NHS
Gloucestershire Hospitals
NHS Foundation Trust

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST
Public Board of Directors Meeting
12.30, Thursday 10 March 2022
Quayside House, Shire Hall, Westgate Street, Gloucester, GL1 2TG
AGENDA

Ref	Item	Purpose	Report type	Time
1	**Chair's Welcome and Introduction**			12.30
2	**Apologies for absence**			
3	**Declarations of interest**			
4	**Minutes of Board meeting held on 10 February 2022**	Approval	Enc 1	12.35
5	**Matters arising from Board meeting held on 10 February 2022**	Assurance		
6	**Patient Story** *Katie Parker-Roberts, Head of Quality*	Information	Presentation	12.45
7	**Chief Executive's Briefing** *Deborah Lee, Chief Executive Officer*	Information	Enc 2	13.10
8	**Trust Risk Register** *Mark Pietroni, Medical Director*	Assurance	Enc 3	13.30
9	**Quality Report** *Matt Holdaway, Chief Nurse and Director of Quality, Mark Pietroni, Medical Director, and Qadar Zada, Chief Operating Officer*	Assurance	Enc 4	13.40
	Break (14.00-14.10)			
10	**Maternity Reports** *Matt Holdaway, Chief Nurse and Director of Quality* • **Ockenden Report** • **Midwifery Staffing Report**	Assurance	Enc 5 Enc 6	14.10
11	**Gender Pay Gap Report** *Claire Radley, Director of People*	Assurance	Enc 7	14.35
12	**Finance Report** *Karen Johnson, Director of Finance*	Assurance	Enc 8	14.45
13	**Digital Programme Report** *Mark Hutchinson, Chief Digital and Information Officer*	Assurance	Enc 9	15.05
14	**Assurance Reports:** • **Quality and Performance Committee** *Alison Moon, Non-Executive Director* • **Finance and Digital Committee** *Robert Graves, Non-Executive Director* • **People and Organisational Development Committee** *Alison Moon, Non-Executive Director*	Assurance	Encs 10-12	15.20
15	**Any other business**		None	15.30
16	**Questions/Comments from Governors**			
	Close by 15.40			

Unconfirmed

GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST Minutes of the Public Board of Directors' Meeting 10 February 2022, 12.30, By Video Conference			
Chair	Peter Lachecki	PL	Chair
Present	Claire Feehily	CF	Non-Executive Director
	Marie-Annick Gournet	MAG	Non-Executive Director
	Robert Graves	RG	Non-Executive Director
	Balvinder Heran	BH	Non-Executive Director
	Matt Holdaway	MHo	Chief Nurse and Director of Quality
	Mark Hutchinson	MH	Executive Chief Digital and Information Officer
	Karen Johnson	KJ	Director of Finance
	Simon Lanceley	SL	Director of Strategy and Transformation
	Deborah Lee	DL	Chief Executive Officer
	Alison Moon	AM	Non-Executive Director
	Michael Napier	MN	Non-Executive Director
	Mark Pietroni	MP	Medical Director and Deputy for Safety, Deputy Chief Executive
	Rebecca Pritchard	RP	Associate Non-Executive Director
	Claire Radley	CR	Director of People
	Roy Shubhabrata	RS	Associate Non-Executive Director
	Elaine Warwicker	EW	Non-Executive Director
	Qadar Zada	QZ	Chief Operating Officer
Attending	James Brown	JB	Director of Engagement, Involvement and Communications
	Kat Cleverley	KC	Trust Secretary (minutes)
	Suzie Cro	SC	Deputy Director of Quality (item 2 only)
	Alan Dyke	AD	Senior Paediatric Respiratory Nurse Specialist (item 2 only)
	Edward Gomm	EG	Governor
	Jessica Gunn	JG	Consultant Rheumatologist (item 2 only)
	Susan Macklin	SM	Deputy Divisional Director for Quality and Nursing (item 2 only)
	Juliette Sherrington	JS	Governor
	Alan Thomas	AT	Lead Governor
	Fran Wilson	FW	Lead Nurse for Recruitment and Retention (item 2 only)

Ref	Item
1	**Welcome and apologies** None.
2	**Staff Story** The Board heard from Nursing, AHP and Midwifery staff about the "We Work Flexibly" programme, with examples of flexible working and culture change that has had positive benefits in the teams. Metrics had previously shown that 18% of leavers had cited "work/life balance" or "flexibility" as reasons for leaving the Trust; the programme aimed to address this by encouraging and celebrating flexible working arrangements. Conversations with staff happened regularly to look at changes that could be made to ensure staff stay at the Trust; for those members of staff working flexibly, regular reviews are undertaken to ensure arrangements continue to suit both the member of staff and the service. The Board was supportive of the programme and its planned next steps, which included dissemination of learning tools to managers, policy implementation, changes to recruitment and job advertising, and the introduction of flexible working ambassadors. Non-Executive Directors asked the Executive Team to ensure

	that the arrangements for flexible working were implemented in a fair and transparent manner, and were equally accessible to all.
3	**Declarations of interest** There were no new declarations.
4	**Minutes of the meeting held on 13 January 2022** The minutes were approved as a true and accurate record.
5	**Matters arising from the meeting held on 13 January 2022** All matters arising were closed.
6	**Chief Executive's Report** The Board received the report and noted key points as follows: • The Trust was reviewing how the change in covid restrictions would apply to healthcare, with the goal to maximise flexibility and productivity throughout the hospitals as much as possible, whilst keeping staff and patients safe. Communications were being planned to reassure patients, public and staff of the safe changes that would be made, including restoration of some aspects of visiting. • The Reset Day had reintroduced forty beds, however the full benefit of this was not realised due to a rise in covid cases the prior weekend. • The national focus on elective recovery remains paramount, and the Board was assured that Gloucestershire was performing well. The Board discussed evidence that ethnic minorities had suffered greater health inequalities during the pandemic; assurance was provided that the Trust had rigorous oversight of this and other at-risk groups including those with a Learning Disability and from deprived areas in the County, with the Elective Recovery Board reviewing detailed data on a regular basis. The Board was advised that there was no disparity in waiting times or care, and patients were not waiting longer because of their characteristics. However, DL advised that the next Board development session would focus on whether "positive action" was warranted in recognition of the inequities known to exist. • Across the country, ambulance response times to Cat A2 patients was worsening and notably so in the South West and Gloucestershire and Cornwall within the South West. DL briefed the Board on recent discussions with the national team and expectations on the Trust. • The draft CQC report received from the pre-Christmas inspection had been received. The Trust was currently undertaking the factual accuracy check. The Board noted that although the narrative of the report included the whole system and interdependencies, an individual organisation report had been received. The Board was pleased to note that the report was positive overall, with many references to frontline colleagues delivering compassionate, good and safe care during adverse times. The report would be presented to the Quality and Performance Committee when finalised. • A petition had been received about the care of women requiring emergency gynaecology care, in particular those experiencing miscarriage. The Trust had repurposed its dedicated gynaecology ward to manage the demands from medical patients and as a result, had lost gynaecology nursing expertise. DL advised that there were now plans in place to reintroduce dedicated beds and specialist staffing on one of the GRH surgical wards, pending delivery of the optimal solution of a dedicated ward in the Women's Centre. • DL updated the Board on the activities associated with National Apprenticeship Week and advised that the Trust's apprenticeship programme was very successful and, as such, had been showcased at the University of Gloucestershire as an exemplar. • Race Equality Week was taking place this week, and the Board was advised of a number of activities underway, including the #MyName campaign, and promotion of the Trust's Diversity Network.

Unconfirmed

7	**Risk Register** The risk register was received for information. Further clarification of covid risks would be completed to determine whether they would become business as usual or specific to the pandemic period. The Board noted the downgraded fractured neck of femur risk in response to significant improvements in associated mortality, which were the best they had been. The Board received assurance that robust monitoring and multidisciplinary team meetings would continue to manage this complex pathway to detect any possible deterioration, as soon as possible.
8	**Quality and Performance Report** The Board received the report and noted the following key points: • Emergency care remained challenging. There was a high number of inpatients who were medically optimised for discharge (MOFD), and the operating pathways for Omicron continued. Performance against the four-hour target had improved slightly, although there had been some patients waiting over twelve hours and triage times had reduced. The degree of congestion in the Emergency Department (ED) and the number of patients waiting to be handed over by ambulance crews or waiting in the community for an ambulance response was of particular concern. • The Board was advised that 453 bed days had been lost to closures due to covid in December; in respect of nosocomial transmission, the Trust was one of the best performers in the Region. • There had been an increase in MSSA cases, which was being reviewed through the Root Cause Analysis (RCA) process. An initial review suggested that there may have been some issues with invasive vascular devices, however further investigation was underway. • An increase in pressure ulcers was reported in December, which was believed to be related to staffing levels and high activity. Numerous actions were in hand to ensure all patients were appropriately assessed for their risk and plans in place for every at-risk patient. • An increase in falls had resulted in some moderate and severe harm incidents. The Board was assured that falls had reduced since December; plans were in place to strengthen the falls reduction programme, including an external review. It was also noted that a return to visiting was likely to have a positive impact on falls. • The Board discussed recovery of elective care, and considered the Trust's potential capacity to provide mutual aid to other organisations. • Assurance was provided that all patients currently on the waiting list were being communicated with and reviewed. It was noted that some previous public confusion about this may be resulting from a misunderstanding of waiting times and clinical priority times. DL explained the latest development in respect of elective recovery, which was the launch of a national mobile application called *My Planned Care.*
9	**Guardian Report on Safe Working Hours for Doctors and Dentists in Training** During the quarter there had been 110 exemption reports, 80% of which related to the Medical division. The reports were primarily focused on working hours and missed educational opportunities. Twenty-four Datix reports had been submitted, mostly related to reduced staffing levels. The Board noted that the number of exception reports had reduced this quarter and had also fallen when compared to the same period in 2020. No fines had been levied during the reporting period. The Board discussed whether this could reflect complacency around reporting, or a lack of time to report; JG provided assurance that she did not think this was the case. The Board reflected on the immediate safety concern report, however there had not been sufficient information provided to determine details and no further contact with the person who raised the report had been possible. DL enquired as to whether Educational Supervisors were involved in assessing these reports and exploring the missing detail. JG confirmed that they were.

	The Board was assured that the exception reporting process was robust and that the Junior Doctor Forum was functioning well and discharging its duties appropriately.
10	**Finance Performance and Capital Report** ***Finance*** • The Trust was reporting a year-to-date surplus of £404k, which was in line with the plan. • The forecast outturn was reporting a mitigated surplus of £3.5m, which would be reduced to close the gap and achieve a breakeven or small surplus position by year end. • The system had reported a small surplus of £11k for H1; the Trust had contributed to this by delivering a £6k surplus. The system had planned to breakeven in H2. • The Trust was reporting a forecast outturn of £6k for the year; a number of risks were associated, all of which were related to creating additional surplus. There were plans in place to explore investment opportunities to maximise patient care, replace ageing equipment and support staff wellbeing. • Planning guidance for 2022-23 had been released. The Trust was now working through this in conjunction with system partners. ***Capital*** • The Trust's forecast capital envelope was currently at £67.9m. To date, the Trust had delivered goods, works or services to the value of £32.3m, which left £35.6m to spend in the remainder of the year. • The delivery of the rest of the capital programme was challenging and, whilst there was no material slippage, some significant concerns remained around the volume of projects due to be completed in the last few months of the year. A real risk to the Trust's year end position would be the reporting of any slippage at this point. The capital programme continued to be monitored and options were being explored to mitigate any potential slippage including bringing forward Digital spend from the 2022-23 programme. • A key aim for the team was to invoice and receipt all orders on the system by the end of the year. Colleagues within procurement and Gloucestershire Managed Services (GMS) were also reviewing any potential delays within the supply chain.
11	**Digital Programme Report** The Board received assurance on the digital programme, noting particularly that progression of digital workstreams and projects was in line with the Trust's ambition to become a digital leader. Significant progress had been made on the Electronic Patient Record (EPR), with additional functionality relating to nurse and doctoring documentation due to be implemented w/c 21 February 2022. The Board was assured that a lot of work was underway to review the Trust's cyber security processes, particularly in relation to a review of any vulnerabilities within the system and current oversight arrangements. MH had provided an updated management response to the recent internal audit report providing additional assurance and evidence of actions to mitigate the known risks. The team was also looking to influence the ICS digital strategy in relation to the implementation of a countywide patient portal.
12	**Committee Chair Assurance Reports** The Board noted the assurance reports for information.
13	**Council of Governors Meeting Minutes 15 December 2021** The Board noted the minutes for information.
14	**Governor Questions and Comments**

	• Additional assurance was requested around pathway zero and ensuring that patients were ready to go home and were being discharged appropriately with the full involvement of their families, especially given the lack of visiting in place. The Board agreed that this was a key point of the patient journey, and the renewed focus on discharge and Criteria to Reside (CTR) included the involvement of families. MHo noted the issues that can arise when family members do not share the patients' view on discharge but have capacity to determine their own care needs. • Governors noted concern about the prevalence of falls, and discussed how there could be potential for falls to reduce once visiting guidance changes and families were able to be with patients and involved in their care. • Poor performance around stroke admissions was discussed, which was due to general patient flow issues and the closure of the unit due to covid. Plans were in place to address this. • Never events were highlighted as a key issue. Some assurance was given that a large piece of work was underway to make significant improvements within theatres.
15	**New risks identified** The existing ambulance response risk would be reviewed in light of the continued deterioration of Cat A2 response times.
16	**Any other business** None.
Close	

Gloucestershire Hospitals
NHS Foundation Trust

PUBLIC BOARD – MARCH 2022
CHIEF EXECUTIVE OFFICER'S REPORT

Introduction

1.1 Since our last meeting, we have all observed with shock and horror the unfolding events in the Ukraine. The inspiring spirit and courage of the Ukraine people has caught the attention of the whole world. Many colleagues have approached us to asking how we are supporting the Ukraine and this has been addressed through our Trust-wide communications but, as is typically the case in such situations, this is largely being managed at governmental level. Closer to home, our 2020 Hub is available to support staff impacted by this situation and managers have been reminded to ensure staff who are affected, and may need flexibility in their working arrangements, are supported.

1.2 Last week, the Government removed the final legal remnants of the COVID-19 restrictions including removing the legal requirement for COVID positive patients to isolate, although guidance remains in place which the public is being asked to observe. I am heartened by the number of people choosing to continue mask wearing and observing the self-isolation guidance. The guidance for hospitals remains unchanged at the current time although this is also expected to change once the NHS steps down from National Alert Level 4, which is triggered by the number of COVID-19 cases nationally. Positively, however, we are now able to commence exploring the opportunities for returning to some face-to- face meetings in the coming months including the public meetings of the Trust Board and Council of Governors.

Operational Context

2.1 Operationally, the Trust remains extremely busy although there are some signs that pressures in urgent and emergency care demand at our front door are reducing, with lower numbers of patients being admitted than previously. However, unfortunately our inability to discharge patients in a timely way means that our Emergency Departments (ED) continue to be congested as a result of being unable to flow patients quickly in and out of the ED. Of particular concern is the impact this has on patients conveyed to hospital by ambulance, who are often required to queue outside the hospital pending their transfer into the Department. The impact of this position on the ability of crews to respond to urgent patients in the community and this issue of delayed responses to Category A2 patients has attracted national attention. Extensive work is in hand to address both the root causes of poor flow and to mitigate the risks until such time the pressures are eased; this includes the agreement of Standard Operating Procedures to ensure the immediate release of crews to respond to emergency ambulance calls, where no other crews are available.

2.2 Of particular note in Gloucestershire are the higher numbers of community cases and, in particular, the number of care homes closed to new admissions due to COVID-19 outbreaks. At the current time, only 2 of the 55 nursing homes in the county are open to admissions which is impacting significantly on our ability to discharge patients who require this type of care. Colleagues in Adult Social Care and Health Protection are working very closely with the Trust and wider system to minimise the impact of these outbreaks but current guidance limits their influence and impact. The issue of the current guidance in the context of managing risk across a whole system has been flagged both regionally and nationally.

2.3 The numbers of patients in our hospital with COVID has also risen considerably since my last report. As in previous reports, many of these patients are asymptomatic and are only picked up as COVID positive on hospital testing; the numbers requiring advanced respiratory support is thankfully extremely low. After careful consideration of the risks and benefits, the way in which we cohort and manage COVID patients is changing. This will not only bring benefits to flow and patients awaiting admission to a ward bed but will reduce the number of times is patient is moved between wards which we know has a huge impact on patient experience and staff workload.

2.4 In keeping with our Winter Plan, wards that were switched to the care of medical patients in recent months are now being reverted to their original purpose and a greater volume of elective care is resuming as a result. On the 28th February we retuned the final orthopaedic ward to its intended purpose to enable orthopaedic recovery to commence in earnest following significant levels of reduced activity arising from cancelled operations due to bed constraints. To further enhance elective recovery, following a period of staff engagement, a series of ward moves will be enacted at Cheltenham General Hospital towards the end of this month to create ringfenced surgical bed capacity. This is in line with the expectations of the national operational planning guidance and work being led by Professor Tim Briggs looking into the best models to deliver high volume, low complexity (HVLC) procedures. Professor Briggs and his team, (virtually) visited the Trust on the 28th February and commended the vision and plans for the future. The Trust's elective and diagnostic performance remains strong; cancer performance is strong relative to the regional position but improving 62 cancer waiting performance remains a huge priority including the continued work to improve histopathology turnaround times.

3 Key Highlights

3.1 Since my last report Trust Governors have concluded a rigorous search for the next Trust Chair. I am delighted to report that Deborah Evans has been appointed and will take up post at the end of April, to allow a short period of handover. Deborah has extensive executive experience in the NHS and healthcare more widely having been a Chief Executive of several commissioning organisations and most recently Managing Director of the West of England Academic Health Science Network. Since her retirement form fulltime NHS work, Deborah has been a Trustee and Chair of Brunel Care, a not-for-profit organisation delivering housing and social care in Bristol and surrounding areas.

3.2 Work to develop our teaching and research offer has taken several steps forward this month. Firstly, with the recent joint appointment of a Professor of Nursing in conjunction with the University of Worcestershire. The role will lead the way on developing nurse, midwife and allied health professional (AHP) based research. This group of professionals are often contributing to work that is informing the evidence base such as quality improvement work but often do not take that next step of writing up and seeking publication of their work. In addition, we also know that we fail to retain and attract senior, research active nurses, midwives and AHPs due to a lack of research support and infrastructure to these professionals. Announcements of the individual will follow as soon as the University has concluded its ratification of the appointment. Secondly, teaching reached another milestone this month with the confirmation that the Three Counties Medical School will welcome their first students later this year, enabled in part by funding from local NHS organisations. These students will undertake a four-year post-graduate medical degree and undertake clinical placements in our organisation and other healthcare settings in the County. Both of these

achievements will support the Trust's ambition to become a University Hospital, in due course.

3.3 As part of our efforts to reduce nursing vacancies and contribute to the diversity of our organisation the Trust has reinvigorated its approach to overseas recruitment and I have had the pleasure of meeting many of the recent arrivals from India. Next year, we look forward to welcoming a further 100+ nurses, midwives, AHPs and doctors from around the globe. This is a hugely daunting personal and professional step for these new recruits, many of whom are coming to England for the first time. In recognition of this, our internal recruitment team has designed and delivered a comprehensive programme of pastoral support. I was delighted, therefore, to hear that in recognition of our efforts, we were one of just three Trusts to be awarded the NHS England Pastoral Care Quality Award for international recruitment.

3.4 Sticking with the theme of success, I was similarly pleased to see that the Trust's Green Plan was one of just three chosen by the Department of Health and Social Care to showcase "what good looks like" in respect of an NHS organisation's approach to sustainability and making this accessible to all through engaging, informative plans. Huge credit to Jen Clearly, Head of Sustainability who led development of the Plan and Gloucestershire Managed Services (GMS) for their focus on delivery. I had the opportunity to join the Trust's Green Council last month and was blown away by the wide range of colleagues engaged on the call and the initiatives underway at local level. To harness this energy and enthusiasm, we will be partnering with the Centre for Sustainable Healthcare (CSH) and will be rolling out their *Green Ward Competition* later this year, which they have delivered to great effect in a small number of other Trusts nationally. Of particular note, beyond the positive impact on carbon footprint, participating Trusts were able to evidence significant improvement in patient and staff experience and a financial return of 6:1 on green investments. More information can be found here https://sustainablehealthcare.org.uk/green-ward-competition.

3.5 On the 23rd February we took the next significant step in our digital journey with the first major implementation of doctors' documentation, bringing ward rounds and clinical noting into the Electronic Patient Record (EPR) for the first time. This is a step change for clinicians; and for many senior consultants it has been their first experience of using Sunrise EPR in their daily routines. Alongside this, we launched additional nursing documentation focussed on food and fluid charts. This is a huge step towards our target of having 90% of nursing documentation on EPR by 2023. The response from nursing teams as always has been fantastic. Therapists have also started using the system for the first time. They now also complete reviews within the EPR clinical notes and have been overwhelmingly positive; suggesting improvements almost immediately.

3.6 No go live comes without its challenges and despite extensive testing, two issues came to light in the first few days. Working closely with clinical teams, the EPR team and Allscripts responded and identified fixes, whilst also putting in place temporary solutions to ensure that clinicians could continue to safely provide care and use the system. Overall, the support from clinical colleagues has been phenomenal and the EPR team will continue to listen, respond and make changes over the coming weeks. Optimisation of the new system will now be the focus going forward but this is a huge step in our digital journey.

3.7 This month, film crews from regional media outlets visited the Trust to showcase the first schemes delivered through our £101m strategic site development programme. Of particular note was not just the focus on new, modern buildings and equipment but the service transformation that these new environments are enabling with the aim of improving

outcomes, patient experience and the length of time people spend in hospital. Congratulations again to our pro-active communications team for the work they continue to do with media partners.

3.8 Such a lot going on!

Deborah Lee
Chief Executive Officer

3rd March 2022

Gloucestershire Hospitals NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	8	Enclosure Number:	3
Date	10 March 2022		
Title	Trust Risk Register		
Author /Sponsoring Director/Presenter	Lee Troake, Head of Corporate Risk, Health and Safety Mark Pietroni, Medical Director		

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

Summary of Report

Purpose

The Trust Risk Register (TRR) enables the Board to have oversight, and be assured of, the active management of the key risks within the organisation.

There were no changes to the TRR at Risk Management Group in 2 March 2022.

Key issues to note

NEW RISKS ADDED TO TRUST RISK REGISTER (TRR)

- None

RISK SCORE REDUCED FOR TRR RISK

- None

RISKS DOWNGRADED FROM THE TRR TO THE DIVISIONAL RISK REGISTER

- None

PROPOSED CLOSURES OF RISKS ON THE TRR

- None

Recommendation

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

Enclosures

- Trust Risk Register

Ref	Inherent Risk	Controls in place	Action / Mitigation	Highest Scoring Domain	Consequence	Likelihood	Score	Current	Executive Lead title	Review Date	Operational Lead for Risk	Approval status
M2353Diab	The risk to patient safety for inpatients with Diabetes whom will not receive the specialist nursing input to support and optimise diabetic management and overall sub-optimal care provision.	1)E referral system in place which is triaged daily Monday to Friday. 2)Limited inpatients diabetes service available Monday - Friday provided by 0.77wte DISN funded by NHSE additional support for wards is dependent on outpatient workload including ad hoc urgent new patients. 3)1.0wte DiSN commenced March 2021, funded by CCG for 12 month and a further one in June 2021 . 4) 0.77 Substantive diabetes nurse increased hours extended for a further 12 months using CCG funding 5) 3 WTE 12 month fixed term dedicated inpatients diabetes nurses NHSE funded - 3rd due to start 11/21	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	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Medical Director	31/01/2022	Greenway, Laura	Trust Risk Register
D&S2404CHaem	Risk of reduced safety as a result of inability to effectively monitor patients receiving haematology treatment and assessment in outpatients due to a lack of Medical capacity and increased workload.	Telephone assessment clinics Locum and WLI clinics Reviewing each referral based on clinical urgency Pending lists for routine follow ups and waiting lists for routine and non-urgent new patients. Business case to address workload growth with permanent staffing agreed Update March 2020 - Complete redesign and restructure of outpatient service with disease specific clinics to address efficiency now in place. Update August 2021- No locums available (agency or NHS) for over 3 months Urgent and chemotherapy patients being prioritised for appointments	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	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Executive Director for Safety	13/12/2021	Johny, Asha	Trust Risk Register
C2669N	The risk of harm to patients as a result of falls	1. Falls prevention assessments on EPR 2. Falls Care Plan 3. Post falls protocol 4. Equipment to support falls prevention and post falls management 5. Acute Specialist Falls Nurse in post 6. Falls prevention champions on wards 7. Falls monitored and reported at the Health and Safety Committee and the Quality and Performance Committee 8. Adequate staffing and nurse:HCA ratios 9. Rapid feedback at Preventing Harm Hub on harm from falls	Discussion with Matrons on 2 ward to trial process Develop and implement falls training package for registered nurses develop and implement training package for HCAs #Litle things matter campaign Discussion with matrons on 2 wards to trial process Review 12 hr standard for completion of risk assessment Alter falls policy to reflect use of hoverjack for retrieval from floor review location and availability of hoverjacks Set up register of ward training for falls Provide training and support to staff on 7b regarding completion of falls risk assessment on EPR Discuss flow sheet for bed rails on EPR at documentation group W158498- discuss concern regarding bank/agency staff not completing EPR with M Murrell Review use of slipper socks with N Jordan SIM training to use hoverjack on 7a	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Bradley, Craig	Trust Risk Register
C2984COOEFD	Risk of harm to patients, staff and visitor from hazardous floor conditions and damaged ceilings as a result of multiple and significant leaks in the roof of the Orchard Centre GRH, (E51), Wotton Lodge (E58), Chestnut House	•Wet floor signs are positioned in affected areas •Existing controls/mitigating actions as referenced in 'Control in Place' including provision of additional domestic staff on wet days to keep floor clear of water (e.g. dry, signage, etc.) •Some short term patch repairs are undertaken (reactive remedial action); •Temporary use of water collection/diversion mechanism in event of water ingress •Risk assessment completed in 2019 and again in 2020 – issue escalated to Executive team •Options provided to TLT regarding building in June 2019	Long term repairs to roofs needed GRH To revise specification and quote for Orchard Centre roof repairs to include affected area. Urgently provide quote and whether can be done this financial year to KJ / Finance Discuss at Infrastructure Delivery Group whether there is sufficient slippage in the Capital Programme for urgent repairs to the Orchard Centre Roof Review of progress	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Chief Operating Officer	30/11/2021	Turner, Bernie	Trust Risk Register
F2895	There is a risk the Trust is unable to generate and borrow sufficient capital for its routine annual plans (estimated backlog value of at least £60m), resulting	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	1. Prioritisation of capital managed through the intolerable risks process for 2019/20 escalation to NHSI and system	Environmental	Major (4)	Likely - Weekly	16	15 - 25 Extreme	Director of Finance	30/11/2021	Zada, Qadar	Trust Risk Register

	in patients and staff being exposed to poor quality care or service interruptions as a result of failure to make required progress on estate maintenance,	Control Group; 3. Capital funding issue and maintenance backlog escalated to NHSI;	To ensure prioritisation of capital managed through the intolerable risks process for 2021/22	Environmental	Major (4)	(4)	16	risk	Director of Finance	30/11/2021	Zaidi, Qaidar	
D&S3562Path	The Risk to the quality of pathology service provision due to functionality issues with TCLE during the implementation phase which prevents the timely booking of samples, access to, or visibility of, critical patient results.	Daily issues calls with issues log Support from Pathology, IT and Intersystems to resolve issues Weekly management meetings Oversight from Pathology Management Board and Divisional Board	Implement daily meeting to review issues with TCLE Implement 4pm catch up meetings for TCLE Continue TCLE weekly management meetings Set up Task and Finish group for TCLE recovery esp in Histopathology Upload TCLE Issue log to datix Obtain urgent E sign off for RA for Specialty RR Obtain Urgent E-Sign off from Divisional Board for Division RR and escalation to Trust Provision of incidents where pathology have been unable to support MDTs Arrange meeting to discuss with Lead Executive and Trust Risk Lead	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Director of quality and chief nurse	08/12/2021	Moore, Philippa	Trust Risk Register
C3431S&T	The risk is that planned reconfiguration of Lung Function and Sleep is considered to be 'substantial change' and therefore subject to formal public consultation.	Feasibility study underway to explore alternative locations for Nuclear Medicine and Lung Function. Work underway to determine whether centralising Nuclear Medicine to CGH (preference of the service) and establishing a hub and spoke model for Lung Function meets the criteria for 'substantial service variation'	Develop case for change for Nuclear Medicine & Lung Function	Business	Catastrophic (5)	Possible - Monthly (3)	15	15 - 25 Extreme risk	Director for Strategy & Transformation	06/12/2021	Hewish, Tom	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	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	28/02/2022	Mills, Joseph	Trust Risk Register
D&S2517Path	The risk of non-compliance with statutory requirements to the control the ambient air temperature in the Pathology Laboratories. Failure to comply could lead to equipment and sample failure, the suspension of pathology laboratory services at GHT and the loss of UKAS accreditation.	Air conditioning installed in some laboratory (although not adequate) Desktop and floor-standing fans used in some areas Quality control procedures for lab analysis Temperature monitoring systems Temperature alarm for body store Contingency plan is to transfer work to another laboratory in the event of total loss of service, such as to North Bristol	Review performance and advise on improvement Review service schedule A full risk assessment should be completed in terms of the future potential risk to the service if the temperature control within the laboratories is not addressed A business case should be put forward with the risk assessment and should be put forward as a key priority for the service and division as part of the planning rounds for 2019/20.	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	31/12/2021	Lewis, Jonathan	Trust Risk Register
C1850NSafe	The risk of harm to patients, staff and visitors in the event of an adolescent 12-18yrs presenting with significant emotional dysregulation, potentially self harming and violent behaviour whilst on the ward. the The risk of a prolonged inpatient stay whilst awaiting an Adolescent Mental Health (Tier 4) facility or foster care placement.	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 are employed via and agency during admission periods to support the care and supervision of these patients. 3. CQC and commissioners have been made formally aware of the risk issues. 4. Individual cases are escalated to relevant services for support . 5. Welfare support for staff after difficult incidents	Develop Intensive Intervention programme Escalation of risk to Mental Health County Partnership Escaled to CCG	Safety	Moderate (3)	Likely - Weekly (4)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Mortimore, Vivien	Trust Risk Register
D&S2976Rad	The risk of breaching of national cancer targets due to a shortage of specialist Doctors in breast imaging.	Additional clinics covered by current staff. Have reduced screening numbers identify what other hospitals are doing given national shortage of Breast Radiologist - Is breast radiology reporting going to be centralised as unable to outsource this. Transferred Symptomatic to Surgery 2 WTE gap If 1 WTE Leaves then further clinics will be cancelled and wait time and breaches will increase for patients. Unable to prioritise patients as patients are similar.	meeting with HR to progress replacement of staff in Breast screening Arrange meeting to discuss with Lead Executive Develop escalation process for when Breast Radiologist is not available to provide service Discuss the possible set up of national reporting center widen recruitment net to include head hunter agencies using Trust agreed supplier listlist	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk		01/12/2021	Chatzakis, Georgios	Trust Risk Register
IT3611CYBER	The risk of unauthorised and malicious access to the GHT and ICS network via an unpatched application (Office 2010) that is out of support and in wide use across the Trust.	Defence in depth approach; In addition to application security which is the gap to which this risk relates, NHSmail is protected by layered security solutions which aim to remove threats before the email is delivered. SBS blocks access to malicious sites MDE prevents malicious activity on devices, complimented by Sophos Central with InterceptX. Users are not permitted to install applications and we have limited numbers of privileged accounts.	Project approach	Business	Catastrophic (5)	Unlikely - Annually (2)	10	8 -12 High risk	S&T	17/01/2022	Turner, Thelma	Trust Risk Register
C1798COO	The risk of delayed follow up care due outpatient capacity constraints all specialities. (Rheumatology & Ophthalmology) Risk to both quality of care through patient experience impact(15)and safety risk associated with delays to treatment(4).	1. Speciality specific review administratively of patients (i.e. clearance of duplicates) (administrative validation) 2. Speciality specific clinical review of patients (clinical validation) 3. Utilisation of existing capacity to support long waiting follow up patients 4.Weekly review at Check and Challenge meeting with each service line, with specific focus on the three specialties 5.Do Not Breach DNB (or DNC)functionality within the report for clinical colleagues to use with 'urgent' patients.	1. Revise systems for reviewing patients waiting over time 2. Assurance from specialities through the delivery and assurance structures to complete the follow-up plan 3. Additional provision for capacity in key specialiities to support f/u clearance of backlog To resolve outstanding areas of concern	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Operating Officer	31/12/2021	Hardy-Lofaro, Neil	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	Monthly Audits of NEWS2. Assessing completeness, accuracy and evidence of escalation. Feeding back to ward teams Development of an Improvement Programme	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	King, Ben	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	Business	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	30/11/2021	Tyers, Candice	Trust Risk Register
C3084P&OD	The risk of inadequate quality and safety management as GHFT relies on the daily use of outdated electronic systems for compliance, reporting, analysis and assurance. Outdated systems include those used for Policy, Safety, Incidents, Risks, Alerts, Audits, Inspections, Claims, Complaints, Radiation, Compliance etc. across the Trust at all levels.	Risk Managers monitoring the system daily Risk Managers manually following up overdue risks, partially completed risks, uncontrolled risks and overdue actions Risk Assessments, inspections and audits held by local departments Risk Management Framework in place Risk management policy in place SharePoint used to manage policies and other documents	Prepare a business case for upgrade / replacement of DATIX Arrange demonstration of DATIX and Ulysis	Quality	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of People and OD	10/01/2022	Troake, Lee	Trust Risk Register
C2628COO	The risk of poor patient experience & outcomes resulting from the non-delivery of appointments within 18 weeks within the NHS Constitutional standards and the impact of Covid-19 in 2020/21.	The RTT standard is not being met and re-reporting took place in March 2019 (February data). RTT trajectory and Waiting list size (NHS I agreed) is being met by the Trust. The long waiting patients (52s)are on a continued downward trajectory and this is the area of main concern Controls in place from an operational perspective are: 1.The daily review of existing patient tracking list 2. Additional resource to support central and divisional validation of the patient tracking list. 3.Review of all patients at 45 weeks for action e.g. removal from list (DNA / Duplicates) or 1st OPA, investigations or TCI. 4. A delivery plan for the delivery to standard across specialities is in place 5. Additional non-recurrent funding (between cancer/ diagnostics and follow ups) to support the reduction in long waiting 6. Picking practice report developed by BI and theatres operations, reviewed with 2 specialities (Jan 2020) and issued to all service lines (Jan 2020) to implement. Reporting through Theatre Collaborative and PCDG. 7. PTL will be reviewed to ensure the management of our patients alongside the clinical review RAG rating	1.RTT and TrakCare plans monitored through the delivery and assurance structures To resolve outstanding areas of concern	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	09/12/2021	Hardy-Lofaro, Neil	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. Recruitment for the new post of Patient flow coordinator Weekly staffing review between matrons under daily huddle Use of the escalation policy; include use of non clinical midwives and on-call community midwives to support the service; closing the unit to new admissions when required to ensure safety Senior Midwives on-call rota to provide out of hours leadership support On-going staffing action plan including A rolling program of recruitment has started. Proactive recruiting into 50% maternity leave Circa 24 WTE midwives due to commence Sept/Oct 21 Bank incentive BBA support withdrawn for September Planned homebirths - letter sent to women to advise that homebirth service may not be supported during September Additional on-call ad hoc support for the free standing birth units Reduction of minimal staffing levels at Cheltenham birth unit to one midwife inline with Stroud model Short & long term sickness and absence management	Implement a rolling program of recruitment. review band incentives to support staff to undertake additional bank shifts as required.	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Chief Nurse	13/12/2021	Mortimore, Vivien	Trust Risk Register
		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	To review and update relevant retention policies									

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.	Temporary Staffing team. 3. Out of hours senior nurse covers Director of Nursing on call for support to all wards and departments and approval of agency staffing shifts. 4. Band 7 cover across both sites on Saturday and Sunday to manage staffing and escalate concerns. 5. Safe care live completed across wards 3 times daily shift by shift of ward acuity and dependency, reviewed shift by shift by divisional senior nurses. 6. Master Vendor Agreement for Agency Nurses with agreed KPI's relating to quality standards. 7. Facilitated approach to identifying poor performance of Bank and Agency workers as detailed in Temporary Staffing Procedure. 8. Long lines of agency approved for areas with known long term vacancies to provide consistency, continuity in workers supplied. 9. Robust approach to induction of temporary staffing with all Bank and Agency nurses required to complete a Trust local Induction within first 2 shifts worked. 10. Regular Monitoring of Nursing Metrics to identify any areas of concern. 11, Acute Care Response Team in place to support deteriorating patients. 12, Implementation of eObs to provide better visibility of deteriorating patients. 13, Agency induction programmes to ensure agency nurses are familiar with policy, systems and processes. 14, Increasing fill rate of bank staff who have greater familiarity with policy, systems and processes.	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	Safety	Moderate (3)	Almost certain - Daily (5)	15	15 - 25 Extreme risk	Director of Quality and Chief Nurse	06/12/2021	Holdaway, Matt	Trust Risk Register
C3295COOCOVID	The risk of patients experiencing harm through extended wait times for both diagnosis and treatment	Booking systems/processes: Two systems were implemented in response to the covid 19 pandemic. (1) The first being that a CAS system was implemented for all New Referrals. The motivation for moving to this model being to avoid a directly bookable system and the risk of patients being able to book into a face to face appointment. This triage system would allow an informed decision as to whether it should be face to face, telephone or video. To assist, specific covid-19 vetting outcomes were established to facilitate the intended use of the CAS and guidance sent out previously, with the expectation being that every referral be categorised as telephone, video or face to face. (2) The second system was to develop a RAG rating process for all patients that were on a waiting list, including for instance those cancelled during the pandemic, those booked in future clinics, and those unbooked. Guidance processes circulated advising Red = must be seen F2F; Amber = Telephone or Video and Green = can be deferred or discharged (with instructions required). Both systems were operational from end March. Activity: Recognising significant loss of elective activity during the pandemic services are required to undertake the above processes and closely review their PTLs. The review process creating both the opportunity of managing patients remotely; identifying the more urgent patients; and deferring or discharging those patients that can be managed in primary care. RTT delivery plans are also being sought to identify the actions available to provide adequate capacity to recover this position. The Clinical Harm Policy has also been reviewed and Divisions undertaking harm reviews as required. Harm reviews suspended aside from Cancer. The RAG process described above has moved into a P category status = all patients are now being validated under this prioritisation on the INPWL - a report has also been provided at speciality level to detail the volume completed	COVID T&F Group to develop Recovery Plan to minimise harm To resolve outstanding areas of concern	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	COO	10/12/2021	Hardy-Lofaro, Neil	Trust Risk Register
M2473Emer	The risk of poor quality patient experience during periods of overcrowding in the Emergency Department	Identified corridor nurse at GRH for all shifts; ED escalation policy in place to ensure timely escalation internally; Cubicle kept empty to allow patients to have ECG / investigations (GRH); Pre-emptive transfer policy Patient safety checklist up to 14 hours Monitoring Privacy & Dignity by Senior nurses	CQC action plan for ED Development of and compliance with 90% recovery plan Winter summit business case Liase with Tiff Cairns to discuss with Steve Hams to get ED corridor risks back up to TRR	Safety	Moderate (3)	Possible - Monthly (3)	9	8 -12 High risk	Director of Quality and Chief Nurse	19/11/2021	Ritsperis, Debra	Trust Risk Register
D&S3507RT	The Safety risk of Radiotherapy patients being cancelled or referred to alternative Trusts due to failure of Microselectron HDR or associated equipment that is past its 10yr life expectancy period.	Routine manufacturer maintenance and regular QA processes Service contract with manufacturer includes software only until July 2022 Stockpiled consumables for use and repair	To complete business case for replacement equipment To complete business case for replacement equipment Progress business case	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	30/04/2022	Moore, Bridget	Trust Risk Register
C2667NIC	The risk to patient safety and quality of care and/or outcomes as a result of hospital acquired C .difficile infection.	1. Annual programme of infection control in place 2. Annual programme of antimicrobial stewardship in place 3. Action plan to improve cleaning together with GMS 4. Trustwide CDI reduction plan launched in Oct 2021	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	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Bradley, Craig	Trust Risk Register
D&S3103Path	The risk of total shutdown of the Chem Path laboratory service on the GRH site due to ambient temperatures exceeding the operating temperature window of the instrumentation.	Air conditioning installed in some laboratory areas but not adequate. Cooler units installed to mitigate the increase in temperature during the summer period (now removed). *UPDATE* Cooler units now reinstalled as we return to summer months. Quality control procedures for lab analysis Temperature monitoring systems Contingency would be to transfer work to another laboratory in the event of total loss of service (however, ventilation and cooling in both labs in GHT is compromised, so there is a risk that if the ambient temperature in one lab is high enough to result in loss of service, the other lab would almost certainly be affected). Thus work may need to be transferred to N Bristol (compromising their capacity and compromising turnaround times).	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	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Operating Officer	15/12/2021	Rees, Linford	Trust Risk Register

S3316	The risk of not discharging our statutory duty as a result of the service's inability to see and treat patients within 18 weeks (Non-Cancer) due to a lack of capacity within the GI Physiology Service.	purchase of anopress machine for use by lower GI surgeons to reduce the numbers requiring GI phys Escalation of patients> 52 weeks to Head of GI physiology to review prioritisation Referral outside of Trust	to discuss alternative treatment options with upper GI surgeons review cost implications and resources for treatment option of bravo capsule Further individual being trained in GI Physiology by Bev Gray. Individual will work 35.5 hours per week total, not all will be GI Physiology, hours TBC. Will increase GI Physiology capacity by >100% Capital application form completed, Candice Tyers presenting to MEF VCPs have been submitted / await outcome of approval	Statutory	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk		01/12/2021	Blair, Shanara	Trust Risk Register
M3396Emer	The risk to patient safety relating to poorer outcomes and potential harm throughout their hospital stay as a result of spending longer than 8 hours in ED	UEC Improvement plan. Actions from UEC pathways and delivery group. POCT Huddles Increased transport provision to maximise green capacity at CGH. Whilst unsuccessful in adding to an ICS risk register we are proactively discussing the risk with system partners	UEC improvement plan Audit in department of 100 patients throughout DEc 2020 Reset culture towards zero tolerance of above 8 hour waits	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Medical Director	16/03/2022	Shaw, Ian	Trust Risk Register
C3565Path	The risk of reduced service quality in all clinical areas and operational flow due to lack of timely access to pathology reports, test status and results on SUNRISE EPR.	Medical staff telephoning microbiology to request verbal updates on blood cultures, growth, incubation etc. IMT leads aware. Weekly meeting in place to resolve any technical issues. Testing was completed before 'go live' of TCLE.	Action Plan on linked Pathology Risk	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Medical Director	08/12/2021	Moore, Philippa	Trust Risk Register
C3223COVID	The risk to safety from nosocomial COVID-19 infection through transmission between patients and staff leading to an outbreak and of acute respiratory illness or prolonged hospitalisation in unvaccinated individuals.	• 2m distancing implemented between beds where this is viable • Perspex screens placed between beds • Clear procedures in place in relation to infection control • COVID-19 actions card / training and support • Planning in relation to increasing green bed capacity to improve patient flow rate • Transmission based precautions in place • NHS Improvement COVID-19 Board Assurance Framework for Infection Prevention and Control • H&S team COVID Secure inspections • Hand hygiene and PPE in place • LFD testing – twice a week • 72 hour testing following outbreak • Regular screening of patients	CAFF inspections to be progressed	Safety	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	Chief Nurse	29/11/2021	Bradley, Craig	Trust Risk Register
C1945NTVN	The risk of moderate to severe harm due to insufficient pressure ulcer prevention controls	1. Evidence based working practices including, but not limited to; Nursing pathway, documentation and training including assessment of MUST score, Waterlow (risk) score, Anderson score (in ED), SSKIN bundle (assessment of at risk patients and prevention management), care rounding and first hour priorities. 2. Tissue Viability Nurse team cover both sites in Mon-Fri providing advice and training. 3. Nutritional assistants on several wards where patients are at higher risk (COTE and T&O) and dietician review available for all at risk of poor nutrition. 4. Pressure relieving equipment in place Trust wide throughout the patients journey - from ED to DWA once assessment suggests patient's skin may be at risk. 5. Trustwide rapid learning from the most serious pressure ulcers, RCAs completed within 72 hours and reviewed at the weekly Preventing Harm Improvement Hub.	1. To create a rolling action plan to reduce pressure ulcers 2. Amend RCSA for presure ulcers to obtain learning and facilitate sharing across divisions 3. Sharing of learning from incidents via matrons meetings, governance and quality meetings, Trust wide pressure ulcer group, ward dashboards and metric reporting. 4. NHS collabborative work in 2018 to support evidence based care provision and idea sharing Discuss DoC letter with Head of patient investigations Advise purchase of mirrors within Division to aid visibility of pressure ulcers update TVN link nurse list and clarify roles and responsibilities implement rolling programme of lunchtime teaching sessions on core topics TVN team to audit and validate waterlow scores on Prescott ward purchase of dynamic cushions share microteaches and workbooks to support react 2 red cascade learning around cheers for ears campaign Education and supprt to staff on 5b for pressure ulcer dressings Review pressure ulcer care for patients attending dilysis on ward 7a Proide training to 5b in the use of cavilon advance +	Safety	Major (4)	Possible - Monthly (3)	12	8 -12 High risk	Director of Quality and Chief Nurse	31/12/2021	Bradley, Craig	Trust Risk Register

			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									
IT3397	The risk of failure of the trust to manage the required move away from the use of Office 2010 and transfer to NHS Digital version of Office 365 or an alternative supported Microsoft office product ahead of the deadline when the product will cease to fully function. Causing widespread disruption to clinical and corporate core business functions	Dedicated Project Manager and two Business Analysts resource Project planning governance	Project approach	Quality	Major (4)	Likely - Weekly (4)	16	15 - 25 Extreme risk	CDIO	07/12/2021	Atherton, Andy	Trust Risk Register
W&C3257	The risk of not having a dedicated gynaecology bed base staffed by gynaecology nurses to keep women safe from avoidable harm and to provide the right care and treatment.	• Two specialist gynae nurses to support in-patient care and nursing staff regardless of patient location • Training provided to 2b staff • Written guidance provided to 2b staff • Alterations made to 2b day room to provide a mock-up of a treatment room to enable preparation of women attending for SMOM • Set up of emergency gynae assessment unit in out-patient setting- to improve flow through ED • Women attending for SMOM and genetic abnormality STOP pre-operatively seen in GOPD in order to provide emotional support and complete necessary documentation while 2b not available- staff beginning their shift early to facilitate this • Helpline for early pregnancy patients provided during EPA office hours • Women with hyperemesis admitted to maternity ward if there is capacity • Women who are having medical management of miscarriage given a choice of being admitted to Delivery suite if capacity allows and if patient in agreement • Checklist completed for theatre/2b/ED for completion of documents and consent forms for pregnancy loss/sensitive disposal • Patients who are stable and suitable to be transferred to SAU while awaiting an in-patient bed from GOPD after 17:00hr with gynae nursing support • Emergency contact details of gynaecology staff provided to SAU • Nurses from within gynaecology division staying after their contracted hours to stay with patients after 17:00hrs if no suitable bed to be transferred to- until such times that this can happen • Trial without catheter (TWOC)for post-operative patients taking place in GOPD	Identify suitable bed base with correct capacity both short and long term	Quality	Major (4)	Likely - Weekly (4)	16	16 - 25 Extreme risk	Director of Quality and Chief Nurse	28/02/2022	Hutchinson, Becky	Trust Risk Register

Report to Public Board of Directors

Agenda item:	9	Enclosure Number:	4
Date	10 March 2022		
Title	Quality Report		
Author /Sponsoring Director/Presenter	Neil Hardy-Lofaro, Deputy Chief Operating Officer Suzie Cro, Deputy Director of Quality Mark Pietroni, Medical Director Matt Holdaway, Director of Quality/Chief Nurse Qadar Zada, Chief Operating Officer		

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

Summary of Report

Purpose

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

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

Key issues to note:

Quality

Number of bed days lost due to infection control outbreaks

Covid

During January the Trust had 444 lost bed days due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways. Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients to prevent the onward transmissions of COVID-19 and hospital acquisition of COVID-19. Outbreak meetings continue to ensure review of all closed areas and weekend working for onsite Infection Prevention and Control Nurses continues.

