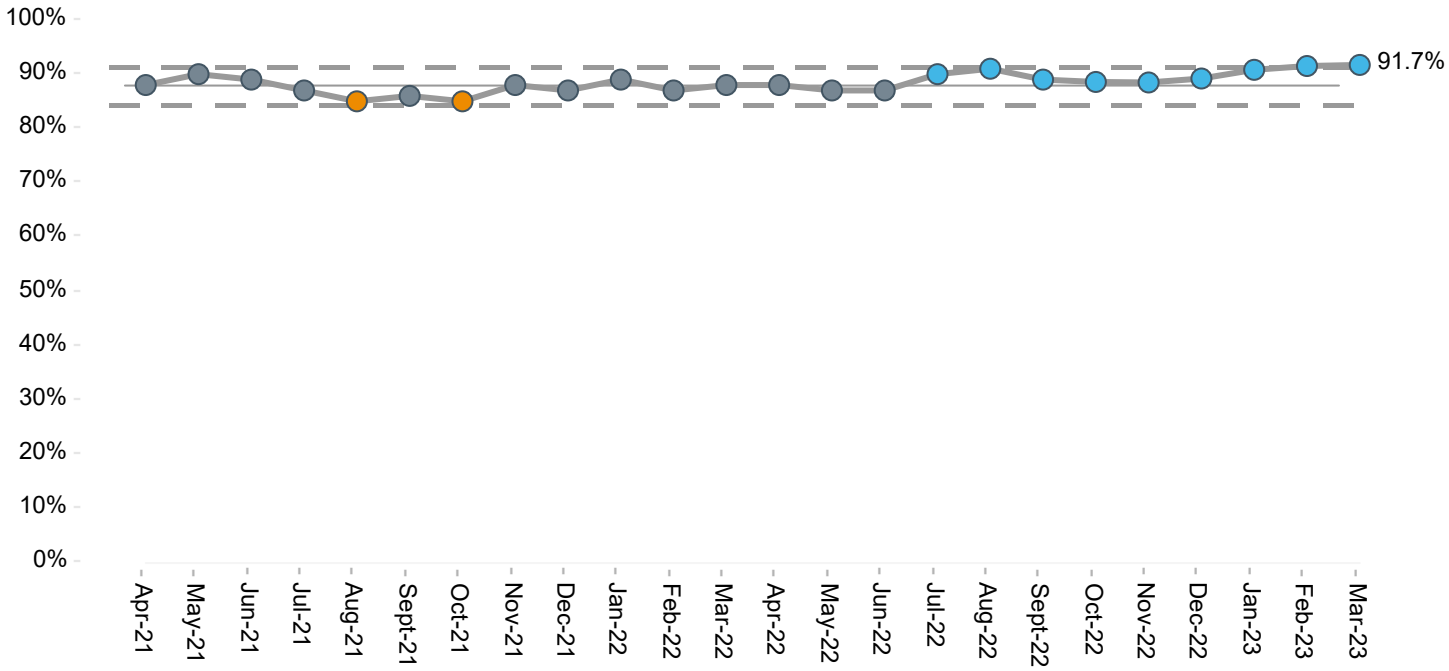
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[153] Inpatients % positive

Target: No Target



Data Observations

[1] SINGLE POINT

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

[2] SHIFT

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

[4] 2 OF 3

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

Commentary

Inpatient % positive 91.5%

The current positive FFT score for Inpatient and Daycase is at 91.7%, a slight increase from 91.5% in January and is the fourth month of increase in score and marks the ninth month of the score above the average of 87% and the second month above the upper control limit.

There is not one initiative that will have driven this increase and we are working with divisional teams to understand further the influencing factors on this improving 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 focussed on lack of staff to be able to provide basic care, communication, corridor care and the ward environment.