MRSA

During January we have had a patient isolate MRSA in blood cultures sent 22/1/2022, the patient was admitted to GRH on 19/1/2022. The patient went from ED to DCC GRH and died on 24/1/2022. It was recognised the patient had a very poor prognosis on admission and was commenced on palliative care soon after admission this represents a hospital onset and healthcare associated case and therefore will be investigated. DCC are currently undertaking an investigation. This case has been escalated to our risk department for scoping for an SI. A rapid

review of the case was completed upon notification of the result and initial findings suggest missed opportunity to send blood cultures on admission, no MRSA decolonisation was commenced and antibiotics with MRSA cover were not started until 22/1/2022 despite a history of MRSA in 2019. This has been discussed with DCC and ED who are addressing as part of the investigation. The patient has been escalated to GHC and CCG to see if the patient had any other healthcare contact prior to admission.

Hospital standardised mortality ratio (HSMR)

HSMR is still significantly impacted by COVID, the modelling still classifies it is viral pneumonia which prior to COVID had a very low mortality. This continues to be monitored closely in HMG. The case mix is also a factor. Of note the SHMI is within the expected range but this excludes COVID cases.

Pressure ulcers acquired as in-patient

Category 2

The increase in the number of reported category 2 pressure ulcers is beginning to decline. There are two main contributory factors. The incidence of pressure damage in hospital is sensitive to nurse staffing levels, including safe RN to HCA ratios. Increases in pressure ulcers correlates with increased absence levels and use of temporary staffing. Wards with adverse RN to HCA rations are associated with a higher incidence of pressure damage. The Tissue Viability Team as a matter of course review and validate reported category 2 pressure ulcers however this work has been disrupted to absence in the team during the winter, including long-term sickness. Some validation work has not taken place

Deep Tissue Injuries

A reduction in deep tissue injuries has been observed with 6 deep tissue injuries reported across 6 wards. Evidence tells us this correlates with staffing challenges; specfically availability of staff, use of temporary workforce and RN to HCA rations.

Unstageable Pressure Ulcers

There were 9 unstageable pressure ulcers reported during January 2022. All of these cases are presented by ward leaders to the Preventing Harm Improvement Hub (PHIH) where rapid feedback is given on the results of the investigation. Themes from that process are late identification of pressure damage leading to possible progression to this later stage and incomplete or missing documentation. Although not identified through the review of cases at PHIH the Tissue Viability Team have received reports of equipment access delays and have taken actions to address this.

Falls Update

Number of falls per 1000 bed days

The number of falls per 1000 bed days is currently stable at a rate of 7.3 in January 2022 and a 12-month rolling average rate of 6.8. The incidence of falls is linked to the amount of access visitors have to our hospitals and it remains a focus for weekly reviews of the visiting policy in relation to the COVID-19 pandemic which has now been relaxed to allow limited visiting.

A Trust-wide falls plan is in place and the medical division has a specific improvement plan following a number of major harm falls within the division. The trust has invited a nearby Trust to carry out a peer-review of our improvement programme that is expected in the Spring.

Number of falls resulting in severe or moderate harm

There have been 4 falls resulting in moderate or major harm during January 2022. The rolling 12-month average of 5.1. Each case is discussed at the weekly preventing harm improvement hub where ward leaders present the case, discuss improvements required and hear rapid feedback. Some cases are then referred to the Serious Incident Panel. Two cases were on the Frailty Assessment Unit, one on Mayhill and the other on Ryeworth.

Improvements are required due to a lack of falls assessment documentation being completed, lack of supervision for high-risk patients and post-falls documentation of care.

% PALS concerns closed in 5 days

In January the team managed 666 calls, including an increasing number of complex cases. Recruitment is underway with a new advisor joining the team in March and an additional post out to recruitment. Bank administrative support is being put in to support the team in triaging calls so that advisors can focus on managing and resolving complex concerns rather than dealing with enquiries which can be signposted effectively at triage point.

Performance

Emergency Care

The Trust did not achieve the 95% operational standard for 4 hours; nor did it achieve the operational standard relating to 12hrs from DTA of 0%.

Attendances to the Emergency Department (ED) were up from January by 490 patients. Performance against the 4-hour standard improved slightly from 62.3% to 63.29. Performance against the 12hr DTA standard was not met. The process of validation against this standard has been improved as part of 'Perfect Week'

Ambulance handover delays increased for both delays over 30 minutes and delays over 60 minutes. Correcting this negative trend remains a priority for the Trust.

Scheduled Care

Validation of Januarys data is ongoing with a submission date of 17th February. RTT performance for January is estimated around 70.6% with approximately 1,279 >52 week waits.

Total incompletes has reduced significantly with around 58,833 in month and therefore within the H2 target of <60,248.

The total number of DNB patients has increased, albeit those unbooked have reduced in month

Validation / Prioritisation of the inpatient waiting list continues using the nationally prescribed P & D categories which demonstrates the categorisation at specialty level, to date. The total number of patients validated has remained static in month.

The validated diagnostic performance for January has deteriorated in month with a position of 20.8%

Challenged services remain unchanged with a focus on Echocardiography (Cardiology), Sleep studies and Urodynamics.

Elective care, measured by RTT performance is likely to be finalised just above 70% which is a reduction on last month. RTT incomplete pathways have reduced significantly, finishing the month 59,008 incomplete pathways. This is first time the Trusts has achieved the target set in September 2021 of less than 60,248 incompletes.

The number of 52-week breaches has again been reduced despite the operational challenges with a finalised position of 1,430 breaches in month. This is the lowest figure in 2021.

Cancer

The Trust met 5 of the 9 CWT metrics in November and exceeded national performance in all 9 of the CWT metrics.

The December performance (data as at 14/01/22) as shown in the QPR against the latest available national data is:

- 2ww: GHFT 92.1%, National 77.4%
- 28 Day: GHFT 80.4%, National 71.3%
- 31 day: GHFT 94.8%, National 93.0%
- 62 day: GHFT 56.3%, National 67.5%

The 62 day and 28 day figures are affected by the delays in pathology; there are still potential cancer treatments to be added to the November (8 treatments) and December (108 treatments).

The Trust performance for 62 urgent referrals in October has increased locally to 71.4% from a submitted position of 69.0% and November has increased locally to 71.3% from a submitted position of 70.9%; this improved data will be reflected in the national figures following the programmed data resubmission

The Trust fell short of the standard for 2-week wait with performance at 92.1%, with breaches attributed to an increased number of referrals, patient choice or COVID self-isolation factors.

The 62-day cancer wait standard was not achieved with a submitted position of 70.9%, although this has risen locally to 71.3%, with the addition of further treatments. The submitted data is affected by the current challenges with pathology, this is likely to increase further.

Recommendation

The Board is asked to receive the report as assurance that the Executive Team and Divisions fully understand the current levels of non-delivery against performance standards and have action plans to improve this position, alongside the plans to clinically prioritise those patients that need treatment, planned or unplanned, during the pandemic as the Trust moves forward to recovery.

Enclosures

- Quality Report

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report

Reporting Period January 2022

Presented at February 2022 Q&P and March 2022 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients. The Trust is phasing in the support for increasing elective activity continues into May and June and currently meets the gateway targets for elective activity.

During January, the Trust did not meet the national standards for 52 week waits, diagnostic or the 4 hour ED standard.

January continued to be a challenging month for the Emergency Department (ED) and saw and increase of 490 patients, compared to the previous month, the majority of these being walk in patients. Despite the increased attendances, January saw an increase in the ED four hour performance metric of 1.2% trust wide, however still sitting much below the target at 63.29%. Ambulance handover delays increased for both delays over 30 minutes and delays over 60 minutes. Correcting this negative trend remains a priority for the Trust, and the ED has implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.

The Trust did not meet the diagnostics standard in January with performance dipping for second successive months moving from 18.6% last month to a validated position of 20.8% this month. The total number of patients waiting has increased from 6,629 to 7,373. The overall number of breaches has increased by approximately 300 which is primarily attributable to Echos, which has increased from 1,073 last month to 1,478.

For cancer, in December's submitted data, the Trust met 5 of the 9 CWT metrics and exceeded national performance in 8 out of 9 of the CWT metrics.
The Trust fell just short of the standard for 2 week wait with performance at 92.3%, with breaches attributed to an increased number of referrals, patient choice or COVID self-isolation factors. The 62 day cancer wait standard was not achieved with a submitted position of 58%, although this has risen locally to 64.3%, with the addition of further treatments. The submitted data is affected by the current challenges with pathology where treatments are added post submission. >62 and >104 day numbers have been declining over last 6 weeks.

For elective care, the RTT performance in is likely to be finalised around 70.6% which is a slight improvement on last month. The total incompletes has improved again on last month with a further reduction made. With validation ongoing at the time of this report, the Trusts position is 58,833 with a further reductions anticipated prior to submission. The Trust therefore continues to achieve the H2 target set in September 2021 of less than 60,248 incompletes. The number of 52 week breaches has again been reduced despite the operational challenges with an anticipated month-end position of 1,279 breaches in month. This is the lowest figure since October 2020 and the most rapid rate of recovery in the South West region. Focus continues to be placed on patients over 78 weeks, which has again reduced in month, and specifically those patients at risk of breaching 104 weeks in this financial year. Currently the Trust has zero patients exceeding 104 weeks with 12 patients at risk of breaching before 31st March and services continue to finalise the plans in advance of this deadline.

The Elective Care Hub continues to make good progress and receive excellent feedback from our patients. A further 6 specialties have recently engaged with the hub, and rollout will continue to further specialties. To date approximately 8% of patients have indicated they do not wish to have treatment, for a variety of reasons. Directors Operational Assurance Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

Performance Against STP Trajectories

Gloucestershire Hospitals NHS Foundation Trust

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

Indicator		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Count of handover delays 30-60 minutes	Trajectory	40	40	40	40	40	40	40	40	40	40	40	40	40
	Actual	286	262	362	316	262	253	440	354	500	523	467	446	504
Count of handover delays 60+ minutes	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	336	219	382	237	85	117	475	294	692	752	1074	952	1057
ED: % total time in department – under 4 hours (types 1 & 3)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%
ED: % total time in department – under 4 hours (type 1)	Trajectory	86.19%	85.36%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%	85.79%
	Actual	68.58%	69.44%	69.97%	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%
Referral to treatment ongoing pathways under 18 weeks (%)	Trajectory	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%	81.00%
	Actual	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	70.25%
Referral to treatment ongoing pathways over 52 weeks (number)	Trajectory	0	0	0	0	0	0	0	0	0	0	0	0	0
	Actual	2234	2640	3061	2657	2263	2016	1724	1554	1598	1590	1492	1430	1280
% waiting for diagnostics 6 week wait and over (15 key tests)	Trajectory	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%	0.99%
	Actual	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%
Cancer – urgent referrals seen in under 2 weeks from GP	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	90.10%	97.00%	97.10%	94.80%	95.40%	92.80%	91.90%	93.50%	92.00%	93.40%	92.10%	92.30%	86.70%
2 week wait breast symptomatic referrals	Trajectory	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
	Actual	71.20%	97.00%	98.30%	93.60%	96.50%	90.70%	96.60%	93.20%	90.80%	89.80%	88.60%	84.90%	87.50%
Cancer – 31 day diagnosis to treatment (first treatments)	Trajectory	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
	Actual	97.10%	99.20%	99.00%	96.60%	98.30%	98.50%	98.30%	97.10%	95.90%	97.90%	96.30%	95.60%	93.70%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	Trajectory	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
	Actual	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	99.40%	100.00%	100.00%	100.00%	100.00%	100.00%	99.20%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	100.00%	100.00%	98.60%	98.10%	97.70%	100.00%	97.50%	98.50%	99.40%	100.00%	97.90%	100.00%	100.00%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	Trajectory	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
	Actual	96.20%	97.20%	97.60%	90.00%	95.60%	95.80%	94.00%	92.60%	88.10%	91.00%	95.10%	94.40%	92.00%
Cancer 62 day referral to treatment (screenings)	Trajectory	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
	Actual	93.10%	87.00%	86.70%	85.30%	90.60%	95.70%	92.00%	82.90%	90.80%	76.50%	81.80%	91.50%	85.50%
Cancer 62 day referral to treatment (upgrades)	Trajectory	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
	Actual	78.40%	93.30%	76.70%	90.80%	65.40%	70.60%	82.10%	63.60%	72.10%	87.10%	70.60%	73.10%	73.00%
Cancer 62 day referral to treatment (urgent GP referral)	Trajectory	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
	Actual	85.80%	82.00%	83.40%	82.00%	76.30%	80.30%	77.60%	72.10%	71.00%	69.00%	70.90%	61.90%	62.10%

Demand and Activity

Gloucestershire Hospitals NHS Foundation Trust

The table below shows monthly activity for key areas. The columns to the right show the percentage change in activity from:

1) The same month in the previous year
2) The same year to date (YTD) period in the previous year

Measure	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	% growth from previous year: Monthly (Jan)	% growth from previous year: YTD
GP Referrals	6,870	7,166	8,956	8,557	8,471	8,959	8,665	7,912	8,302	8,141	8,500	7,106	7,732	12.5%	18.2%
OP Attendances	45,549	46,059	57,846	50,410	51,179	54,944	52,155	47,542	52,893	49,477	56,355	47,298	50,972	11.9%	19.6%
New OP Attendances	13,617	13,532	17,948	15,998	16,328	17,228	16,158	14,661	16,656	15,948	18,280	15,334	16,297	19.7%	22.2%
FUP OP Attendances	31,932	32,527	39,898	34,412	34,851	37,716	35,997	32,881	36,237	33,529	38,075	31,964	34,675	8.6%	18.4%
Day cases	3,286	3,172	4,381	4,192	4,552	4,742	4,790	4,514	4,296	4,177	4,519	3,915	4,039	22.9%	30.7%
All electives	3,620	3,604	4,987	5,043	5,415	5,687	5,815	5,452	5,214	5,205	5,464	4,907	4,700	29.8%	31.6%
ED Attendances	8,289	8,021	10,687	11,063	11,930	11,976	12,295	12,006	13,186	13,044	11,988	10,943	11,433	37.9%	24.3%
Non Electives	3,569	3,381	4,108	4,018	4,398	4,642	4,531	4,333	4,244	3,998	3,866	3,446	3,472	-2.7%	12.9%

Trust Scorecard - Safe (1)

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

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Infection Control																		
COVID-19 community-onset – First positive specimen <=2 days after admission	640	485	116	39	3	6	22	95	92	72	119	108	114	139	341	770	No target	
COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	66	46	16	4	0	4	13	14	15	16	18	28	55	60	101	223	No target	
COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	48	41	5	2	0	1	1	5	3	1	1	1	21	19	23	53	No target	
COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	34	29	3	2	0	1	1	3	8	1	9	5	24	30	38	82	No target	
Number of trust apportioned MRSA bacteraemia	0	0	0	0	0	0	1	0	0	0	0	0	0	1	0	2	Zero	
MRSA bacteraemia – infection rate per 100,000 bed days	0.0	0.0	0.0	0.0	0.0	0.0	3.9	0.0	0.0	0.0	0.0	0.0	0.0	3.4	0.0	.7	Zero	
Number of trust apportioned Clostridium difficile cases per month	75	4	11	8	3	14	11	10	15	7	4	12	8	3	20	88	2020/21: 75	
Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	29	2	5	3	3	7	7	5	9	4	1	8	5	2	13	51	<=5	
Number of community-onset healthcare-associated Clostridioides difficile cases per month	46	2	6	5	0	7	4	5	6	3	3	4	3	1	7	37	<=5	
Clostridium difficile – infection rate per 100,000 bed days	22.7	19.2	21.8	30.9	13.5	60.2	42.6	34.9	51.1	23.5	13	40.6	27.3	10.2	26.8	31.3	<30.2	
Number of MSSA bacteraemia cases	18	1	2	3	1	2	2	2	5	5	0	2	5	3	7	28	<=8	
MSSA – infection rate per 100,000 bed days	6.4	3.8	5.9	11.6	4.5	8.6	7.7	7	17	16.8	0.0	6.8	17	10.2	7.8	10.1	<=12.7	
Number of ecoli cases	30	2	3	2	4	5	3	2	0	3	5	7	5	5	17	39	No target	
Number of pseudomona cases	6	0	1	1	1	2	0	0	1	1	0	1	0	0	1	6	No target	
Number of klebsiella cases	12	3	0	2	2	1	3	3	3	4	2	2	2	0	6	22	No target	
Number of bed days lost due to infection control outbreaks	9			0	0	6	161	15	60	1	93	176	453	444	722	1,409	<10	>30

Trust Scorecard - Safe (2)

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Patient Safety Incidents																		
Number of patient safety alerts outstanding	0	0	0	0	1	1	1	1	0	0	0	1	1		1		Zero	
Number of falls per 1,000 bed days	6.5	8.6	7.5	6.6	6.1	6.2	6.2	7.1	7.5	7	6.7	7	6.7	7.3	6.8	6.8	<=6	
Number of falls resulting in harm (moderate/severe)	18	4	6	6	4	2	3	9	5	5	5	3	9	5	15	48	<=3	
Number of patient safety incidents – severe harm (major/death)	19	4	3	10	7	2	1	9	3	6	7	10	7	7	24	59	No target	
Medication error resulting in severe harm	0	0	0	0	0	0	0	0	0	0	2	1	0	1	3	4	No target	
Medication error resulting in moderate harm	2	6	6	4	2	2	1	2	3	2	14	4	6	6	24	42	No target	
Medication error resulting in low harm	34	14	10	11	11	4	13	6	4	7	5	11	3	9	19	72	No target	
Number of category 2 pressure ulcers acquired as in-patient	79	27	19	29	16	22	17	24	27	19	22	41	43	37	106	268	<=30	
Number of category 3 pressure ulcers acquired as in-patient	2	0	1	1	1	0	1	0	3	0	1	2	4	2	7	14	<=5	
Number of category 4 pressure ulcers acquired as in-patient	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	Zero	
Number of unstagable pressure ulcers acquired as in-patient	14	2	3	1	4	3	4	3	5	1	4	9	9	12	22	54	<=3	
Number of deep tissue injury pressure ulcers acquired as in-patient	22	6	3	4	1	4	8	9	4	6	1	7	12	13	20	65	<=5	
RIDDOR																		
Number of RIDDOR	55	3	2	4	4	1	3	3	2			3	5		12		SPC	
Safeguarding																		
Number of DoLs applied for		32	46	29	54	73	57	55	59		53	48	68	64			No target	
Total attendances for infants aged < 6 months, all head injuries/long bone fractures	7	0	3	4	3	8	3	3	7	4	6	1	5	1	12	41	No target	
Total attendances for infants aged < 6 months, other serious injury		0	0	1	1	0	0	0	0	0	0		0	0			No target	
Total admissions aged 0-18 with DSH	30	6	9	15	13	26	15	13	11	18	35	39	18	46	92	234	No target	
Total ED attendances aged 0-18 with DSH	189	46	55	88	62	99	84	65	52	73	102	115	54	124	271	830	No target	
Total number of maternity social concerns forms completed			50	62	68	58	77	63	46		58	65	52	67			No target	
Total admissions aged 0-18 with an eating disorder										9	11		8	5			No target	

Trust Scorecard - Safe (3)

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Sepsis Identification and Treatment																		
Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	71.00%				70.00%												>=90%	<50%
Serious Incidents																		
Number of never events reported	2	0	2	0	0	2	0	0	1	0	1	1	2	1	4	9	Zero	
Number of serious incidents reported	13	2	5	4	4	3	2	4	4	6	4	4	4	4	12	37	No target	
Serious incidents – 72 hour report completed within contract timescale	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	>90%	
Percentage of serious incident investigations completed within contract timescale	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	>80%	
VTE Prevention																		
% of adult inpatients who have received a VTE risk assessment	91.2%	90.4%	89.2%	92.2%	89.9%	89.8%	89.3%	87.0%	87.1%	92.0%	92.3%	90.7%	90.9%	87.5%	91.3%	89.6%	>95%	

Trust Scorecard - Effective (1)

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Dementia Screening																		
% of patients who have been screened for dementia (within 72 hours)	68.0%	65.0%	69.0%	70.0%													>=90%	<70%
Maternity																		
% of women on a Continuity of Carer pathway	0.60%	0.00%	0.00%	0.00%		10.40%	9.70%	9.70%	10.80%	10.90%	11.80%	10.30%	9.60%	10.20%	9.70%	10.30%	No target	
% C-section rate (planned and emergency)	29.44%	28.12%	26.79%	31.67%	30.43%	28.88%	33.96%	29.04%	32.02%	30.42%	31.59%	31.63%	32.44%	33.26%	31.87%	31.36%	<=27%	>=30%
% emergency C-section rate	15.56%	15.65%	12.24%	17.71%	16.30%	17.72%	16.77%	15.58%	17.98%	16.76%	17.76%	17.05%	15.61%	17.81%	16.84%	16.94%	No target	
% of women booked by 12 weeks gestation	92.8%	94.2%	93.1%	93.6%	93.2%	91.9%	91.2%	91.8%	91.1%	88.5%	90.9%	91.6%	92.5%	90.8%	91.6%	91.4%	>90%	
% of women that have an induced labour	31.42%	33.91%	30.72%	30.63%	28.05%	27.92%	26.40%	25.90%	28.49%	25.54%	25.00%	25.66%	24.95%	29.49%	25.21%	26.69%	<=30%	>33%
% stillbirths as percentage of all pregnancies	0.39%	0.25%	0.23%	0.62%	0.00%	0.22%	0.42%	0.19%	0.00%	0.00%	0.19%	0.00%	0.00%	0.43%	0.06%	0.14%	<0.52%	
% of women smoking at delivery	10.90%	8.80%	9.24%	10.21%	9.42%	8.23%	9.56%	10.48%	8.19%	10.14%	10.07%	8.80%	11.86%	12.61%	10.20%	9.92%	<=14.5%	
% breastfeeding (discharge to CMW)	57.5%	58.5%	60.2%	56.7%	54.0%	48.7%	49.0%	51.1%	48.4%	53.9%	48.0%	50.3%	48.1%	47.1%	49.1%	50.1%		
% breastfeeding (initiation)	79.9%	81.1%	83.1%	82.4%	81.0%	75.9%	78.4%	78.5%	79.8%	80.8%	81.1%	79.5%	76.3%	78.8%	79.1%	79.1%	>=81%	
% PPH >1.5 litres	4.4%	3.9%	2.5%	5.2%	5.9%	5.0%	4.2%	5.2%	6.7%	4.9%	4.5%	3.4%	4.9%	3.6%	4.3%	4.8%	<=4%	
Number of births less than 27 weeks	19	2	1	3	2	0	2	0	0	1	2	2	0	1	4	10		
Number of births less than 34 weeks	104	6	7	10	7	15	13	8	11	18	13	9	10	7	32	110		
Number of births less than 37 weeks	379	23	27	29	28	44	34	41	33	47	49	32	44	33	125	384		
Number of maternal deaths	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0		
Total births	5,570	408	437	483	463	468	486	526	544	558	546	537	497	471	1,580	5,095		
Percentage of babies <3rd centile born > 37+6 weeks	1.7%		1.8%	1.0%	2.3%	1.5%	1.7%	1.9%	0.9%	1.4%	1.1%	1.9%	2.4%	3.2%	1.6%	1.8%		

Trust Scorecard - Effective (2)

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Mortality																		
Summary hospital mortality indicator (SHMI) – national data	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0						1.0	NHS Digital	
Hospital standardised mortality ratio (HSMR)	107.9	109.9	108.4	105.2	103.2	104.2	106.2	108.4	108.6	108.3	108.8					108.8	Dr Foster	
Hospital standardised mortality ratio (HSMR) – weekend	111.7	113	113.6	107.1	104.6	107.1	109.2	113.4	113.8	113.8	115.6					115.6	Dr Foster	
Number of inpatient deaths	565	277	159	129	145	154	146	182	156	163	183	191	189	217	563	1,726	No target	
Number of deaths of patients with a learning disability	19	2	1	0	2	4	0	4	2	2	2	4	1	3	7	21	No target	
Readmissions																		
Emergency re-admissions within 30 days following an elective or emergency spell	8.27%	8.96%	8.10%	7.90%	7.94%	7.84%	7.78%	8.40%	8.29%	7.81%	7.07%	7.25%	6.89%		7.08%	7.72%	<8.25%	>8.75%
Research																		
Research accruals	4,152	177	110	220	547	239	327	179	191	447	425	233	165	166	823	1,354	No target	
Stroke Care																		
Stroke care: percentage of patients receiving brain imaging within 1 hour	52.5%	56.1%	62.5%	54.4%	53.5%	48.9%				47.5%	51.9%	50.0%	45.8%	72.7%	48.4%	72.7%	>=43%	<25%
Stroke care: percentage of patients spending 90%+ time on stroke unit	86.0%	84.6%	88.4%	90.2%	83.1%	89.3%	91.8%	82.7%	91.8%	84.9%	66.7%	72.7%				88.2%	>=85%	<75%
% of patients admitted directly to the stroke unit in 4 hours	30.70%	24.40%	38.80%	49.20%	37.00%	44.10%				12.70%	15.10%	16.70%	8.70%	9.10%	12.30%	9.10%	>=75%	<55%
% patients receiving a swallow screen within 4 hours of arrival	52.30%	71.80%	74.60%	60.70%	63.20%	67.90%				44.60%	48.80%	40.50%	39.60%	54.50%	38.40%	54.50%	>=75%	<65%
Trauma & Orthopaedics																		
% of fracture neck of femur patients treated within 36 hours	67.6%	75.8%	61.5%	64.1%	84.4%	52.5%	66.3%	68.2%	60.7%	56.1%	43.5%	50.8%	47.9%	59.4%	47.5%	58.2%	>=90%	<80%
% fractured neck of femur patients meeting best practice criteria	67.58%	75.76%	61.54%	64.06%	84.44%	52.54%	66.27%	68.18%	59.02%	56.10%	43.55%	50.77%	47.95%	58.00%	47.50%	58.05%	>=65%	<55%

Trust Scorecard - Caring (1)

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Friends & Family Test																		
Inpatients % positive	88.4%	89.7%	89.4%	89.6%	88.3%	90.2%	89.7%	87.0%	85.4%	86.4%	85.0%	88.0%	87.8%	89.1%	86.9%	86.5%	>=90%	<86%
ED % positive	81.4%	87.2%	83.9%	77.5%	76.3%	73.6%	74.8%	62.7%	70.5%	60.9%	66.7%	68.0%	78.8%	78.6%	70.9%	67.5%	>=84%	<81%
Maternity % positive	92.9%	98.6%	92.9%	92.6%	96.2%	93.0%	89.2%	92.9%	84.8%	87.7%	82.4%	89.7%	84.3%	94.1%	85.6%	86.3%	>=97%	<94%
Outpatients % positive	94.0%	94.7%	94.7%	94.5%	94.4%	93.6%	94.3%	93.1%	93.7%	93.2%	93.3%	93.9%	94.7%	94.3%	94.1%	93.8%	>=94.5%	<93%
Total % positive	90.7%	93.2%	92.9%	92.1%	91.5%	91.1%	91.2%	90.7%	88.5%	86.2%	85.4%	89.4%	91.2%	91.0%	89.2%	88.1%	>=93%	<91%
Number of PALS concerns logged	2,394	137	204	262	256	275	191	241	238	264	274	248	230	266	754	1,465	No Target	
% of PALS concerns closed in 5 days	79%	86%	86%	83%	82%	85%	90%	85%	82%	76%	65%	78%	71%	65%	73%	83%	>=95%	<90%
MSA																		
Number of breaches of mixed sex accommodation	67	2	0	1	0	0	0	0	1	0	0	0	0	0	0	1	<=10	>=20

Trust Scorecard - Responsive (1)

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Cancer																		
Cancer – 28 day FDS two week wait	0.0%	0.0%	76.7%	78.8%	79.7%	77.9%	77.3%	79.5%	78.2%	78.5%	85.3%	79.6%	83.1%	75.5%	83.1%	75.5%	No target	
Cancer – 28 day FDS breast symptom two week wait	0.0%	0.0%	96.8%	100.0%	79.1%	77.7%	77.3%	79.9%	78.9%	78.3%	83.1%	78.9%	80.8%	92.1%	80.9%	79.5%	No target	
Cancer – 28 day FDS screening referral	0.0%	0.0%	83.0%	86.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	21.1%	0.0%	21.1%	No target	
Cancer – urgent referrals seen in under 2 weeks from GP	94.9%	90.1%	97.0%	97.1%	94.8%	95.4%	92.8%	91.9%	93.5%	92.0%	93.4%	92.1%	92.3%	86.7%	92.5%	92.5%	>=93%	<90%
2 week wait breast symptomatic referrals	89.7%	71.2%	97.0%	98.3%	93.6%	96.5%	90.7%	96.6%	93.2%	90.8%	89.8%	88.6%	84.9%	87.5%	86.9%	89.9%	>=93%	<90%
Cancer – 31 day diagnosis to treatment (first treatments)	98.5%	97.1%	99.2%	99.0%	96.6%	98.3%	98.5%	98.3%	97.1%	95.9%	97.9%	96.3%	95.6%	93.7%	96.3%	96.8%	>=96%	<94%
Cancer – 31 day diagnosis to treatment (subsequent – drug)	99.8%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	99.4%	100.0%	100.0%	100.0%	100.0%	100.0%	99.2%	100.0%	99.9%	>=98%	<96%
Cancer – 31 day diagnosis to treatment (subsequent – surgery)	97.1%	96.2%	97.2%	97.6%	90.0%	95.6%	95.8%	94.0%	92.6%	88.1%	91.0%	95.1%	94.4%	92.0%	93.7%	92.9%	>=94%	<92%
Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	99.5%	100.0%	100.0%	98.6%	98.1%	97.7%	100.0%	97.5%	98.5%	99.4%	100.0%	97.9%	100.0%	100.0%	99.7%	99.1%	>=94%	<92%
Cancer 62 day referral to treatment (urgent GP referral)	83.7%	85.8%	82.0%	83.4%	82.0%	76.3%	80.3%	77.6%	72.1%	71.0%	69.0%	70.9%	61.9%	62.1%	67.2%	72.7%	>=85%	<80%
Cancer 62 day referral to treatment (screenings)	88.8%	93.1%	87.0%	86.7%	85.3%	90.6%	95.7%	92.0%	82.9%	90.8%	76.5%	81.8%	91.5%	85.5%	78.9%	86.5%	>=90%	<85%
Cancer 62 day referral to treatment (upgrades)	80.5%	78.4%	93.3%	76.7%	90.8%	65.4%	70.6%	82.1%	63.6%	72.1%	87.1%	70.6%	73.1%	73.0%	73.1%	73.0%	>=90%	<85%
Number of patients waiting over 104 days with a TCI date	50	3	0	0	2	1	2	3	4	9	10	4	3	2	17	40	Zero	
Number of patients waiting over 104 days without a TCI date	269	14	14	12	14	10	11	9	12	18	21	23	25	14	69	157	<=24	
Diagnostics																		
% waiting for diagnostics 6 week wait and over (15 key tests)	19.48%	24.59%	20.33%	19.48%	15.11%	11.18%	11.39%	13.07%	20.19%	18.26%	18.83%	17.03%	18.60%	20.87%	20.87%	20.87%	<=1%	>2%
The number of planned / surveillance endoscopy patients waiting at month end	1,969	1,969	1,946	1,919	1,773	1,680	1,527	1,482	1,439	1,435	1,397	1,410	1,422	1,334	1,410	1,490	<=600	
Discharge																		
Patient discharge summaries sent to GP within 24 hours	57.2%	53.4%	59.3%	58.8%	61.1%	61.4%	62.2%	62.3%	61.1%	61.7%	60.5%	61.4%	58.5%		60.2%	61.2%	>=88%	<75%

Trust Scorecard - Responsive (2)

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Emergency Department																		
ED: % total time in department – under 4 hours (type 1)	69.37%	68.58%	69.44%	69.97%	64.75%	61.44%	69.52%	62.57%	66.85%	60.00%	62.17%	62.96%	61.97%	63.17%	62.37%	63.56%	>=95%	<90%
ED: % total time in department – under 4 hours (types 1 & 3)	78.93%	77.65%	78.58%	80.16%	78.43%	76.28%	78.32%	72.40%	75.27%	70.35%	72.81%	73.52%	72.23%	72.57%	72.87%	74.19%	>=95%	<90%
ED: % total time in department – under 4 hours CGH	99.81%	99.92%	100.00%	99.62%	99.73%	99.68%	94.75%	84.95%	88.74%	77.05%	83.00%	79.80%	79.03%	79.17%	80.72%	85.31%	>=95%	<90%
ED: % total time in department – under 4 hours GRH	69.37%	68.58%	69.44%	69.97%	64.75%	61.44%	63.34%	53.00%	57.55%	51.82%	52.48%	54.91%	53.96%	55.55%	53.74%	57.13%	>=95%	<90%
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	168	95	21	1	0	0	1	10	1	15	53	448	631	670	1,132	1,829	Zero	
ED: % of time to initial assessment – under 15 minutes	56.7%	64.5%	62.4%	46.3%	40.9%	47.3%	43.1%	7.1%	35.1%	28.0%	30.3%	30.3%	37.4%	35.5%	32.4%	33.3%	>=95%	<92%
ED: % of time to start of treatment – under 60 minutes	38.6%	48.9%	44.2%	26.4%	17.5%	15.1%	14.4%	1.9%	19.1%	19.5%	19.1%	24.9%	30.3%	29.5%	24.4%	19.0%	>=90%	<87%
% of ambulance handovers that are over 30 minutes	5.00%	8.14%	8.06%	9.82%	8.61%	6.66%	6.73%	11.91%	9.48%	13.85%	14.55%	14.21%	13.90%	15.56%	14.23%	11.38%	<=2.96%	
% of ambulance handovers that are over 60 minutes	3.67%	9.57%	6.74%	10.36%	6.45%	2.16%	3.11%	12.86%	7.88%	19.16%	20.92%	32.67%	29.68%	32.62%	27.53%	16.05%	<=1%	>2%
Operational Efficiency																		
Cancelled operations re-admitted within 28 days	74.29%	14.30%	76.50%	92.30%	92.00%	87.80%	87.50%	80.95%	89.06%	80.60%	73.75%	74.03%	80.23%	71.60%	76.13%	80.77%	>=95%	
Urgent cancelled operations	66	4	3	3	0	1	13	12	10	1	44	24	1	1	69	107	No target	
Number of patients stable for discharge	121	118	136	110	113	114	123	161	159	180	180	219	213	238	204	170	<=70	
Number of stranded patients with a length of stay of greater than 7 days	378	367	383	384	359	334	416	367	421	472	468	503	499	493	490	433	<=380	
Average length of stay (spell)	5.65	6.22	5.55	5.23	4.68	4.78	5.14	4.98	4.84	5.32	5.47	6.02	6.01	6.08	5.82	5.3	<=5.06	
Length of stay for general and acute non-elective (occupied bed days) spells	5.95	6.41	5.92	5.56	5.18	5.25	5.7	5.57	5.39	5.99	6.22	6.97	7	6.72	6.71	5.95	<=5.65	
Length of stay for general and acute elective spells (occupied bed days)	3.12	4.15	2.61	2.88	2.31	2.57	2.64	2.43	2.31	2.25	2.48	2.17	2.39	2.41	2.35	2.4	<=3.4	>4.5
% day cases of all electives	88.75%	90.75%	87.99%	87.83%	83.11%	84.04%	83.37%	82.36%	82.78%	82.37%	80.23%	82.69%	79.76%	85.91%	80.95%	82.66%	>80%	<70%
Intra-session theatre utilisation rate	85.36%	79.35%	85.64%	88.64%	90.44%	90.40%	88.17%	89.70%	89.45%	85.25%	87.93%	85.45%	83.06%	86.33%	85.55%	87.70%	>85%	<70%

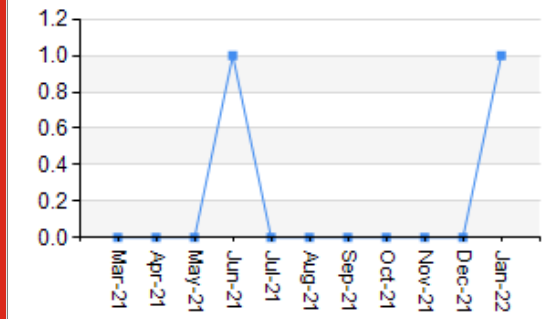
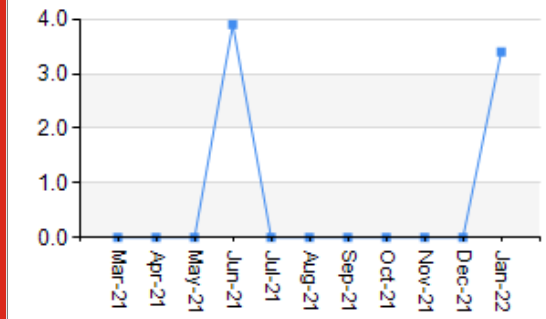
Trust Scorecard - Responsive (3)

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Outpatient																		
Outpatient new to follow up ratio's	2.15	2.14	2.23	2.09	2.06	2.02	2.04	2.1	2.13	1.99	1.93	1.93	1.94	1.93	1.93	2.01	<=1.9	
Did not attend (DNA) rates	5.96%	6.46%	5.80%	5.69%	5.89%	6.02%	6.72%	7.05%	7.24%	7.18%	7.20%	7.05%	7.28%	7.67%	7.17%	6.93%	<=7.6%	>10%
RTT																		
Referral to treatment ongoing pathways under 18 weeks (%)	66.59%	69.89%	69.23%	69.75%	70.03%	72.66%	74.45%	74.37%	74.39%	72.85%	72.04%	72.27%	70.03%	70.25%	71.45%	72.33%	>=92%	
Referral to treatment ongoing pathways 35+ Weeks (number)	6,337	6,628	6,415	6,474	6,541	6,426	6,159	5,713	5,582	5,642	5,593	5,642	5,847	5,366	5,694	5,851	No target	
Referral to treatment ongoing pathways 45+ Weeks (number)	2,881	4,787	4,306	3,747	3,572	3,657	3,320	2,854	2,906	2,946	2,935	2,641	2,605	2,328	2,727	2,976	No target	
Referral to treatment ongoing pathways over 52 weeks (number)	1,416	2,234	2,640	3,061	2,657	2,263	2,016	1,724	1,554	1,598	1,590	1,492	1,430	1,280	1,504	1,760	Zero	
Referral to treatment ongoing pathways 70+ Weeks (number)	127	243	304	459	608	667	745	806	611	403	295	228	205	205	243	477	No target	
SUS																		
Percentage of records submitted nationally with valid GP code	100.0%	100.0%	100.0%	100.0%													>=99%	
Percentage of records submitted nationally with valid NHS number	99.9%	99.9%	99.9%	99.9%													>=99%	

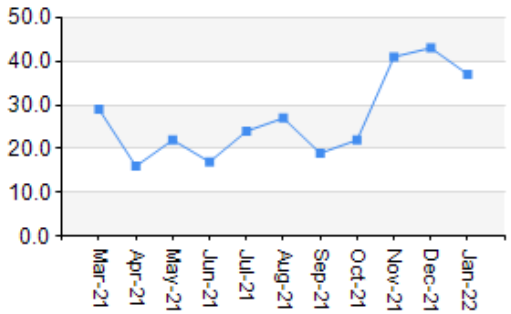
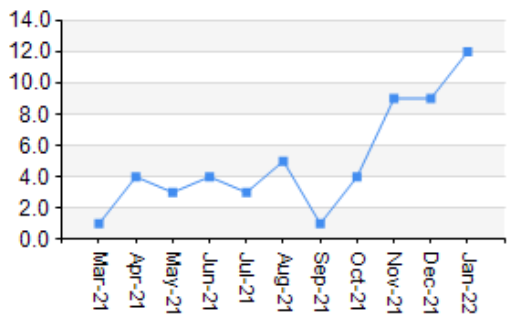
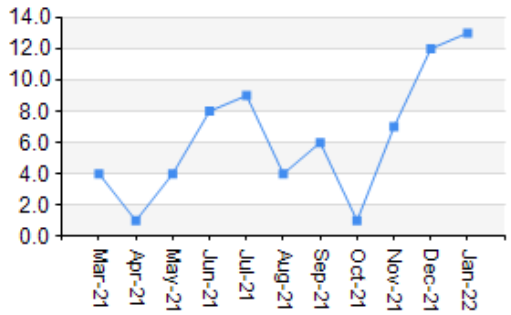
Trust Scorecard - Well Led (1)

	20/21	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	21/22 Q3	21/22	Standard	Threshold
Appraisal and Mandatory Training																		
Trust total % overall appraisal completion	83.0%	80.0%	80.0%	83.0%	85.0%	85.0%	84.0%	80.0%	79.0%	78.0%	78.0%	79.0%	80.0%	80.0%	80.0%		>=90%	<70%
Trust total % mandatory training compliance	90%	93%	92%	90%	91%	90%	91%	90%	90%	88%	87%	87%	87%	87%	87%		>=90%	<70%
Safe Nurse Staffing																		
Overall % of nursing shifts filled with substantive staff	94.82%	90.88%	95.00%	93.10%	98.29%	96.75%	91.64%	96.56%	97.22%	99.61%	97.11%	95.93%	89.16%		93.74%	95.52%	>=75%	<70%
% registered nurse day	93.97%	89.81%	93.14%	90.71%	96.38%	96.05%	90.72%	94.84%	95.11%	98.11%	95.49%	94.07%	87.59%		92.07%	94.01%	>=90%	<80%
% unregistered care staff day	104.90%	94.97%	95.53%	101.28%	106.08%	104.33%	95.67%	100.44%	98.32%	96.58%	95.82%	95.07%	84.77%		91.37%	97.19%	>=90%	<80%
% registered nurse night	96.36%	92.76%	98.22%	97.31%	101.83%	97.99%	93.27%	99.57%	101.09%	102.46%	100.10%	99.31%	91.99%		96.78%	98.25%	>=90%	<80%
% unregistered care staff night	113.19%	99.23%	113.17%	108.91%	111.13%	113.00%	103.77%	109.58%	111.39%	111.67%	105.90%	103.45%	94.98%		101.01%	106.91%	>=90%	<80%
Care hours per patient day RN	6	6.1	6.2	5.8	5.2	5.5	5.3	5.3	4.7	4.6	5	5.2	5.3		5.2	5.1	>=5	
Care hours per patient day HCA	3.7	3.6	3.9	3.7	3.7	3.5	3.5	3.5	3.3	3.5	3.2	3.2	3.2		3.2	3.4	>=3	
Care hours per patient day total	9.7	9.7	10.1	9.5	8.9	9	8.7	8.8	8	8.1	8.2	8.4	8.5		8.3	8.5	>=8	
Vacancy and WTE																		
% total vacancy rate		5.57%	4.36%	4.75%	4.30%	7.12%		7.00%	7.50%	6.82%	6.39%	7.37%	8.09%	11.16%			<=11.5%	>13%
% vacancy rate for doctors		1.77%	1.83%	0.73%	1.38%	4.15%		9.40%	7.80%	7.41%	6.74%	7.45%	7.05%	8.88%			<=5%	>5.5%
% vacancy rate for registered nurses		8.80%	5.08%	7.92%	7.24%	6.60%		8.50%	9.40%	7.89%	7.87%	8.17%	8.64%	14.46%			<=5%	>5.5%
Staff in post FTE		6560.89	6666.58	6653.99	6678.31	6672.09	6672.85	6680.26	6685.55	6730.66	6718.8	6686.83	6627.94	6648.33			No target	
Vacancy FTE		409.32	286.96	330.61	298.88	510		505.63	537.29	491.56	457.02	530.17	582.02	834.81			No target	
Starters FTE		50.64	48.84	67.2	86.69	50.85	56.53	36.05	36.53	79.76	42.43	59.94	70.65	77.03			No target	
Leavers FTE		50.03	34.82	45.79	36	57.02	62.03	52.16	78.84	68.51	89.94	66.53	81.1	88.76			No target	
Workforce Expenditure and Efficiency																		
% turnover		9.5%	9.5%	9.2%	9.2%	9.5%	10.0%	10.2%	10.7%	11.1%	11.7%	11.7%	12.3%	12.9%			<=12.6%	>15%
% turnover rate for nursing		9.83%	9.83%	9.86%	8.88%	8.96%	9.18%	9.80%	9.77%	9.72%	9.70%	10.52%	10.83%	10.99%			<=12.6%	>15%
% sickness rate		3.7%	3.7%	3.6%	3.7%	3.7%	3.6%	3.6%	3.8%	3.9%	3.8%	3.8%	3.8%	3.9%			<=4.05%	>4.5%