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

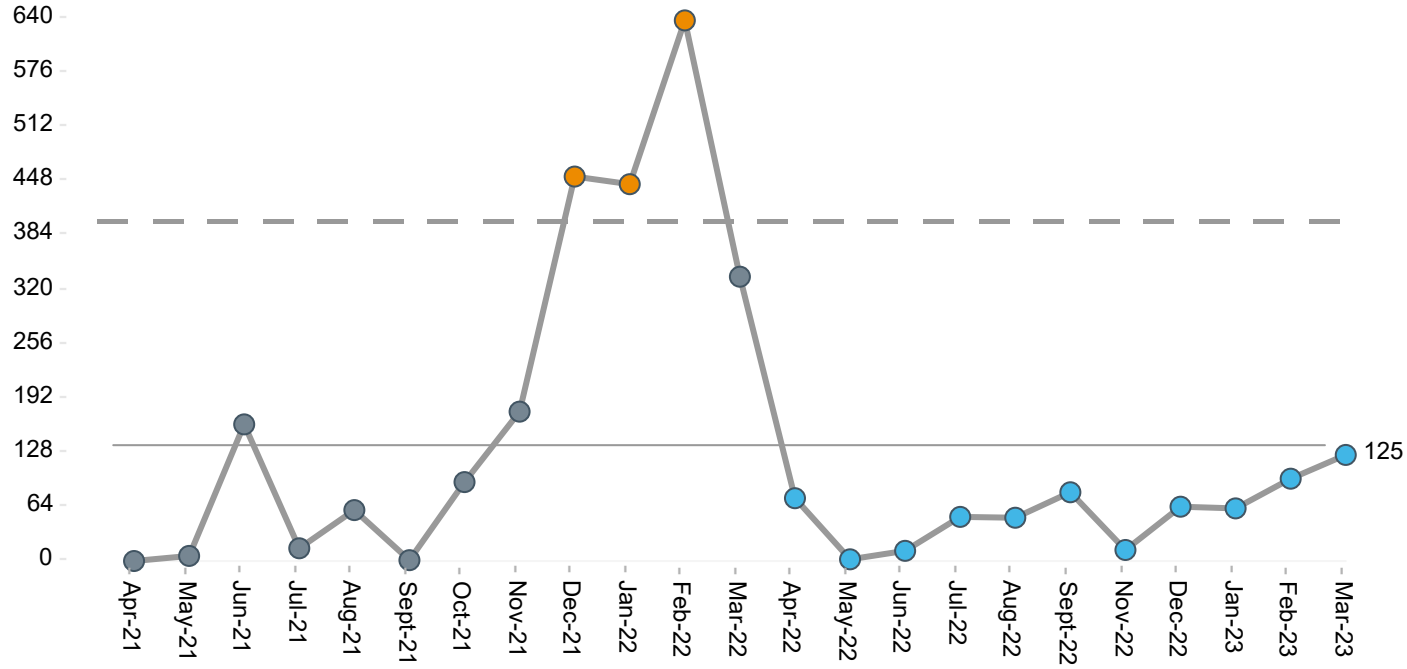
Head of Quality

Quality

SPC - Special Cause Variation

[455] Number of bed days lost due to infection control 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 March 2023 125 bed days we lost due to outbreaks mostly associated with transmission of COVID-19 which increased significantly throughout March compared to February and one ongoing outbreak of Norovirus. 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.

Associate Chief Nurse, Director of Infection Prevention & Control

Quality

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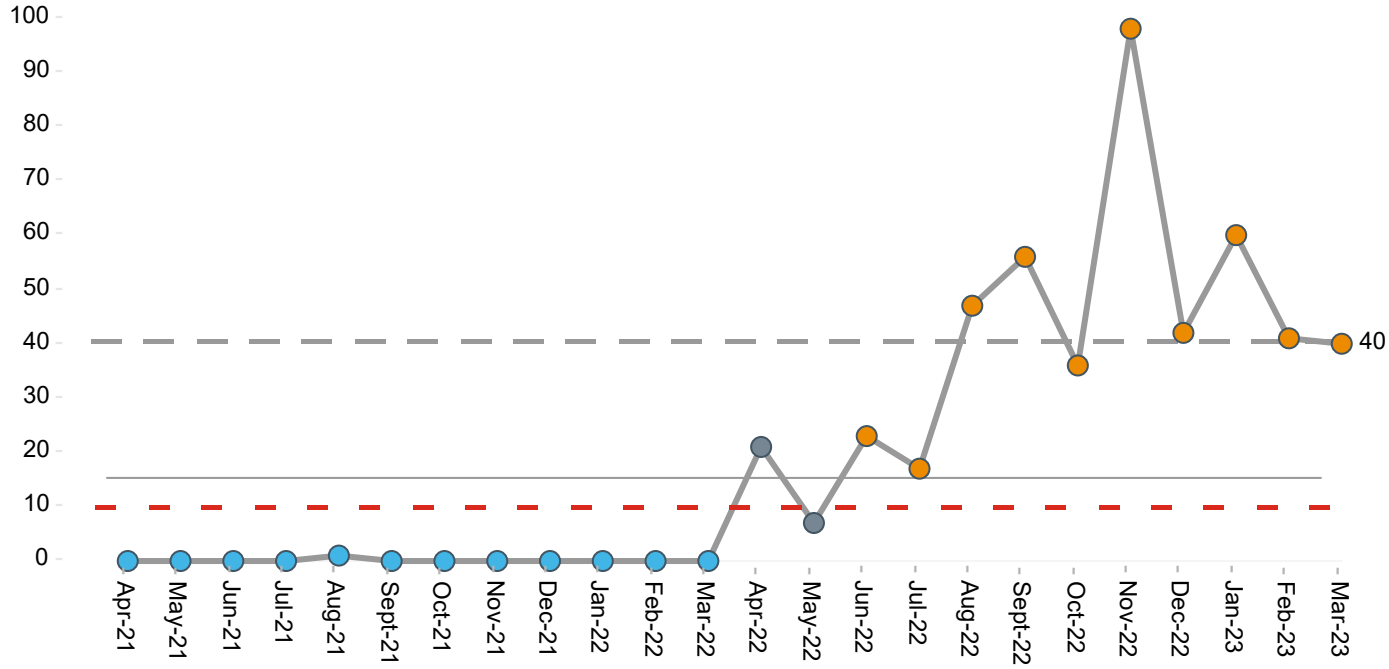
[148] Number of breaches of mixed sex accommodation

- - - Target: ≤ 10



Data Observations

[1] SINGLE POINT

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[2] SHIFT

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Commentary

Mixed sex accommodation breaches are currently recorded manually and in accordance with national guidelines. Breaches are not planned and are almost always a result of operational pressures. Divisions are being tasked with improvement plans, surgery have this as part of the CQC plan and medicine are working up a plan in relation to breaches in unscheduled care.