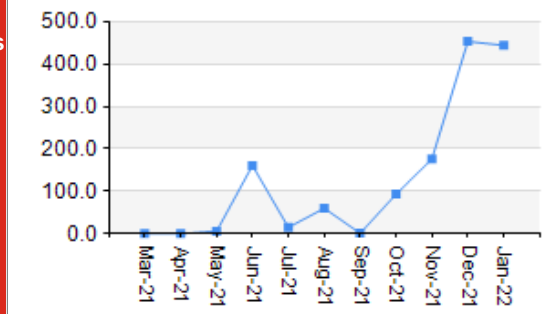
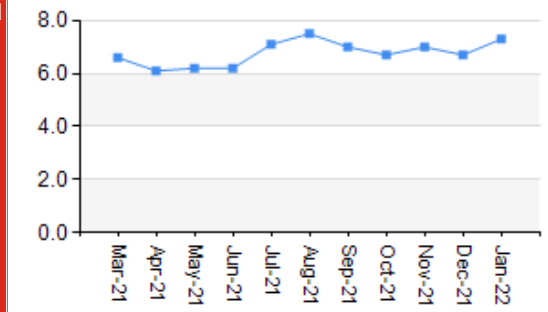
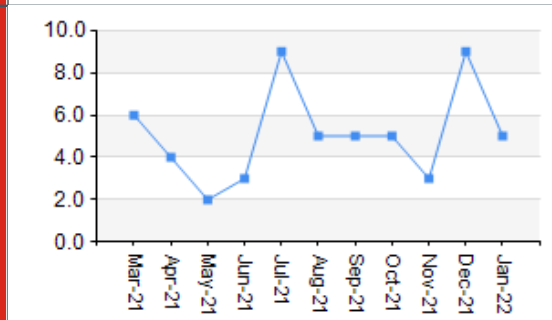
Exception Reports - Safe (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of trust apportioned MRSA bacteraemia **Standard: Zero**		During January we have had a patient isolate MRSA in blood cultures sent 22/1/2022, the patient was admitted to GRH on 19/1/2022. The patient went from ED to DCC GRH and died on 24/1/2022. It was recognised the patient had a very poor prognosis on admission and was commenced on palliative care soon after admission this represents a hospital onset and healthcare associated case and therefore will be investigated. DCC are currently undertaking an investigation. This case has been escalated to our risk department for scoping for an SI. A rapid review of the case was completed upon notification of the result and initial findings suggest missed opportunity to send blood cultures on admission, no MRSA decolonisation was commenced and antibiotics with MRSA cover were not started until 22/1/2022 despite a history of MRSA in 2019. This has been discussed with DCC and ED who are addressing as part of the investigation. The patient has been escalated to GHC and CCG to see if the patient had any other healthcare contact prior to admission.	**Associate Chief Nurse, Director of Infection Prevention & Control**
MRSA bacteraemia – infection rate per 100,000 bed days **Standard: Zero**			

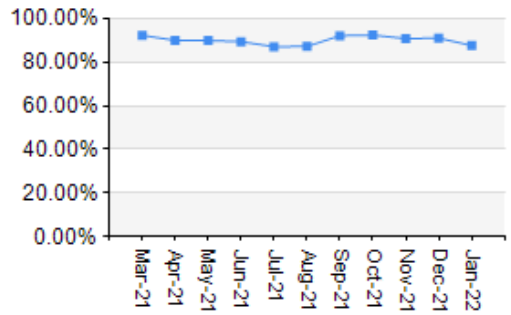
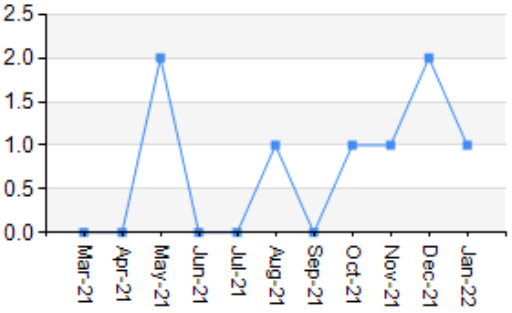
Exception Reports - Safe (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of category 2 pressure ulcers acquired as in-patient **Standard: <=30**		The increase in the number of reported category 2 pressure ulcers is beginning to decline. There are two main contributory factors. The incidence of pressure damage in hospital is sensitive to nurse staffing levels, incldiuing safe RN to HCA ratios. Increases in pressure ulcers correlates with increased abscence levels and use of temporary staffing. Wards with adverse RN to HCA rations are associated with a higher incidence of pressure damage. The Tissue Viability Team as a matter of course review and validate reported category 2 pressure ulcers however this work has been disrupted to absecence in the team during the winter, inlcuding long-term sickness. Some validation work has not taken place	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of unstagable pressure ulcers acquired as in-patient **Standard: <=3**		There were 9 unstageable pressure ulcers reported during January. All of these cases are presented by ward leaders to the Preventing Harm Improvement Hub (PHIH) where rapid feedback is given on the results of the investigation. Themes from that process are late identification of pressure damage leading to possible progression to this later stage and incomplete or missing documentation. Although not identified through the review of cases at PHIH the Tissue Viability Team have received reports of equipment access delays and have taken access to address this	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of deep tissue injury pressure ulcers acquired as in-patient **Standard: <=5**		A reduction in deep tissue injuries has been observed with 6 deep tissue injuries reported across 6 wards. Evidence tells us this correlates with staffing challenges; specfically availability of staff, use of temporary workforce and RN to HCA rations.	**Associate Chief Nurse, Director of Infection Prevention & Control**

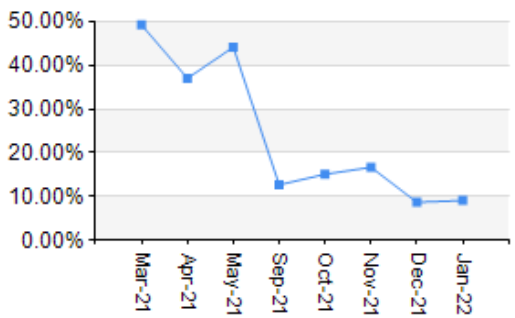
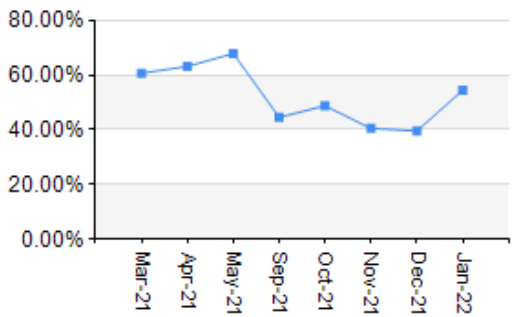
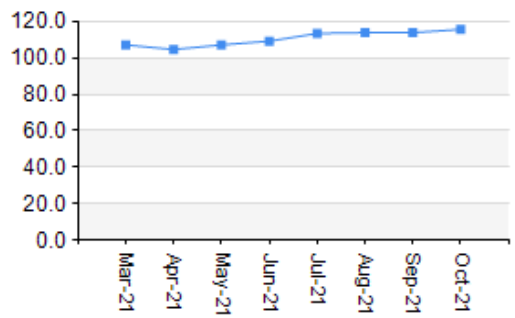
Exception Reports - Safe (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of bed days lost due to infection control outbreaks **Standard: <10**		During January we had lost 444 bed days due to COVID-19 outbreaks and/or COVID-19 positive patients being identified within low risk pathways. Wards and bays were closed at the agreement of the outbreak control management group to prevent the admission and transfer of new inpatients to prevent the onward transmissions of COVID-19 and hospital acquisition of COVID-19. Outbreak meetings continue to ensure review of all closed areas and weekend working for onsite IPC Nurses continues.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls per 1,000 bed days **Standard: <=6**		The number of falls per 1000 bed days is currently stable at a rate of 7.3 in January 2022 and a 12-month rolling average rate of 6.8. The incidence of falls is linked to the amount of access visitors have to our hospitals and it remains a focus for weekly reviews of the visiting policy in relation to the COVID-19 pandemic which has now been relaxed to allow limited visiting. Falls can be reduced where falls assessments are completed and interventions are put in place to prevent harm, whilst there have been improvements with falls assessments on admission there remains work to do and repeat assessments on current in-patients. A trustwide falls plan is in place and the medical division has a specific improvement plan following a number of major harm falls within the division. The trust has invited a nearby Trust to carry out a peer-review of our improvement programme that is expected in the Spring.	**Associate Chief Nurse, Director of Infection Prevention & Control**
Number of falls resulting in harm (moderate/severe) **Standard: <=3**		There have been 4 falls resulting in moderate or major harm during January 2022. The rolling 12-month average of 5.1. Each case is discussed at the weekly preventing harm improvement hub where ward leaders present the case, discuss improvements required and hear rapid feedback. Some cases are then referred to the Serious Incident Panel. Two cases were on the Frailty Assessment Unit, one on Mayhill and the other on Ryeworth. Improvements are required due to a lack of falls assessment documentation being completed, lack of supervision for high risk patients and post-falls documentation of care.	**Associate Chief Nurse, Director of Infection Prevention & Control**

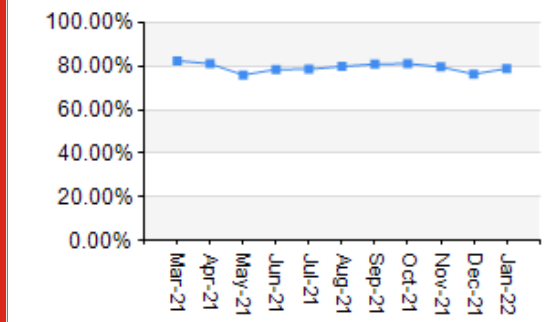
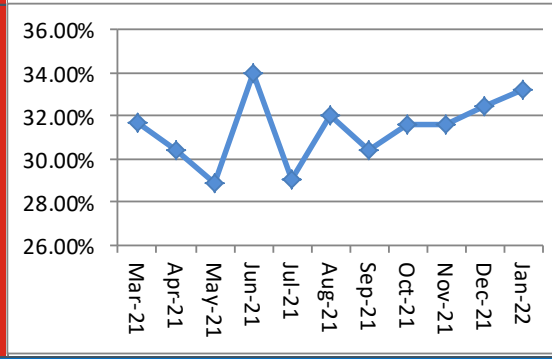
Exception Reports - Safe (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of adult inpatients who have received a VTE risk assessment **Standard: >95%**		The plan to incorporate the electronic capture of data with the new prescribing system is still in place. The VTE committee has just updated the policy which reflects the current NICE guidance	**Quality Improvement & Safety Director**
Number of never events reported **Standard: Zero**		Progress on improvement of systems in theatre to prevent wrong site and wrong implant Never Events continue with progress monitored at Divisional and at QDG levels with reports to QPC. External support is being provided by the CCG and potential the national safety team. Progress is shared with the CCQ, NHSIE regional team and the CCG Newer Never Events are currently undergo a barrier assessment investigation.	**Quality Improvement & Safety Director**

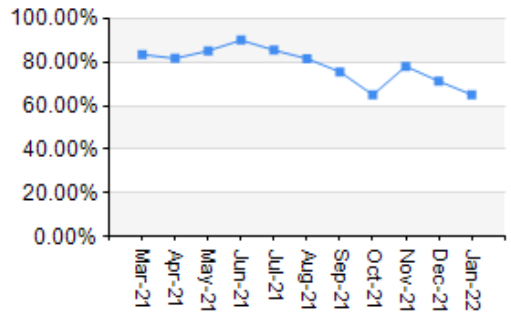
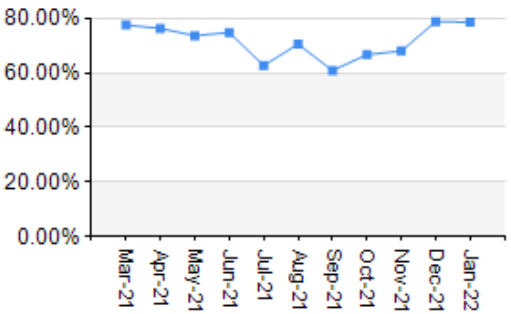
Exception Reports - Effective (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of patients admitted directly to the stroke unit in 4 hours **Standard: >=75%**		Slight improvement from previous month. Primarily, patients are delayed due to difficulty in maintain a ring fenced bed due to pressures in ED and the availability of HASU beds caused by issues with flow throughout the hospitals. The closure of HASU due to a COVID outbreak has also impacted performance. Other barriers include delays due to an unclear diagnosis leading to further tests before admission and delay in assessment as the Stroke team were not informed by ED.	**General Manager for COTE, Neuro and Stroke**
% patients receiving a swallow screen within 4 hours of arrival **Standard: >=75%**		16% improvement on previous month but still below target. The main contributing factors for this are the delays with being admitting to HASU within 4hrs, patients who are too unwell for swallow screen to be performed and patients who were located outside the unit and a delay in request for the swallow screen to be performed.	**General Manager for COTE, Neuro and Stroke**
Hospital standardised mortality ratio (HSMR) – weekend **Standard: Dr Foster**		See HSMR - metric still affected by COVID. The detail shows HSMR is higher if admitted on Sunday but the same if admitted Monday to Saturday, this may be related to case mix as significant amount elective work done on Saturdays with a very mortality which is not done on Sundays. Will continue to be monitored at the Hospital Mortality Group meetings.	**Deputy Medical Director**

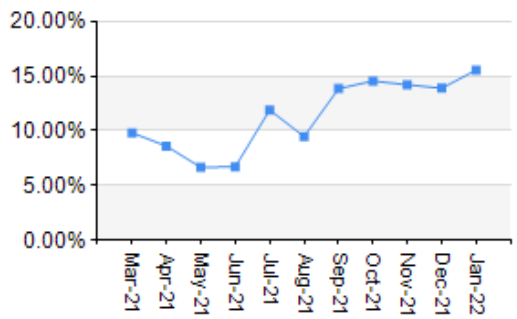
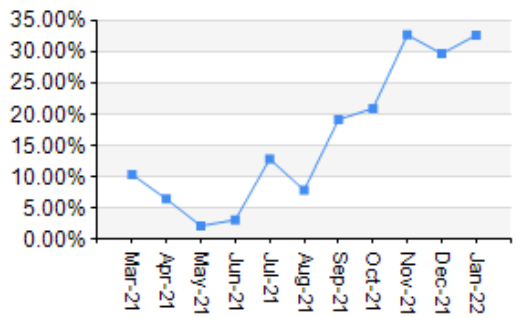
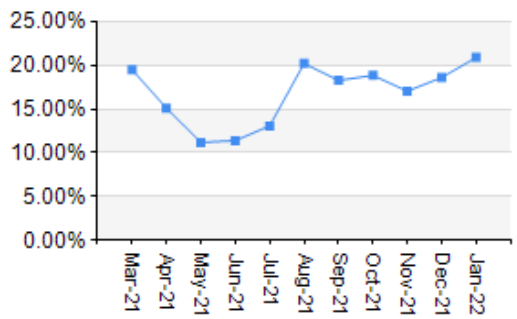
Exception Reports - Effective (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% breastfeeding (initiation) **Standard: >=81%**		Some of this decision is a personal choice element. Due to COVID antenatal classes, where feeding is discussed, is still not face to face, so this is a potential factor. Staff training has now been suspended as a result of COVID, this also includes the multi-professional training between health visitors and midwives. Covid related sickness absence within the team that deliver ongoing breast feeding support has also had an impact.	**Divisional Director of Quality and Nursing and Chief Midwife**
% C-section rate (planned and emergency) **Standard: <=27%**		We are offering LSCS or ongoing induction for women who have completed one course (24 hours) of prostaglandins or mechanical induction. This may increase our section rate. Work is ongoing with LMNS to improve benchmarking. We also offer women with ruptured membranes,who are not in established labour,the offer of an elective birth.	**Divisional Director of Quality and Nursing and Chief Midwife**

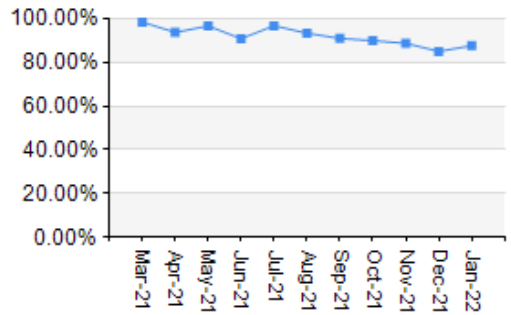
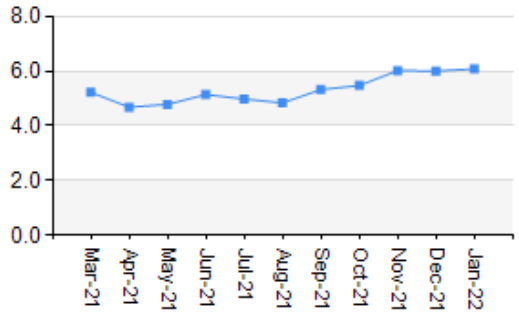
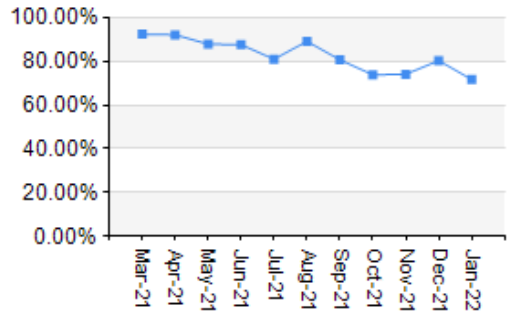
Exception Reports - Caring (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of PALS concerns closed in 5 days **Standard: >=95%**		In January the team managed 666 calls, including an increasing number of complex cases. Recruitment is underway with a new advisor joining the team in March and an additional post out to recruitment. Bank administrative support is being put in to support the team in triaging calls so that advisors can focus on managing and resolving complex concerns rather than dealing with enquiries which can be signposted effectively at triage point.	**Head of Quality**
ED % positive **Standard: >=84%**		ED FFT has shown a slight increase again this month, with an overall score of 78.6% (81.3% at CGH and 76.6% at GRH). Waiting times remain the key area of concern raised, but the Patient Experience lead is continuing to identify areas for improvement and is working with volunteers and patient experience team to implement and monitor changes.	**Head of Quality**

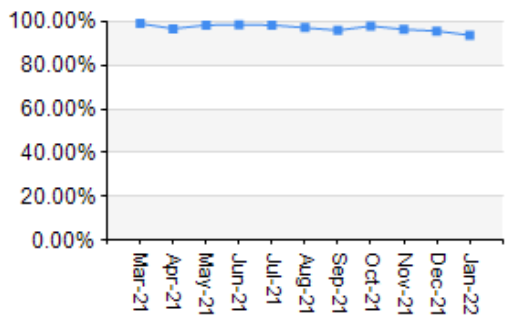
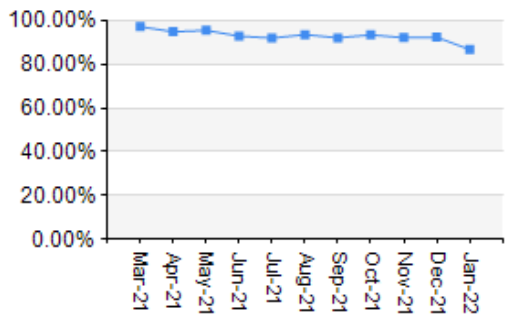
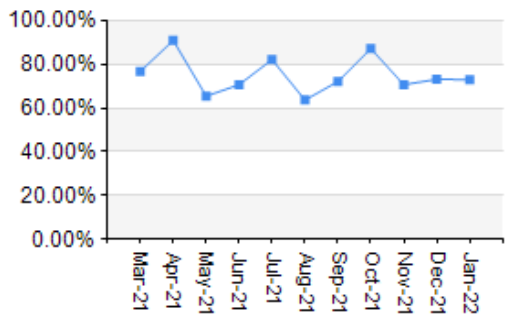
Exception Reports - Responsive (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% of ambulance handovers that are over 30 minutes **Standard: <=2.96%**		The number of 30 minute ambulance breaches have increased this month. Reduced flow and capacity throughout the hospital has limited the department's ability to create capacity for ambulance patients, resulting in increased handover delays.	**General Manager of Unscheduled Care**
% of ambulance handovers that are over 60 minutes **Standard: <=1%**		The number of 60 minute ambulance breaches have increased this month. Reduced flow and capacity throughout the hospital has limited the department's ability to create capacity for ambulance patients, resulting in increased handover delays.	**General Manager of Unscheduled Care**
% waiting for diagnostics 6 week wait and over (15 key tests) **Standard: <=1%**		Performance has dipped for successive months moving from 18.6% last month to a validated position of 20.8% this month. The total number of patients waiting has increased from 6,629 to 7,373. The overall number of breaches has increased by approximately 300 which is primarily attributable to Echos, which has increased from 1,073 last month to 1,478.	**Associate Director of Elective Care**

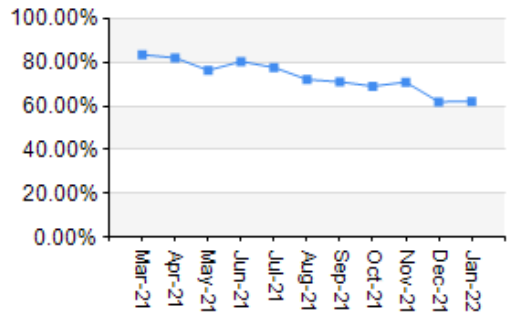
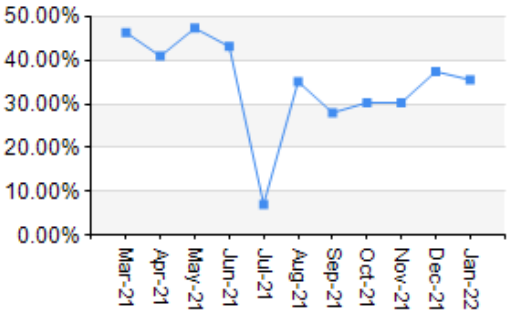
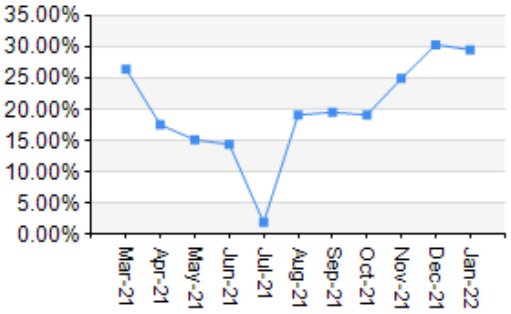
Exception Reports - Responsive (2)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
2 week wait breast symptomatic referrals **Standard: >=93%**		2ww breast symptoms performance (unvalidated) Standard = 93% National = 50% GHFT = 87.5% DFS = 120 Breaches = 15	**General Manager - Cancer**
Average length of stay (spell) **Standard: <=5.06**		Deterioration in month due mainly to reduced volume of discharges overall; Slight increase in patients unable to moveout of hospital due to C19 capacity. Note multiple moves contributes negatively to LoS in almost all cases. There has been a increase in overall volume of moves of IP to alternative wards. This is factor to be cognoscente of and minimise where possible.	**Deputy Chief Operating Officer**
Cancelled operations re-admitted within 28 days **Standard: >=95%**		Cancelled operations continue to be reviewed at specialty level and every effort made to reschedule within the 28 days. In December there were a total of 24 patients that could not be rescheduled within 28 days, which is an increase on the previous month. The predominant reasons this month were no bed capacity and staff sickness, but also there were 7 patients cancelled on the day at Tewkesbury due to a failed air conditioner unit.	**Associate Director of Elective Care**

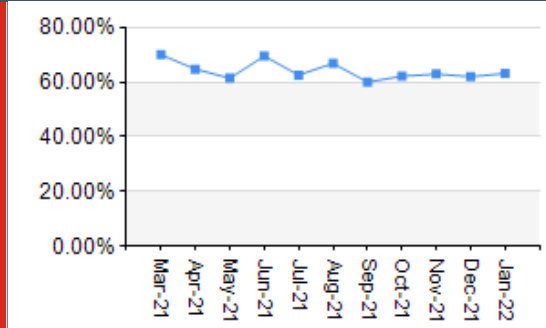
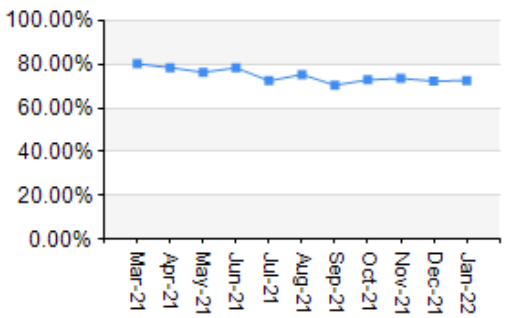
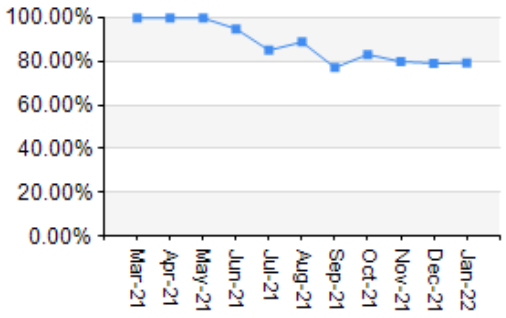
Exception Reports - Responsive (3)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer – 31 day diagnosis to treatment (first treatments) **Standard: >=96%**		31 day new performance (unvalidated) Standard = 96% National = 93% GHFT = 93.7% Treated = 286, Breaches = 18 Breast = 5 Urology = 5 Skin = 4 LGI = 3	**General Manager - Cancer**
Cancer – urgent referrals seen in under 2 weeks from GP **Standard: >=93%**		2ww Performance (unvalidated) Standard = 93% National = 78% GHFT = 86.7% DFS=2124 Breaches=282, Breast =94, LGI=45, Gynae=33, Urology= 27, Skin=49. Significant referrals received across most specialities. Outpatient capacity accounted for 158 breaches, patient choice 64.	**General Manager - Cancer**
Cancer 62 day referral to treatment (upgrades) **Standard: >=90%**		62 day upgrades performance (unvalidated) Standard = N/A National = 78% GHFT = 73.1% Treated= 19.5, Breaches=5	**General Manager - Cancer**

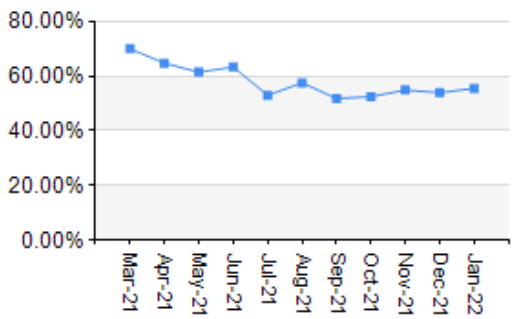
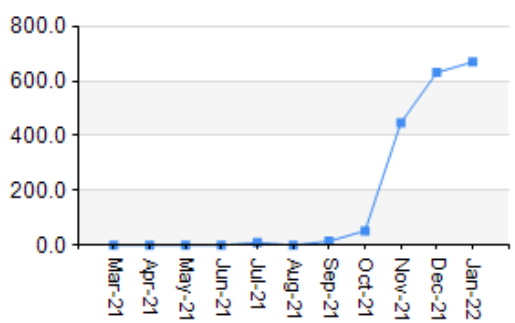
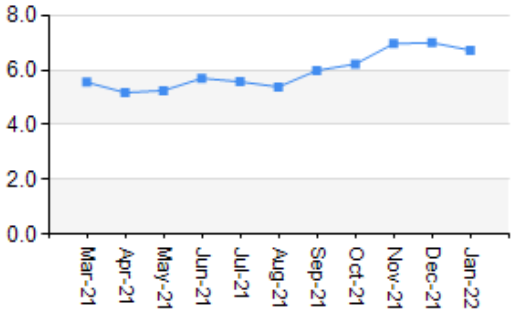
Exception Reports - Responsive (4)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Cancer 62 day referral to treatment (urgent GP referral) **Standard: >=85%**		62 day GP performance (unvalidated) Standard = 85% National = 67% GHFT = 61.8% Treatments =152, Breaches 58, LGI=12, Urology=20.5, Gynae=11.5, H&N=3 Impact of outstanding pathology relating to tx pathology and delayed diagnostic pathology from last few months, now at the treatment stage of their pathway	**General Manager - Cancer**
ED: % of time to initial assessment – under 15 minutes **Standard: >=95%**		Time to triage has increased this month for both walk in and ambulance patients. An increased number of patients visiting the department, combined with several vacancies in the nursing team, not always allowing for two triage nurses, have both been contributing factors.	**General Manager of Unscheduled Care**
ED: % of time to start of treatment – under 60 minutes **Standard: >=90%**		January saw a peak in doctor sickness, especially COVID related, meaning less doctors were on the shop floor at any given time. This, combined with increasing numbers of patients visiting the department, as well as limited space to access patients, has led to a negative increase in this metric.	**General Manager of Unscheduled Care**

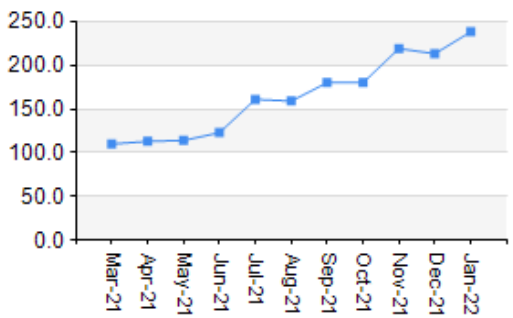
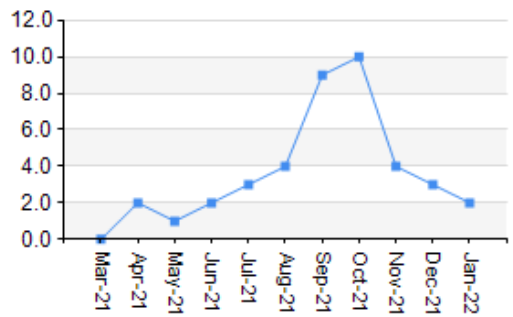
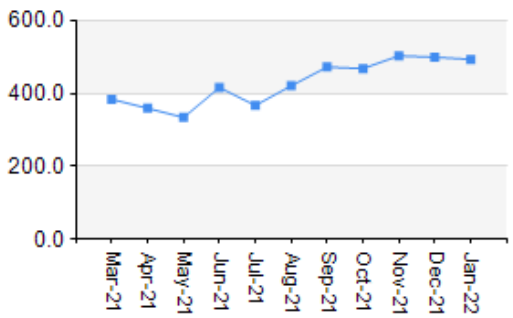
Exception Reports - Responsive (5)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours (type 1) **Standard: >=95%**		With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards	**General Manager of Unscheduled Care**
ED: % total time in department – under 4 hours (types 1 & 3) **Standard: >=95%**		With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards	**General Manager of Unscheduled Care**
ED: % total time in department – under 4 hours CGH **Standard: >=95%**		With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards	**General Manager of Unscheduled Care**

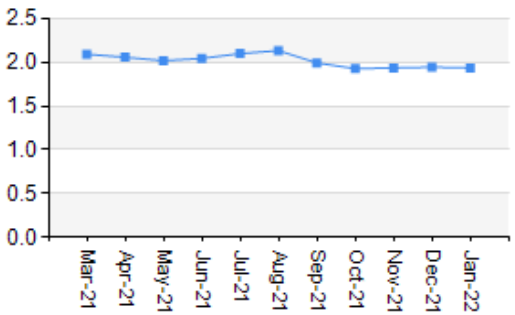
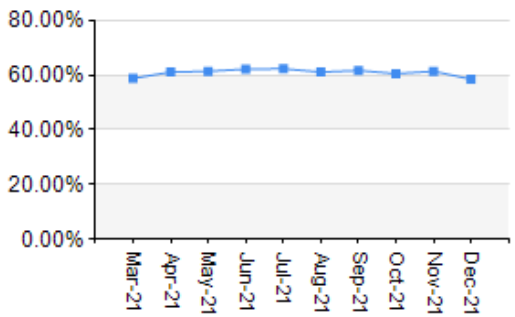
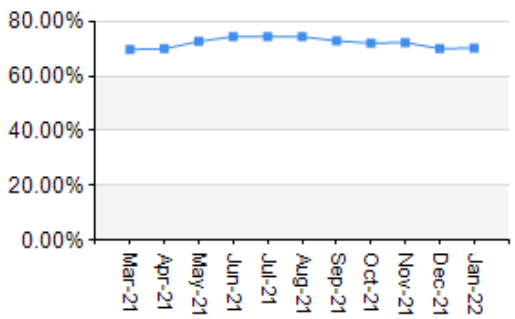
Exception Reports - Responsive (6)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
ED: % total time in department – under 4 hours GRH **Standard: >=95%**		With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards	**General Manager of Unscheduled Care**
ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission) **Standard: Zero**		With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards	**General Manager of Unscheduled Care**
Length of stay for general and acute non-elective (occupied bed days) spells **Standard: <=5.65**		Marginal deterioration from last month. Need to monitor impact of internal moves and reducing impact on C19 related delays.	**Deputy Chief Operating Officer**

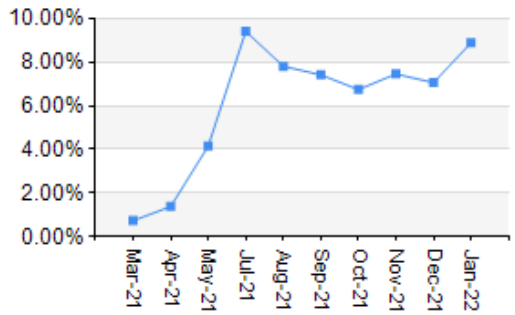
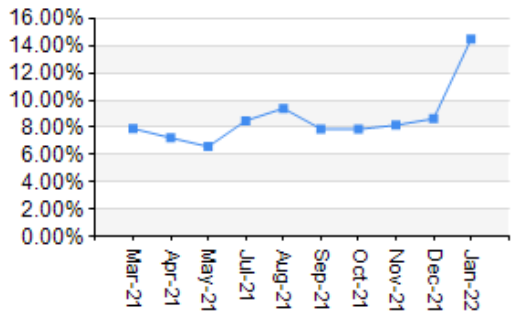
Exception Reports - Responsive (7)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Number of patients stable for discharge **Standard: <=70**		Numbers continuing to rise alongside ongoing issues within DomCare linked to staffing and COVID care home closures which has significantly reduced flow across all pathways.	**Head of Therapy & OCT**
Number of patients waiting over 104 days with a TCI date **Standard: Zero**		4 patients Urology 2 Lung 1 Lower GI 1	**General Manager - Cancer**
Number of stranded patients with a length of stay of greater than 7 days **Standard: <=380**		Flat line for this measure. No significant impact on additional capacity in a non acute setting. Patients delayed for Home First, D2A. C19 still impacting discharges to community due to staff sickness, closed nursing home capacity due to capacity and POC returned to GCC. Daily review and monitoring. Refocus on Check and Challenge for NEWS of 0-1; criteria to reside and criteria to admit. Planning for Perfect week.	**Deputy Chief Operating Officer**

Exception Reports - Responsive (8)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
Outpatient new to follow up ratio's **Standard: <=1.9**		The ratio generally remains consistent, being just over 1.9 for the past few months which is the lowest all year, and slightly over the target of <=1.9.	**Associate Director of Elective Care**
Patient discharge summaries sent to GP within 24 hours **Standard: >=88%**		Performance is stable at around 60% complete within 24 hours, unlikely to change significantly before implementation of electronic prescribing.	**Medical Director**
Referral to treatment ongoing pathways under 18 weeks (%) **Standard: >=92%**		See Planned Care Exception report for full details. RTT performance has improved slightly in month with an anticipated month-end position around 70.6%. Many of the same factors experienced in December have continued including; a particular focus on reducing incompletes (majority being <18 weeks); staff absence/sickness; and operational challenges through COVID.	**Associate Director of Elective Care**

Exception Reports - Well Led (1)

Metric Name & Standard	Trend Chart	Exception Notes	Owner
% vacancy rate for doctors **Standard: <=5%**		Hard to fill medical vacancies continue to be closely managed through Divisions. The workforce plans for 2022/23 will ensure proactive recruitment interventions are in place for both known and forecast vacancies, supported by alternative roles such as SAS Doctors and Physicians Associates.	**Director of Human Resources and Operational Development**
% vacancy rate for registered nurses **Standard: <=5%**		Staff Nurse/ODP establishment has increased by 37.25fte since November. The Trust's planned pipeline of international registered nurses continue to be recruited in year. 25 newly appointed nurses arrived early February 2022 bringing the total cohort to date for 21/22 to 103. Planning for ongoing overseas recruitment is in place for 2022/23, which includes the recruitment of international midwives in partnership with NHS partners in Swindon and Salisbury.	**Director of Human Resources and Operational Development**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Quality and Performance Report Statistical Process Control Reporting

Reporting Period January 2022

Presented at February 2022 Q&P and March 2022 Trust Board

Contents

Gloucestershire Hospitals NHS Foundation Trust

Guidance

Gloucestershire Hospitals NHS Foundation Trust

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

How to interpret variation results:

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

How to interpret assurance results:

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

Source: NHSI Making Data Count

Executive Summary

Gloucestershire Hospitals NHS Foundation Trust

The key areas of focus remain the assurance of patient care and safety as we continue with restoration and recovery of services. For elective care (Cancer; Screening and RTT), all patients are being reviewed and clinically prioritised and national guidance enacted. We are ensuring that we are tracking all patients and that our waiting list size is consummate with those patients requiring secondary care opinion. For unscheduled care the approach has equally been to support the safety and care of our patients to enable them to access specialist emergency care as they need to. Teams across the hospital have supported each other to offer the best care for all our patients. The Trust is phasing in the support for increasing elective activity continues into May and June and currently meets the gateway targets for elective activity.

During January, the Trust did not meet the national standards for 52 week waits, diagnostic or the 4 hour ED standard.

January continued to be a challenging month for the Emergency Department (ED) and saw and increase of 490 patients, compared to the previous month, the majority of these being walk in patients. Despite the increased attendances, January saw an increase in the ED four hour performance metric of 1.2% trust wide, however still sitting much below the target at 63.29%. Ambulance handover delays increased for both delays over 30 minutes and delays over 60 minutes. Correcting this negative trend remains a priority for the Trust, and the ED has implemented a number of actions from 1st November, aimed at reducing the number of handover breaches and increasing ambulance availability.

The Trust did not meet the diagnostics standard in January with performance dipping for second successive months moving from 18.6% last month to a validated position of 20.8% this month. The total number of patients waiting has increased from 6,629 to 7,373. The overall number of breaches has increased by approximately 300 which is primarily attributable to Echos, which has increased from 1,073 last month to 1,478.

For cancer, in December's submitted data, the Trust met 5 of the 9 CWT metrics and exceeded national performance in 8 out of 9 of the CWT metrics.
The Trust fell just short of the standard for 2 week wait with performance at 92.3%, with breaches attributed to an increased number of referrals, patient choice or COVID self-isolation factors. The 62 day cancer wait standard was not achieved with a submitted position of 58%, although this has risen locally to 64.3%, with the addition of further treatments. The submitted data is affected by the current challenges with pathology where treatments are added post submission. >62 and >104 day numbers have been declining over last 6 weeks.

For elective care, the RTT performance in is likely to be finalised around 70.6% which is a slight improvement on last month. The total incompletes has improved again on last month with a further reduction made. With validation ongoing at the time of this report, the Trusts position is 58,833 with a further reductions anticipated prior to submission. The Trust therefore continues to achieve the H2 target set in September 2021 of less than 60,248 incompletes. The number of 52 week breaches has again been reduced despite the operational challenges with an anticipated month-end position of 1,279 breaches in month. This is the lowest figure since October 2020 and the most rapid rate of recovery in the South West region. Focus continues to be placed on patients over 78 weeks, which has again reduced in month, and specifically those patients at risk of breaching 104 weeks in this financial year. Currently the Trust has zero patients exceeding 104 weeks with 12 patients at risk of breaching before 31st March and services continue to finalise the plans in advance of this deadline.

The Elective Care Hub continues to make good progress and receive excellent feedback from our patients. A further 6 specialties have recently engaged with the hub, and rollout will continue to further specialties. To date approximately 8% of patients have indicated they do not wish to have treatment, for a variety of reasons. Directors Operational Assurance Group will review the Unscheduled and Scheduled performance indicators with the Divisions and the wider Executive team.

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Cancer	Cancer – 28 day FDS two week wait	No target	Jan-22	75.5%
Cancer	Cancer – 28 day FDS breast symptom two week wait	No target	Jan-22	92.1%
Cancer	Cancer – 28 day FDS screening referral	No target	Jan-22	21.1%
Cancer	Cancer – urgent referrals seen in under 2 weeks from GP	>=93%	Jan-22	86.7%
Cancer	2 week wait breast symptomatic referrals	>=93%	Jan-22	87.5%
Cancer	Cancer – 31 day diagnosis to treatment (first treatments)	>=96%	Jan-22	93.7%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – drug)	>=98%	Jan-22	99.2%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – surgery)	>=94%	Jan-22	92.0%
Cancer	Cancer – 31 day diagnosis to treatment (subsequent – radiotherapy)	>=94%	Jan-22	100.0%
Cancer	Cancer 62 day referral to treatment (urgent GP referral)	>=85%	Jan-22	62.1%
Cancer	Cancer 62 day referral to treatment (screenings)	>=90%	Jan-22	85.5%
Cancer	Cancer 62 day referral to treatment (upgrades)	>=90%	Jan-22	73.0%
Cancer	Number of patients waiting over 104 days with a TCI date	Zero	Jan-22	2
Cancer	Number of patients waiting over 104 days without a TCI date	<=24	Jan-22	14
Diagnostics	% waiting for diagnostics 6 week wait and over (15 key tests)	<=1%	Jan-22	20.87%
Diagnostics	The number of planned / surveillance endoscopy patients waiting at month end	<=600	Jan-22	1,334
Discharge	Patient discharge summaries sent to GP within 24 hours	>=88%	Dec-21	58.50%
Emergency Department	ED: % total time in department – under 4 hours (type 1)	>=95%	Jan-22	63.17%
Emergency Department	ED: % total time in department – under 4 hours (types 1 & 3)	>=95%	Jan-22	72.57%
Emergency Department	ED: % total time in department – under 4 hours CGH	>=95%	Jan-22	79.17%
Emergency Department	ED: % total time in department – under 4 hours GRH	>=95%	Jan-22	55.55%

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Emergency Department	ED: number of patients experiencing a 12 hour trolley wait (>12hours from decision to admit to admission)	Zero	Jan-22	670
Emergency Department	ED: % of time to initial assessment – under 15 minutes	>=95%	Jan-22	35.5%
Emergency Department	ED: % of time to start of treatment – under 60 minutes	>=90%	Jan-22	29.5%
Emergency Department	% of ambulance handovers that are over 30 minutes	<=2.96%	Jan-22	15.56%
Emergency Department	% of ambulance handovers that are over 60 minutes	<=1%	Jan-22	32.62%
Maternity	% of women booked by 12 weeks gestation	>90%	Jan-22	90.8%
Operational Efficiency	Number of patients stable for discharge	<=70	Jan-22	238
Operational Efficiency	Number of stranded patients with a length of stay of greater than 7 days	<=380	Jan-22	493
Operational Efficiency	Average length of stay (spell)	<=5.06	Jan-22	6.08
Operational Efficiency	Length of stay for general and acute non-elective (occupied bed days) spells	<=5.65	Jan-22	6.7247
Operational Efficiency	Length of stay for general and acute elective spells (occupied bed days)	<=3.4	Jan-22	2.4
Operational Efficiency	% day cases of all electives	>80%	Jan-22	85.9%
Operational Efficiency	Intra-session theatre utilisation rate	>85%	Jan-22	86.3%
Operational Efficiency	Cancelled operations re-admitted within 28 days	>=95%	Jan-22	71.6%
Operational Efficiency	Urgent cancelled operations	No target	Jan-22	1
Outpatient	Outpatient new to follow up ratio's	<=1.9	Jan-22	1.93
Outpatient	Did not attend (DNA) rates	<=7.6%	Jan-22	7.7%
Readmissions	Emergency re-admissions within 30 days following an elective or emergency spell	<8.25%	Dec-21	6.9%
Research	Research accruals	No target	Jan-22	166

Access Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

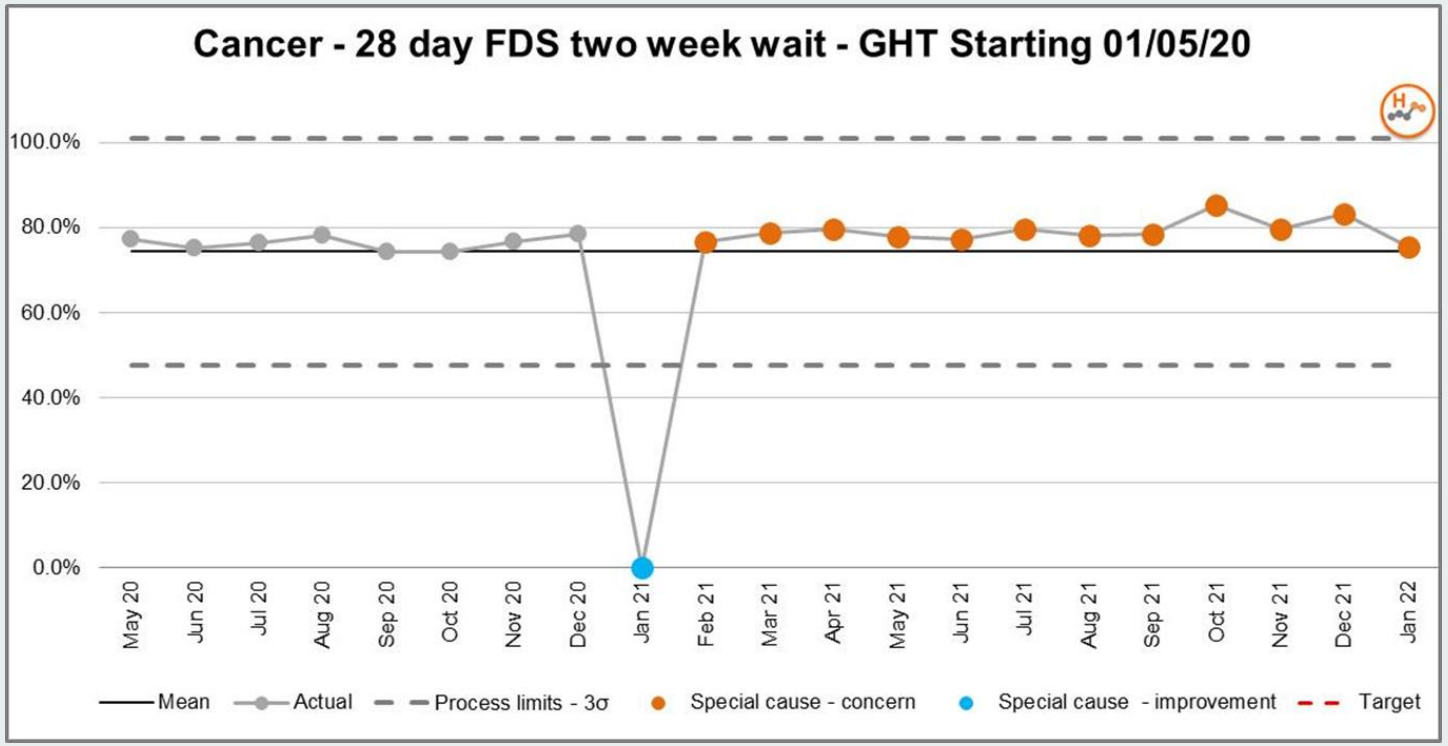
Key

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

MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
RTT	Referral to treatment ongoing pathways under 18 weeks (%)	>=92%		Jan-22	70.25%	
RTT	Referral to treatment ongoing pathways 35+ Weeks (number)	No target		Jan-22	5,366	
RTT	Referral to treatment ongoing pathways 45+ Weeks (number)	No target		Jan-22	2,328	
RTT	Referral to treatment ongoing pathways over 52 weeks (number)	Zero		Jan-22	1,280	
RTT	Referral to treatment ongoing pathways 70+ Weeks (number)	No target		Jan-22	205	
Stroke Care	Stroke care: percentage of patients receiving brain imaging within 1 hour	>=43%		Jan-22	72.7%	
Stroke Care	Stroke care: percentage of patients spending 90%+ time on stroke unit	>=85%		Nov-21	72.7%	
Stroke Care	% of patients admitted directly to the stroke unit in 4 hours	>=75%		Jan-22	9.1%	
Stroke Care	% patients receiving a swallow screen within 4 hours of arrival	>=75%		Jan-22	54.5%	
SUS	Percentage of records submitted nationally with valid GP code	>=99%		Mar-21	100.00%	
SUS	Percentage of records submitted nationally with valid NHS number	>=99%		Mar-21	99.9%	
Trauma & Orthopaedics	% of fracture neck of femur patients treated within 36 hours	>=90%		Jan-22	59.40%	
Trauma & Orthopaedics	% fractured neck of femur patients meeting best practice criteria	>=65%		Jan-22	58.0%	