Associate Chief Nurse, Director of Infection Prevention & Control

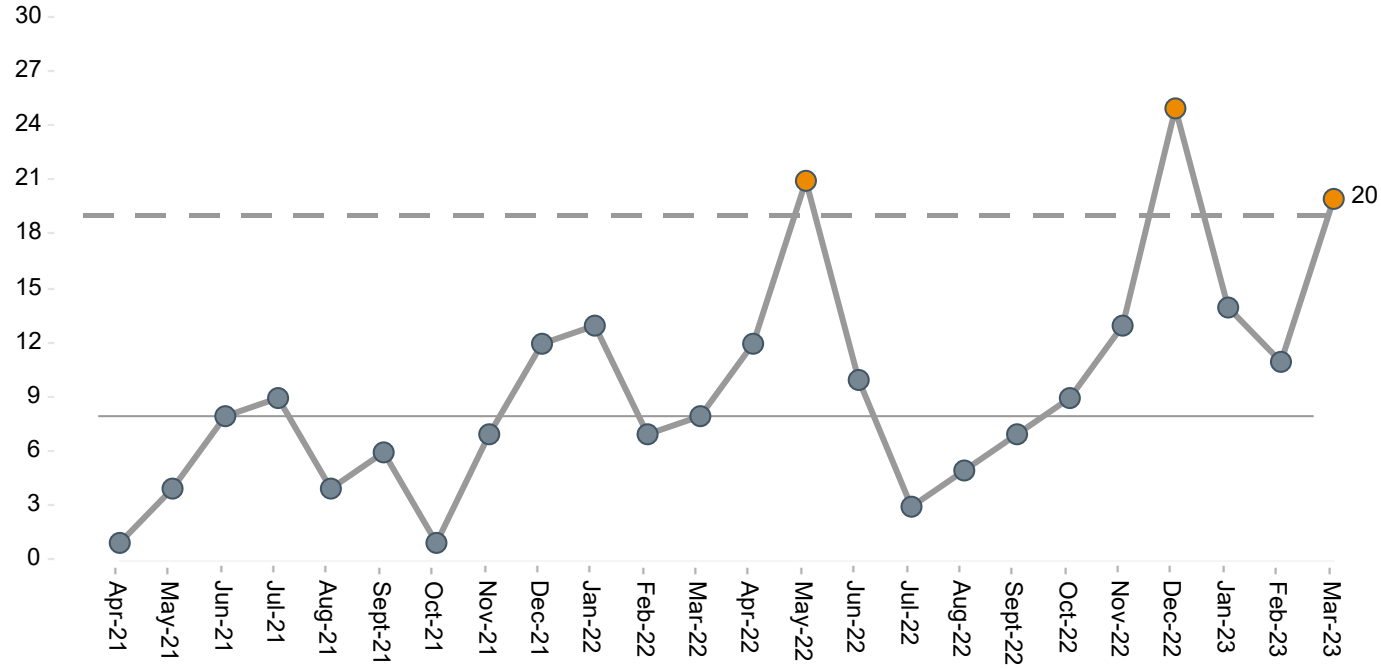
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Data Observations

[1] SINGLE POINT

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

Commentary

Pressure ulcers have increased over the winter period. Contributing factors include prolonged immobility in the pre-hospital and emergency care stage of admission and lack of regular repositioning.

Hospital acquired pressure ulcers are very sensitive to nurse staffing levels. Where there is a reduced amount of nursing hours available there is a clear correlation to the development of pressure ulcers, this can be due to reduced numbers of nursing staff but is more commonly due to more patients on each ward than the staffing model permits.

Current improvement focus is on specialist review of all hospital-acquired pressure ulcers to validate categorisation and give specialist advice to prevent deterioration. New equipment procured and available in the equipment library. React to red study days are now taking place monthly to increase throughput.

Associate Chief Nurse, Director of Infection Prevention & Control

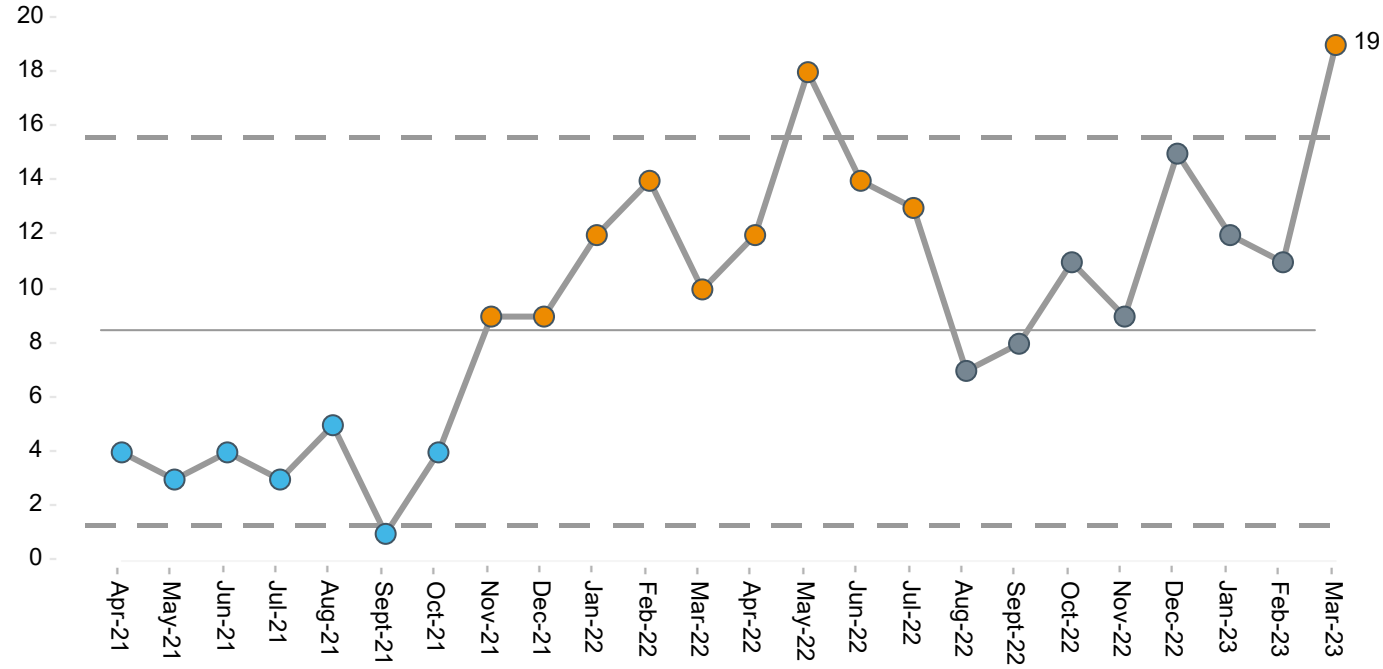
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

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

- - - Target: ↓ Lower



Data Observations

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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

We have seen a significant increase in pressure ulcers since boarding was introduced to ward corridors. This does not affect patients in the corridor but is an effect of reducing the available nursing time to other patients overall.

Associate Chief Nurse, Director of Infection Prevention & Control

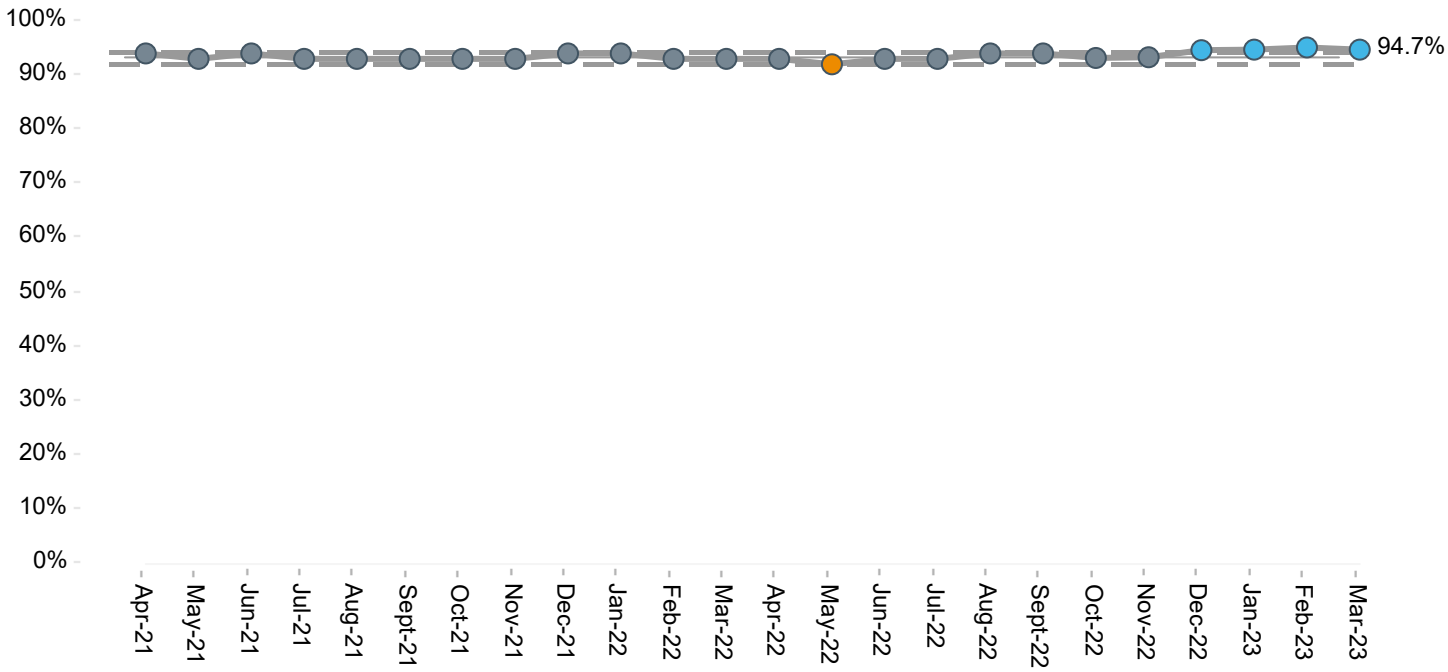
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[291] Outpatients % positive