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

28 day FDS (GP referral)
Standard = 75%
National = 70.5% (all routes)
GHFT = 76%

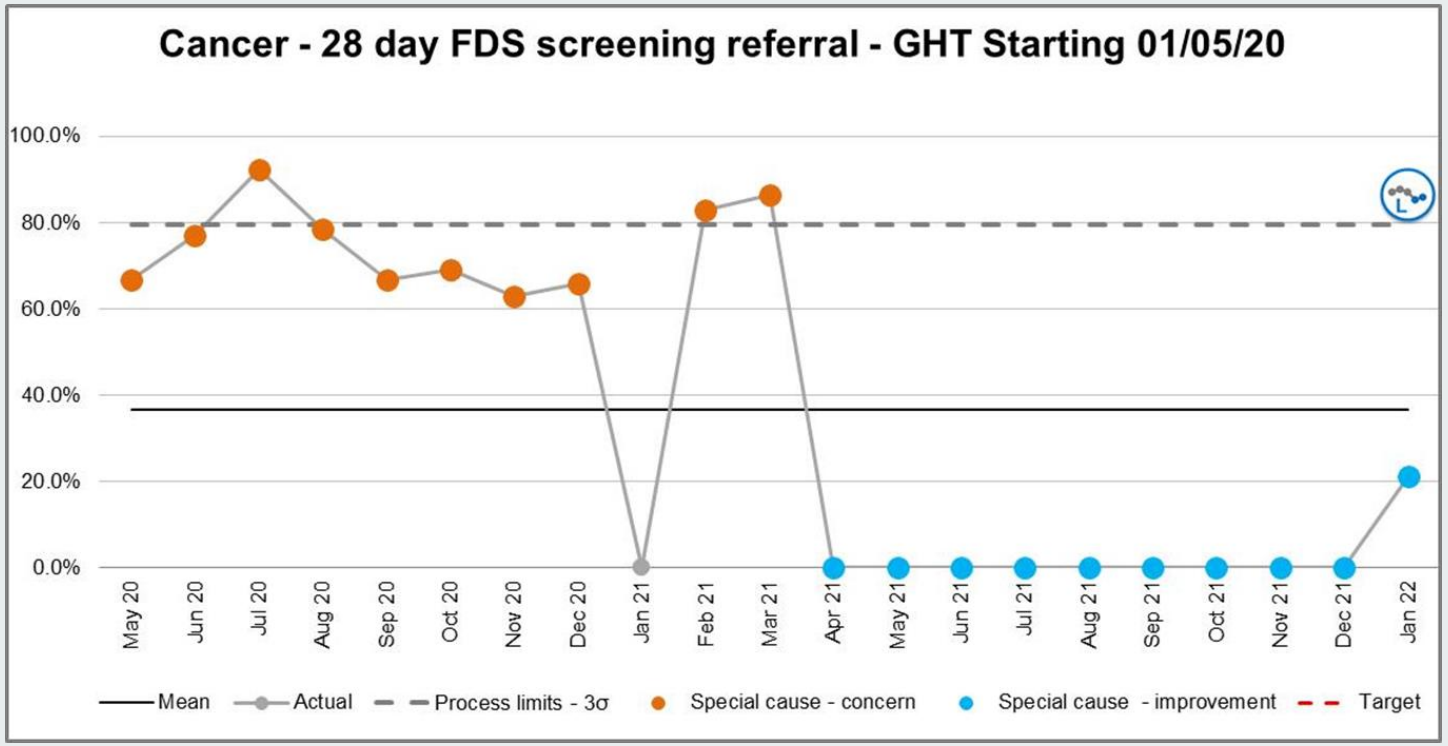
- General Manager - Cancer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

28 day FDS (GP referral)
Standard = 75%
GHFT = 21.5%

Bowel met target with breaches in Breast (18.8%) and Cervical (12.8%)

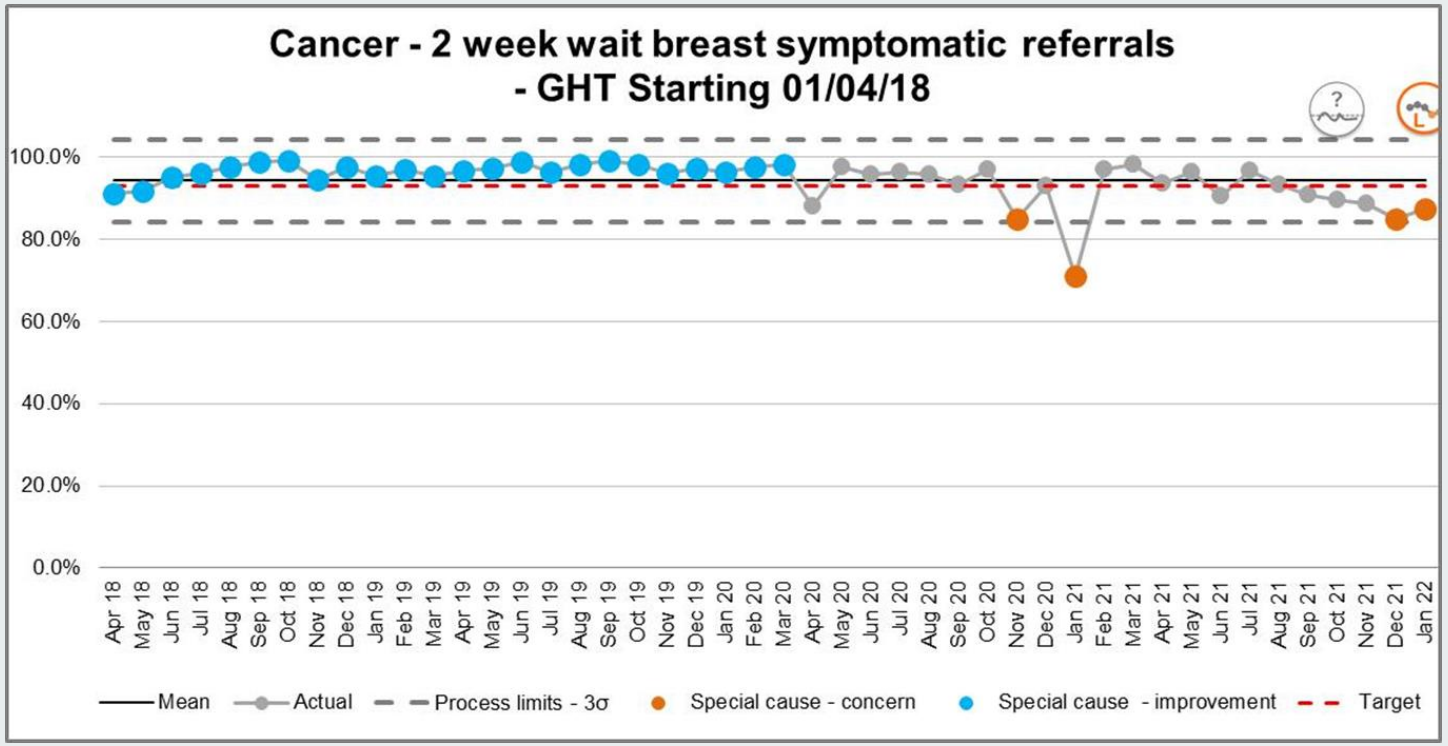
- General Manager - Cancer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

2ww breast symptoms performance (unvalidated)
Standard = 93%
National = 50%
GHFT = 87.5%

DFS = 120 Breaches = 15

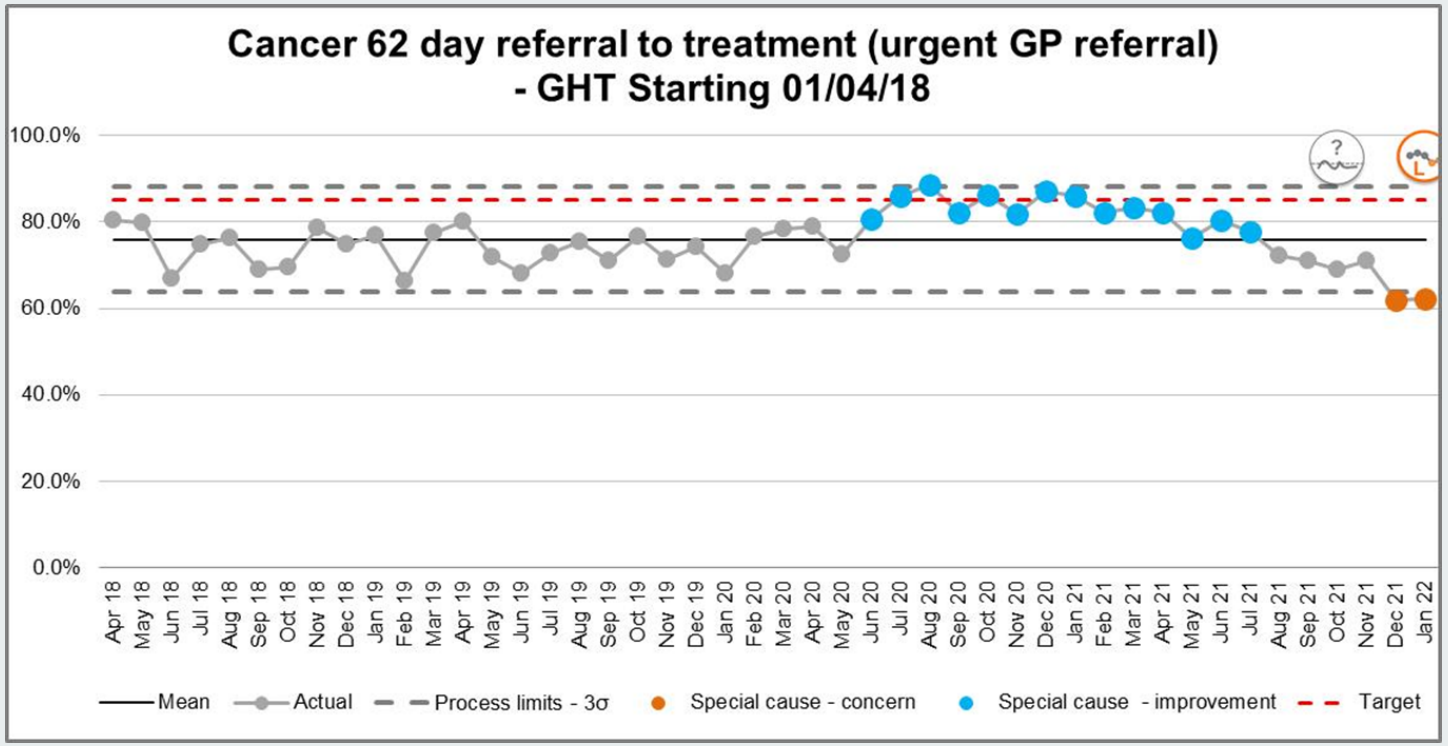
- General Manager - Cancer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

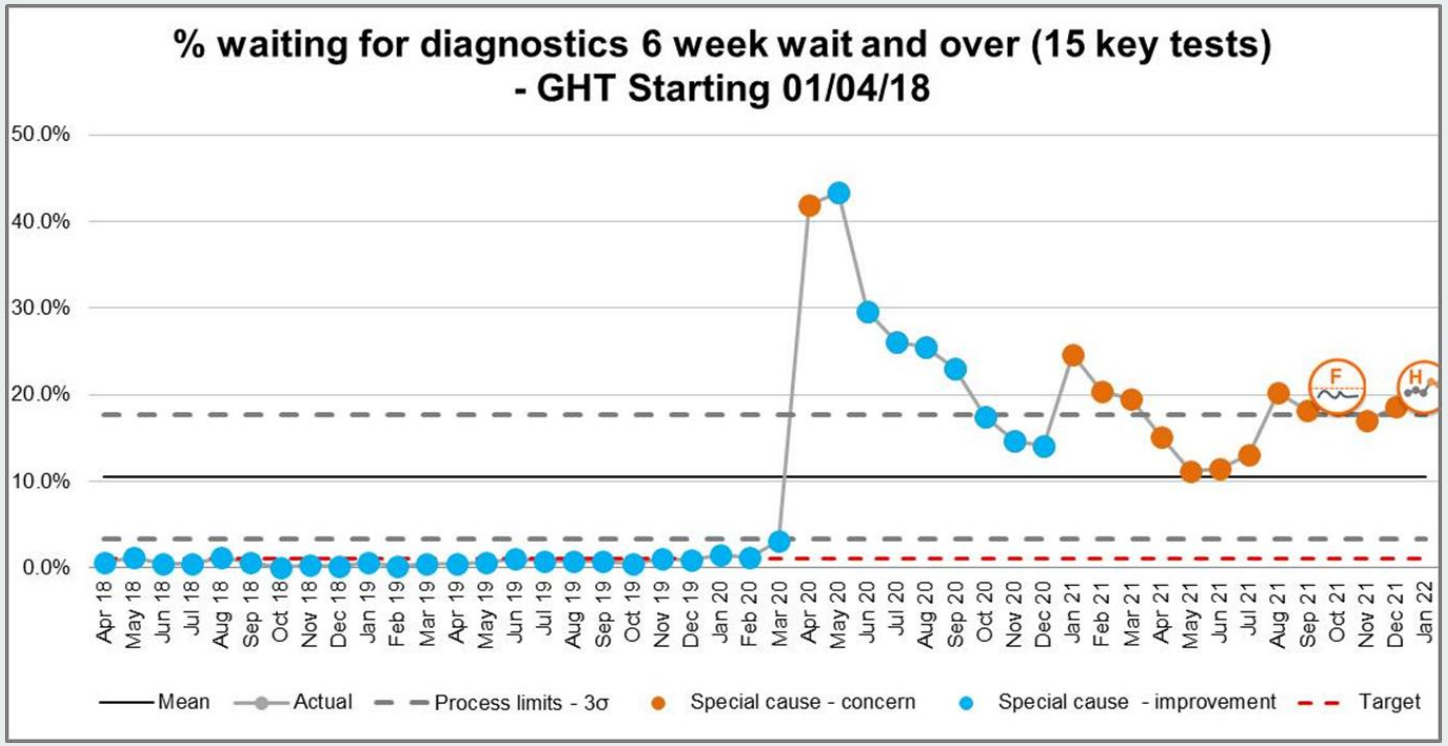
62 day GP performance (unvalidated)
Standard = 85%
National = 67%
GHFT = 61.8%
Treatments =152, Breaches 58, LGI=12, Urology=20.5, Gynae=11.5, H&N=3
Impact of outstanding pathology relating to tx pathology and delayed diagnostic pathology from last few months, now at the treatment stage of their pathway
- General Manager - Cancer

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance has dipped for successive months moving from 18.6% last month to a validated position of 20.8% this month. The total number of patients waiting has increased from 6,629 to 7,373. The overall number of breaches has increased by approximately 300 which is primarily attributable to Echos, which has increased from 1,073 last month to 1,478.

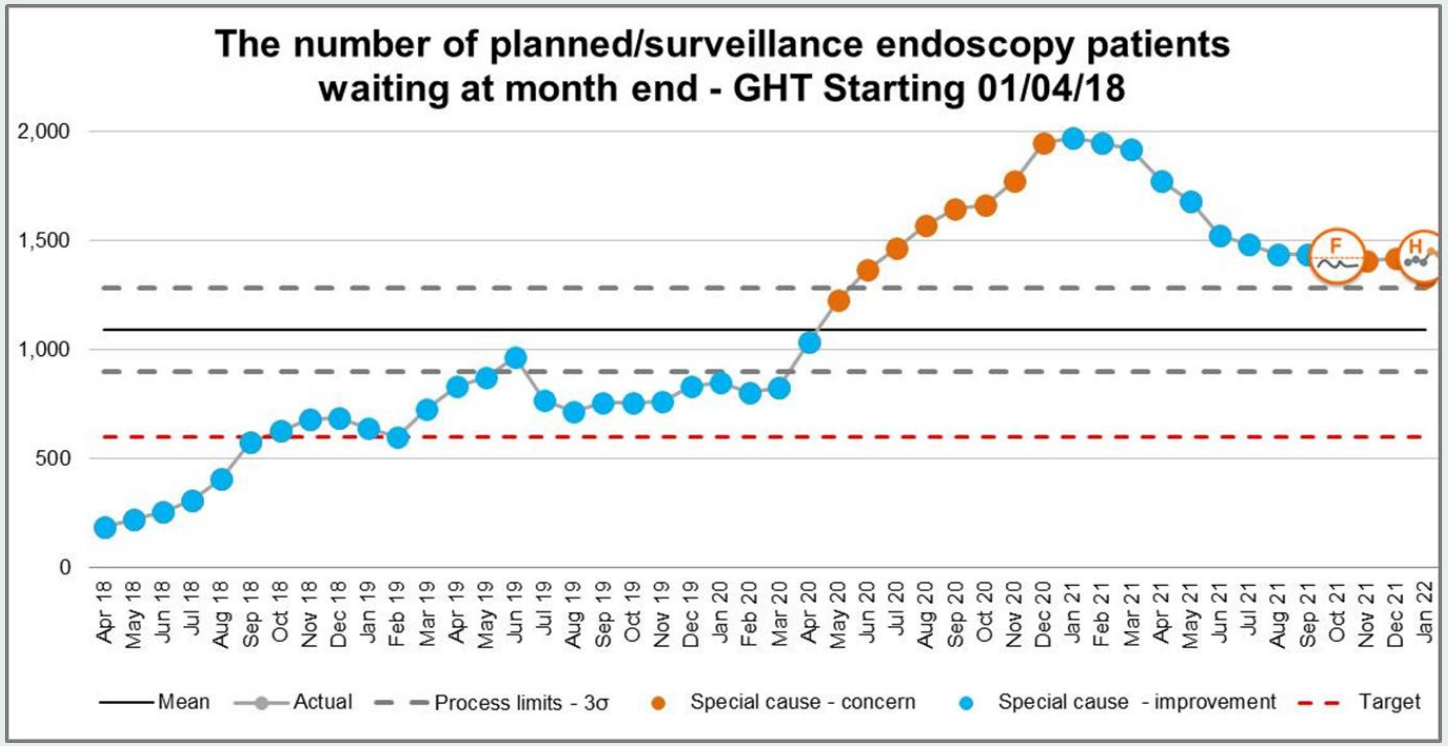
- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 14 data points which are above the line. There are 24 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Breach numbers are high due to baseline demand and capacity gap, and the lower priority level to book cohort in comparison to risk stratified 2WW, BCSP and requirement to meet DM01 target - historically attempted to backfill with locum cover, and use of outsource capacity. Planned surveillance endoscopy breaches continues to reduce month on month through a process of dedicated clinical validation sessions to confirm if patients still require the procedure, and carved out capacity in month. From FY 22/23 Q2 onwards, the extra endoscopy theatre at CGH and associated cover (as part of the Endoscopy Training Academy) will provide sufficient activity to fill current demand gap, enabling further reduction of surveillance backlog.

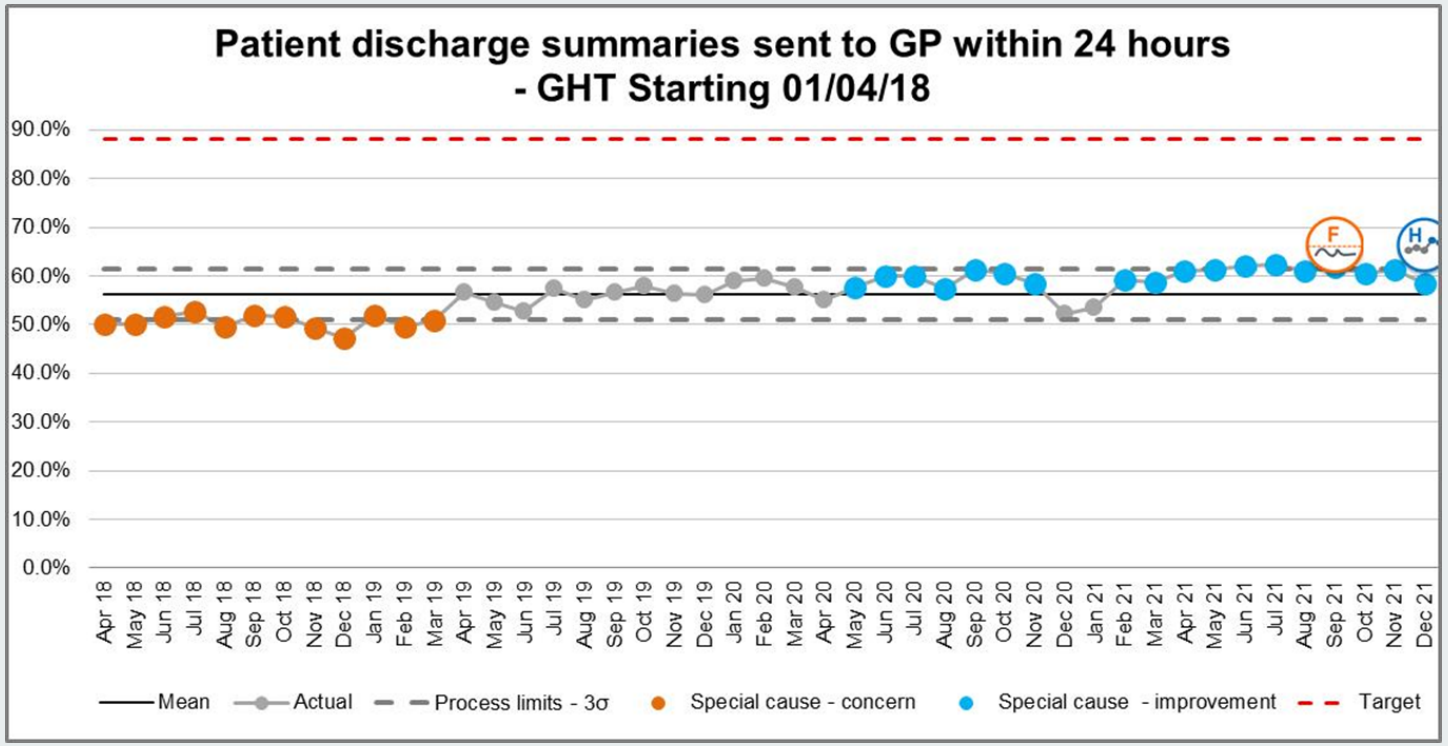
- General Manager of Endoscopy

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 20 data points which are above the line. There are 23 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising and falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Performance is stable at around 60% complete within 24 hours, unlikely to change significantly before implementation of electronic prescribing.

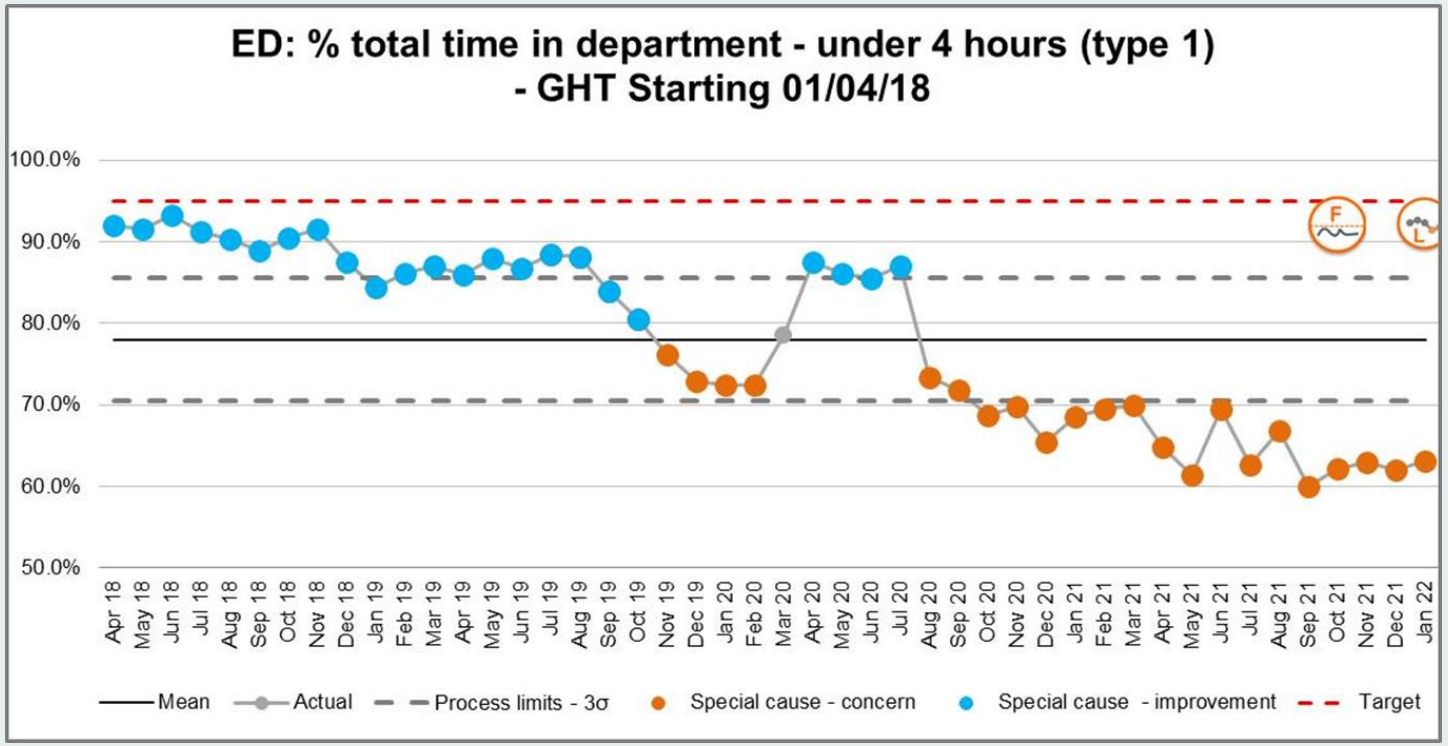
- Medical Director

Data Observations

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

Access:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 19 data points which are above the line. There are 16 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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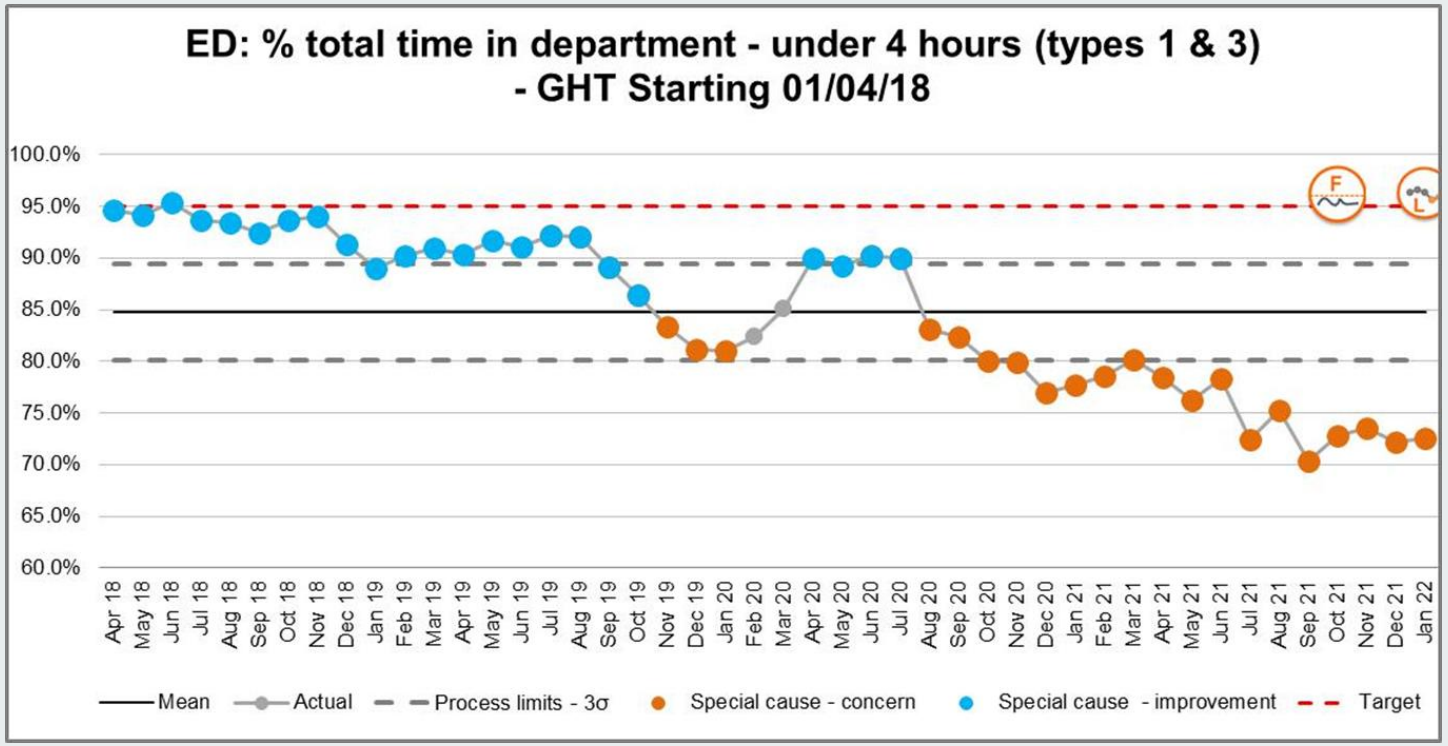

Commentary

With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 19 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
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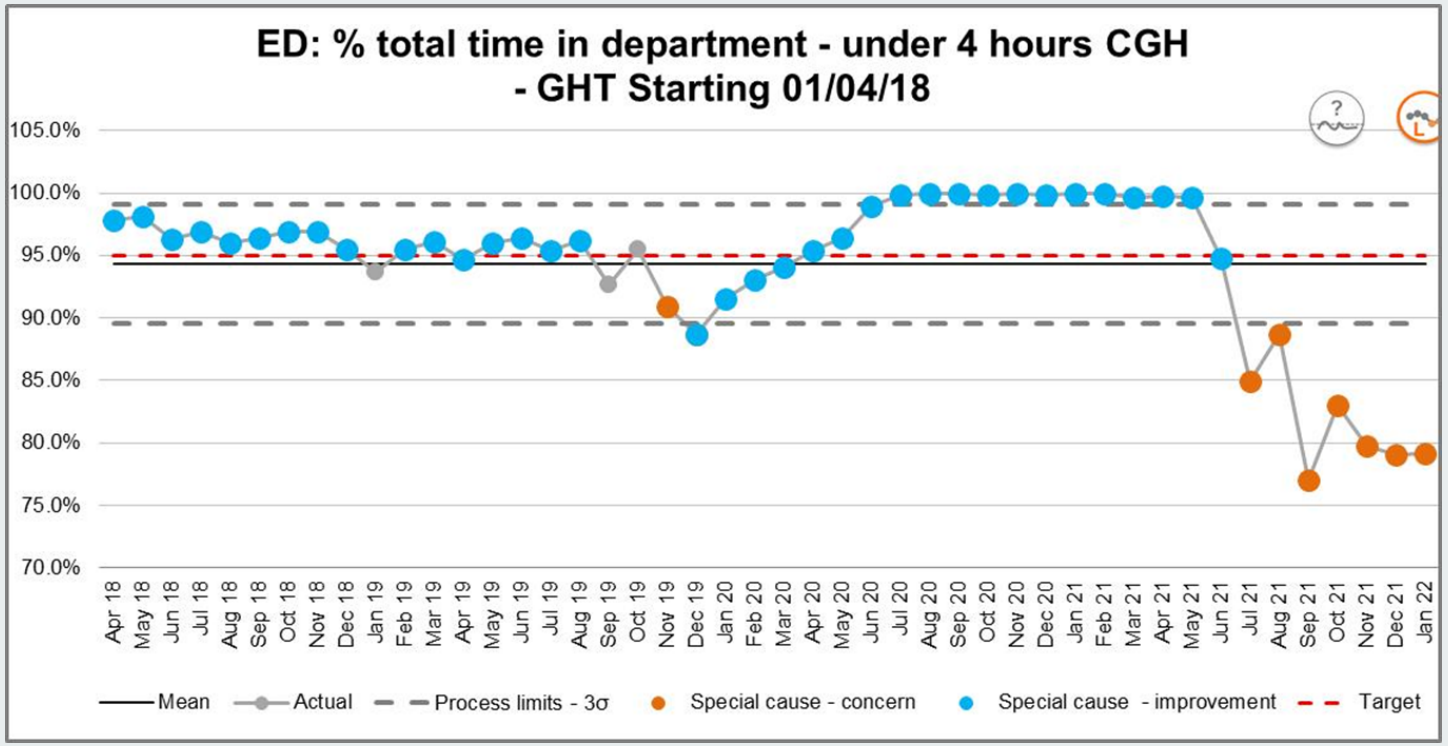

Commentary

With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 11 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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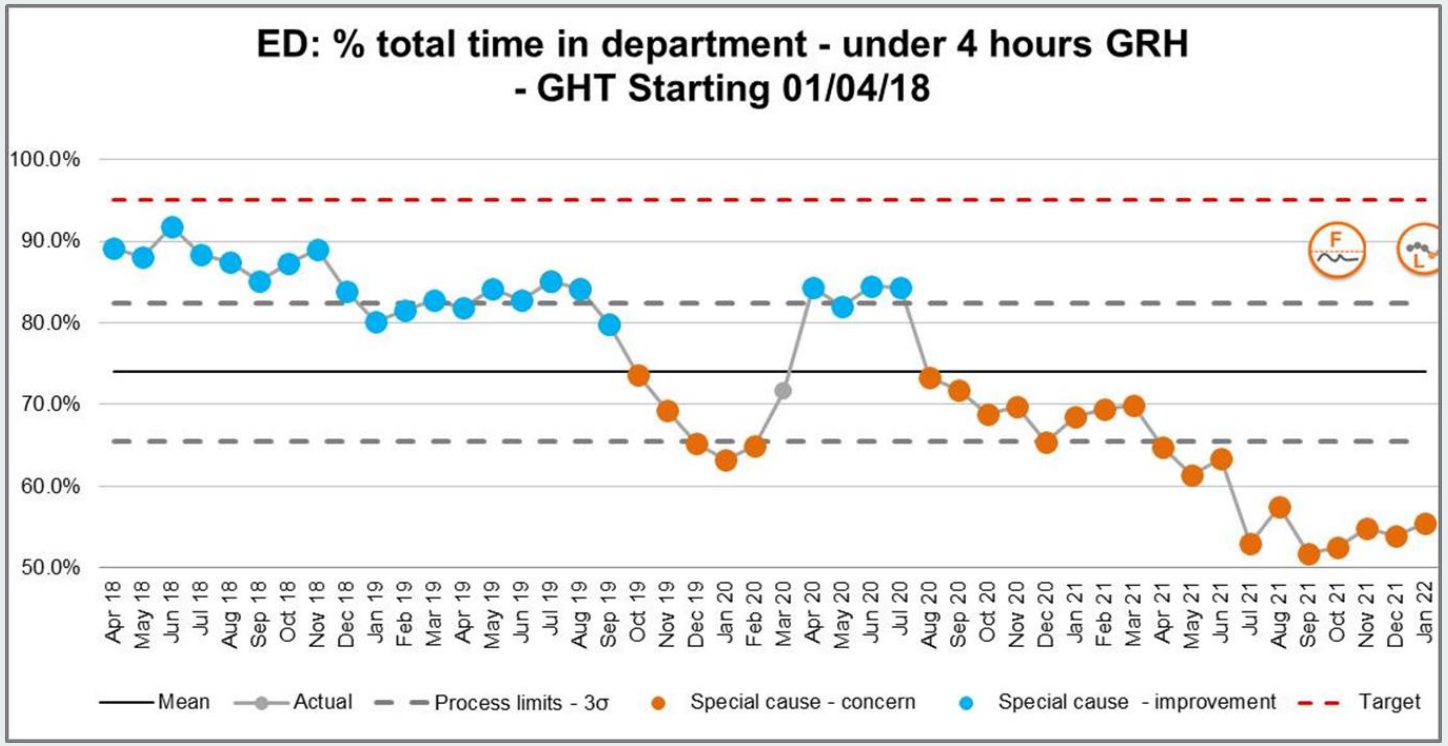

Commentary

With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 17 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of falling points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

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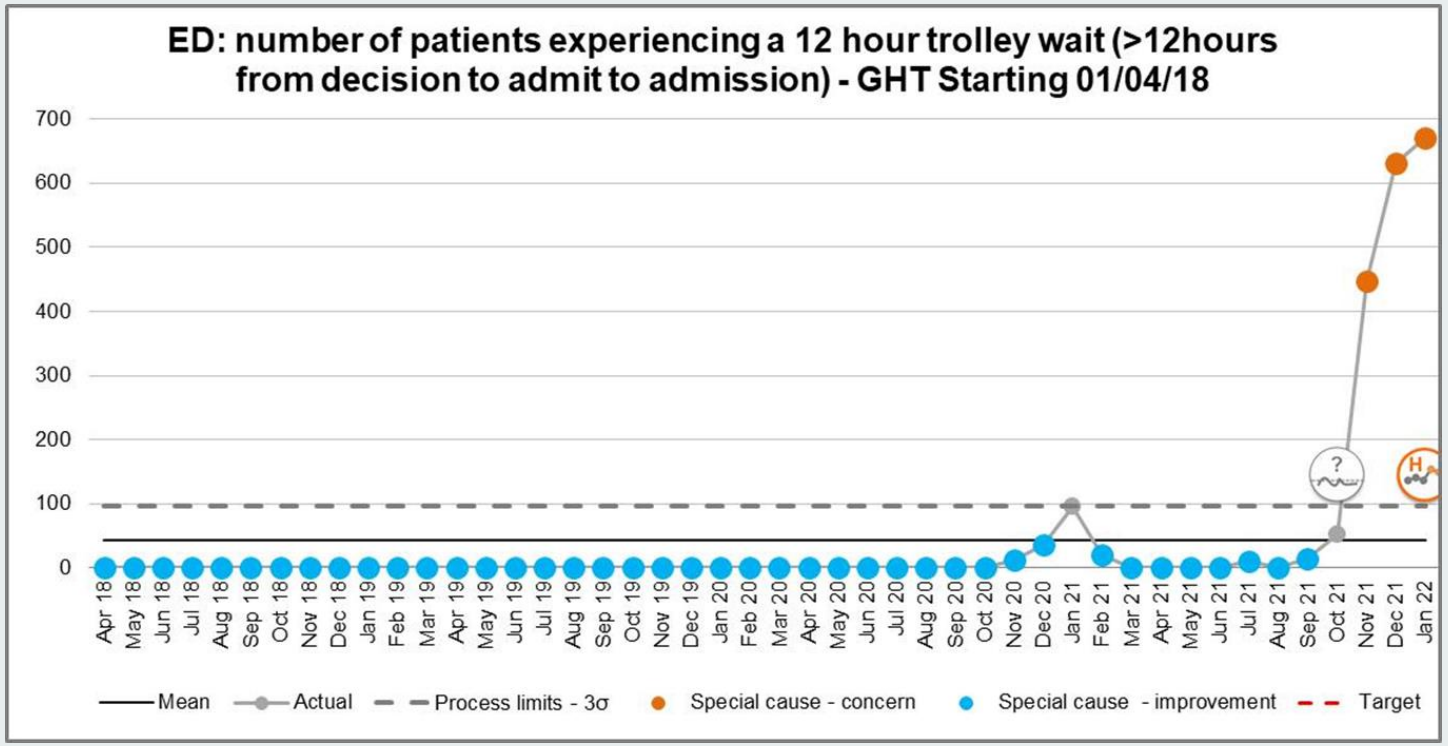

Commentary

With over 220 MOFD patients throughout the trust, capacity & flow are low. Movement throughout the hospital is incredibly slow, and despite having relatively low WTBS times, the emergency department struggle to discharge patient onto wards

- General Manager of Unscheduled Care

Data Observations

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

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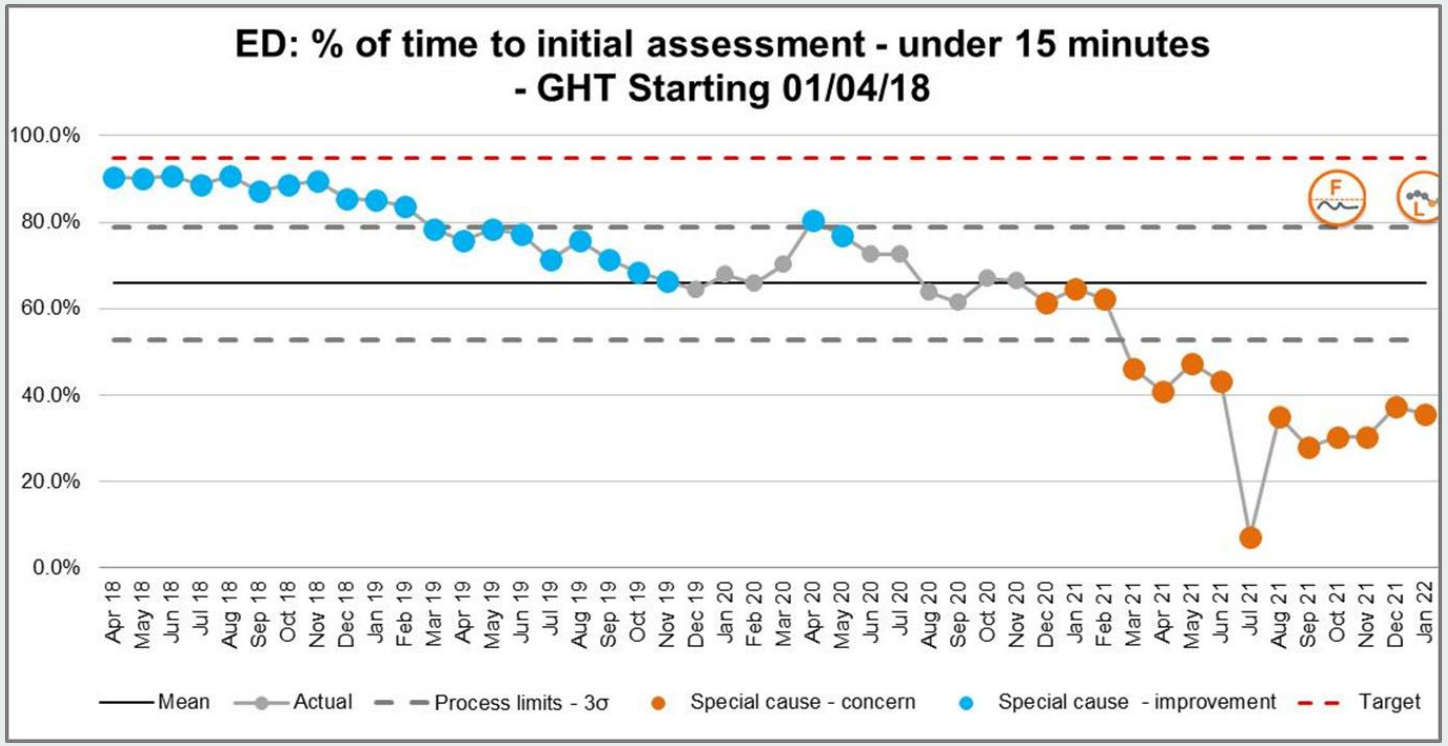

Commentary

Time to triage has increased this month for both walk in and ambulance patients. An increased number of patients visiting the department, combined with several vacancies in the nursing team, not always allowing for two triage nurses, have both been contributing factors.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 12 data points which are above the line. There are 11 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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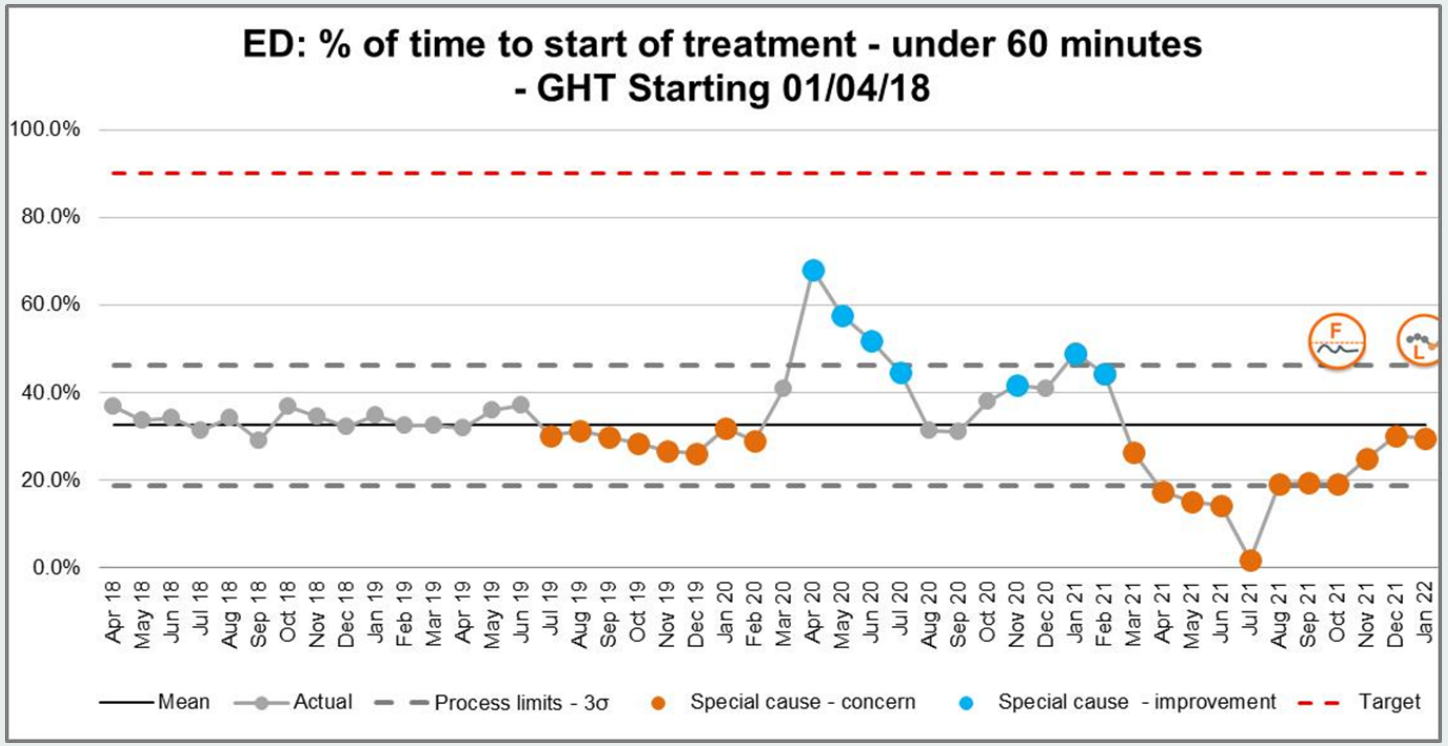

Commentary

January saw a peak in doctor sickness, especially COVID related, meaning less doctors were on the shop floor at any given time. This, combined with increasing numbers of patients visiting the department, as well as limited space to access patients, has led to a negative increase in this metric.