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

Outpatient % positive 94.7%

The current positive FFT score for Outpatients is 94.7%, a slight decrease from 95.1% in February. However, this is the fourth month of the positive score being above the upper limit.

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 and appointments feeling rushed.

Head of Quality

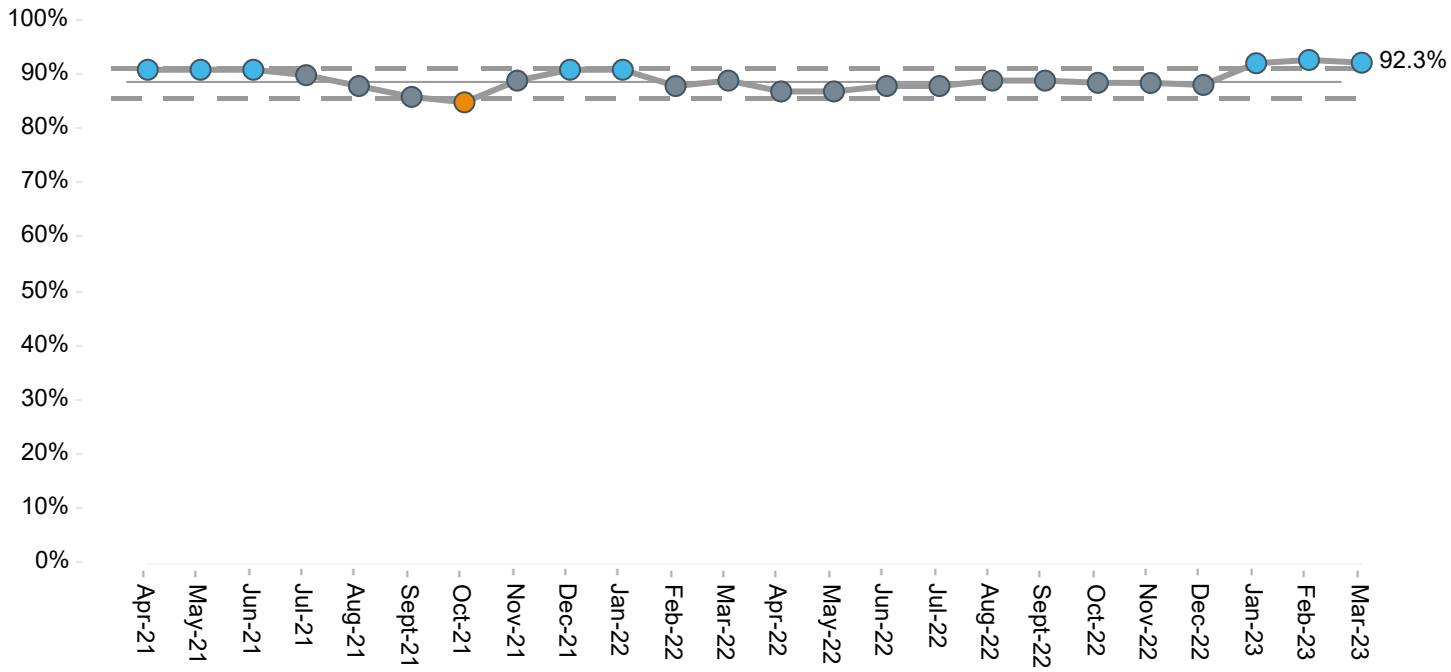
Quality

SPC - Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust

[156] Total % positive

Target: No Target



Data Observations

[1] SINGLE POINT

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[4] 2 OF 3

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Commentary

The overall Trust FFT positive score has seen a slight decrease this month to 92.3% compared to 92.8% in February. Our overall score does, however, move us above the upper control limit for the third month running. This is largely due to increases in the positive FFT score for all care types and above average scores for 3/4 care types including ED which contributes a significant number of responses to our overall score.

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

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Audit and Assurance Committee, 28 March 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**
Internal Audit Progress Report	The outpatient clinic management review had been finalised; however, executive sign off had been delayed and was not available at the time of the meeting. The Committee was advised that the Head of Internal Audit Opinion would seek assurance from engagement in reviews and follow ups, and improvement in recommendation completions would be required. ***Follow up Report*** The Committee received a summary of completed and overdue recommendations. Fifteen recommendations had been made from 2022-23 audit reports; two recommendations related to risk maturity had been completed, with three risk maturity and two HFMA recommendations now due. There was no response related to one further risk maturity recommendation. Eight recommendations were not yet due. ***Accounts Payable Internal Audit Review*** The review was given a Substantial rating for Design Opinion and Design Effectiveness, with a number of areas of good practice identified. One key finding had been raised, related to new suppliers and the need to undertake appropriate due diligence checks. ***Internal Audit Plan 2023-24*** The Committee discussed the draft plan, and agreed that the Freedom to Speak Up Guardian review would not take place in Q1, however appraisal and revalidation review could go ahead as planned.	The outpatient clinic management review would be received in May. A data cleansing exercise would be undertaken to close down older outstanding recommendations. A rationale for risk closure would be discussed at the next meeting. Executives would review and finalise the plan to ensure timings of key reviews were appropriate. Virtual approval would be sought from the Committee.
GMS Report	Key points were noted as follows: • Internal audit progress was slightly behind for 2022-23, although almost completed. The internal audit plan for 2023-24 had been approved by GMS Board. • Staffing remained a key concern. • A high-level single tender waiver dashboard had been appended to the main report for information; additional analysis would take place to reflect the response to the capital programme.	Additional analysis into waiver activity would be discussed at the next meeting.
Risk Assurance Report	Two new risks had been added to the register. The Committee discussed the assurance that would need to be taken to provide understanding on the risks underlying the key performance indicators and how the report would be structured to highlight the framework used. The report would also include immediate internal learning points, as well as wider strategic learning. Inclusion of immediate internal learning and wider strategic learning.	The CEO and Chair of the Committee would agree the format and level of assurance required within the report.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
External Audit	Interim audit was progressing well, with a few samples outstanding but	None.

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.

Progress Report	nothing concerning. Timetables for GMS and charity audits were in place. Auditors would test the value of provision for healthcare support workers. The Committee noted that more work would be taking place on site and would be coordinated with teams.	
Losses and Compensations Report	The Committee noted 12 ex-gratia payments totalling £4735 and approved the write-off of 242 invoices with a total credit value of £2,600.77.	None.
Single Tender Actions Report	Four waivers had been processed within the reporting period, with a value of £289,610.	None.
Items not Rated		
None.		
Impact on Board Assurance Framework (BAF)		
The full Board Assurance Framework was received; the usual monthly review process would be undertaken to continue to refine the risks and associated actions. Further work to ensure the BAF was utilised fully in committee meetings would be undertaken. The Committee encouraged executives to review the risk target scores to ensure they were appropriately ambitious.		