- General Manager of Unscheduled Care

Data Observations

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

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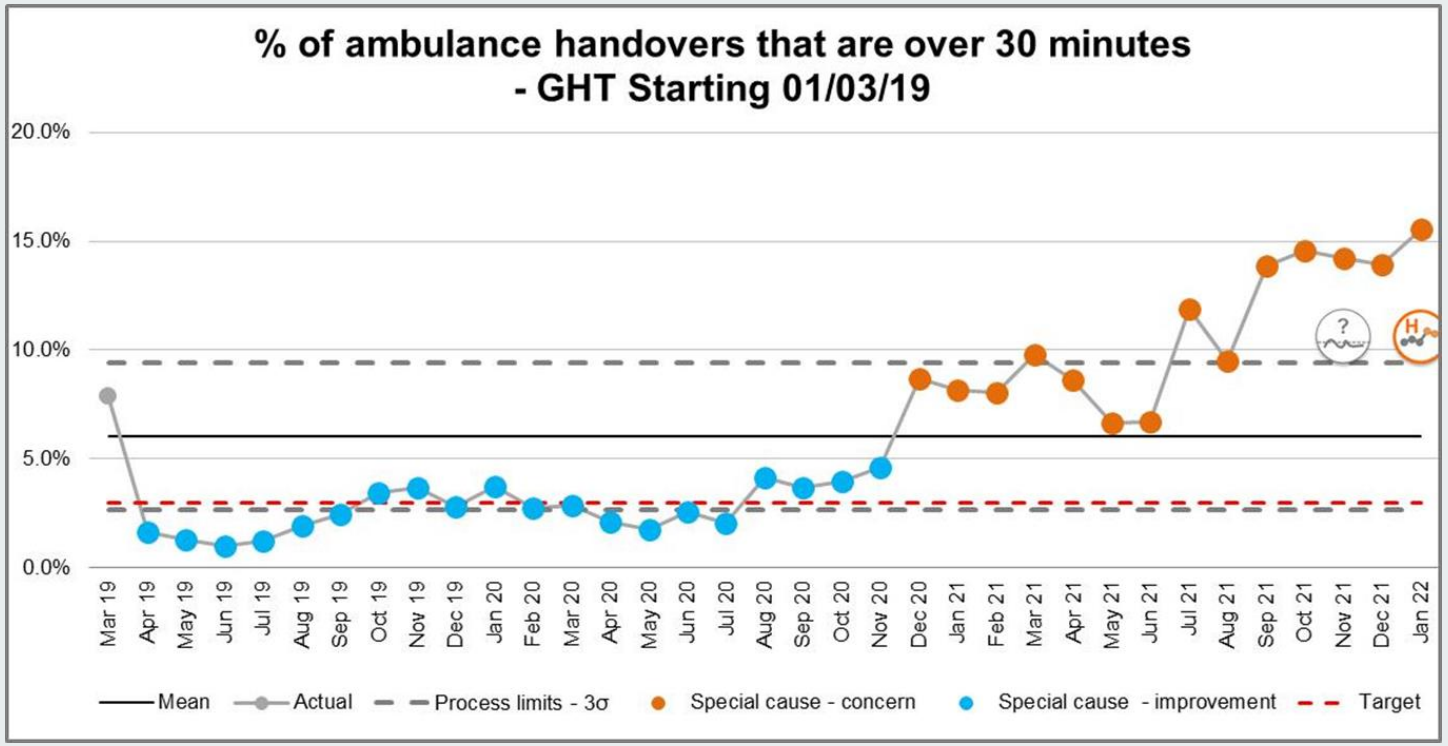

Commentary

The number of 30 minute ambulance breaches have increased this month. Reduced flow and capacity throughout the hospital has limited the department's ability to create capacity for ambulance patients, resulting in increased handover delays.

- General Manager of Unscheduled Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 8 data points which are above the line. There are 10 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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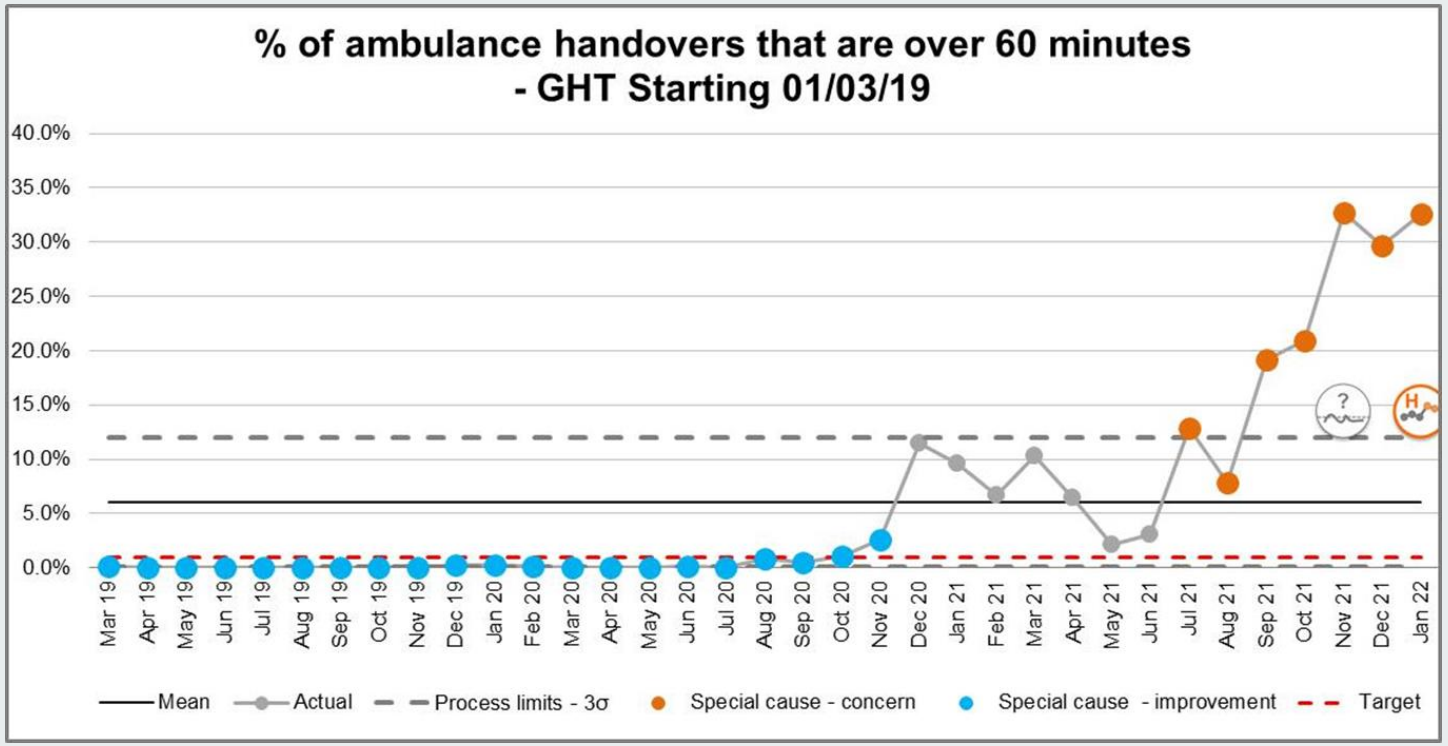

Commentary

The number of 60 minute ambulance breaches have increased this month. Reduced flow and capacity throughout the hospital has limited the department's ability to create capacity for ambulance patients, resulting in increased handover delays.

- General Manager of Unscheduled Care

Data Observations

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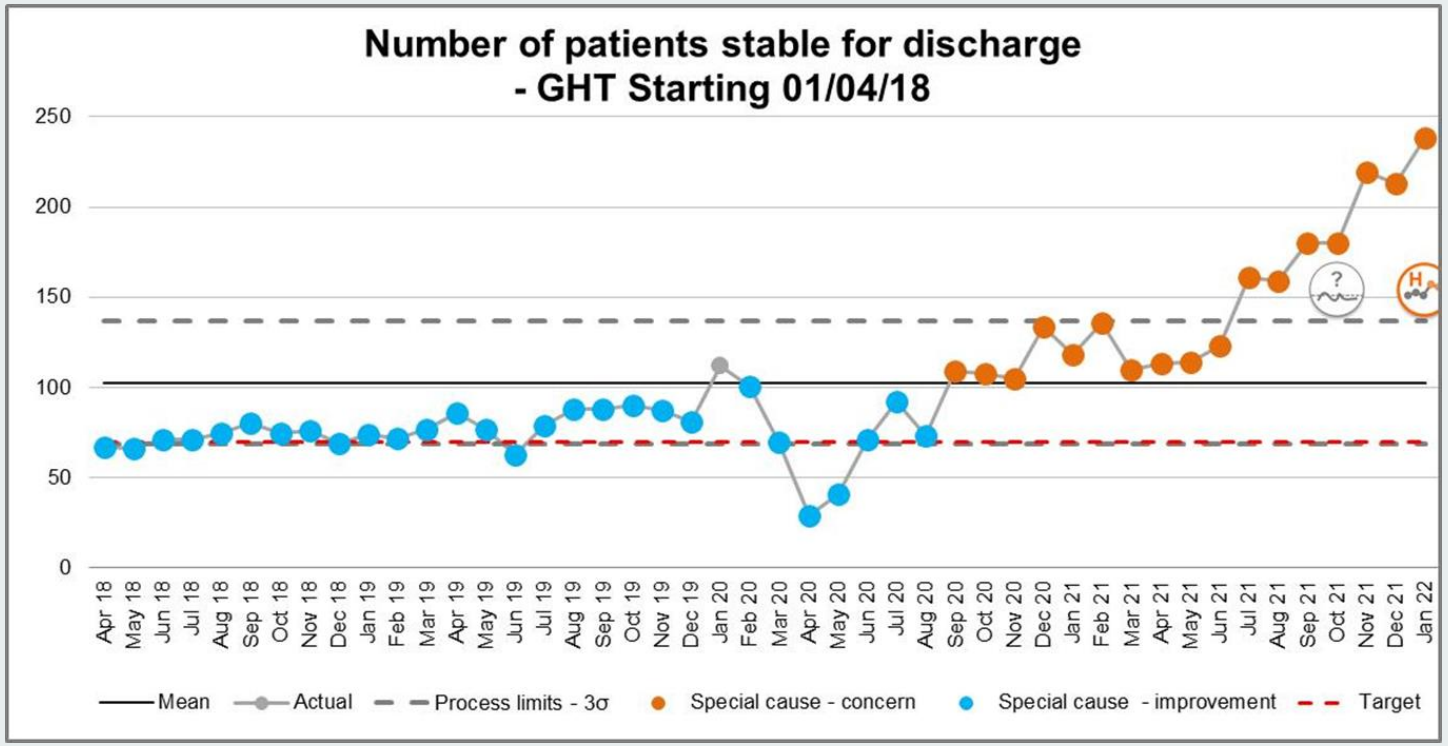

Commentary

Numbers continuing to rise alongside ongoing issues within DomCare linked to staffing and COVID care home closures which has significantly reduced flow across all pathways.

- Head of Therapy & OCT

Data Observations

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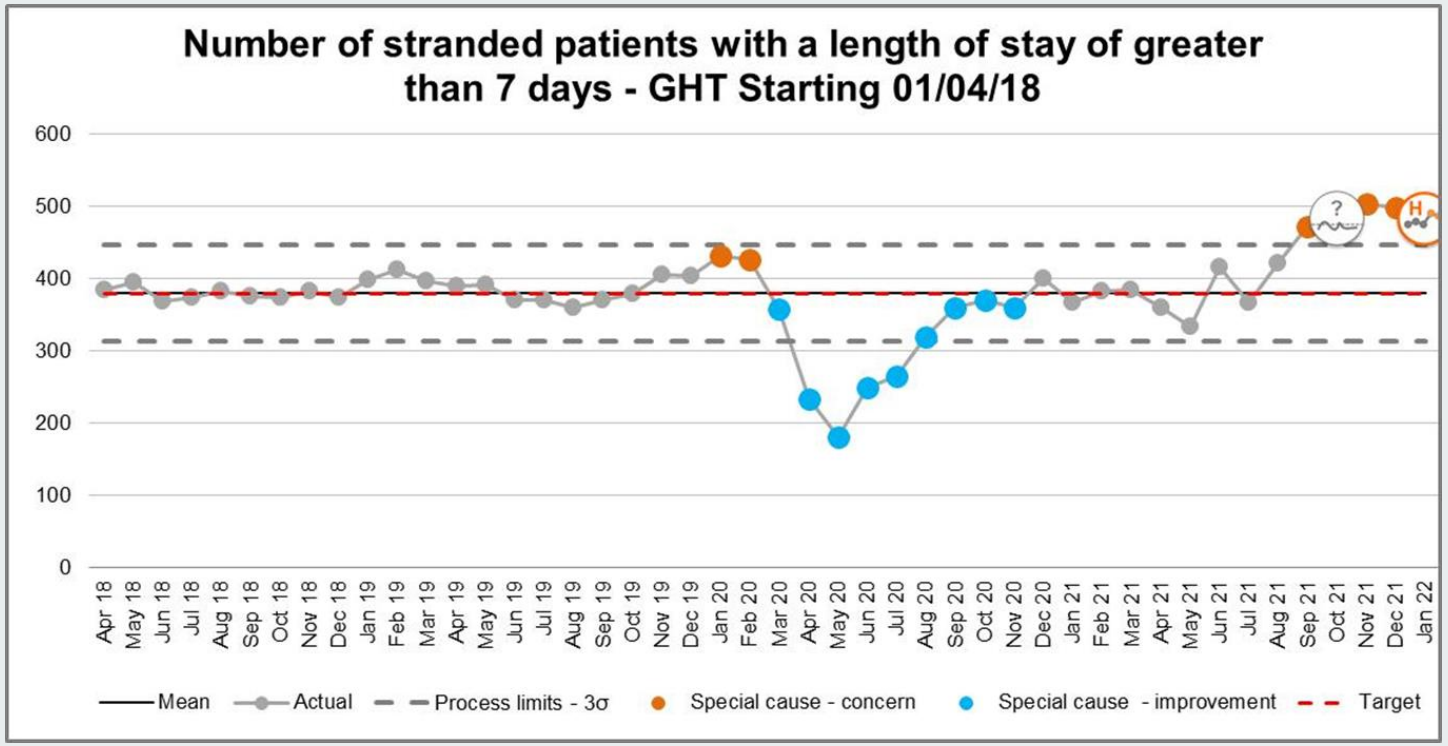

Commentary

Flat line for this measure. No significant impact on additional capacity in a non acute setting. Patients delayed for Home First, D2A. C19 still impacting discharges to community due to staff sickness, closed nursing home capacity due to capacity and POC returned to GCC. Daily review and monitoring. Refocus on Check and Challenge for NEWS of 0-1; criteria to reside and criteria to admit. Planning for Perfect week.

- Deputy Chief Operating Officer

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 4 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
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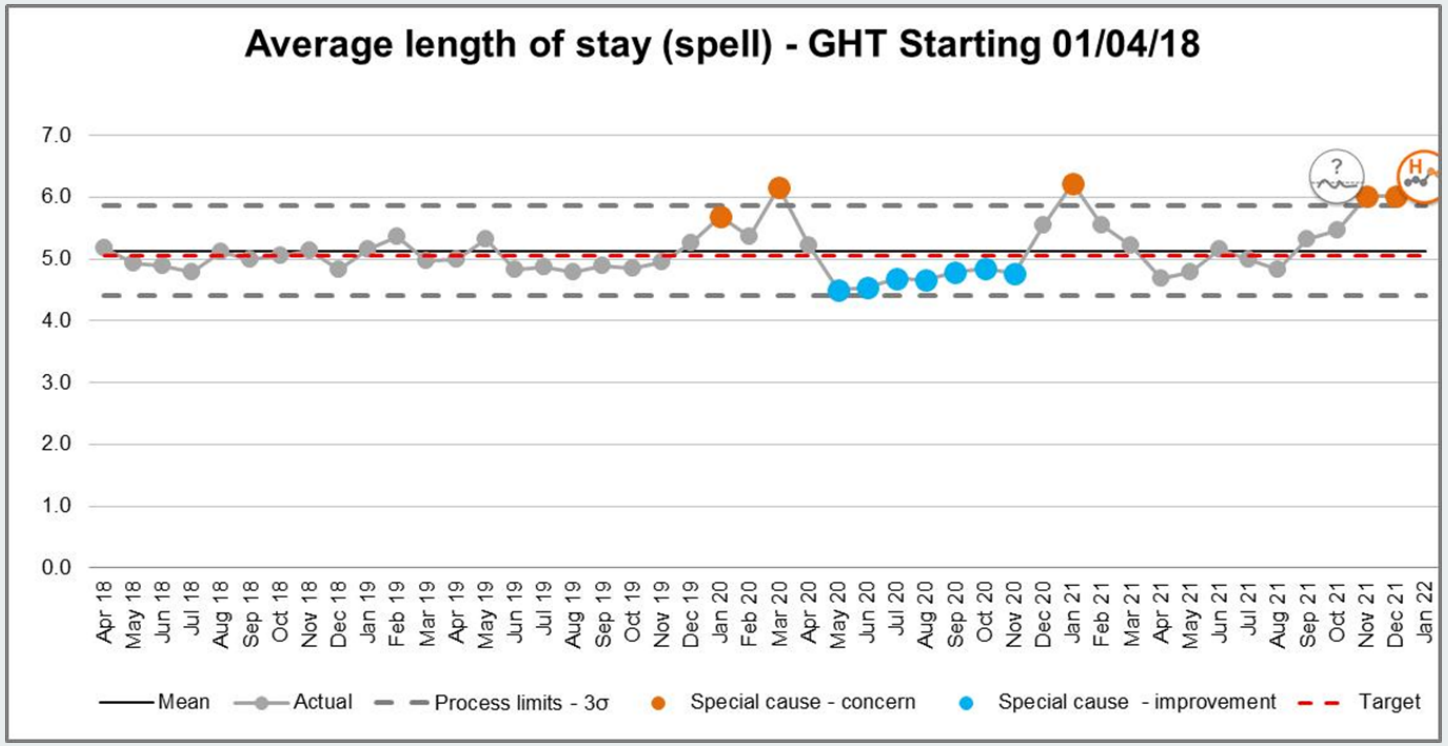

Commentary

Deterioration in month due mainly to reduced volume of discharges overall; Slight increase in patients unable to moveout of hospital due to C19 capacity. Note multiple moves contributes negatively to LoS in almost all cases. There has been a increase in overall volume of moves of IP to alternative wards. This is factor to be cognoscente of and minimise where possible.

- Deputy Chief Operating Officer

Data Observations

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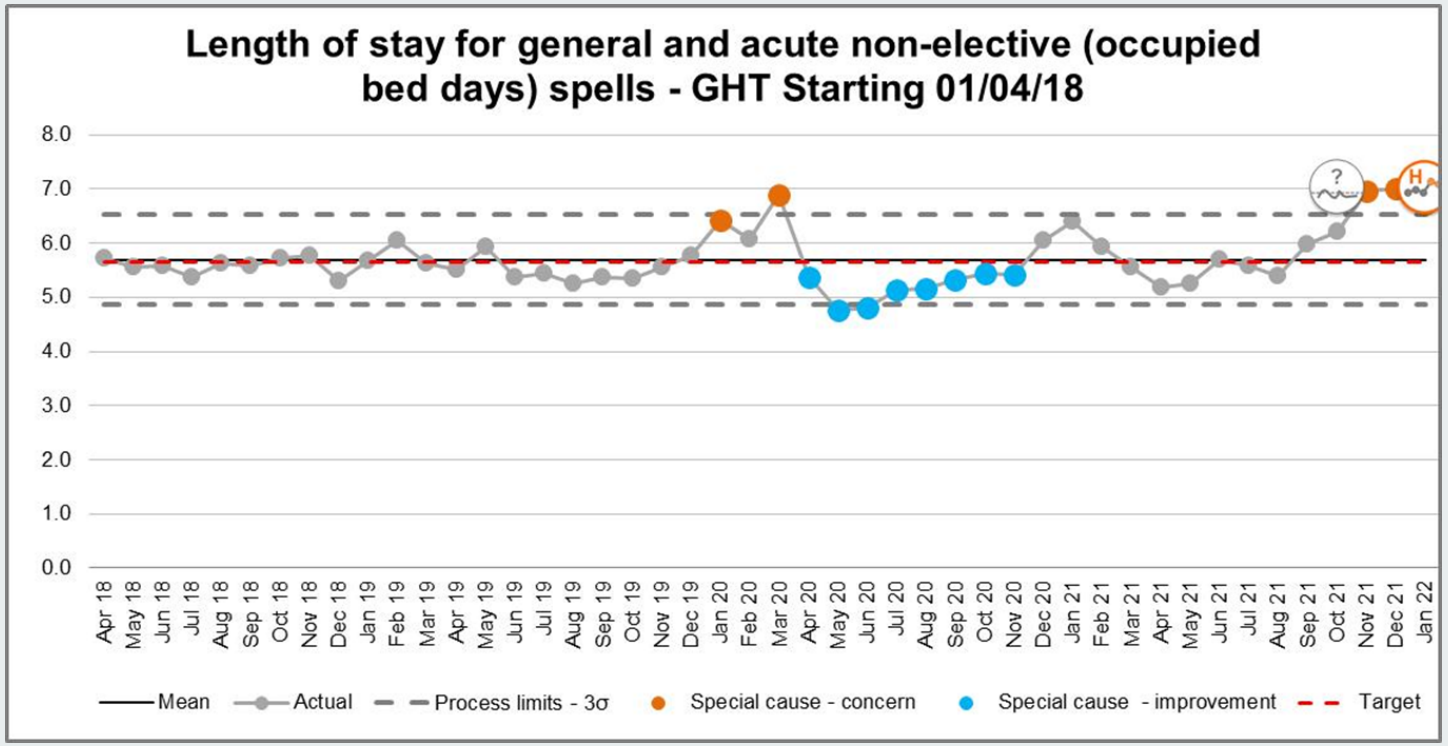

Commentary

Marginal deterioration from last month. Need to monitor impact of internal moves and reducing impact on C19 related delays.

- Deputy Chief Operating Officer

Data Observations

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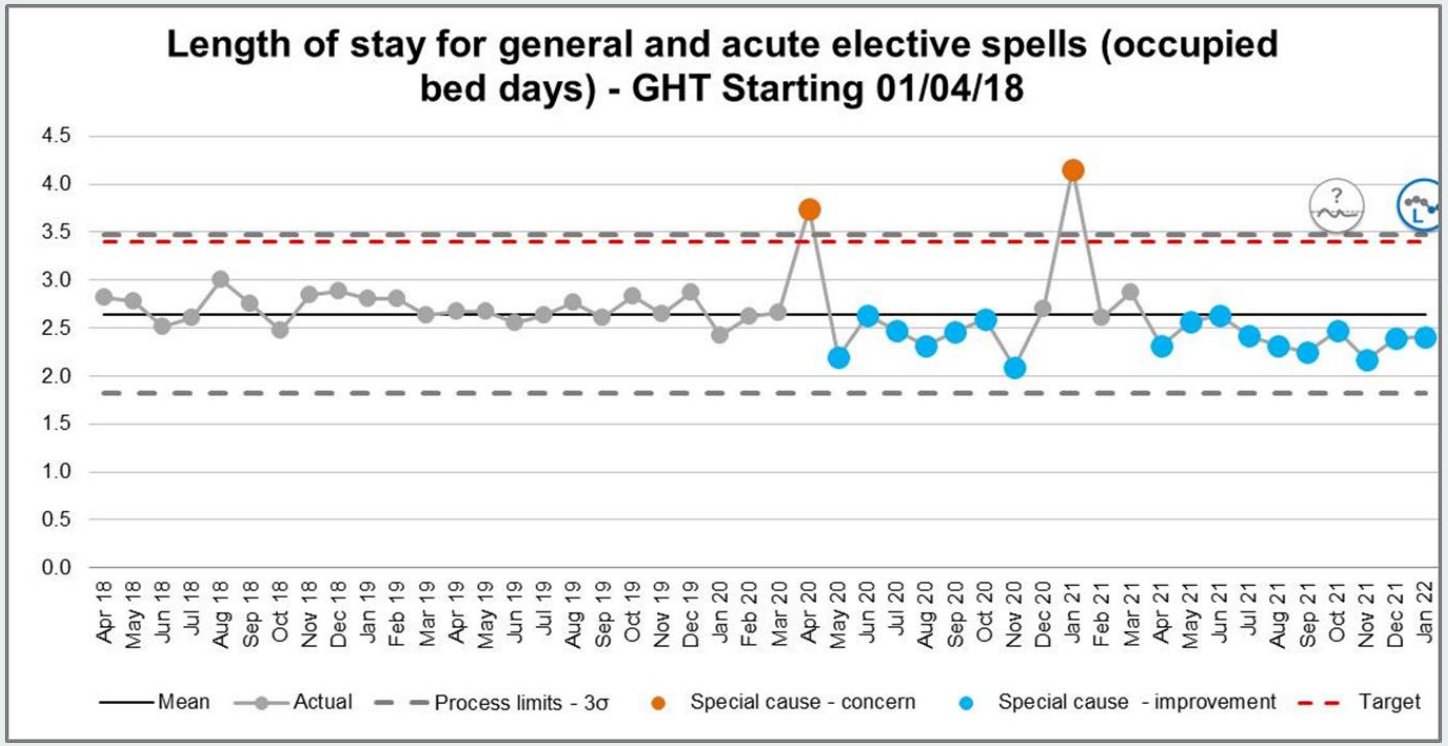

Commentary

Note marginal deterioration relating from last month. Observe and encourage current actions. Minimise moving of patients where possible

- Deputy Chief Operating Officer

Data Observations

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

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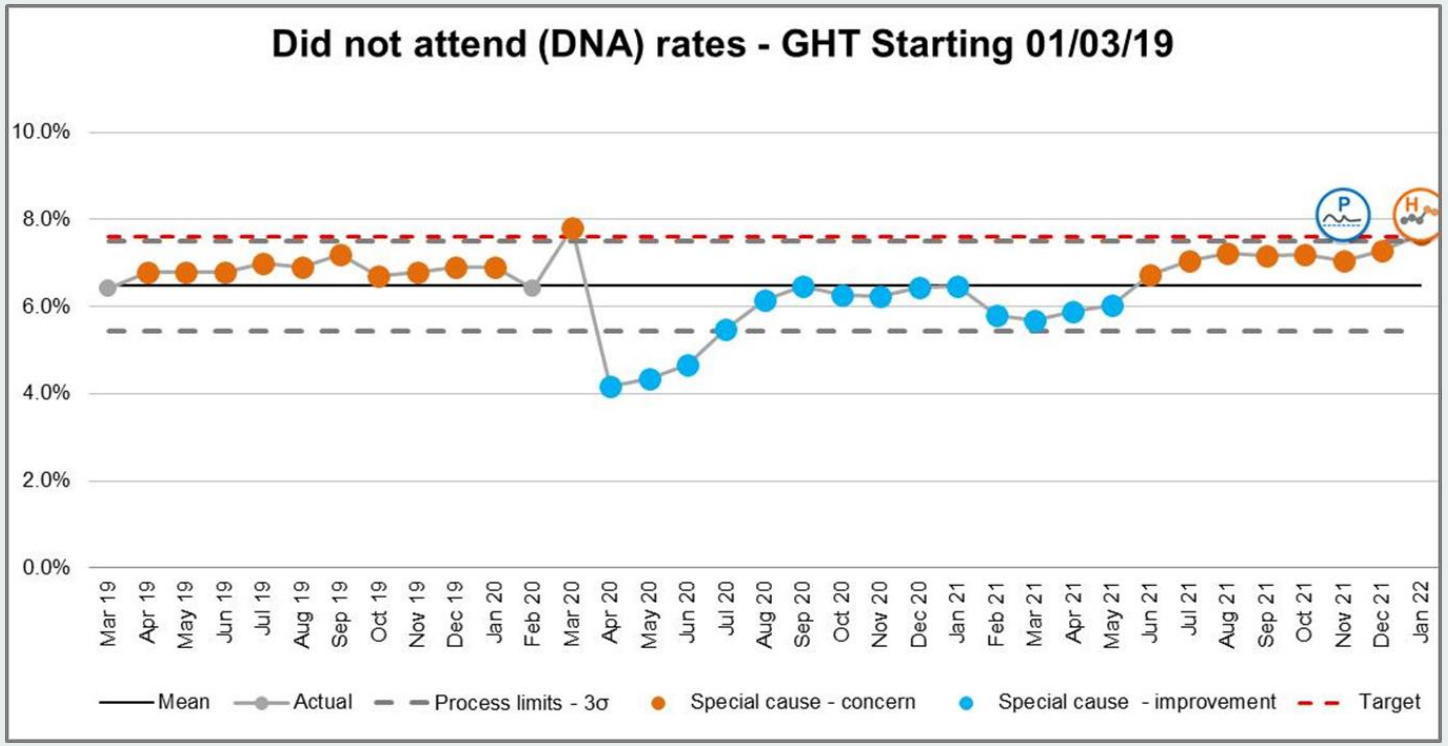

Commentary

The DNA rate has drifted outside of target for the first time this year by 0.7%. Factors typically contributing to this rate continue to be short notice appointments and clinic set up, together with some seasonal variation. No tangible reasons for this marginal increase are available other than potentially patients being unwell through omicron.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There is 2 data point which is above the line. There are 3 data point(s) below the line
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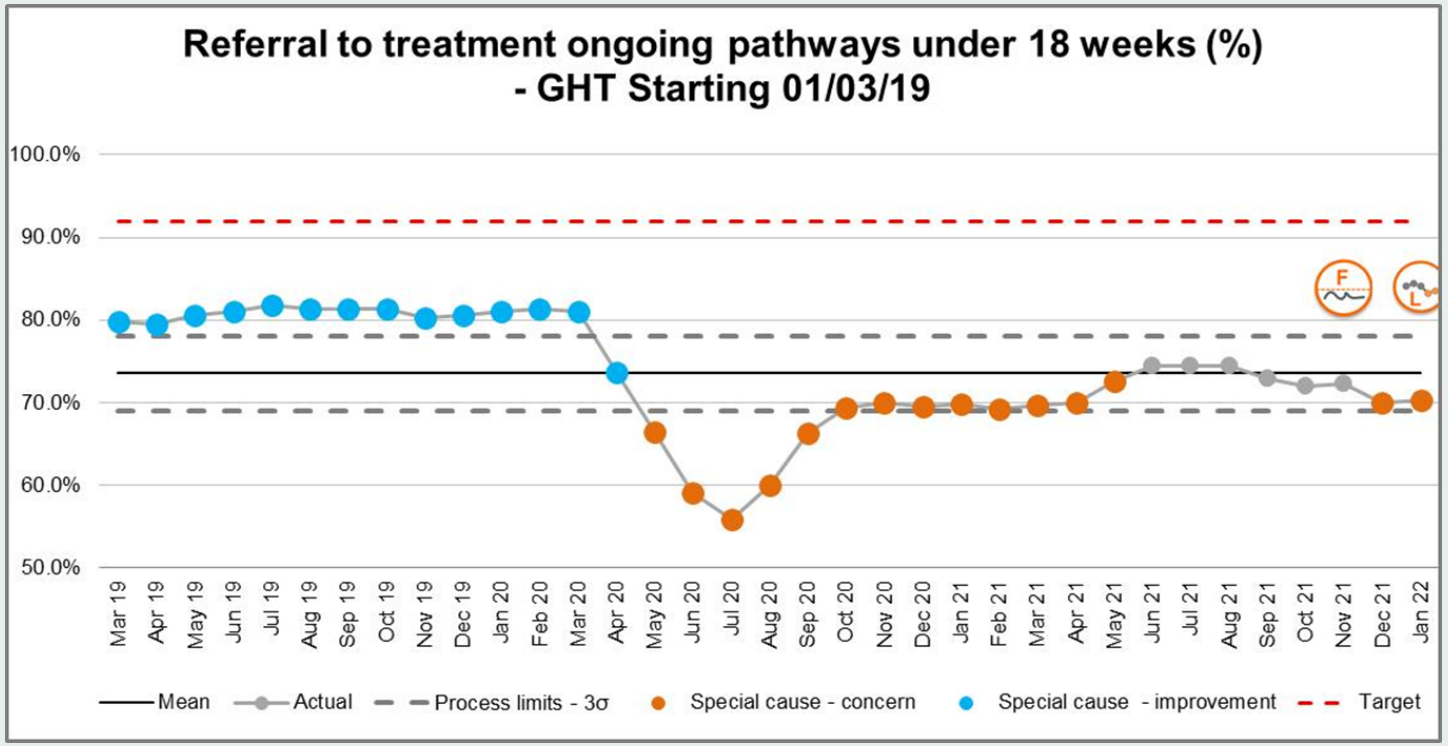

Commentary

See Planned Care Exception report for full details. RTT performance has improved slightly in month with an anticipated month-end position around 70.6%. Many of the same factors experienced in December have continued including; a particular focus on reducing incompletes (majority being <18 weeks); staff absence/sickness; and operational challenges through COVID.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 13 data points which are above the line. There are 5 data point(s) below the line
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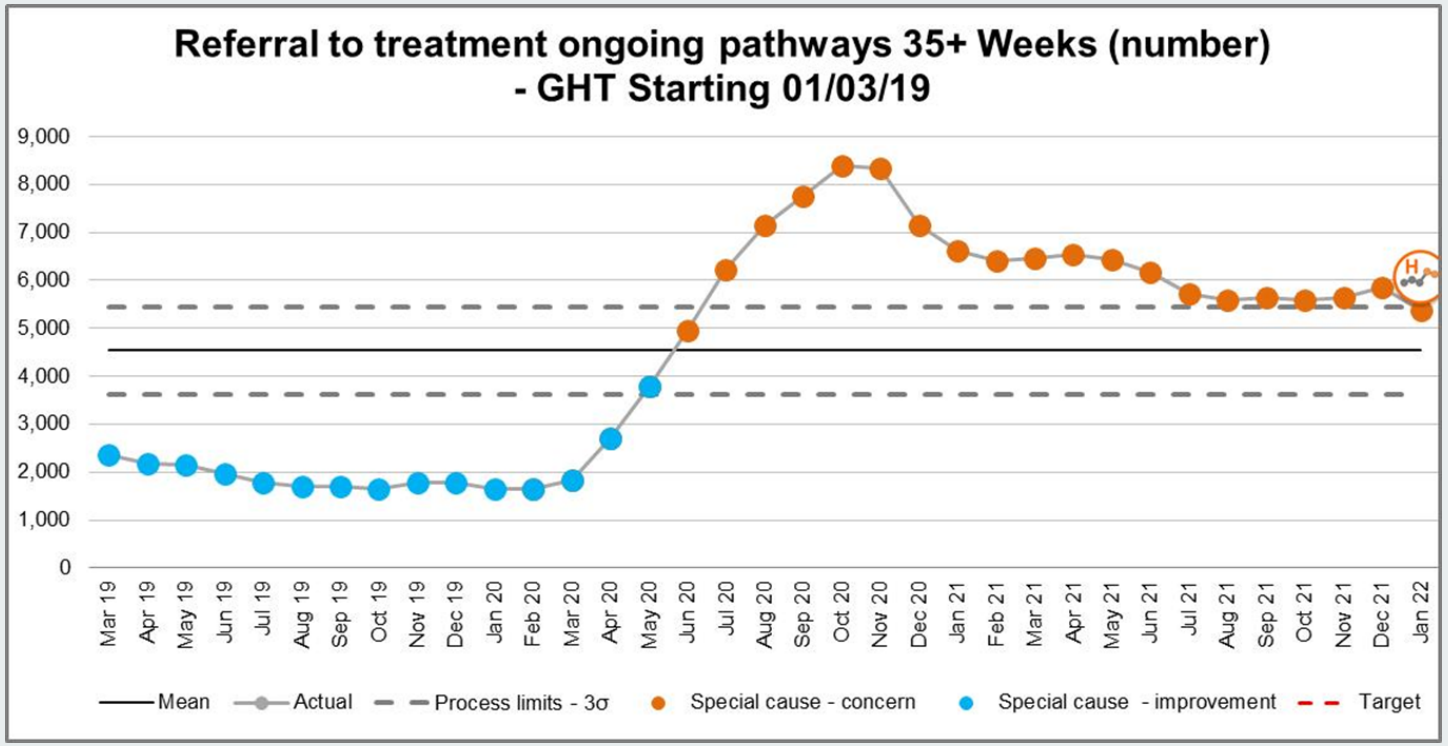

Commentary

A notable reduction has been seen with the number of patients waiting greater than 35 weeks, having reduced by approximately 10% in month. As with many of the cohorts (35's, 45's and 52's) there has been increased focus in attempting to reduce the total number of incompletes together with applying a logic fix to a number of RAS records.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 18 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a sigificant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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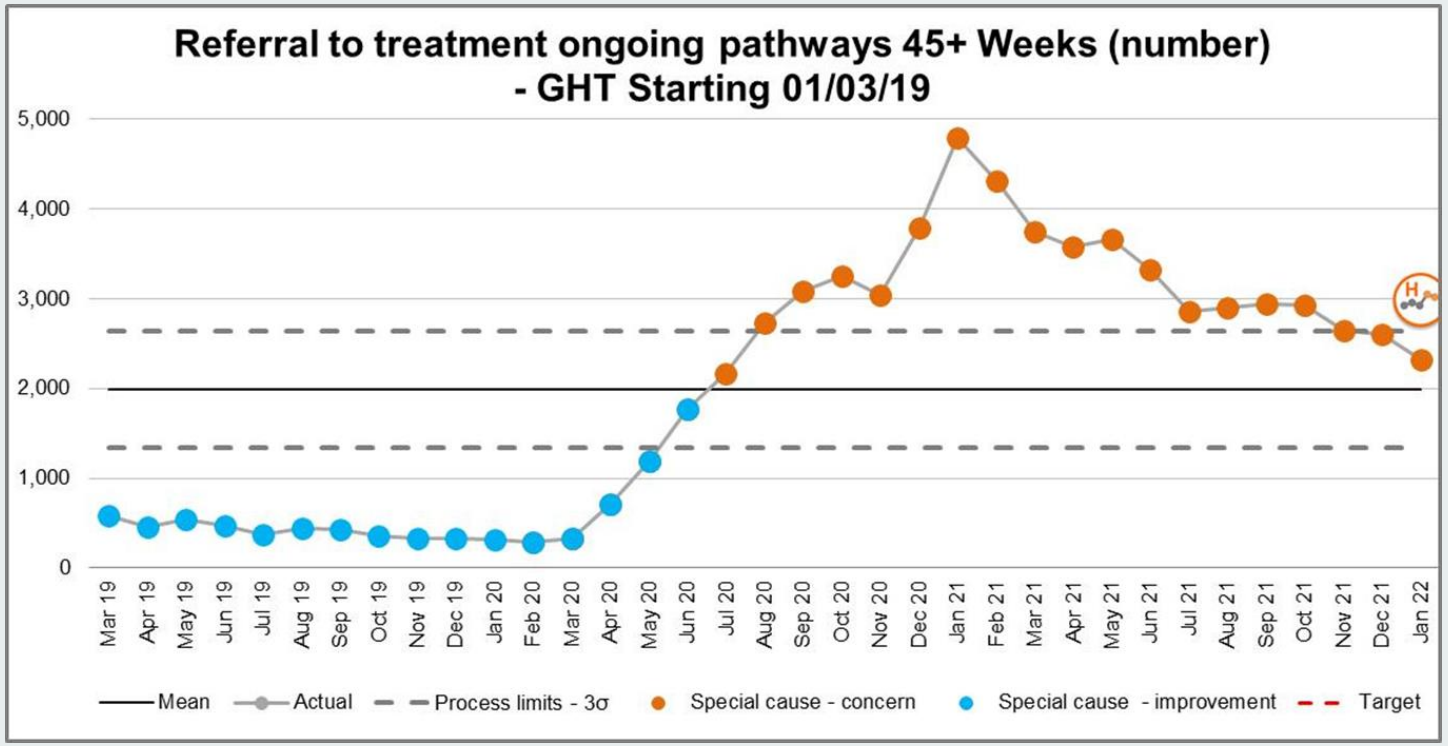

Commentary

A reduction of approximately 280 has been seen in month, maintaining the monthly downward trend.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 16 data points which are above the line. There are 15 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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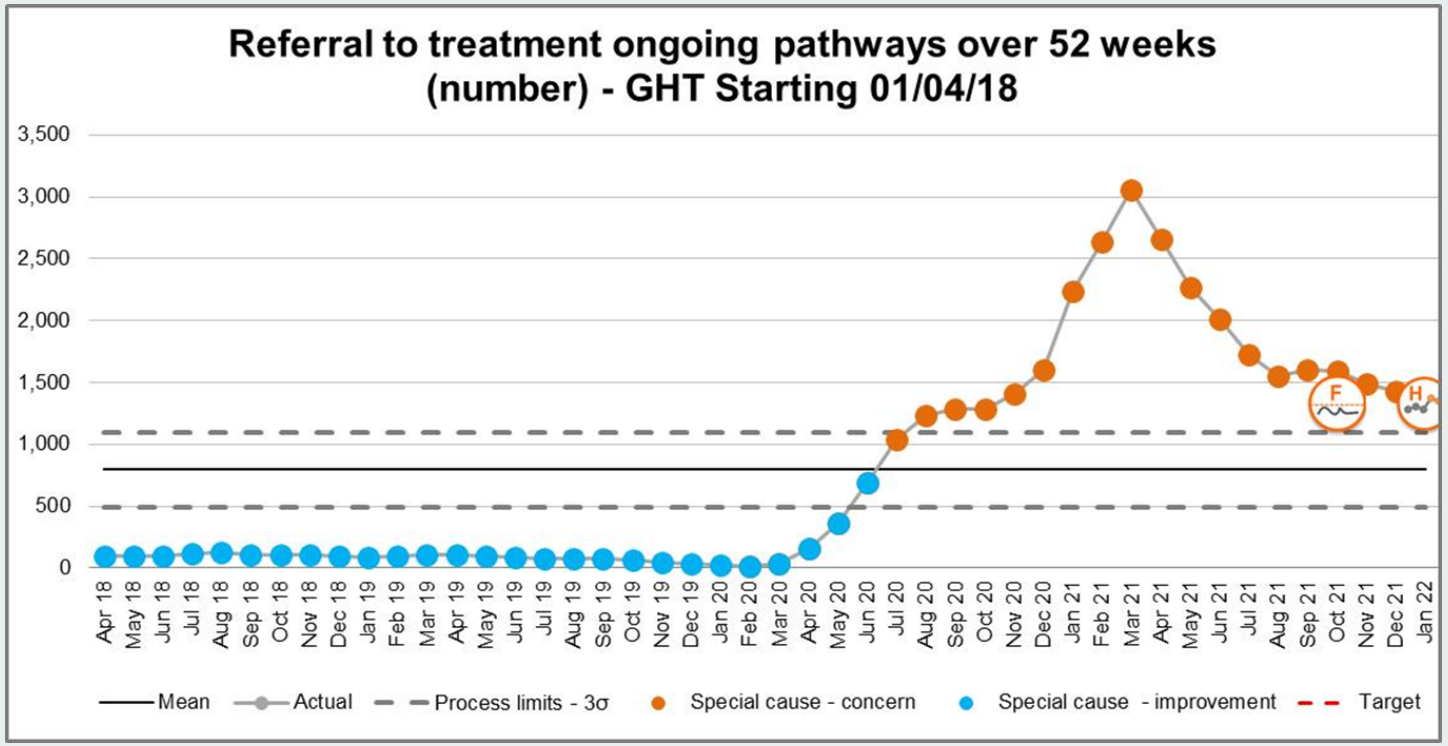

Commentary

See Planned Care Exception report for full details. A further reduction has been made in month, of approximately 150 which is one of the largest monthly gains for some months. Since March 2020, with the exception of just 1 month, gains have consistently been made every month, with this being the lowest number of 52 week waits since October 2020.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 18 data points which are above the line. There are 26 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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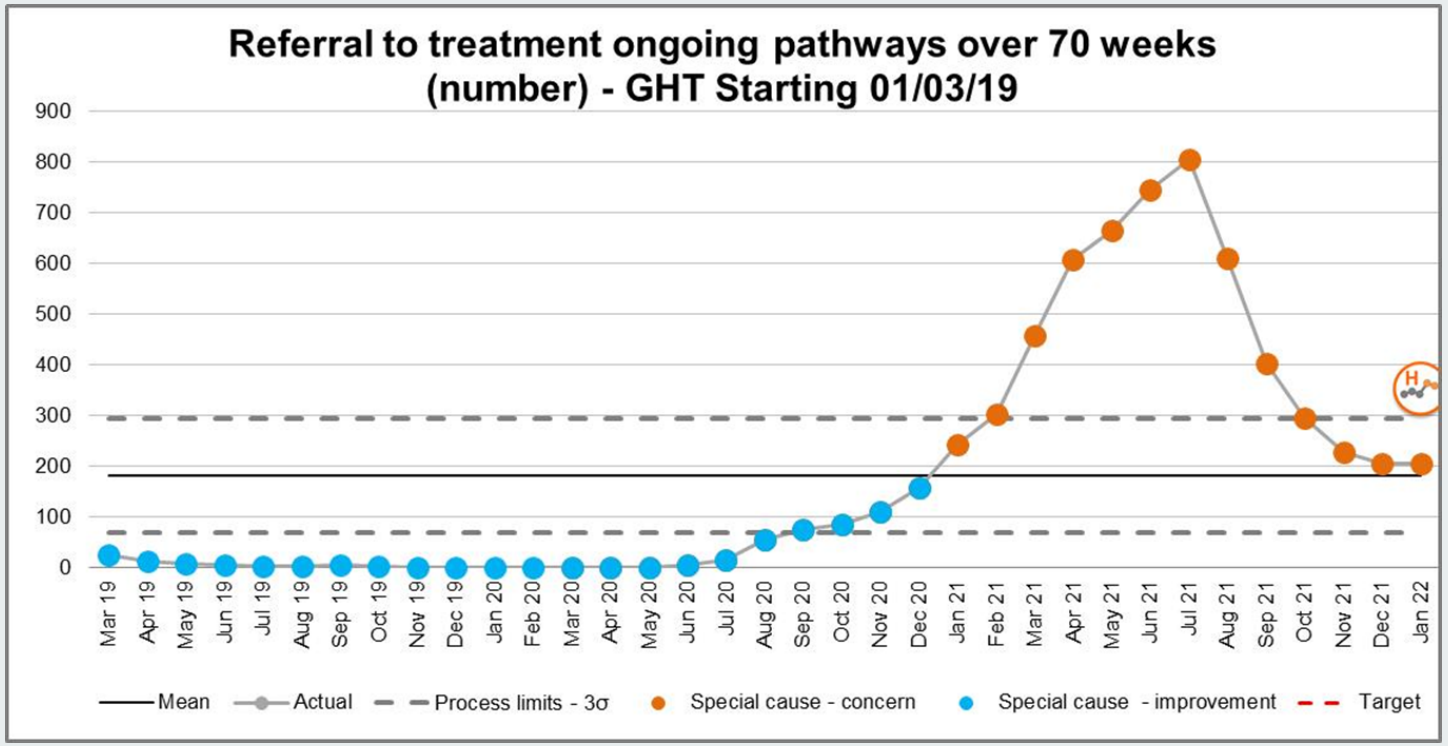

Commentary

The number of patients waiting 70 weeks or more has remained consistent for consecutive months. Although not captured within this reporting it should be noted that those greater than 78 weeks has reduced significantly from last month, moving from 86 down to 57. This approach of focusing on specific cohorts (as well as P2 patients) will be continued.

- Associate Director of Elective Care

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 9 data points which are above the line. There are 18 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
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Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Dementia Screening	% of patients who have been screened for dementia (within 72 hours)	>=90%	Mar-21	70%
Friends & Family Test	Inpatients % positive	>=90%	Jan-22	89.1%
Friends & Family Test	ED % positive	>=84%	Jan-22	78.6%
Friends & Family Test	Maternity % positive	>=97%	Jan-22	94.1%
Friends & Family Test	Outpatients % positive	>=94.5%	Jan-22	94.3%
Friends & Family Test	Total % positive	>=93%	Jan-22	91.0%
PALS	Number of PALS concerns logged	No Target	Jan-22	266
PALS	% of PALS concerns closed in 5 days	>=95%	Jan-22	65%
Infection Control	Number of trust apportioned MRSA bacteraemia	Zero	Jan-22	1
Infection Control	MRSA bacteraemia – infection rate per 100,000 bed days	Zero	Jan-22	3.4
Infection Control	Number of trust apportioned Clostridium difficile cases per month	2020/21: 75	Jan-22	3
Infection Control	Number of community-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jan-22	1
Infection Control	Number of hospital-onset healthcare-associated Clostridioides difficile cases per month	<=5	Jan-22	2
Infection Control	Clostridium difficile – infection rate per 100,000 bed days	<30.2	Jan-22	10.2
Infection Control	Number of MSSA bacteraemia cases	<=8	Jan-22	3
Infection Control	MSSA – infection rate per 100,000 bed days	<=12.7	Jan-22	10.2
Infection Control	Number of ecoli cases	No target	Jan-22	5
Infection Control	Number of pseudomona cases	No target	Jan-22	0
Infection Control	Number of klebsiella cases	No target	Jan-22	0
Infection Control	Number of bed days lost due to infection control outbreaks	<10	Jan-22	444
Infection Control	COVID-19 community-onset – First positive specimen <=2 days after admission	No target	Jan-22	139
Infection Control	COVID-19 hospital-onset indeterminate healthcare-associated – First positive specimen 3-7 days after admission	No target	Jan-22	60
Infection Control	COVID-19 hospital-onset probably healthcare-associated – First positive specimen 8-14 days after admission	No target	Jan-22	19
Infection Control	COVID-19 hospital-onset definite healthcare-associated – First positive specimen >=15 days after admission	No target	Jan-22	30
Maternity	% C-section rate (planned and emergency)	<=27%	Jan-22	0
Maternity	% emergency C-section rate	No target	Jan-22	17.8%
Maternity	% of women smoking at delivery	<=14.5%	Jan-22	0
Maternity	% of women that have an induced labour	<=30%	Jan-22	29.5%
Maternity	% stillbirths as percentage of all pregnancies > 24 weeks	<0.52%	Jan-22	0.43%
Maternity	% of women on a Continuity of Carer pathway	No target	Jan-22	10.20%
Maternity	% breastfeeding (initiation)	>=81%	Jan-22	78.8%
Maternity	% PPH >1.5 litres	<=4%	Jan-22	3.6%
Maternity	Number of births less than 27 weeks	NULL	Jan-22	1
Maternity	Number of births less than 34 weeks	NULL	Jan-22	7
Maternity	Number of births less than 37 weeks	NULL	Jan-22	33
Maternity	Number of maternal deaths	NULL	Jan-22	0
Maternity	Total births	NULL	Jan-22	471
Maternity	Percentage of babies <3rd centile born > 37+6 weeks	NULL	Jan-22	3.18%
Maternity	% breastfeeding (discharge to CMW)	NULL	Jan-22	47.1%
Mortality	Summary hospital mortality indicator (SHMI) – national data	NHS Digital	Sep-21	1.0
Mortality	Hospital standardised mortality ratio (HSMR)	Dr Foster	Oct-21	108.8
Mortality	Hospital standardised mortality ratio (HSMR) – weekend	Dr Foster	Oct-21	115.6

Quality Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

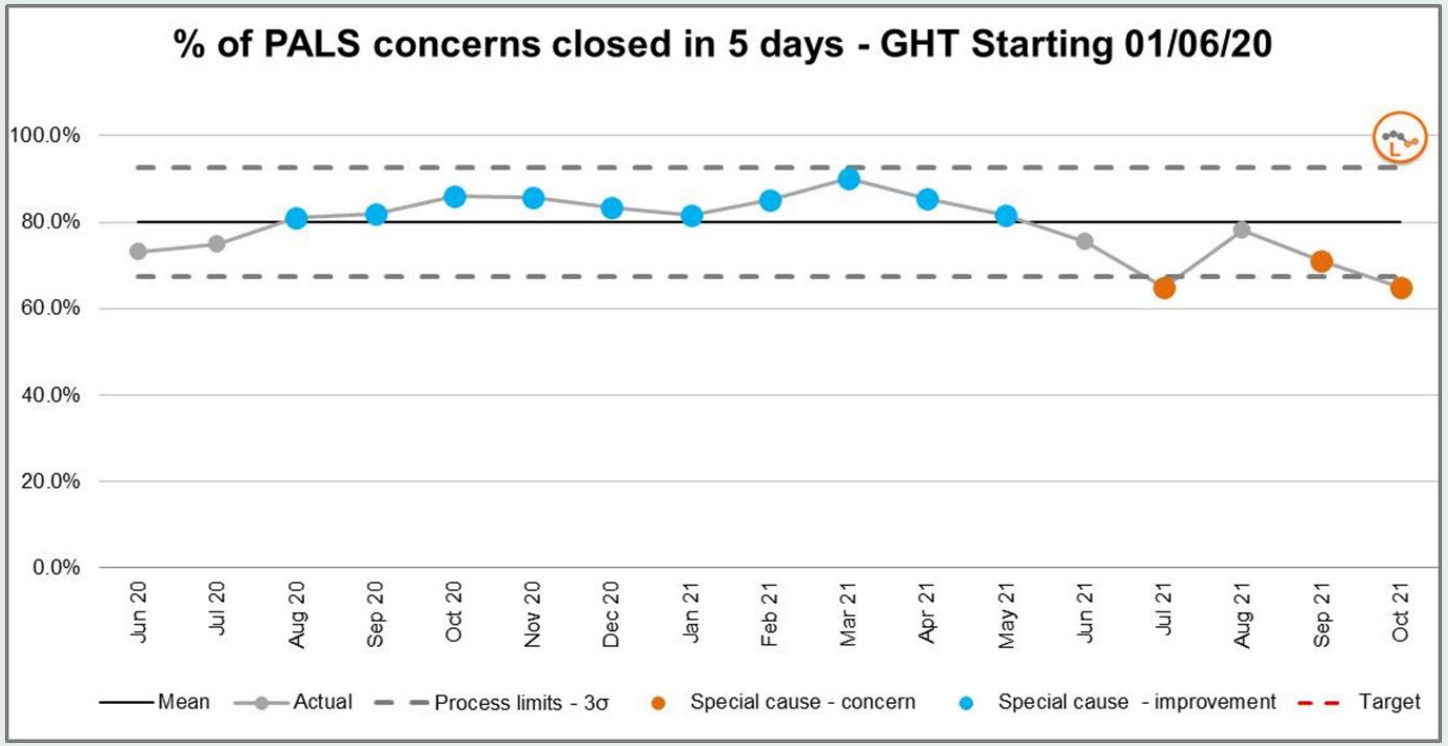
Key

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
Mortality	Number of inpatient deaths	No target	Jan-22	217	
Mortality	Number of deaths of patients with a learning disability	No target	Jan-22	3	
MSA	Number of breaches of mixed sex accommodation	<=10	Jan-22	0	
Patient Safety Incidents	Number of patient safety alerts outstanding	Zero	Dec-21	1	
Patient Safety Incidents	Number of falls per 1,000 bed days	<=6	Jan-22	7.3	
Patient Safety Incidents	Number of falls resulting in harm (moderate/severe)	<=3	Jan-22	5	
Patient Safety Incidents	Number of patient safety incidents – severe harm (major/death)	No target	Jan-22	7	
Patient Safety Incidents	Medication error resulting in severe harm	No target	Jan-22	1	
Patient Safety Incidents	Medication error resulting in moderate harm	No target	Jan-22	6	
Patient Safety Incidents	Medication error resulting in low harm	No target	Jan-22	9	
Patient Safety Incidents	Number of category 2 pressure ulcers acquired as in-patient	<=30	Jan-22	37	
Patient Safety Incidents	Number of category 3 pressure ulcers acquired as in-patient	<=5	Jan-22	2	
Patient Safety Incidents	Number of category 4 pressure ulcers acquired as in-patient	Zero	Jan-22	0	
Patient Safety Incidents	Number of unstagable pressure ulcers acquired as in-patient	<=3	Jan-22	12	
Patient Safety Incidents	Number of deep tissue injury pressure ulcers acquired as in-patient	<=5	Jan-22	13	
Sepsis Identification	Proportion of emergency patients with severe sepsis who were given IV antibiotics within 1 hour of diagnosis	>=90%	Apr-21	70%	
RIDDOR	Number of RIDDOR	SPC	Dec-21	5	
Safety Thermometer	Safety thermometer – % of new harms	>96%	Mar-20	97.8%	
Serious Incidents	Number of never events reported	Zero	Jan-22	1	
Serious Incidents	Number of serious incidents reported	No target	Jan-22	4	
Serious Incidents	Serious incidents – 72 hour report completed within contract timescale	>90%	Jan-22	100.0%	
Serious Incidents	Percentage of serious incident investigations completed within contract timescale	>80%	Jan-22	100%	

MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance		
VTE Prevention	% of adult inpatients who have received a VTE risk assessment	>95%	Jan-22	87.5%	
Safeguarding	Level 2 safeguarding adult training - e-learning package	No target	Nov-19	95%	
Safeguarding	Number of DoLs applied for	No target	Jan-22	64	
Safeguarding	Total attendances for infants aged < 6 months, all head injuries/long bone fractures	No target	Jan-22	1	
Safeguarding	Total attendances for infants aged < 6 months, other serious injury	No target	Jan-22	0	
Safeguarding	Total admissions aged 0-18 with DSH	No target	Jan-22	46	
Safeguarding	Total ED attendances aged 0-18 with DSH	No target	Jan-22	124	
Safeguarding	Total admissions aged 0-18 with an eating disorder	No target	Jan-22	5	
Safeguarding	Total number of maternity social concerns forms completed	No target	Jan-22	67	

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

In January the team managed 666 calls, including an increasing number of complex cases. Recruitment is underway with a new advisor joining the team in March and an additional post out to recruitment. Bank administrative support is being put in to support the team in triaging calls so that advisors can focus on managing and resolving complex concerns rather than dealing with enquiries which can be signposted effectively at triage point.

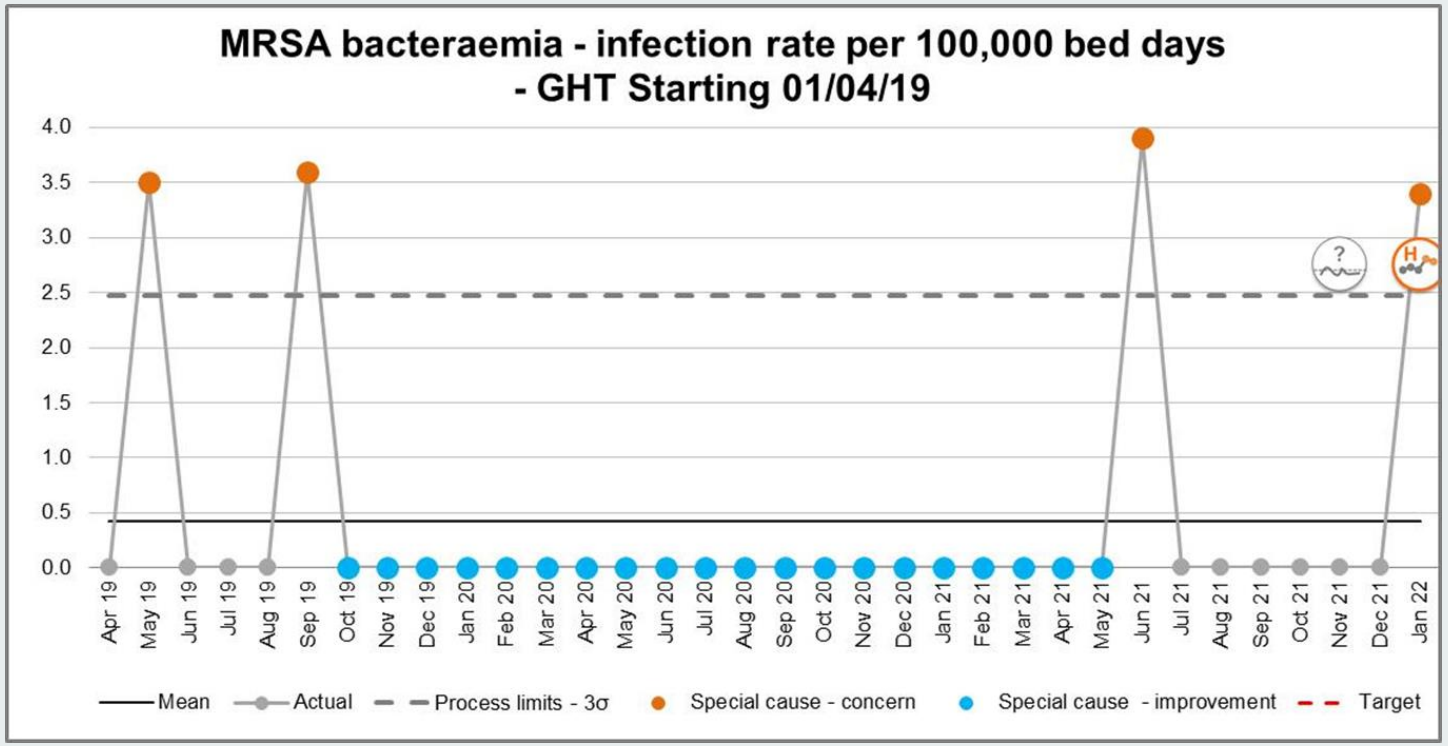
- Head of Quality

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

During January we have had a patient isolate MRSA in blood cultures sent 22/1/2022, the patient was admitted to GRH on 19/1/2022. The patient went from ED to DCC GRH and died on 24/1/2022. It was recognised the patient had a very poor prognosis on admission and was commenced on palliative care soon after admission this represents a hospital onset and healthcare associated case and therefore will be investigated. DCC are currently undertaking an investigation. This case has been escalated to our risk department for scoping for an SI. A rapid review of the case was completed upon notification of the result and initial findings suggest missed opportunity to send blood cultures on admission, no MRSA decolonisation was commenced and antibiotics with MRSA cover were not started until 22/1/2022 despite a history of MRSA in 2019. This has been discussed with DCC and ED who are addressing as part of the investigation. The patient has been escalated to GHC and CCG to see if the patient had any other healthcare contact prior to admission.

- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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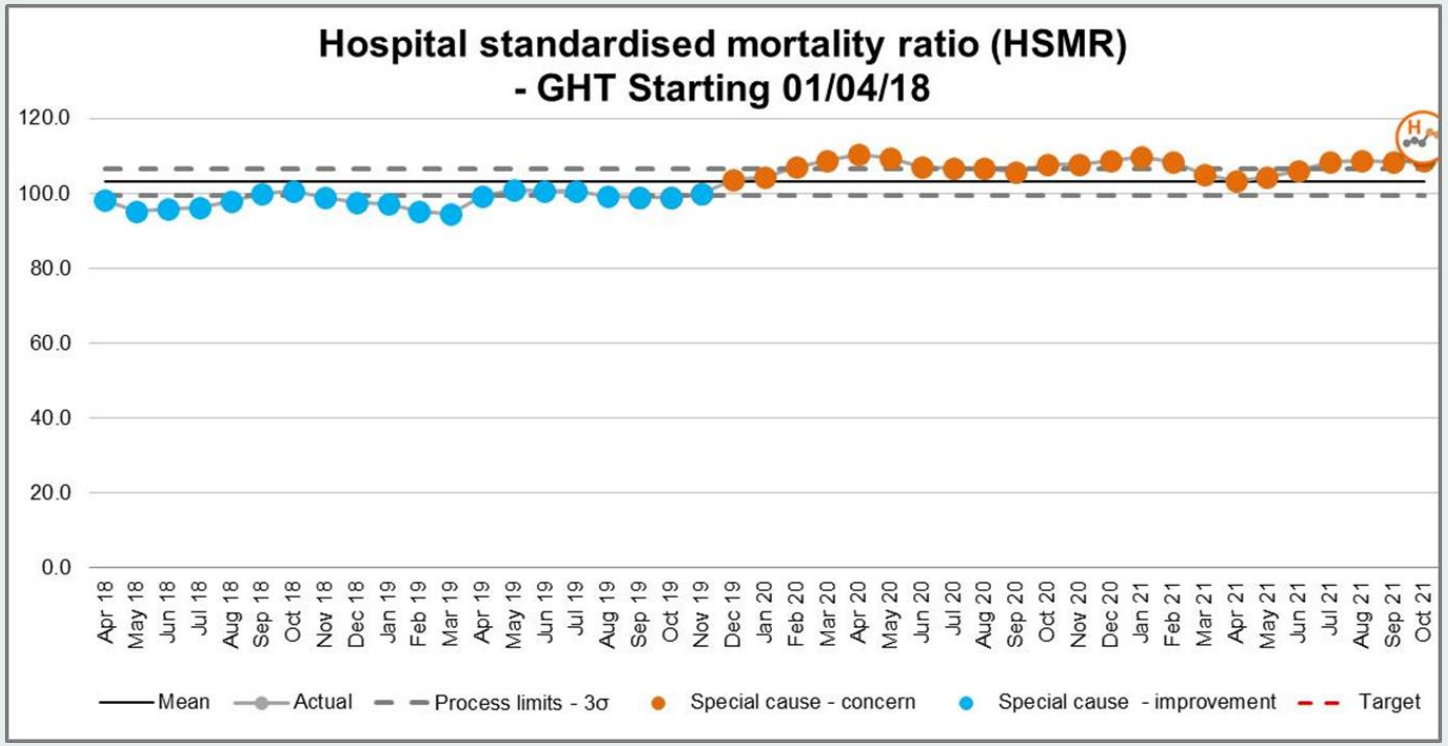
Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

HSMR is still significantly impacted by COVID, the modelling still classifies it is viral pneumonia which prior to COVID had a very low mortality. This continues to be monitored closely in HMG. The case mix is also a factor. Of note the SHMI is within the expected range but this excludes COVID cases.

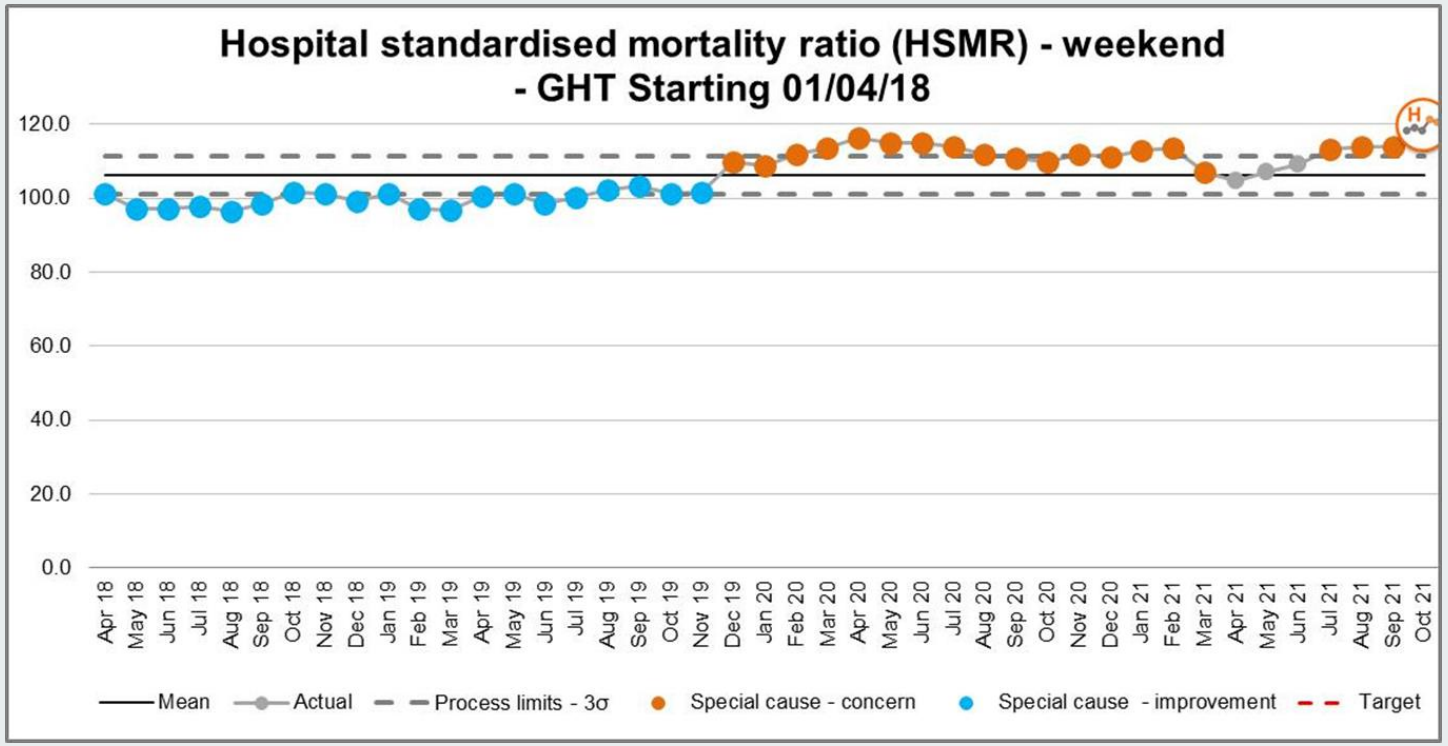
- Deputy Medical Director

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 15 data points which are above the line. There are 14 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

See HSMR - metric still affected by COVID. The detail shows HSMR is higher if admitted on Sunday but the same if admitted Monday to Saturday, this may be related to case mix as significant amount elective work done on Saturdays with a very mortality which is not done on Sundays. Will continue to be monitored at the Hospital Mortality Group meetings.

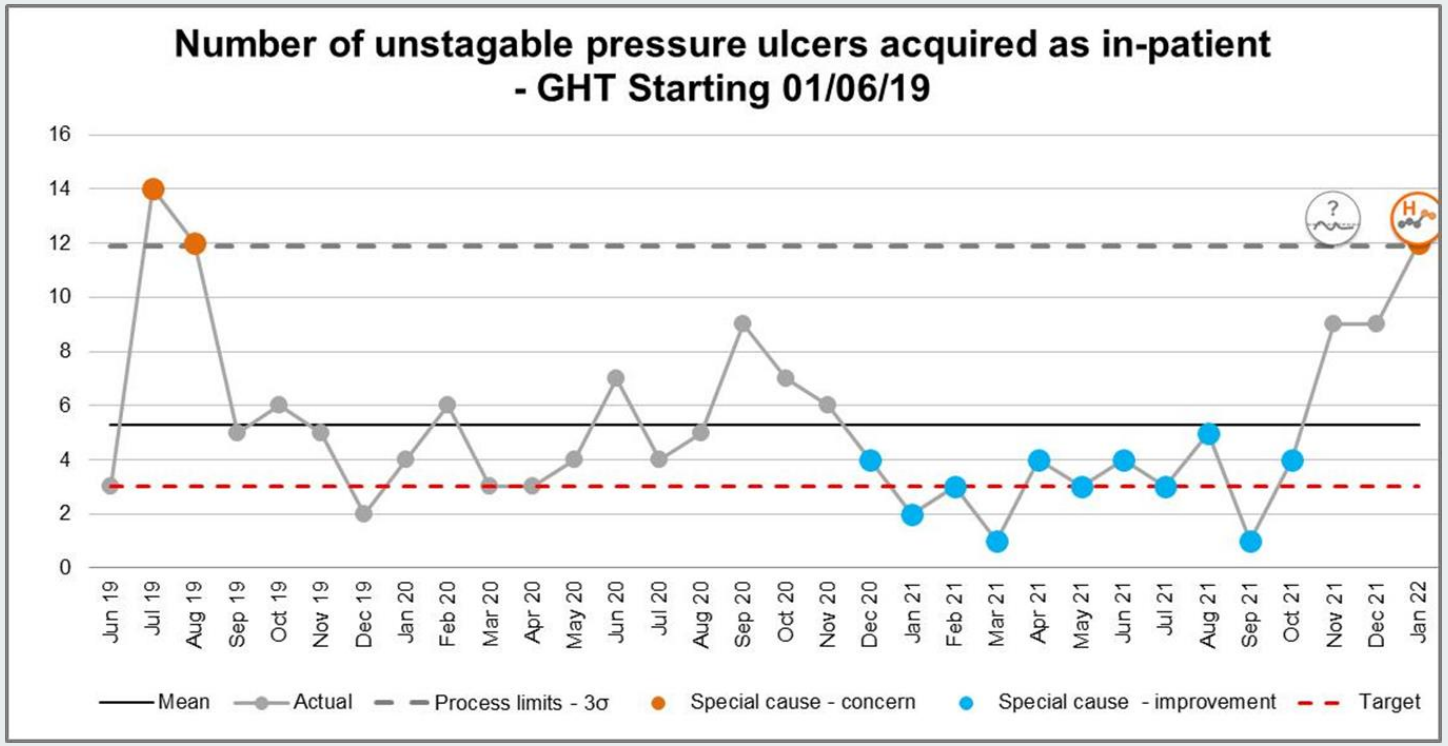
- Deputy Medical Director

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

There were 9 unstageable pressure ulcers reported during January. All of these cases are presented by ward leaders to the Preventing Harm Improvement Hub (PHIH) where rapid feedback is given on the results of the investigation. Themes from that process are late identification of pressure damage leading to possible progression to this later stage and incomplete or missing documentation. Although not identified through the review of cases at PHIH the Tissue Viability Team have received reports of equipment access delays and have taken access to address this.

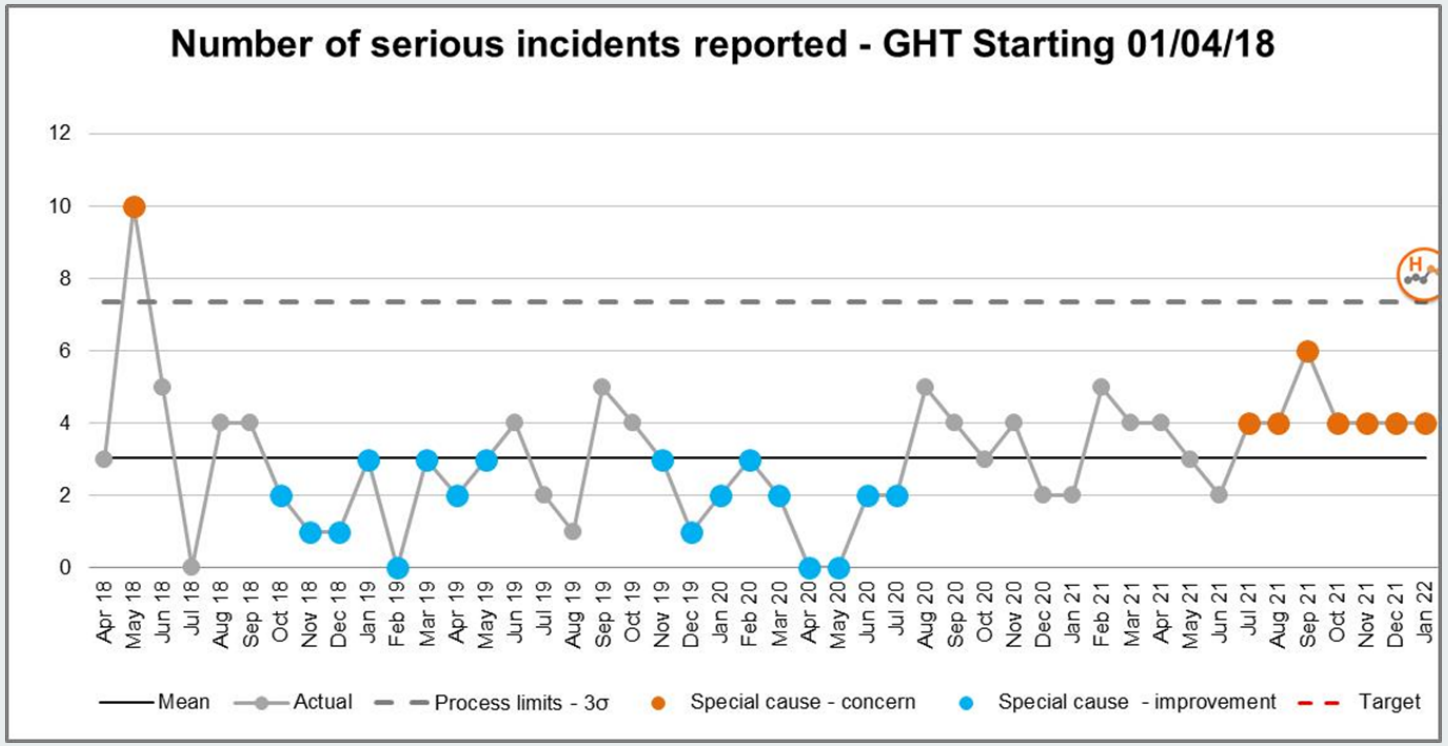
- Associate Chief Nurse, Director of Infection Prevention & Control

Data Observations

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

Quality:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

Under Review

- Quality Improvement & Safety Director

Data Observations

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

Financial Dashboard

Gloucestershire Hospitals NHS Foundation Trust

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

Key

Assurance

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

Variation

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

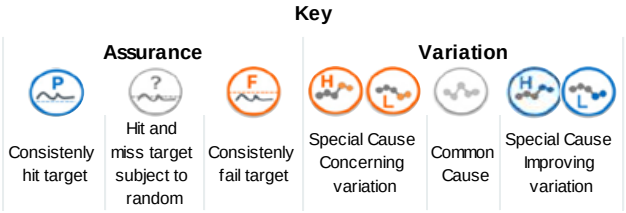
MetricTopic	MetricNameAlias	Target & Assurance	Latest Performance & Variance	
Finance	Total PayBill Spend		Sep-20	34.7
Finance	YTD Performance against Financial Recovery Plan		Sep-20	0
Finance	Cost Improvement Year to Date Variance		Sep-20	
Finance	NHSI Financial Risk Rating		Sep-20	
Finance	Capital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

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

People & OD Dashboard

Gloucestershire Hospitals NHS Foundation Trust

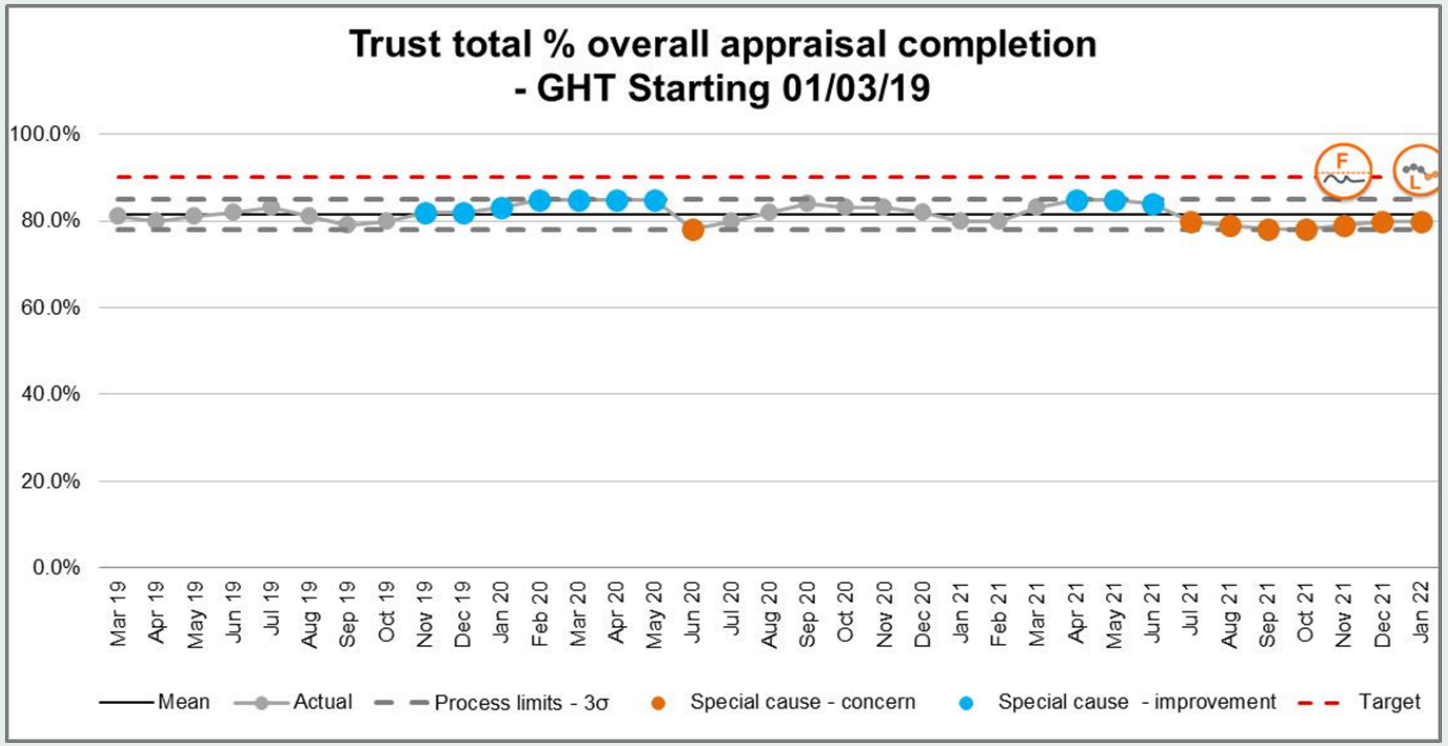
This dashboard shows the most recent performance of metrics in the People & Organisational Development category. Where SPC analysis is not possible the metric is RAG rated against national standards. Exception reports are shown on the following pages.



MetricTopic	MetricNameAlias	Target & Assurance		Latest Performance & Variance		
Appraisal and Mandatory	Trust total % overall appraisal completion	>=90%	F	Jan-22	80.0%	
Appraisal and Mandatory	Trust total % mandatory training compliance	>=90%	?	Jan-22	87%	
Safe Nurse Staffing	Overall % of nursing shifts filled with substantive staff	>=75%	P	Dec-21	89.2%	
Safe Nurse Staffing	% registered nurse day	>=90%	?	Dec-21	87.6%	
Safe Nurse Staffing	% unregistered care staff day	>=90%	P	Dec-21	84.8%	
Safe Nurse Staffing	% registered nurse night	>=90%	?	Dec-21	92.0%	
Safe Nurse Staffing	% unregistered care staff night	>=90%	P	Dec-21	95.0%	
Safe Nurse Staffing	Care hours per patient day RN	>=5		Dec-21	5.3	
Safe Nurse Staffing	Care hours per patient day HCA	>=3	P	Dec-21	3.2	
Safe nurse staffing	Care hours per patient day total	>=8		Dec-21	8.5	
Vacancy and WTE	Staff in post FTE	No target		Jan-22	6648.3	
Vacancy and WTE	Vacancy FTE	No target		Jan-22	834.81	
Vacancy and WTE	Starters FTE	No target		Jan-22	77.03	
Vacancy and WTE	Leavers FTE	No target		Jan-22	88.76	
Vacancy and WTE	% total vacancy rate	<=11.5%	P	Jan-22	11.16%	
Vacancy and WTE	% vacancy rate for doctors	<=5%	?	Jan-22	8.88%	
Vacancy and WTE	% vacancy rate for registered nurses	<=5%	F	Jan-22	14.46%	
Workforce Expenditure	% turnover	<=12.6%	P	Jan-22	12.9%	
Workforce Expenditure	% turnover rate for nursing	<=12.6%	P	Jan-22	11.0%	
Workforce Expenditure	% sickness rate	<=4.05%	P	Jan-22	3.9%	

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

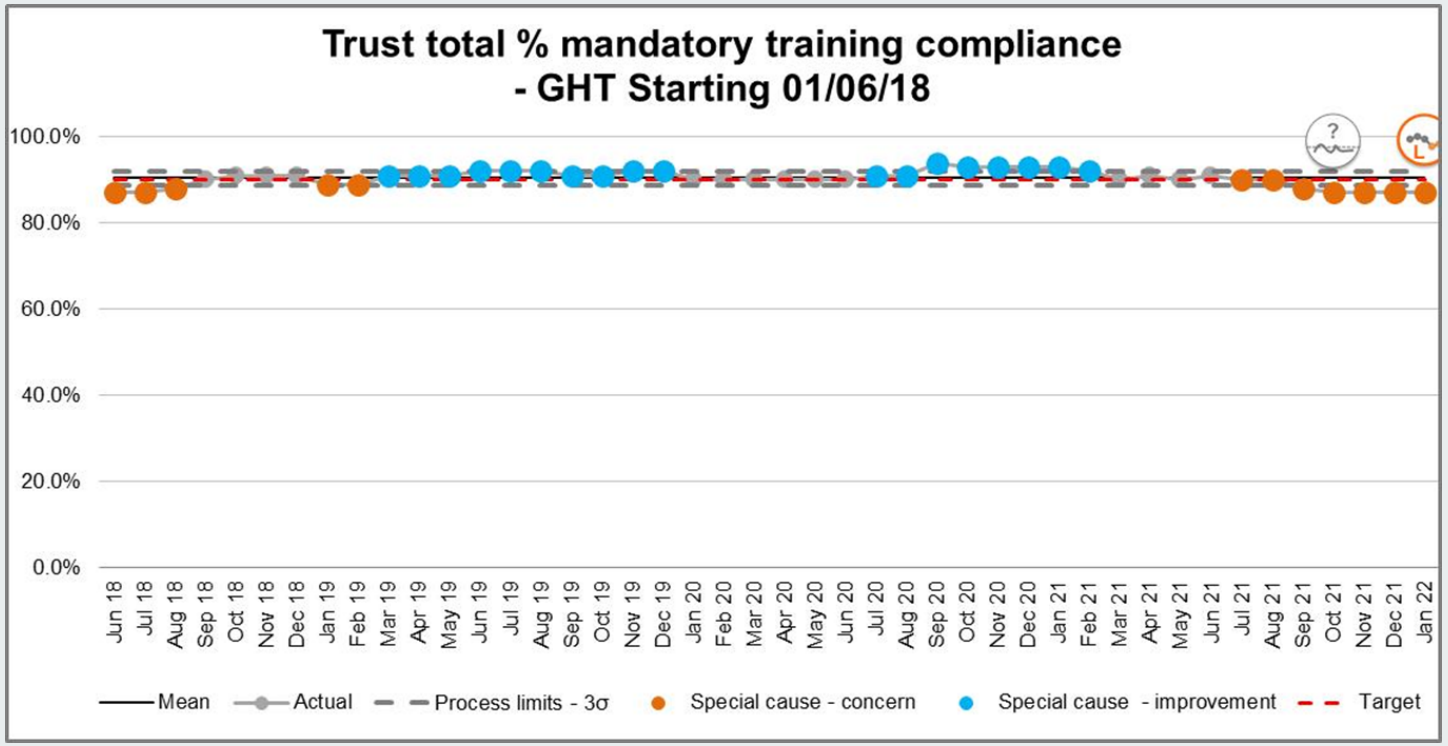
- **Deputy Director of People and Organisational Development**

Data Observations

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

People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals
NHS Foundation Trust



Commentary

- **Deputy Director of People and Organisational Development**

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 5 data points which are above the line. There are 8 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above the mean.
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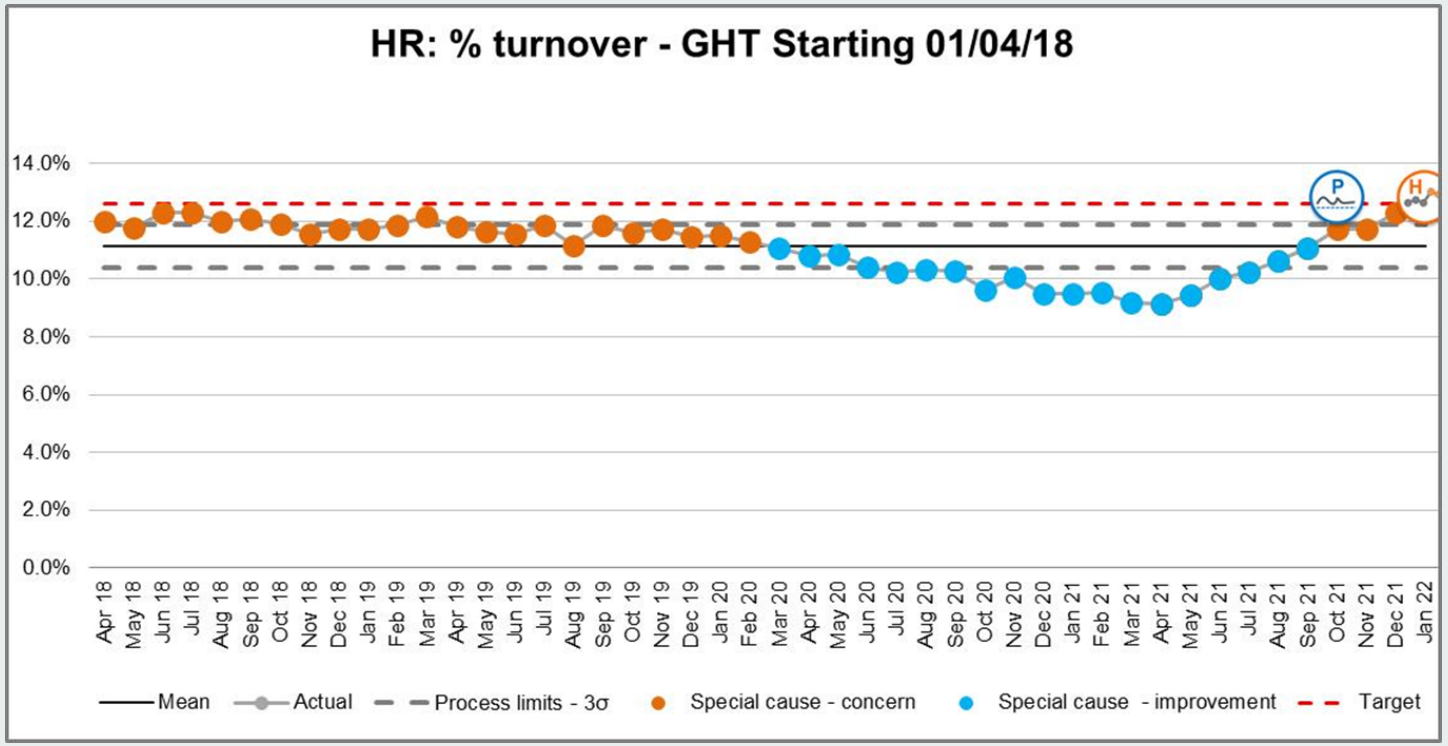
People & OD:
SPC – Special Cause Variation

Gloucestershire Hospitals NHS Foundation Trust



Commentary

The Trust's turnover rate continues to be of key focus across all staff groups, particularly with the ongoing flight risk following the pandemic and, whilst currently paused, the challenges of the Government's mandated vaccination regulations. Understanding reasons for staff leaving is under close attention in order to support the development of informed retention initiatives and activities.

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

Data Observations

Single point	Points which fall outside the grey dotted lines (process limits) are unusual and should be investigated. They represent a system which may be out of control. There are 9 data points which are above the line. There are 13 data point(s) below the line
Shift	When more than 7 sequential points fall above or below the mean that is unusual and may indicate a significant change in process. This process is not in control. There is a run of points above and below the mean.
Run	When there is a run of 7 increasing or decreasing sequential points this may indicate a significant change in the process. This process is not in control. In this data set there is a run of rising points
2 of 3	When 2 out of 3 points lie near the LPL and UPL this is a warning that the process may be changing

Gloucestershire Hospitals NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	10	Enclosure Number:	5
Date	10 March 2022		
Title	Ockenden Review of Maternity Services: One Year On		
Author /Sponsoring Director/Presenter	Vivien Mortimore, Divisional Director of Nursing and Quality/Chief Midwife Matt Holdaway, Director of Quality/Chief Nurse		

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

Summary of Report

Purpose

The purpose of this report is to provide an update on progress of the delivery of the 7 Immediate and Essential Actions (IEAs) one year on (Ockendon, Dec 2020).

In response to the "*Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust"* (Ockendon Report, 2020) the maternity service, at the Trust, has continued to focus on delivering the Immediate and Essential Actions (IEAs), despite the sustained pressure on the service caused by the Covid-19 pandemic.

Key issues to note

Ensuring local system oversight of maternity services was a key element in the Ockendon review therefore our regional NHSE/I team have handed over and shared a final position with the LMNS on 22 Feb 2022. Our LMNS then checked and confirmed the Trust current position of the 7IEAs (24 February 2022). The Trust have confirmed the planned actions to achieve full compliance.

Summarised progress against IEAs one year on (Regional and LMNS Assessment) and our plan to ensure full compliance

7 Immediate and Essential Actions (IEAs)	NHSE/I Regional assessment 22/2/2022	Gloucestershire LMNS assessment 24/2/2022	Maternity service plan to achieve full compliance
IEA1 Enhanced Safety	Compliant	Partial (compliant if confirmation that exception report goes to the Trust Board)	- External monitoring of SIs will be in place by April 2022. - Perinatal Clinical Quality Surveillance Report (PCQR) report reviewed by Q&P and not Board - for full compliance report needs to be reviewed by Board. Action: Q4 PCQSR to be attached to Q&P Chair's Report as appendix - Structure (organogram) for national to local flow of information for PCQS to

			be agreed by April 2022.
IEA2 Listening to women and their families	Compliant	Compliant	- No further action
IEA3 Staff training and working together	Compliant	Part 1 compliant Part 2 partial Part 3 partial	- Training Needs Analysis (TNA) to be shared with LMNS in March 2022 with a quarterly review thereafter.
IEA4 Managing complex pregnancies	Partial	Compliant	- No further action
IEA5 Risk Assessment throughout pregnancy	Partial	Partial	– Audit to be completed for Personal Care Plans by 30.06.2022 and presented to July LMNS. Audits to be yearly thereafter. – Birth Options clinics to be set up by 31.07.2022
IEA6 Monitoring fetal wellbeing	Compliant	Compliant	- No further action
IEA7 Informed consent	Partial	Partial	- Risk assessment audits to be completed by 30.06.2022 - Approved maternity leaflets to be added to Trust website by 01.04.22. - A risk assessment guideline will be developed by June 2022
Maternity Workforce			- Maternity Workforce Planning will be strengthened to ensure 6 monthly reviews (see Maternity Staffing Report to Board March 2022)

The LMNS, after checking the evidence, re-confirmed the compliance status and then checked the Trust's action plan. The LMNS were assured that the GHT Maternity Service would deliver all the proposed actions within the time frames specified.

Conclusion

NHSE/I have specifically asked for this update now (Appendix 1) as we prepare for the publication of further reports into maternity services during 2022 (Ockendon 2nd Report and the Independent Investigation into East Kent Maternity Services (IIEKMS).

Women and families using our maternity services deserve the best care. We recognise the huge efforts our maternity service has made in driving the improvements required. Ensuring local system oversight of maternity services was a key element in the Ockendon review and therefore we have shared and agreed our position and action plan with the LMNS. The Trust will also report on our progress again with our Regional NHSE/I Maternity Team by 15 April 2022.

Recommendation

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

Enclosures

- Ockenden Letter
- Ockenden Report

To: NHS Trust and Foundation Trust Chief Executives

cc. Trust Chairs and Directors of Nursing
ICS, CCG, LMS Leaders,
Regional Directors,
Regional Chief Nurses,
Regional Chief Midwives,
and Regional Obstetricians

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

25 January 2022

Dear colleagues,

Ockenden review of maternity services – one year on

Thank you for all your efforts in response to the Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust published in December 2020, and for your continued focus on the Immediate and Essential Actions (IEAs) despite the sustained pressure on your services throughout the pandemic. As well as ensuring progress continues, we need to prepare for the publication of further reports into maternity services during 2022.

The national response to the Ockenden report included a £95.6M investment into maternity services across England including funding for:

- 1200 additional midwifery roles,
- 100 wte equivalent consultant obstetricians,
- backfill for MDT training
- International recruitment programme for midwives
- Support to the recruitment and retention of maternity support workers

In our letter of 14 December 2020, we asked you to use the Assurance Assessment Tool, which includes the recommendations from the Morecambe Bay investigation report and the Ockenden report, to support a discussion at your trust public Board. One year on, we are asking that you again discuss progress at your public Board before the end of March 2022.

We expect the discussion to cover:

- Progress with implementation of the 7 IEAs outlined in the Ockenden report and the plan to ensure full compliance,
- Maternity services workforce plans,

Ensuring local system oversight of maternity services was a key element in the Ockenden review and therefore you should ensure progress is shared and discussed with your LMS and ICS. Progress must also be reported to your regional maternity team by 15 April 2022.

As you will no doubt agree, women and families using our maternity services deserve the best of NHS care. We recognise the huge efforts being made across the system and thank you for your continued commitment and support in driving the improvements required.

Yours faithfully

Sir David Sloman
Chief Operating Officer
NHS England and NHS Improvement

Ruth May
Chief Nursing Officer, England
NHS England and NHS Improvement

Ockendon - December 2020

Seven Immediate and Essential Actions (7IEAs) One Year on

March 2022

Authors
Women and Children's Divisional Director of Quality and Nursing
Vivien Mortimore
Deputy Director of Quality
Suzie Cro

Presenter
Director of Quality and Chief Nurse (Interim)
Matt Holdaway

Ockenden – LMNS/System progress on implementation of recommendations

LMNS implementation – progress status	Blue	Complete	Actions/Mitigations:
	Green	On track	
	Amber	At risk- plan in place	
	Red	Not on track + support required	
To oversee quality in line with *Implementing a revised perinatal quality surveillance model*			The 5 principles for improving and assuring oversight of clinical quality and safety within Gloucestershire's maternity & neonatal services have been developed and agreed. The principles are set out in the Gloucestershire LMNS Perinatal Quality & Safety Framework as the LMNS evolves to become the maternity arm of the ICS in Gloucestershire. Clear lines of responsibility and accountability for addressing quality and safety concerns are in place at each level of the system; Trust-level, LMNS/ICS, regional and national.
To share information and learning in a structured and systematic way, working with partners to turn learning into service improvement.			Gloucestershire and BSW LMNS have developed a formal buddy arrangement. A shared Glos/BSW Clinical Forum will support sharing of information and learning from clinical incidents and feedback from service users to improve outcomes in maternity and neonatal care. Maternity Experience Workstream relaunched User feedback for maternity collected from a variety of sources including Picker Surveys, FFT Surveys and the Maternity Voices Partnership. Action log developed and now used to keep track of all feedback provided and actions taken as a result. Triangulation of feedback from all sources is used to identify any emerging themes. All user feedback is presented at the maternity experience workstream and assigned to the relevant LMNS workstream. Actions are developed in coproduction with MVP and other service users.

Ockenden – LMNS/System progress on implementation of recommendations

To ensure action is taken to improve the culture of maternity and neonatal services as a building block for safe, personal and more equitable care.		**Staff culture action plan developed and will be taken forward by the maternity experience workstream that will feed into the LMNS. This includes the OD action plan and WRES data. SCORE survey data from 2019 will also be added in as well (to compare to the SCORE survey when repeated this year).**
To co design and implement a vision for local maternity and neonatal services with local women through Maternity Voices Partnerships.		
To implement shared solutions wherever possible through shared clinical and operational governance.		Maternity & Neonatal/Trust/LMNS/CCG/ICS governance framework agreed and implemented. Combined clinical dashboard developed and reviewed regularly by Trust Maternity Delivery Group, with exception reporting to Trust Q & P committee and Trust Board, LMNS and CCG/ICS QSG.
ICSs should set out a plan for how formal, structured and systematic oversight of how their LMNS will deliver its functions		Gloucestershire Quality & Safety Surveillance Framework developed and agreed. Revised template shared and agreed for LMNS reporting on quality and safety issues to the Regional Perinatal Quality Safety Surveillance Group
LMNSs, in consultation with regional teams, to identify a buddy LMS and implement processes for peer review and support		Memorandum of Understanding in Place with BSW . We are now at the point of going out to recruit experts across the service.
ICSs to ensure the LMS Board is part of governance arrangements, and ensure that future arrangements maintain direct line of sight from the statutory ICS Board to the LMS Board, (although there may be a period of transition during 2021/22)		Gloucestershire LMNS Framework for Perinatal Quality and Safety Surveillance and Oversight in place.

Ockenden 7IEAs- One Year on
Progress and action plan

The seven immediate and essential actions from the Ockenden report *please use data from your LMNS dashboard and assess as key	Green 1 Green/Amber 2 Amber 3 Amber/Red 4 Red 5	**Actions/Mitigations:**
Enhanced Safety	2	External monitoring of SIs will be in place by April 2022. Perinatal Clinical Quality Surveillance Report (PCQR) report reviewed by Q&P and not Board - for full compliance report needs to be reviewed by Board. Action: Q4 PCQSR to be attached to Q&P Chair's Report as appendix Structure (organogram) for national to local flow of information for PCQS to be agreed by April 2022.
Listening to women and families	1	
Staff Training and Working Together	2	Training Needs Analysis (TNA) to be shared with LMNS in March 2022 with a quarterly review thereafter.
Managing Complex Pregnancy	1	
Risk Assessment Throughout Pregnancy	2	Audit to be completed for Personal Care Plans by 30.06.2022 and presented to July LMNS. Audits to be yearly thereafter. Birth Options clinics to be set up by 31.07.2022
Monitoring Fetal Wellbeing	1	
Informed Consent	2	Risk assessment audits to be completed by 30.06.2022 Approved maternity leaflets to be added to Trust website by 01.04.22. A risk assessment guideline will be developed by June 2022

Gloucestershire Hospitals NHS Foundation Trust

Report to Public Board of Directors			
Agenda item:	**10**	**Enclosure Number:**	**6**
Date	10 March 2022		
Title	Maternity Staffing Report (July-December 2021)		
Author /Sponsoring Director/Presenter	Suzie Cro, Deputy Director of Quality Lisa Stephens, Head of Midwifery Vivien Mortimore, Divisional Director of Nursing and Quality/Chief Midwife Matt Holdaway, Director of Quality/Chief Nurse		

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

Summary of Report

Purpose

The purpose of this report is to provide assurance to the Trust Board that there is an effective system of maternity workforce planning and an effective system for the monitoring of safe staffing levels. This report covers the period July to December 2021.

Key issues to note

The Covid-19 pandemic has increased staff related absences and has provided further complexity to the Maternity Service provision.

Obstetric medical workforce

The medical Obstetric Team currently comprises:

- 12 consultant obstetricians, who are resident on call from 0830-2100 Monday – Friday; 0830- 1430, 2000 – 2130 at weekends (77.5 hours/week), and then on call overnight.
- 24-hour Registrar presence for obstetrics, supported by a registrar for gynaecology, with 12.5 hour shifts
- 24 hour SHO presence – 0830-1700 for obstetrics, 1700-0830 and weekends for both obstetrics and gynaecology
- A Registrar for the elective caesarean section list, 5 days a week, from 0830-1700; supported by the Gynaecology consultant
- 10.5 weekly Consultant run antenatal clinics across the county, including specialist clinics for
  - Maternal medicine
  - Perinatal mental health
  - Substance misuse and blood borne viruses
  - Teenage pregnancies
  - High BMI
  - Preterm birth prevention (about to be started)
- There are 6 consultant fetal medicine sessions per week, across both sites.
- The obstetric consultant team and maternity senior management team have acknowledged and are committed to incorporating the principles outlined in the RCOG (June 2021) workforce document: 'Roles

and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into the maternity service.

- The maternity service will monitor compliance of consultant attendance for the clinical situations listed in this document, for when a consultant is required to attend in person. This data will be presented to the LMNS, Maternity Delivery Group and also to the Maternity Safety Champions to meet NHS Resolution (NHSR) Maternity Incentive Scheme Safety Action 4 (2021).

Anaesthetic medical workforce

To meet the Royal College of Anaesthetists Anaesthesia Clinical Services Accreditation (1.7.2.1) a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising anaesthetic consultant at all times. The Maternity Service can confirm this standard is in place (NHSR, Maternity Incentive Scheme Safety Action 4 (2021)).

Neonatal medical workforce

- There are 6 Neonatal Consultants full time with split rota allowing specialist cover for neonatal unit 24 hours a day, 7 days a week. Daily ward rounds. Resident 09.00-17.00 weekdays and 09.00-14.00 weekends
- There is 24 hr tier 2 resident cover
- There is 24 hr tier 1 resident cover, with additional 2 tier 1s 09.00-17.00
- The Trust meets the BAPM national standards for junior medical staffing (NHSR Maternity Incentive Scheme Safety Action 4 (2021)).

Neonatal nursing workforce

- The unit is funded for 11 WTE neonatal nurses on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines (NHSR Maternity Incentive Scheme Safety Action 4 (2021)).
- Agency and bank are utilised if required and admin/teaching days are withdrawn depending on clinical needs of the unit.
- Staffing was reviewed as part of the SW Neonatal Network and Gloucester was awarded £115,092 to enhance nursing care (this funding has yet to be allocated to posts).
- Year to date the unit has not had its GIRFT assessment and we have a provisional date set for May 2022.
- The Unit has been challenged in relation to nurse staffing due to high numbers of maternity leave and long term sick.
- We have followed our Escalation plans to support nursing which has included utilising all nursing time in to clinical shifts and advanced booking of agency nurses who are Neonatal Qualified in Speciality (QIS) trained.

Midwifery workforce

Systematic review of midwifery staffing

- Birthrate+ (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units for a significant number of years. GHT had a formal midwifery workforce review completed by BR+ in early 2019 detailing that an uplift of midwifery staffing was required, which was funded.
- The further roll out of Midwifery Continuity of Care (MCoC) will impact on the establishments as there will need to be redesigned pathways and models of care. A MCoC service delivery model and business plan is being written to outline how we can achieve the national ambition of the MCoC model locally.
- Currently a BR+ review is being undertaken and the report is due in Spring 2022. Once the results have been received an action plan will be drawn up and this will be presented to Divisional Board with any issues/concerns escalated. To meet the NHSR Maternity Incentive Scheme Safety Action 5 this report and action plan must be presented to the Trust Board when completed.

- As recommended there are currently 11% of specialist midwives and midwives in managerial positions employed and this accounts for 8-10% of the establishment, which are not included in clinical numbers, as recommended by BR+ (NHSR Maternity Incentive Scheme Safety Action 5).

Shortages of midwifery staff

- In relation to the current funded establishment there is currently a midwifery staffing shortage of **24 whole time equivalents (WTE)** due to turnover, maternity leave and sickness absence. This risk has been placed on the Trust risk register (W&C3536OBS) with a score of 15 for safety.
- To mitigate this risk robust controls have been put in place. For example:
  - Daily review of staffing across the whole service and reallocation of staff.
  - Twice daily Multidisciplinary Team (MDT) huddles to prioritise clinical workload.
  - An allocated "Band 8 (manager) of the day" to support flow and staffing/ activity coordination.
  - Weekly staffing reviews between the Matrons and the Head of Midwifery.
  - Use of the escalation policy; which includes the use of specialist midwives to support the clinical service, on-call midwives being called in (hospital and community) and a review of all urgent/non-urgent clinical activity.
  - An enhanced Senior Midwives on-call rota to provide out of hours' leadership support.
  - Offering an increased incentive to do Bank Shifts with increased use of temporary staffing to fill shifts. However, it must be noted that not all shifts are being filled and so this averages out that the service runs with **90-105 unfilled shifts** per month.
  - Mandatory and non-mandatory training has been cancelled (mandatory training compliance has decreased from 92% June to 81% in December).
  - Temporary closure of the Aveta Birth Centre at Cheltenham for a period of 9 weeks to support staffing within the main Gloucester Royal site.
  - There is a plan is to recruit 5 International Midwives by June 2022.

Ongoing monitoring of safety metrics and data

- Safe midwifery staffing is monitored by the completion of the Birthrate Plus acuity tool (4 hourly), daily staffing safety huddles, monitoring of the midwife to birth ratio and monitoring of red flags as per NICE Guidance (NICE NG4, 2021).
- Use the Birthrate+ Acuity tool enables monitoring of compliance with supernumerary labour ward co-ordinator status and provision of 1:1 care in labour.
- Presently only the data on CDS is reliable.
  - 99 % of the time (on 11 occasions) there was a midwifery co-ordinator in charge of labour ward who had supernumerary status (defined as having no caseload of their own during their shift) to ensure there is oversight of all birth activity within the service (standard 100%).
  - There were 4 occasions on CDS where women who were in active labour was not able to receive one-to-one midwifery care of the time (standard 100 %).
- There were on average 21 red flags events per month (a red flag event is an event where basic care was not provided).
- Our current midwife to birth ratio is 1:27, whilst funded establishment is 1:26. This does not take account of long and short-term sickness and maternity leave. This is monitored via the Divisional Dashboard at the Maternity Clinical Governance Meeting and Divisional Board.

Plans to create a sustainable midwifery workforce in the long term

The maternity service is focused on being an attractive employer by launching Respectful Resolutions initiatives, offering more opportunities for flexible working and embedding collective compassionate and inclusive leadership style to create cultures within which midwives want to work and build their careers.

Conclusions

The evidence described in this report provides assurance that there are effective workforce planning tools being

used currently to review current establishments. This report describes the urgent action being taken to tackle the staff shortages and the increased pressures this has on staff, which have been exacerbated by the Covid-19 pandemic.

It is recognised that staffing shortages increase pressure on the workforce across the whole service leading to high levels of stress. Workforce shortages are being regularly monitored on a shift by shift basis. Colleague wellbeing initiatives have been put in place for staff to access, as required, through the service and also through the 2020 Staff Advice and Support Hub.

Recommendation

The Board is asked to:

- Note the contents of the report.
- Review the Birthrate+ report and action plan when available to enable the service to meet NHSR Maternity Incentive Scheme Standards.

Enclosures

- Maternity Staffing Report

Gloucestershire Hospitals
NHS Foundation Trust

BOARD March 2022

MATERNITY STAFFING REPORT

1. Purpose of Report

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

1.2. This report covers the period July to December 2021. Our focus was to ensure women, babies and their families receive the maternity care they need, including care in all:
- maternity services (for example, pre-conception, antenatal, intrapartum and postnatal services, clinics, home visits and maternity units)
- settings where maternity care is provided (for example, home, community, free-standing and alongside midwifery-led units, hospitals including obstetric units, day assessment units, and fetal and maternal medicine services).

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

2. Executive Summary

The Covid-19 pandemic has increased staff related absences and has provided further complexity to the Maternity Service provision.

Obstetric medical workforce

2.1. The obstetric consultant team and maternity senior management team have acknowledged and are committed to incorporating the principles outlined in the RCOG (June 2021) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into the maternity service.

2.2. The maternity service will monitor compliance of consultant attendance for the clinical situations listed in this document, for when a consultant is required to attend in person. This data will be presented to the LMNS, Maternity Delivery Group and also to the Maternity Safety Champions to meet NHS Resolution (NHSR) Maternity Incentive Scheme Safety Action 4 (2021).

Anaesthetic medical workforce

2.3. To meet the Royal College of Anaesthetists Anaesthesia Clinical Services Accreditation (1.7.2.1) a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and they have clear lines of communication to the supervising

anaesthetic consultant at all times. The Maternity Service can confirm this standard is in place (NHSR, Maternity Incentive Scheme Safety Action 4 (2021)).

Neonatal medical workforce

2.4. The Trust meets the BAPM national standards for junior medical staffing (NHSR Maternity Incentive Scheme Safety Action 4 (2021)).

Neonatal medical workforce

2.5. The unit is funded for 11 WTE neonatal nurses on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines (NHSR Maternity Incentive Scheme Safety Action 4 (2021)).

Midwifery workforce

2.6. Currently a BR+ review is being undertaken and the report is due in Spring 2022. Once the results have been received an action plan will be drawn up and this will be presented to Divisional Board with any issues/concerns escalated. To meet the NHSR Maternity Incentive Scheme Safety Action 5 this report and action plan must be presented to the Trust Board when completed.

2.7. In summary, this report has been written to respond to the request made by NHSE/I 25 Jan 2022 to review Maternity Workforce Plans (see letter at appendix 1).

3. Background

3.1. The National Quality Board (NQB) standards for nursing and midwifery (2018) provide the guidelines for NHS providers and this paper describes the Trust's approach to meeting those expectations/ standards.

3.2. The publication of a range of highly critical reports surrounding maternity units including the Report of the Morecambe Bay investigation (2015), Cwm Taf Morgannwg (2017) and Shrewsbury and Telford in 2020 have contributed to the high profile afforded to maternity safety and quality.

3.3. NICE guidance - Safe midwifery staffing for maternity settings published in 2015 identified recommendations surrounding organisational requirements, setting the midwifery establishment, assessing the difference in number and skill mix of midwives, and monitoring and evaluating midwifery staffing requirements.

3.4. Year four of the Maternity Incentive Scheme (MIS) (NHSR, 2021) asks Trusts to continue to apply the principles of the 10 safety actions and given that the aim of MIS is to support the delivery of safer maternity care, workforce planning and review are within standard 4 and 5 of the scheme. This report has been written to meet these standards so that we can demonstrate we have an effective system of clinical

workforce planning to the specified standards and have action plans in place for any gaps/issues identified.

OBSTETRIC MEDICAL WORKFORCE

4. Obstetric medical workforce

4.1. The medical Obstetric team currently comprises: -

- 12 consultant obstetricians, who are resident on call from 0830-2100 Monday – Friday; 0830- 1430, 2000 – 2130 at weekends (77.5 hours/week), and then on call overnight.
- 24-hour Registrar presence for obstetrics, supported by a registrar for gynaecology, with 12.5 hour shifts
- 24 hour SHO presence – 0830-1700 for obstetrics, 1700-0830 and weekends for both obstetrics and gynaecology
- A Registrar for the elective caesarean section list, 5 days a week, from 0830-1700; supported by the Gynaecology consultant
- 10.5 weekly Consultant run antenatal clinics across the county, including specialist clinics for
    - Maternal medicine
    - Perinatal mental health
    - Substance misuse and blood borne viruses
    - Teenage pregnancies
    - High BMI
    - Preterm birth prevention (about to be started)
- There are 6 consultant fetal medicine sessions per week, across both sites

4.2. The obstetric consultant team and maternity senior management team have acknowledged and committed to incorporating the principles outlined in the RCOG (June 2021) workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into the maternity service.

Picture: Roles and responsibilities of an O&G Consultant

4.3. The maternity service will monitor compliance of consultant attendance for the clinical situations listed in this document for when a consultant is required to attend in person.

Picture: Situations when the on-call Consultant MUST attend.

Situations in which the consultant MUST ATTEND
GENERAL
In the event of high levels of activity e.g a second theatre being opened, unit closure due to high levels of activity requiring obstetrician input
Any return to theatre for obstetrics or gynaecology
Team debrief requested
If requested to do so
OBSTETRICS
Early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary
Caesarean birth for major placenta praevia / abnormally invasive placenta
Caesarean birth for women with a BMI >50
Caesarean birth <28/40
Premature twins (<30/40)
4th degree perineal tear repair
Unexpected intrapartum stillbirth
Eclampsia
Maternal collapse e.g septic shock, massive abruption
PPH >2L where the haemorrhage is continuing and Massive Obstetric Haemorrhage protocol has been instigated
GYNAECOLOGY
Any laparotomy

4.4. Episodes where attendance has not been possible will be reviewed at the unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.

4.5. Audits related to Consultant attendance is ongoing to meet Ockendon requirements

OBSTETRIC ANAESTHETIC MEDICAL WORKFORCE

5. Obstetric anaesthetic medical cover

5.1. The obstetric anaesthetist is a member of the delivery unit team. Approximately 60 per cent of women require anaesthetic intervention around the time of delivery of their baby. The staffing of anaesthetics for maternity services is allocated according to Guidelines from Obstetric Anaesthetic Association 2013.

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

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

5.4. The national recommendation is that busier obstetric units should consider having two duty anaesthetists available 24/7, in addition to the supervising consultant. GHT maintains a 95% compliance with two duty anaesthetists during the hours of 0800-1800 Monday to Friday.

5.5. Funding is not at present available for a second duty anaesthetist out of hours or at weekends. Mitigation for the risk of 2nd anaesthetist in these cases is that the senior anaesthetic trainee on call, who also covers anaesthetic services in other departments (ED, DCC, Theatres), should be called.

5.6. The duty anaesthetist has a clear line of communication to the supervising consultant at all times (see contact details on appendix 2 Obstetric anaesthetic rota).

5.7. The anaesthetist who is on duty for delivery suite is invited to attend the ward round alongside the Obstetric Consultant, Obstetric Registrar. Evidence of compliance for this requirement is kept on delivery suite. Should the duty anaesthetist be attending a woman (in theatre or delivery room) when the round takes place the Obstetric Registrar will hand over any relevant information as soon as the anaesthetist is available.

5.8. Additional consultant programmed activities are allocated for:

- elective caesarean deliveries

- antenatal anaesthetic clinics

5.9. There is a named consultant anaesthetist responsible for every elective caesarean delivery operating list and this consultant should be immediately available. The named consultant should have no other clinical responsibilities. GHT Maternity Service is fully compliant with this recommendation (Appendix 2 Obstetric Anaesthetic Rota GHT).

5.10. Consultant support is available at all times with a response time of not more than half an hour to attend the delivery suite, and maternity operating theatre. The supervising consultant should not therefore be responsible for two or more geographically separate obstetric units. GHT Maternity Service is fully compliant with this recommendation (Appendix 2 Obstetric Anaesthetic Rota GHT)

5.11. In busy units, consideration should be given to extending resident consultant cover into the evening. At present, there is no funding available to provide this level of cover. A business case would need to be submitted if we are to be compliant with this recommendation.

5.12. **In summary**, to meet the NHSR MIS Standards (2021) GHT can confirm that there is a duty anaesthetist is immediately available for the obstetric unit 24 hours a day and has clear lines of communication to the supervising anaesthetic consultant at all times. Where the duty anaesthetist (requirement for 2nd anaesthetist between 16:00 and 08:00) has other responsibilities, they are able to delegate care of their non-obstetric patients in order to be able to attend immediately to obstetric patients. (ACSA standard 1.7.2.1).

NEONATAL MEDICAL WORKFORCE

6. Neonatal Medical Workforce

6.1. There are 6 Neonatal Consultants full time with split rota allowing specialist cover for neonatal unit 24 hours a day, 7 days a week.

6.2. Daily ward rounds. Resident 09.00-17.00 weekdays and 09.00-14.00 weekends

- 24 hr tier 2 resident cover
- 24 hr tier 1 resident cover, with additional 2 tier 1s 09.00-17.00

- The neonatal unit meets the British Association of Perinatal Medicine (BAPM) national standards of junior medical staffing (NHSR Maternity Incentive Scheme Safety Action 4 (2021)).

NEONATAL NURSING WORKFORCE

7. Neonatal Nursing Workforce

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

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

7.3. The unit is funded for 11 WTE neonatal nurses on every shift and this is amended based on occupancy and dependency of the babies as per BAPAM guidelines (NHSR Maternity Incentive Scheme Safety Action 4 (2021)).

7.4. Agency and bank are utilised if required and admin/teaching days are withdrawn depending on clinical needs of the unit.

7.5. Staffing was reviewed as part of the SW Neonatal Network and Gloucester was awarded £115,092 to enhance nursing care (this funding has yet to be allocated to posts).

7.6. Year to date the unit has not had its GIRFT assessment and we have a provisional date set for May 2022.

7.7. The Unit has been challenged in relation to nurse staffing due to high numbers of maternity leave and long term sick.

7.8. We have followed our Escalation plans to support nursing which has included utilising all nursing time in to clinical shifts and advanced booking of agency nurses who are Neonatal Qualified in Specialty (QIS) trained.

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

7.10. Succession planning for consultant neonatal nurses is a current challenge

MIDWIFERY STAFFING

8. Right staff - evidence based midwifery workforce planning

8.1. Birthrate+ (BR+) is a framework for workforce planning and strategic decision-making and has been in use in UK maternity units for a significant number of years. GHT had a formal midwifery workforce review completed by BR+ in early 2019 detailing that an uplift of midwifery staffing was required, which was funded.

8.2. Currently a BR+ review is being undertaken and the report is due in Spring 2022. Once the results have been received an action plan will be drawn up and this will be presented to Divisional Board with any issues/concerns escalated. To meet the NHSR

Maternity Incentive Scheme Safety Action 5 this report and action plan must be presented to the Trust Board when completed.

8.3. As recommended there are currently 11% of specialist midwives and midwives in managerial positions employed and this accounts for 8-10% of the establishment, which are not included in clinical numbers, as recommended by BR+ (NHSR Maternity Incentive Scheme Safety Action 5).

8.4. Below is the breakdown of the midwifery clinical establishment as supported by Birthrate+ and this includes the professional judgement of the senior midwifery team.

Table: Funded midwifery clinical establishment Dec 2021

	Band	**Funded establishment**	**WTE in post**
Team Leaders	7	22.16	24.22
Clinical Midwives	5/6	218.25	205.75
	Total	**240.41**	**229.97**

8.5. In addition to the clinical establishment are the specialist posts and managerial positions (calculated by BR+ at approximately 8-10% of the clinical workforce). Our current figure is 11% The specialist posts and managerial posts will be reviewed as part of the next BR+ review.

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

Table: Funded midwifery specialist and management posts Dec 2021

Role	**Band**	**Funded**	**WTE Post**
Chief Midwife/DDQN	8D	1.0	1.0
Head of Midwifery/DDQN (Gynae)	8C	1.0	1.0
Consultant Midwife	8B	0.6	0
Midwifery Matrons	8A	3.0	3.0
Governance Lead	8A	1.0	1.0
Specialist Midwives	6/7	19.96	23.52

Role	Band	Funded	WTE Post
	Total	26.56	28.52

8.7. The table below shows the range of roles required within midwifery which support meeting local, regional or national requirements. These posts are both Band 6 and Band 7 roles.

Table: Specialist midwifery roles

SPECIALIST MIDWIVES
Bereavement Midwife
A/N Screening Advisors
Practice Facilitator (Ward Based)
Practice Facilitator (Community Based)
Frenulotomy
A/N Screening Advisors
PDM hours
Breast Feeding Support
Trakcare/I.T.
Substance Misuse Midwife
Practice Development
Infant Feeding Advisor
Practice Dev Support
Teenage Pregnancy
A/N Screening Advisors
Peri-Natal Mental Health
Peri-Natal Mental Health
Safeguarding
Risk Specialist Midwife
Safeguarding Support Midwife
Project re MSW
Audit Midwife (CNST)
Risk Support Midwife (CNST)
Fetal monitoring midwife

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

8.8. NHS England (NHSE) (Oct 2021) has provided guidance to Trusts for the delivery of the MCoC programme. The roll out of MCoC will impact on the establishments as there will need to be redesigned pathways and models of care. This will impact positively upon perinatal outcomes and empowers midwives to achieve excellence in care. The approach, which is underpinned by a changing service delivery, is supported by the NHSE Midwifery Work Force Tools. A MCoC service delivery model and business plan is being written to outline how we can achieve the national ambition of the MCoC model locally.

8.9. Three MCoC teams were rolled out in April 2021. The three teams comprise two teams which are based in Gloucester City and the third team in Cheltenham. The demographic of the geographic area is known to suffer with co-morbidities associated with health inequalities. The emphasis on 'equity rather than equality' has determined the families who are in receipt of this level of midwifery care first. The priority for

modern maternity services is to provide choice with an emphasis on safe, high quality maternity care for all women and babies. Central to this is a model of care for the most vulnerable who are more likely to have poor outcomes. Studies have shown that these families do better if they are looked after by a small group of staff that they know well and can form a trusting relationship with. To do this, it is essential that an appropriately skilled maternity workforce has the 'right people in the right place at the right time'.

9. Right skills – midwifery attraction, recruitment and retention

Midwifery establishment versus actual staffing levels

9.1. The maternity service has effective strategies to attract, recruit, retain and develop our staff, as well as managing and planning for predicted loss of staff to avoid over-reliance on temporary staff.

Vacancies

9.2. There are currently 7.44 WTE vacancies in the clinical workforce funded establishment.

9.3. Significant attrition has arisen from newly qualified appointees withdrawing from accepted posts prior to commencing employment.

9.4. A regular Band 5/6 advert has seen significant interest with the recent appointment of a number of both experienced and newly registered midwifery staff.

Table: Midwifery Vacancies – Band 5, 6, 7

Funded	240.41
In – post	226.97
Vacancies	**7.44**

Turnover, absence and sickness

9.5. Currently there are 24 WTE shortage of midwifery staff due to turnover, maternity leave, and sickness absence.

Table: Staffing leave/ absence and secondment

Number WTE	**Reason**
13.16	Maternity Leave
3.8	seconded staff
6.92	Long term sickness

9.6. To offset the shortfall arising from vacancies and absence, a number of new and

ongoing actions are presented monthly and those from the past 6 months listed below:

- Daily review of staffing across the whole service and reallocation of staff.
- Twice daily Multidisciplinary Team (MDT) huddles to prioritise clinical workload.
- An allocated “Band 8 of the day” to support flow and staffing/ activity coordination.
- Weekly staffing reviews between the Matrons and the Head of Midwifery.
- Use of the escalation policy; which includes the use of specialist midwives to support the clinical service, on-call midwives being called in (hospital and community) and a review of all urgent/non-urgent clinical activity.
- An enhanced Senior Midwives on-call rota to provide out of hours’ leadership support.
- Offering an increased incentive to do Bank Shifts with increased use of temporary staffing to fill shifts. However, it must be noted that not all shifts are being filled and so this averages out that the service runs with **90-105 unfilled shifts** per month.
- Mandatory and non-mandatory training has been cancelled (mandatory training compliance has decreased from 92% June to 81% in December). Bank has been offered so that staff can engage with mandatory training to offset the shortfall
- Temporary closure of the Aveta Birth Centre at Cheltenham for a period of 9 weeks to support staffing within the main Gloucester Royal site.
- There is a plan is to recruit 5 International Midwives by June 2022.
- There is an ongoing advert, punctuated with fortnightly closing dates for Band 5 & 6 staff with regular interviews in place.
- New job roles have been created to attract external staff to our department - B6 Maternity Flow & Quality (no applicants).
- Posts offered at Band 7:
    - 3.24 for Delivery Suite (3 external candidates)
    - 3.0 Community Lead, Continuity Lead, Standalone Birth Centre lead (all internal)
    - 1.0 Birth Centre Lead (external candidate)
- Posts offered at Band 6:
    - Community Practice Facilitator Band 6 (internal)
    - Safeguarding midwife
- Matrons and Band 7s have invited staff in for a “Stay Conversation” to talk about flexible working options.
- Band 8 of the day to oversee running of unit and sickness reporting has commenced
- Standard Operating Procedure (SOP) developed for Band 8 of the day to monitor workforce has been completed.
- Midwives who return from Maternity leave can secure no more than 4 weeks’ annual leave prior to return.
- The on-call rota has now been split to include a Senior Midwife on call rota and a Unit on call rota. Currently the unit on call rota is covered by Band 7 midwives whilst awaiting a consultation with staff to include all Band 5/6 /7.
- International midwifery recruitment has commenced in conjunction with Bath

Wiltshire and Swindon.

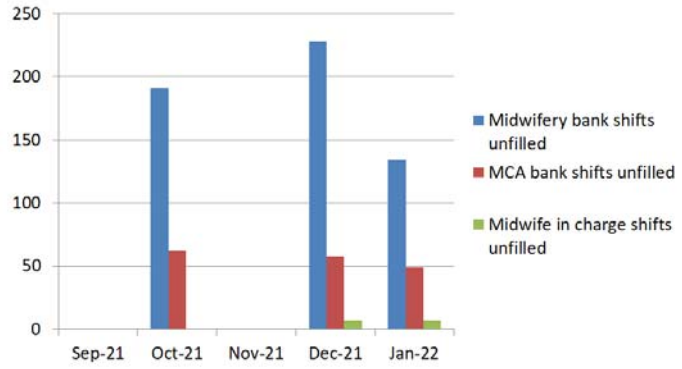
- Nursery Nurses are being interviewed with a view to supporting the Maternity Ward/ and transitional newborn care
- A bank Band 5 surgical nurses pool has been developed to support the postnatal ward

Temporary workforce (Agency and Bank)

9.7. The maternity service used agency and bank to fill shifts where there are shortages of staff. A nursing bank pool is being developed for the maternity ward. Enhanced bank rates have increased fill rates.

9.8. However, even with agency and bank usage in every month there were approximately 90-105 **unfilled midwifery shifts** and this has an impact on the midwives' wellbeing and the safety of the service.

Table: Unfilled shifts



Midwifery leadership

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

9.10. In addition, the central delivery suite is funded to have a supernumerary Band 7 shift coordinator allocated to each shift to provide professional leadership, clinical expertise and will have responsibility for the shift; this individual should have detailed knowledge of activity on the delivery suite supplemented by an awareness of activity within the inpatient areas and pending admissions from outpatient and triage areas. This 'helicopter view' is essential for overall assessment of the acuity. They are supported 24 hours a day, 7 days a week either by the "Band 8 of the day" or the Senior Midwife on call. The shift coordinator is responsible for liaising with all areas to ensure safe and effective use of resources to ensure safe delivery of care at all times.

9.11. The responsibility for addressing known midwifery staffing shortfalls rests with the Senior Band 7 for the area, where staffing shortages remain an issue this will be escalated to the designated Matron or “Band 8 of the day”.

9.12. Further actions in response to staffing shortfall over the past 6 months have been a feature of managing the midwifery requirements of the service.

9.13. To note is there is an increasing number of Midwife in charge (Band 7) unfilled shifts. To mitigate this risk these shifts were covered by those senior core Band 6 staff who have completed a ‘co-ordinator transition programme’. In addition, these shifts were typically during social hours ensuring senior midwifery cover with mangers on site supporting the Band 6 co-ordinator and their team.

Safer midwifery staffing

9.14. Ongoing monitoring of safety metrics and data

- Safe midwifery staffing is monitored by the completion of the Birthrate Plus acuity tool (4 hourly), daily staffing safety huddles, monitoring of the midwife to birth ratio and monitoring of red flags as per NICE Guidance (NICE NG4, 2021).
- We use the Birthrate+ Acuity tool which monitors compliance with supernumerary labour ward co-ordinator status and provision of 1:1 care in labour.
- Presently only the data on CDS is reliable.
    - 99 % of the time (on 11 occasions) there was a midwifery co-ordinator in charge of labour ward who had supernumerary status (defined as having no caseload of their own during their shift) to ensure there is oversight of all birth activity within the service (standard 100%).
    - There were 4 occasions on CDS where women who were in active labour was not able to receive one-to-one midwifery care of the time (standard 100 %).
- There were on average 21 red flags events per month (a red flag event is an event where basic care was not provided).
- Our current midwife to birth ratio is 1:27, whilst funded establishment is 1:26. This does not take account of long and short-term sickness and maternity leave. This is monitored via the Divisional Dashboard at the Maternity Clinical Governance Meeting and Divisional Board.

Escalation and Trust risk register entry

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

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

9.17. The risk associated with midwifery staffing (**W&C3536OBS)** remains on the Trust Risk Register (score 15 for safety). An improvement action plan was developed.

9.18. This has now been followed by a prospective Retention and Recruitment plan for 2022 with key areas being prioritised to support workforce growth and development including:

- Retention lead posts
- Midwifery development and leadership
- Emotional wellbeing project
- Development of MSW growth.

9.19. Day to day management of the suboptimal staffing is being managed by increased, visible midwifery leadership in key areas. A daily and weekly service wide overview of staffing has been implemented to enable oversight and planning ahead for staffing issues.

10. Right skills – mandatory training, development and education

10.1. Our staffing establishments take account of the need to enable clinical staff the time to undertake mandatory training and continuous professional development, meet revalidation requirements, and fulfil teaching, mentorship and supervision roles, including the support of preregistration and undergraduate students.

10.2. Over the last few months due to the pandemic and surges of Covid-19 mandatory and non-mandatory training has been cancelled which has impacted on our mandatory training compliance rates. **Mandatory training compliance has decreased from 92% in June to 81% in December** (Trust target 90% compliance).

10.3. A recovery plan is being put in place with additional training dates so that compliance can be met by end of May 2022.

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

10.5. Over the last few months due to the pandemic and surges of Covid-19 **appraisal rates have decreased from 90% in June to 68%** in December (Trust target 90% compliance). A recovery plan is being put in place with additional training dates so that compliance can be met by end of June 2022.

10.6. The maternity service analyses training needs and uses this analysis to help identify, build and maximise the skills of staff. This forms part of the organisation's training and development strategy, which also aligns with Health Education England's quality framework. The maternity service has commissioned a review of training so that we can evidence that we have a robust **local training plan** in place that ensures that all

six core modules of the Core Competency Framework are included in our unit training programme over the next 3 years (NHSR, MIS safety action 8). The training plan will include;

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

This review will be completed by the end of April 2022.

11. Conclusions

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

11.2. It is recognised that staffing shortages increase pressure on the workforce across the whole service leading to high levels of stress. Workforce shortages are being regularly monitored on a shift by shift basis. Colleague wellbeing initiatives have been put in place for staff to access, as required, through the service and also through the 2020 Staff Advice and Support Hub.

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Gloucestershire Hospitals NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	11	Enclosure Number:	7
Date	10 March 2022		
Title	Gender Pay Gap Report		
Author /Sponsoring Director/Presenter	Coral Boston, Equality, Diversity and Inclusion Lead Claire Radley, Director of People and Organisational Development		

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 report shares information due to be published on 30 March 2022 as part of our requirement to participate in national Gender Pay Gap reporting. The data set used for this report, as determined by national reporting requirements, is data extracted from March 2021.

The data excludes GMS who are required to submit their own report during March 2022.

Key issues to note

The report seeks to explain the reasons for the gender pay gap; based on the application of national terms and conditions that are designed to reward length of service and the payment of Clinical Excellence Awards to Consultants. To support the readers understanding of the issues associated with the application of national terms and conditions, the report separates the pay gaps between those paid on Agenda for Change terms and conditions, colleagues paid on Medical terms and conditions and a combined picture. Pay quartiles are also detailed within the report, to demonstrate the impact that length of service has on the pay gap.

1.0 Gender Pay Gap – All Staff

Mean Gender Pay Gap Reporting (National Requirement)

The average hourly rate for ALL female staff has increased by 8.3% from £16.70 to £18.08, when compared to 2020 data. The average hourly rate for ALL male staff increased by 8.5%, from £23.30 to £25.29. The gender pay gap, based on the average hourly rate, for all staff is almost the same as 2020 from 28.6%, reported in 2020, to 28.5% in favour of males (a decrease of 0.1%).

Median Gender Pay Gap Reporting (National Requirement)

The Gender Pay Gap report also includes analysis on the Median hourly rate pay gap, which shows an increase from 19.8% (2020 data) to 23.4% in favour of males (a increase of 3.6%).

2.0 Non-Medical Workforce

This report shows that when the Medical workforce is excluded from the pay gap calculations, the mean hourly

pay for males is £0.81 higher than that of females (£17.09/£16.28) which gives a gender pay gap of 4.7% (compared to 3.9% in 2020, an increase of 0.8%). The median rate for both male & female staff is £15.66. The quartile split demonstrates that males remain in a higher proportion in the upper quartile thus increasing the mean, where length of service is recognised by top of band remuneration.

3.0 Medical Workforce

The report separates the Medical Workforce, which includes hosted GP Trainees, and profiles length of service between male and female Medics – demonstrating the pay gap across the four pay quartiles. The analysis of pay quartiles shows similar trends to previously reported data, with the majority of movement being in Pay Quartile 1 & 3, with an increase in male numbers in Q1 & female in Q3.

When analysing only Medical Staff, GHFT still has a higher percentage of females than males in its overall workforce. Of the 1460 Medical staff counted as part of the gender pay gap reporting (including Hosted GP Trainees), 54.5% were female. However, when we analyse the Senior Medical staff within this group; there are fewer women in these senior roles, with female staff making up only 36.5% of the group (157/273).

Clinical Excellence Award (CEA) (Bonus) Payments

The only bonuses paid in the time frame covered by this report (1st April 2020 to 31st March 2021) were to Medical Consultants, in the form of CEAs and distinction awards. There were 194 bonuses paid in the period; 63 were to female consultants and 131 were to male consultants. When compared with the proportion of male Consultants to female Consultants, 67.5% of bonuses were paid to male consultants who make up 63.5% of all consultant posts, and 32.5% were paid to female consultants, who make up 36.5% of all consultant posts. Despite efforts to encourage more female staff to apply for CEA over the last 3 years, the mean GPG has increased to 47.8% from 43% last year.

Conclusions

The Gloucestershire Hospitals NHS Foundation Trust gender pay gap at 31 March 2021, is reported at:

- The mean gender pay gap is the difference between mean pay for men and women in the organisation. In GHFT, the mean pay for men is 28.5% higher than for women (28.6% in 2020)
- The median gender pay gap is the difference between median for men and women in the organisation. In GHFT, the median pay for men is 23.4% higher than for women (19.8% in 2020)

These figures reflect the combined gender pay gap of both medical and non-medical staff.

The Board is asked to NOTE that the gender pay gap can be objectively explained, when we consider the application of terms and conditions which are set nationally and reward length of service. Furthermore, there is no significant Gender Pay Gap reported across our Non-Medical workforce, which accounts for approximately 83% of the total workforce, as a result of the agenda for change framework.

With regard to the distribution of Clinical Excellence Awards, the Board is asked to note the trend reported in previous gender pay gap reports associated with the proportion of male to female consultants receiving levels 8 and above.

The gender pay report continues to evidence the assumption that the overarching pay gap is associated with length of service of a number of senior male Doctors; with further analysis demonstrating that the number of females, both entering the Medical workforce and existing staff, within pay quartiles 1-3 will lead to a reverse in this pay gap in future years. The Board is therefore advised that as such, the current pay gap is a consequence of

the application of nationally driven terms and conditions and clinical excellence awards.
Recommendation
The Board is asked to note the contents of the report.
Enclosures
• Gender Pay Gap Report

GENDER PAY GAP REPORT

February 2022

Data reported as at 31 March 2021, unless otherwise indicated.

1. Summary

This is Gloucestershire Hospitals NHS Foundation Trust's (GHFT) fifth Gender Pay Gap report. It is based on a snapshot of all GHFT employees on 31 March 2021. On that date, GHFT permanent workforce head count was made up of **7889 staff; 80% women and 20% men.**

The analysis used to prepare this Report identifies a 'mean' and a 'median' gender pay gap

The measured position on the gender pay gap at 31 March 2021 is as follows:-

- **The mean gender pay gap is the difference between mean pay for men and women in the organisation. In GHFT, the mean pay for men is 28.5% higher than for women 28.6% in 2020 (a decrease of 0.1%)**
- **The median gender pay gap is the difference between median for men and women in the organisation. In GHFT, the median pay for men is 23.4% higher than for women 19.8% in 2020 (an increase of 3.6%)**

It is critical to emphasise this does not mean that a male and a female staff member doing equal work receive different levels of pay. Rather, the above statistics are driven largely by (i) the pay of the medical workforce which has an amplified effect on statistics relating to the total workforce and (ii) the distribution of males and females within different parts of the workforce.

The dominant theme is that if the medical workforce and their CEA are excluded, the median gender pay gap is nullified. Analysing pay across all staff except medical staff creates a mean gender pay gap of 4.7% in favour of males, but a median gap of 0%. The clear implication is that the pay gap across the medical workforce is sufficient to nullify the female zero gender pay gap across the remainder of the Trust's workforce, and generate the overall results set out in the bullet points above.

Analysis of gender pay across the medical workforce reveals a complex distribution. For early years' medical trainees there is a gap in favour of female doctors, however at more senior consultant levels, the gap switches to one in favour of male doctors.

2. Introduction

The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 (***the Regulations***) require public sector organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website. This report captures data as at 31st March 2021.

GHFT employs circa. 8000 staff in a number of Staff Groups, including: administrative; nursing; allied health; and medical roles. All staff except for medical and Very Senior Managers (VSMs) are on

Agenda for Change pay-scales, which provide a clear process of paying employees equally, irrespective of their gender or ethnicity.

What is the gender pay gap?

The gender pay gap shows the difference in the average pay between all males and females in the Trust. If there is a particularly high gender pay gap, it can indicate there may be several issues with which to deal, and the individual calculations may help to identify what those issues are.
The gender pay gap is different to equal pay. Equal pay deals with pay difference between males and females who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are male or female.

What do we have to report on?

The statutory requirements of the Gender Pay Gap legislation is that each public sector organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payment

Definitions of pay gap

The **mean pay gap** is the difference between the pay of all male and all female employees when added up separately and divided respectively by the total number of males, and the total number of females in the workforce.

The **median pay gap** is the difference between the pay of the middle male and the middle female, when all male employees and then all female employees are listed from the highest to the lowest paid.

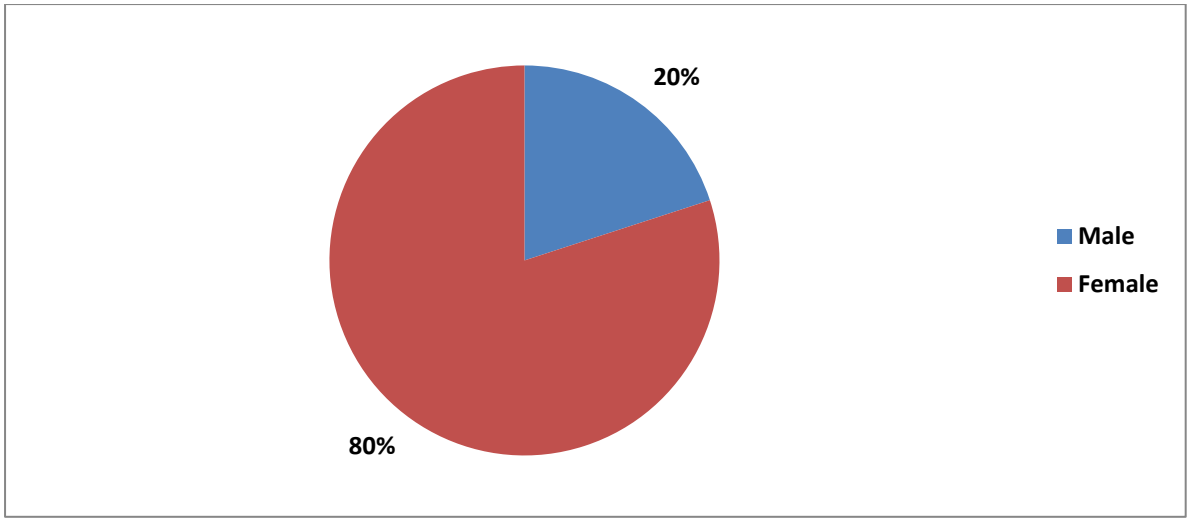
Who is included?

All staff who were employed by GHFT and on full pay on the snapshot date (31st March 2021) are included. Bank staff who worked a shift on that date are also included. Employees who are on half or nil absence, less than full pay maternity leave and agency staff are not included.

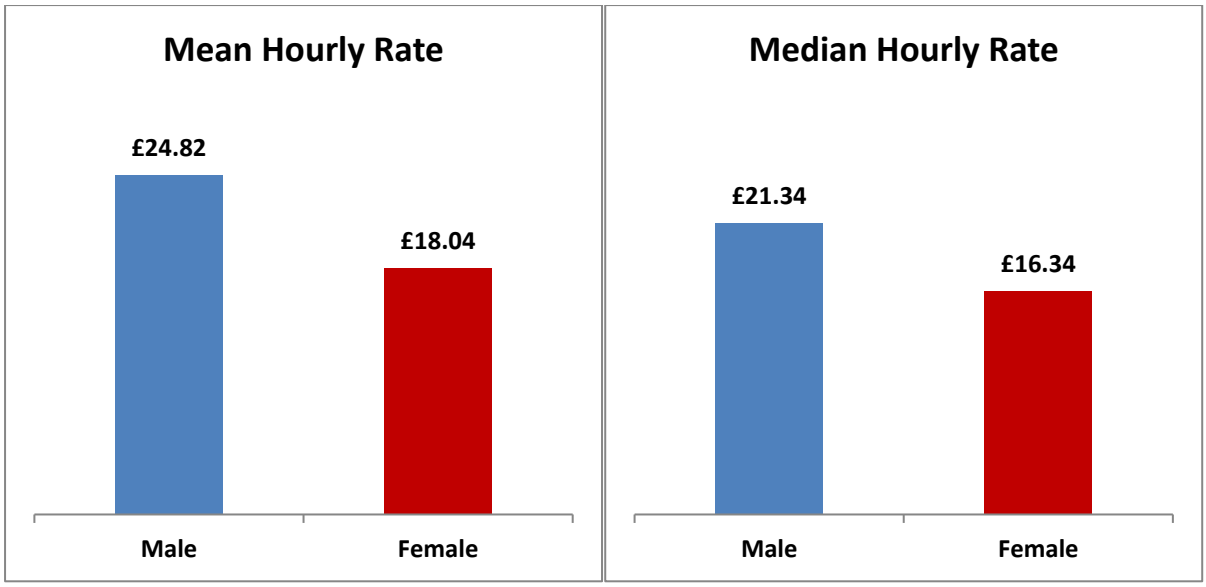
3. Results for Gloucestershire Hospitals NHS Foundation Trust

Trust Gender Profile (based on headcount)

GHFT, as is typical of the NHS, has a higher proportion of females to males in its workforce – of the 7889 staff counted as part of the gender pay gap reporting**, 6,313 were female compared to 1576 male**



Gender Pay Gap GHFT <u>including</u> Medical Staff



Mean gender pay gap – 28.5%

Median gender pay gap – 23.4%

The above charts show that the mean hourly pay for males is **£6.78** higher than that of females, a gender pay gap of **28.5%**

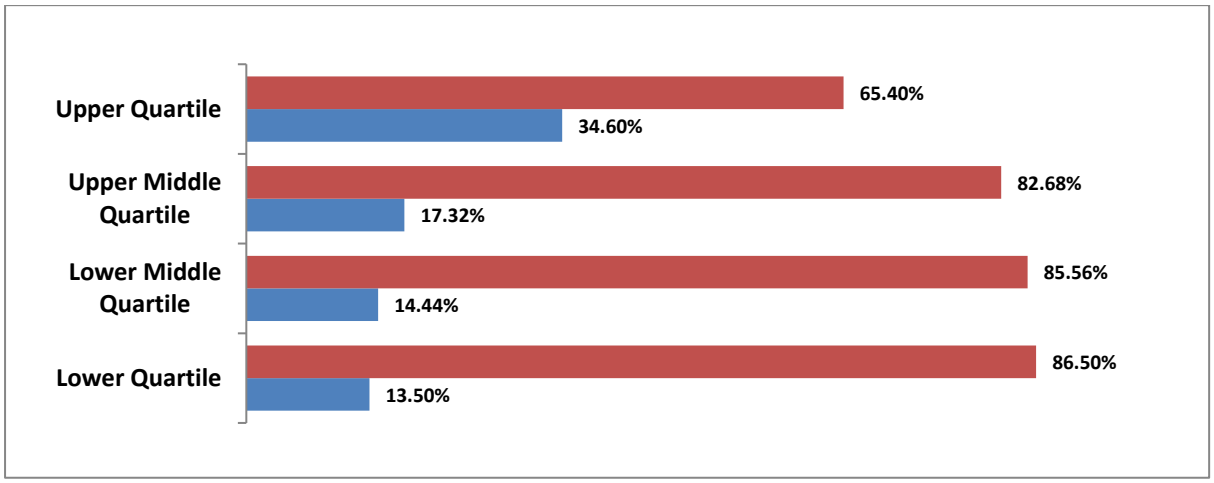
They also show that median pay for males is £5 higher than females, a gender pay gap of **23.4%.**

We are also required to split the workforce into quartiles (blocks of 25%) split by pay and show the proportion of males and females in each quartile. The results of this split are shown below. In broad terms this shows that compared to the position across the workforce as a whole, where males represent **20%** of the workforce there are relatively more males in the highest pay quartile (**34.6%).**

As explained in the introduction, the inclusion of Medical staff with the rest of the workforce has a significant effect on the GPG figures. The next three pages illustrate this.

Pay quartile split:

Percentage of gender in Pay Quartiles including Medical Staff



Gender Pay Gap GHFT excluding Medical Staff

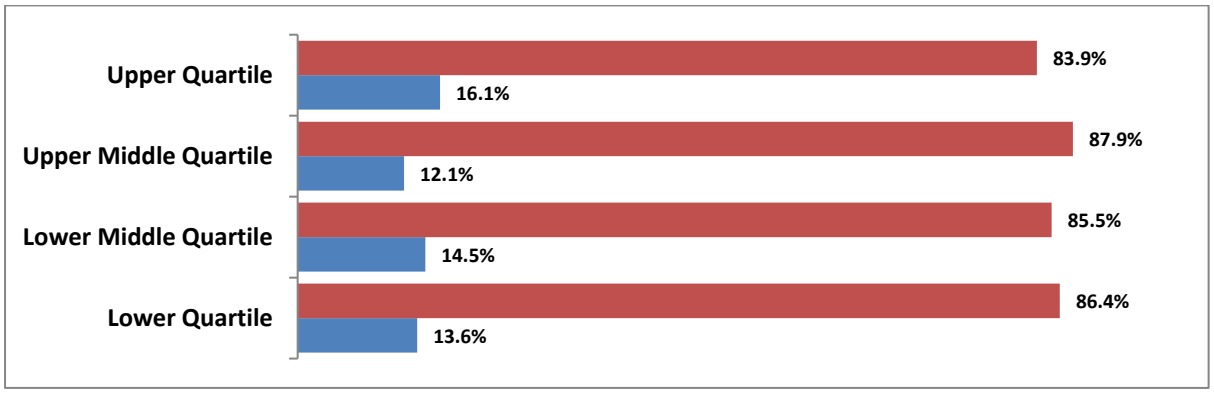
When removing Medical Staff from the equation, GHFT has an even higher percentage of females than males in its workforce – of the 6407 staff counted as part of the gender pay gap reporting, 86% were female (from 80% when Medical Staff included). The Gender Pay Gap is much smaller as an average, and is zero for the median.

The above charts show that the mean hourly pay for males is £0.81 higher than that of females, a gender pay gap of 4.7%.

They also show that median pay for males is the same as females - a gender pay gap of 0%

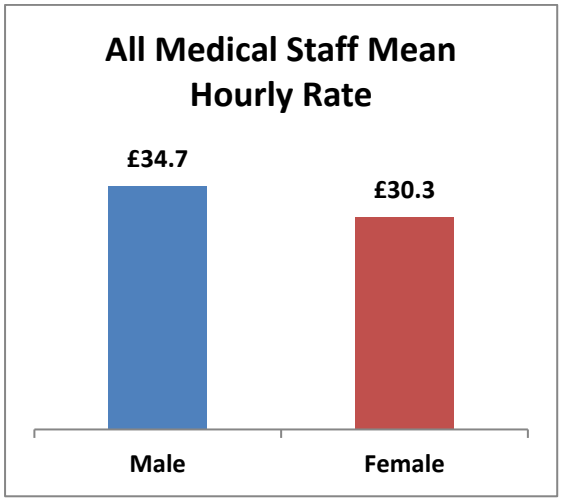
The quartile split also looks very different, where males are again in a higher proportion in the Upper Quartile; however the margin is considerably smaller.

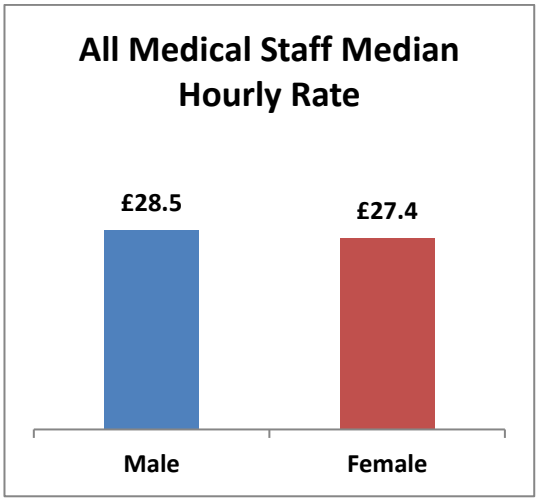
Percentage of gender in Pay Quartiles excluding Medical Staff

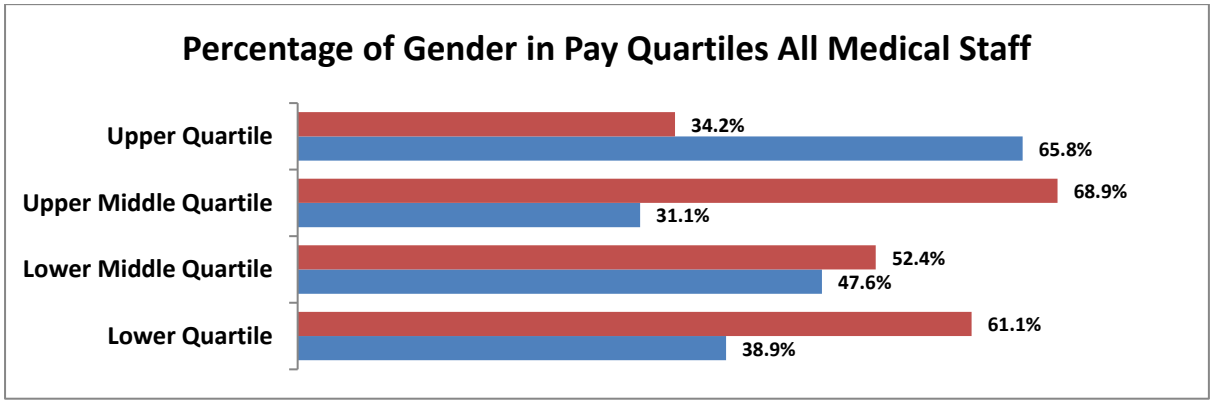


Gender Pay Gap GHFT Medical Staff Only

When including only Medical Staff, GHFT still has a higher percentage of females than males overall in its workforce, but the difference isn't so great. Of the 1471 Medical staff counted as part of the gender pay gap reporting (including GPT), 54.2% were female (from 80% when non-Medical Staff included).







The above charts show that the mean hourly pay for males is **£4.40** higher than that of females, a gender pay gap of **12.7%.**

They also show that median pay for males is **£1.10** higher than females, a gender pay gap of **3.9%.**

The quartile split shows that the lower quartile is **61.1%** female, while in the upper quartile this is completely reversed and **65.8%** are male.

What does this mean?

The figure for the median pay gap is usually considered to be more representative of gender pay gap across the workforce. However that still does not take account of the small numbers of higher paid employees (Senior Medical staff) that are skewing the data when combined with non-medical staff. The effect is simply more extreme when using the mean.

The gender composition and pay gaps in each individual band are examined below; for ease of reference we have highlighted in green where the higher average pay is to be found (male or female cohort).

Grade	No. of Male Staff	No. of Female Staff	Male Average Hourly Rate*	Female Average Hourly Rate*	Difference	Gap
Apprentice	3	50	£5.42	£5.70	-0.28	-5.10%
Band 1	3	5	£9.21	£9.21	0.00	0.00%
Band 2	208	1170	£10.86	£10.67	0.19	1.82%
Band 3	77	741	£10.93	£11.00	-0.07	-0.71%
Band 4	62	369	£11.75	£12.06	-0.31	-2.63%
Band 5	221	1459	£14.89	£15.06	-0.18	-1.16%
Band 6	144	1125	£18.46	£18.34	0.13	0.70%
Band 7	98	521	£21.98	£21.81	0.17	0.78%
Band 8a	40	151	£24.94	£24.98	-0.04	-0.15%
Band 8b	23	44	£30.28	£30.05	0.24	0.67%
Band 8c	20	16	£34.33	£35.30	-0.97	-2.81%
Band 8d	10	20	£37.85	£34.52	3.33	9.35%
Band 9	2	7	£53.66	£50.75	2.91	5.43%
VSM	4	4	£70.28	£88.47	-18.19	-5.88%
Medical - Consultant	273	157	53.51	51.41	£2.10	3.93%
Medical - non Consultant	392	638	£27.53	£26.23	1.30	4.74%

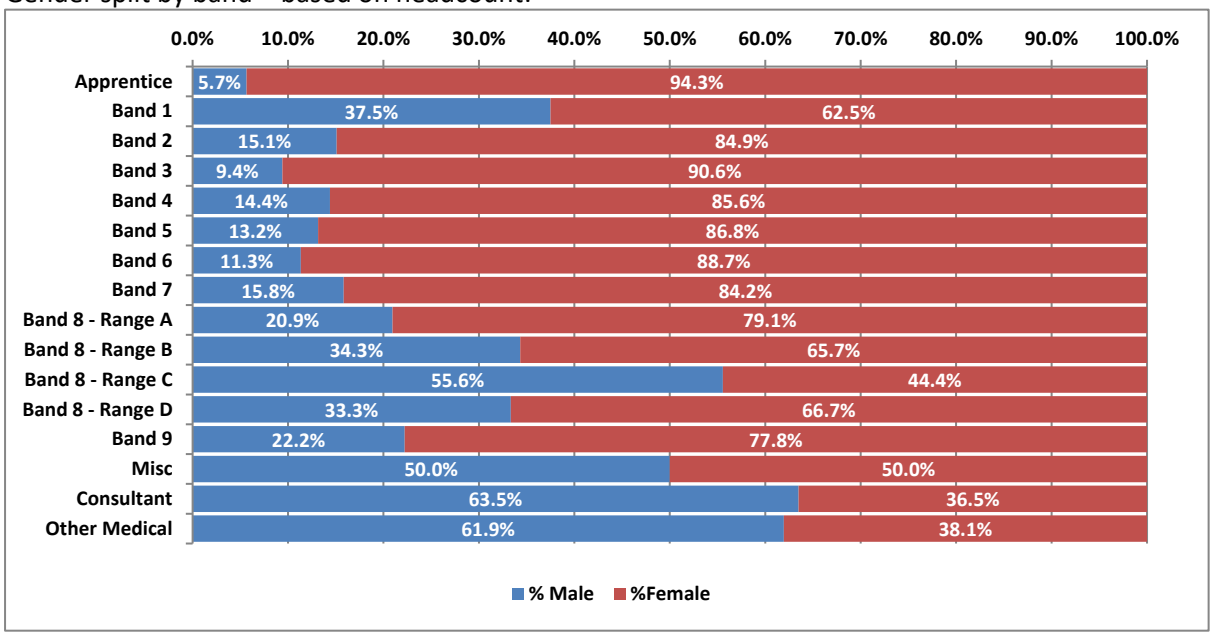
*refers to the mean hourly rate

ǂnegative values mean that the difference and the gap are favourable to females

The above table shows that, on average, females earn more in half of the pay bands than males - the bands where males earn more are 2, 6, 7,8b, 8d & 9; and medical roles (both Consultant and non-Consultant).

We have also analysed the proportion of males and females across each of the above bands, and the results of this are shown in the bar chart below.

Gender split by band – based on headcount:



4. Specific Focus Areas

Medical staff

The most significant feature of the data at 31 March 2021 is that if all Medical staff were to be removed from the calculations, then the median gap is nullified and the mean is reduced to 4.7% from 27.3%.

Medical staff group comprises a large group, from Foundation level doctors in their first year post qualification to Consultants. The pay gap for Medical staff as a whole is 20% - males get paid on average £4.40 per hour more than females.

Please note Clinical Excellence awards have been excluded from the Medical Pay Calculations in this document. The Bonus section will address the Awards.

	No. Male Staff	No. Female Staff	Male Average Hourly Rate	Female Average Hourly Rate	Difference	Gap
Foundation Year 1	15	39	14.81	14.83	-£0.02	-0.14%
Foundation Year 2	17	38	17.53	17.88	-£0.35	-2.01%
Specialty Registrar	288	488	23.98	24.42	-£0.44	-1.85%

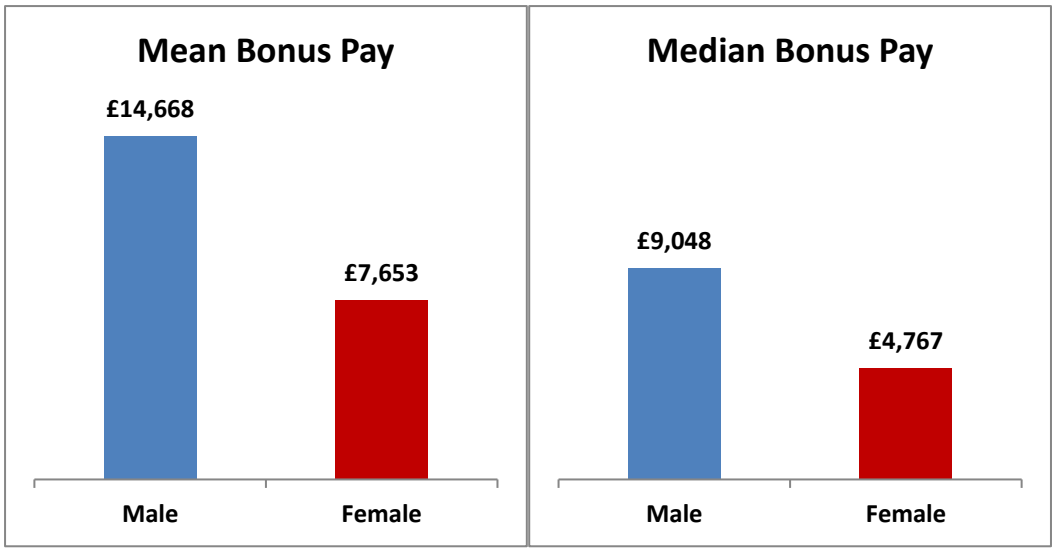
Clinical Assistant (Closed to new entrants)	2	3	23.99	23.99	£0.00	0.00%
Hospital Practitioner (Closed to new entrants)	2	0	31.66			
Specialty Doctor	32	39	32.91	33.40	-£0.49	-1.50%
Associate Specialist (Closed to new entrants)	11	8	38.95	44.18	£5.23	11.84%
Consultant	273	157	53.51	51.41	£2.10	3.93%

5. Bonuses

The only bonuses paid in the time frame covered by this Report (1st April 2020 to 31st March 2021) were to Medical Consultants, in the form of Clinical Excellence Awards (CEA's) and distinction awards. There were **194 bonuses** paid in the period, **63** were to female consultants and **131** were to male consultants. When compared with the proportion of male Consultants to female Consultants, **67.5%** of bonuses were paid to male consultants when they make up **63.5%** of all consultants, and **32.5%** were paid to female consultants, when female consultants make up 36.5% of all consultants.

Despite efforts to encourage more female staff to apply for CEA over the last 3 years, the mean GPG has increased to **47.8%** from **43%** last year, and the median has increased to **47.3%** from 40% in 2020.

NHS Employers recognise that the current local clinical excellence award system does not work and exacerbates inequalities for women, BME colleagues and those that work part-time. In response to this a consultation commenced in September 2020 with a tripartite negotiating group, which includes the Department for Health and Social Care (DHSC) and the British Medical Association (BMA) and the HCSA. Further feedback on potential proposals is expected in April 2022.



Mean gender pay gap, bonus – 47.8% **Median gender pay gap, bonus – 47.3%**

6. Recommendations

The gap in our mean and median pay and particularly bonus pay, shows there is more work to be done. we will continue to take steps to reduce our pay gap and explore best practice, to support the integration and learning from these findings, the following next steps are proposed:

- Consider and identify specific actions to reduce and eliminate the existing gender pay gap as part of formulating our EDI priorities for 2022-24
- As part of development of our new EDI priorities for 2022 – 24, by May 2022 we will identify specific actions we can take to reduce and eliminate the existing gender pay gap. In line with other EDI activities these will be monitored through the bimonthly Equality, Diversity and Inclusion Steering Group which reports to the People and Organisational Development Committee.
- During March and April 2022, work in partnership with the Director of Medical Education to understand the new system which will be coming in to replace the Clinical Excellence Awards and the impact this may have on pay gap for medical staff in the future. However, under a commission from the Department for Health and Social Care, the British Medical Association and the HCSA, the parties report that agreement on a package of reform has not been reached.

7. Conclusion

The Gloucestershire Hospitals NHS Foundation Trust gender pay gap **at 31 March 2021** is reported at:

- **Median gender pay gap, 23.4% in favour of male employees (19.8% in 2020)**
- **Mean gender pay gap, 28.5% in favour of male employees (28.6% in 2020)**

These figures reflect the **combined** gender pay gap of both medical and non-medical staff.

The People and OD Committee are asked to **NOTE** that the gender pay gap can be objectively explained, when we consider the application of terms and conditions which are set nationally and reward length of service. Furthermore, there is no significant Gender Pay Gap reported across our Non-Medical workforce, which accounts for approximately **83%** of the total workforce as a result of the agenda for change framework.

With regard to the distribution of Clinical Excellence Awards, the People & OD Committee are asked to **NOTE** the trend reported in previous gender pay gap reports associated with the proportion of male to female consultants receiving levels 8 and above.

The gender pay report continues to evidence the assumption that the overarching pay gap is associated with length of service of a number of senior male Doctors; with further analysis demonstrating that the number of females both entering the Medical workforce and existing staff within pay quartiles 1-3 will lead to a reverse in this pay gap in future years. The committee are therefore advised that as such, the current pay gap is a consequence of the application nationally driven terms and conditions and clinical excellence awards.

Gloucestershire Hospitals NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	12	Enclosure Number:	8
Date	10 March 2022		
Title	Finance Report		
Author /Sponsoring Director/Presenter	Johanna Bogle, Associate Director of Financial Management Craig Marshall, Projects Accountant Karen Johnson, Director of Finance		

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 purpose of this report is to present the Financial position of the Trust at Month 10 to the Board of Directors.

Revenue

Key issues to note

The Trust is reporting a £271k surplus, which is on plan for the year to date.

Month 10 overview

Month 10 reports a £133k deficit in month, which is on plan for the month. We have planned to report a small deficit each month for the rest of the year to bring us back to our planned £6k surplus. The profiling of these deficits are due to the one-off release of a legal provision in Month 7. For the YTD we report £271k surplus, which is on plan.

Activity delivered 100% of the YTD 19/20 activity levels, and 90% of the January 2020 levels.

Forecast Outturn

We are reporting to NHSEI a forecast outturn of £6k surplus for the full year.

There are a number of risks to this forecast, all of which are upsides (more surplus), although this is in line with what we reported last month. The main drivers continue to be our ability to spend non-recurrent funding due to workforce constraints and the level of elective demand being lower than anticipated. In order to mitigate this, we continue to explore investment opportunities to maximise patient care, replace aging equipment and support staff wellbeing.

Planning update 2022-23

The Trust is currently working through the system position for 2022/23 with system partners.

Conclusions

The Trust is reporting a year-to-date surplus of £271k, on plan for the year to date.

Capital

Funding

The Trust's forecast capital envelope is currently at £68.0m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£28.6m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

M10 Position

As at M10, the Trust had goods delivered, works done or services received to the value of £39.1m.

The Trust has reported within the M10 NHSIE financial monitoring return a forecast that equals the funding available of £68.0m.

February and March

There remains a significant challenge to deliver £28.9m within the next two months.

No material levels of slippage have been reported however there remains significant concerns around the volume of projects due to be completed in the last few months of the financial year. Any slippage would now become a real risk to our year end position.

There is a significant amount of effort being put into to maximise the deliverability of the schemes with project leads and coupled with the most recent project forecasts there remains a degree of confidence around getting close to the reported forecast outturn. However, given the amount still left to spend, delivering the full programme remains a significant risk.

The programme continues to be monitored and mitigations explored for any potential slippage that may materialise.

Recommendation

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

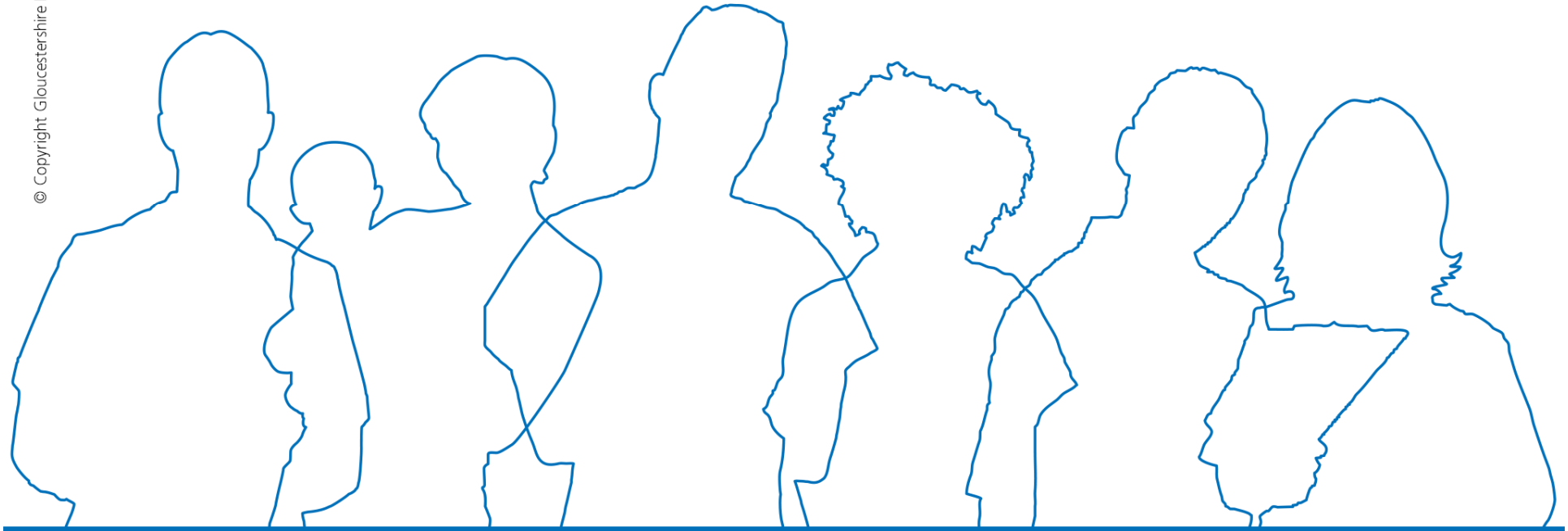
Enclosures

- Finance Report (Month 10)

Gloucestershire Hospitals
NHS Foundation Trust

Report to the Trust Board

Financial Performance Report
Month Ended 31st January 2022



Gloucestershire Hospitals
NHS Foundation Trust

Revenue

Director of Finance Summary

System Position for Full Year

For H1 (April – September 2021) the Gloucestershire System reported a small surplus of £11k. The Trust contributed to this by delivering £6k of the £11k surplus.

For H2 (October 2021 – March 2022), the ICS partners are working together to review and mitigated the overall system's financial position - currently it has been communicated to NHS England that there is the potential for an unmitigated surplus of c£7m. Of this c£4-5m is linked to additional ERF income generated from performance within the independent sector.

Month 10 overview

Month 10 reports a £133k deficit in month, which is on plan for the month. We have planned to report a small deficit each month for the rest of the year to bring us back to our planned £6k surplus. The profiling of these deficits are due to the one-off release of a legal provision in Month 7. For the YTD we report £271k surplus, which is on plan.

Activity delivered 100% of the YTD 19/20 activity levels, and 90% of the January 2020 levels.

Forecast Outturn

We are reporting to NHSEI a forecast outturn of £6k surplus for the full year. There are a number of risks to this forecast, all of which are upsides (more surplus), although this is in line with what we reported last month. The main drivers continue to be our ability to spend non-recurrent funding due to workforce constraints and the level of elective demand being lower than anticipated. In order to mitigate this, we continue to explore investment opportunities to maximise patient care, replace aging equipment and support staff wellbeing.

2022/23 Planning update

The Trust is working alongside the ICS and other system partners to get to an overall financial position for next year. Currently, the draft position is showing a deficit position even with a level of efficiencies from each organisation. Discussions are taking place with CEOs to understand what's driving this and also what more can be done to close the gap. The regional expectation is the system will be in financial balance.

Month 10 headlines

Gloucestershire Hospitals
NHS Foundation Trust

Headline	Compared to plan	Narrative
I&E Position YTD is £271k surplus		Overall YTD financial performance is £271k surplus. This is on plan. £133k deficit in month, reflecting the plan phasing of income and cost relating to the Month 7 release of a legal provision from 2018/19 that we will not need to pay out.
Income is better than plan at £559.9m YTD.		YTD £25.8m better than plan, predominantly due to £7.3m Salix grant funding (removed in the final reported position), £7.8m high cost drugs and devices above plan, £3.1m Elective Recovery Fund (ERF) above plan, £3.8m pay award funding, £2.8m Covid (outside envelope) funding, less £0.6m net of under-recovery of income (including private patients, road traffic accident, overseas visitors, catering and recharges to other organisations)
Pay costs are more than plan at £336.0m YTD.		YTD £8.1m adverse to plan. Broadly, the pay award cost amounts to £4.0m, Registered Mental Health Nurses £1.1m, Covid outside envelope not included in the plan at £1.3m ytd, plus Waiting List Initiatives of £0.9m, plus £0.8m other overspends, mainly around temporary staffing.
Non-Pay expenditure is more than plan at £209.3m.		YTD this is £10.3m adverse to plan. The main drivers of this are the £7.8m high cost drugs and devices above plan, £1.5m Covid outside envelope costs excluded from the plan, CNST incentive costs £0.4m, Gen Med VAT costs £0.7m, Cath labs hire £0.2m plus £0.3m other underspends.
Financial Sustainability schemes are ahead of plan at YTD.		The Trust has delivered £6.8m of efficiency ytd. This is £1.3m ahead of plan. These additional savings have mitigated some of the overspends seen in our Medicine division to date.
The cash balance is £91.8m.		Increase in cash is reflected in the increase of accruals and provisions.

Month by Month Trend

Gloucestershire Hospitals NHS Foundation Trust

Month 9 to Month 10 overall has a difference of £2k and a £133k deficit in month. This is on plan in month for the YTD.

While individual categories of income and spend have changed month-on-month, the net difference is minimal. This is due to the Trust managing the additional non-recurrent funding we have been allocated with additional costs that reflect our one-off opportunity to replace aging equipment and support staff wellbeing. This is being tightly controlled so that there will be no detrimental impact to our costs on an ongoing basis as we move into 2022/23, when funding is expected to be more restricted.

We had another Salix grant in month; this passes through to GMS for capital expenditure but must be shown in Trust accounts and then adjusted against our bottom line.

	6 months' Run Rate Actuals						Month 9 to Month 10 change
	M05	M06	M07	M08	M09	M10	
Pay	(32,524)	(36,577)	(33,498)	(32,746)	(32,824)	(33,535)	(711)
Non Pay	(21,607)	(19,001)	(19,939)	(20,939)	(21,230)	(22,190)	(959)
Pay - Covid (in envelope)	(209)	(239)	(309)	(327)	(389)	(348)	41
Non Pay - Covid (in envelope)	(257)	(260)	(279)	(212)	(412)	(207)	205
Covid Costs (in envelope)	(466)	(499)	(588)	(539)	(801)	(555)	246
Pay - Covid (outside envelope)	(79)	(51)	(128)	(98)	(171)	(162)	9
Non Pay - Covid (outside envelope)	(71)	(139)	(229)	(121)	(52)	(254)	(202)
Covid Costs (outside envelope)	(150)	(190)	(357)	(219)	(223)	(416)	(193)
Non-operating Costs	(810)	(704)	(765)	(769)	(795)	(730)	65
Remove impact of Salix Grant		(302)	(1,249)	(693)	(722)	(350)	372
Remove impact of Donated Asset Depreciation / impairments	48	48	48	49	48	49	1
Total Cost	(55,509)	(59,223)	(56,348)	(55,857)	(56,547)	(57,728)	(1,181)
Run Rate Funding / Billable Income	54,022	57,797	57,127	55,034	56,190	57,179	989
Est Elective Recovery Fund Income	1,341	1,101		0			0
Covid Income (outside envelope)	150	190	357	219	223	416	193
Total Reported Surplus / (Deficit)	**5**	**(135)**	**1,136**	**(604)**	**(135)**	**(133)**	**2**

M10 Group Position versus Plan

Gloucestershire Hospitals
NHS Foundation Trust

The financial position as at the end of January 2022 reflects the Group position including Gloucestershire Hospitals NHS Foundation Trust and Gloucestershire Managed Services Limited, the Trust's wholly-owned subsidiary company. The Group position in this report excludes the Hospital Charity, and excludes the Hosted GP Trainees (which have equivalent income and cost) each month.

In January the Group's consolidated position shows a £271k surplus. This is on plan.

Statement of Comprehensive Income (Trust and GMS)

	TRUST POSITION *			GMS POSITION			GROUP POSITION **		
Month 10 Financial Position	**YTD Plan £000s**	**YTD Actuals £000s**	**YTD Variance £000s**	**YTD Plan £000s**	**YTD Actuals £000s**	**YTD Variance £000s**	**YTD Plan £000s *** **	**YTD Actuals £000s**	**YTD Variance £000s**
SLA & Commissioning Income	484,194	496,721	12,526			0	484,194	496,721	12,526
PP, Overseas and RTA Income	3,106	3,264	158			0	3,106	3,264	158
Other Income from Patient Activities	3,974	7,287	3,313			0	3,974	7,287	3,313
Elective Recovery Fund	3,000	6,071	3,071			0	3,000	6,071	3,071
Operating Income	36,282	42,955	6,673	50,520	57,215	6,695	39,845	46,575	6,731
Total Income	**530,556**	**556,298**	**25,742**	**50,520**	**57,215**	**6,695**	**534,119**	**559,917**	**25,799**
Pay	(309,683)	(318,057)	(8,375)	(18,157)	(17,922)	235	(327,840)	(335,980)	(8,140)
Non-Pay	(215,594)	(226,216)	(10,622)	(30,398)	(36,723)	(6,324)	(199,036)	(209,344)	(10,308)
Total Expenditure	**(525,277)**	**(544,273)**	**(18,997)**	**(48,555)**	**(54,645)**	**(6,090)**	**(526,876)**	**(545,323)**	**(18,448)**
EBITDA	**5,279**	**12,024**	**6,745**	**1,965**	**2,570**	**605**	**7,243**	**14,594**	**7,351**
EBITDA %age	**1.0%**	**2.2%**	**1.2%**	**3.9%**	**4.5%**	**0.6%**	**1.4%**	**2.6%**	**1.3%**
Non-Operating Costs	(5,478)	(4,952)	526	(1,965)	(2,570)	(605)	(7,442)	(7,522)	(80)
Surplus / (Deficit)	**(199)**	**7,072**	**7,271**	**0**	**(0)**	**(0)**	**(199)**	**7,072**	**7,271**
Fixed Asset Impairments	0								
Surplus / (Deficit) after Impairments	**(199)**	**7,072**	**7,271**	**0**	**(0)**	**(0)**	**(199)**	**7,072**	**7,271**
Excluding Donated Assets & Salix grant	471	(6,801)	(7,271)				471	(6,801)	(7,271)
Control Total Surplus / (Deficit)	**271**	**271**	**(0)**	**0**	**(0)**	**(0)**	**271**	**271**	**(0)**

* Trust position excludes £30.2m of Hosted Services income and costs. This relates to GP Trainees

** Group position excludes £53.6m of inter-company transactions, including dividends

*** YTD Plan excludes a late adjustment in H1 ICS-agreed cost and income for ERF-related transactions.

Balance Sheet

Gloucestershire Hospitals
NHS Foundation Trust

Trust Financial Position	Opening Balance 31st March 2021 £000	GROUP Balance as at M10 £000	B/S movements from 31st March 2021 £000
Non-Current Assests			
Intangible Assets	8,280	7,287	(993)
Property, Plant and Equipment	276,161	300,230	24,069
Trade and Other Receivables	6,149	3,708	(2,441)
Total Non-Current Assets	**290,590**	**311,225**	**20,635**
Current Assets			
Inventories	8,934	10,108	1,174
Trade and Other Receivables	18,054	20,510	2,456
Cash and Cash Equivalents	77,216	91,797	14,581
Total Current Assets	**104,204**	**122,415**	**18,211**
Current Liabilities			
Trade and Other Payables	(87,606)	(99,749)	(12,143)
Other Liabilities	(11,585)	(13,831)	(2,246)
Borrowings	(3,404)	(3,800)	(396)
Provisions	(10,824)	(16,662)	(5,838)
Total Current Liabilities	**(113,419)**	**(134,042)**	**(20,623)**
Net Current Assets	**(9,215)**	**(11,627)**	**(2,412)**
Non-Current Liabilities			
Other Liabilities	(6,517)	(6,062)	455
Borrowings	(37,438)	(35,261)	2,177
Provisions	(2,892)	(2,888)	4
Total Non-Current Liabilities	**(46,847)**	**(44,211)**	**2,636**
Total Assets Employed	**234,528**	**255,387**	**20,859**
Financed by Taxpayers Equity			
Public Dividend Capital	332,033	345,824	13,791
Reserves	27,975	27,975	0
Retained Earnings	(125,480)	(118,412)	7,068
Total Taxpayers' Equity	**234,528**	**255,387**	**20,859**

The table shows the M10 balance sheet and movements from the 2020/21 closing balance sheet. The opening balances have been adjusted to reflect the final audited position for 2020-21.

Gloucestershire Hospitals
NHS Foundation Trust

Capital

Capital

Director of Finance Summary

Gloucestershire Hospitals NHS Foundation Trust

Funding

The Trust's forecast capital envelope is currently at £68.0m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£28.6m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

M10 Position

As at M10, the Trust had goods delivered, works done or services received to the value of £39.1m.

The Trust has reported within the M10 NHSIE financial monitoring return a forecast that equals the funding available of £68.0m

February and March

There remains a significant challenge to deliver £28.9m within the next two months.

No material levels of slippage have been reported however there remains significant concerns around the volume of projects due to be completed in the last few months of the financial year. Any slippage would now become a real risk to our year end position.

There is a significant amount of effort being put into to maximise the deliverability of the schemes with project leads and coupled with the most recent project forecasts there remains a degree of confidence around getting close to the reported forecast outturn. However, given the amount still left to spend, delivering the full programme remains a significant risk.

The programme continues to be monitored and mitigations explored for any potential slippage that may materialise.

21/22 Programme Funding Overview

Gloucestershire Hospitals
NHS Foundation Trust

The Trust's forecast capital envelope is currently at £68.0m. The programme can be divided into four components; System Capital (£24.4m), National Programme (£28.6m), IFRIC 12 (£0.9m) and Government Grant/Donations (£14.1m)

This increased by £0.1m due to the £0.6m Digital Maternity MoU being received netted off by the removal of £0.5m perioperative care fund which turned out to be a revenue funding offer.

	M9	M10	Change
Programme Allocation	**£000's**	**£000's**	**£000's**
System Capital	24,404	24,404	0
National Programme	28,538	28,639	101
Donations and Government Grants	14,050	14,050	0
IFRIC 12	874	874	0
Total Programme	**67,866**	**67,967**	**101**

21/22 Programme Spend Overview

Gloucestershire Hospitals
NHS Foundation Trust

As at M10, the Trust had goods delivered, works done or services received to the value of £39.1m. The breakdown of the YTD expenditure by programme allocation and the reported forecast returned within the M10 NHSIE financial monitoring return is shown below.

	In Month	Year to Date	Forecast		
Programme Allocation	Actual £000's	Actual £000's	Forecast Funds £000's	Actual £000's	Variance £000's
System Capital	2,401	14,084	24,404	24,404	0
National Programme	3,659	14,895	28,639	28,639	0
Donation and Government Grants	698	9,438	14,050	14,050	0
IFRIC 12	73	729	874	874	0
Total Programme	6,831	39,145	67,967	67,967	0
Forecast to spend last month	7,086				
Difference to Forecast	255				

The forecasts received last month indicated that the Trust would deliver £7.1m this month. The Trust delivered £6.8m. - A significant challenge remains to deliver £28.9m within the final two months.

Whilst the latest forecasts and assurances from project leads suggest that significant spend and delivery of the programme is still possible, the volume and limited time that remains has meant that the closing of the M11 (February) position will be a hard close and treated in the same way as a year end.

Daily tracking of the position is underway to maximise deliverability and to understand and manage any issues as early as possible.

Risks

Gloucestershire Hospitals
NHS Foundation Trust

Key risks to the 21/22 capital programme include:

The level of YTD spend indicates that without robust plans to deliver the projects within the programme, mitigations will need developed to ensure that the level of capital funding available is spent by the end of the financial year..

Incomplete and inaccurate project progress reports could lead to incorrect management action and failure to deliver the capital programme. - Without the timely receipt of updated and accurate forecasts for all the capital projects then the decisions that the Trust will make could be weakened by the quality of the information available.

The large volume of items being procured will place a bottle neck to transact the items (including; procurement, Finance, GMS and Divisions)

The physical delivery of schemes remains essential and the Project Accountant needs to be informed where delivery is not to take place. Transfer of Ownership documents may be considered where there is strong evidence from the supplier that a supply chain risk exists and that by paying for the items now eliminates this risk and represents a commercial, value for money reason for doing so. The Trust will not enter Transfer of Ownerships without strong evidence as this would pose a risk to the true and fair view of the accounts and external audit.

Recommendations

Gloucestershire Hospitals
NHS Foundation Trust

The Board is asked to:

- Note the Trust is reporting a year to date surplus of £271k, which is on plan.
- Note the Trust is forecasting a £6k surplus for the year end.

Capital

- Note the reported M10 year to date capital position and reported year end forecast outturn.
- Note the current risks to delivery.

Authors:	**Johanna Bogle, Associate Director of Financial Management** **Caroline Parker, Head of Financial Services** **Craig Marshall, Project Accountant**
Presenting Director:	**Karen Johnson, Director of Finance**
Date:	**February 2022**

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Report to Public Board of Directors

Agenda item:	13	Enclosure Number:	9
Date	10 March 2022		
Title	Digital and Electronic Patient Record (EPR) Report		
Author /Sponsoring Director/Presenter	Nicola Davies, Digital Engagement and Change Manager Mark Hutchinson, Executive Chief Digital and Information Manager		

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 paper provides updates and assurance on the delivery of Digital workstreams and projects, as well as business as usual functions. The progression of this agenda is in line with our ambition to become a digital leader.

Key issues to note

- The next phase of clinical documentation on Sunrise EPR goes live on 23 February 2022.
- This impacts all clinical staff working in adult inpatient areas, documenting in medical notes and providing clinical support.
- The new clinical data storage platform will also launch on 23 February, which will pull even more letters and documents to be viewed in EPR.

Conclusions

The importance of improving GHFT's digital maturity in line with our strategy has been significantly highlighted throughout the COVID-19 pandemic. Our ability to respond and care for our patients has been greatly enabled by our delivery so far, but needs to continue at pace.

Implications and future action required

As services continue to move on-line and with an increase in remote working, demand for digital support is increasing.

Recommendation

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

Enclosures

- Digital and EPR Programme Report

FINANCE AND DIGITAL COMMITTEE – FEBRUARY 2022

DIGITAL & EPR PROGRAMME REPORT

1. Purpose of Report

This report provides updates and assurance on the delivery of digital projects within GHFT, as well as business as usual functions within the digital team. This includes Sunrise EPR, digital programme office and IT. The progression of the digital agenda is in line with our ambition to become a digital leader.

2. Sunrise EPR Programme Update

This section provides status updates on Sunrise EPR work-streams and interdependent digital projects.

2.1 EPR High Level Programme Plan

The programme plan below details the EPR functionality already delivered and planned for 2021/22. *Blue indicates projects already delivered.*

Functionality	Estimated Go-live	Delivered
Nursing Documentation (adult inpatients)	June 2020	November 2019
E-observations (adult inpatients)	June 2020	February 2020
Order Communications (adult inpatients)	December 2020	August 2020
Order Communications (other inpatient areas)	February 2021	February 2021
Cheltenham MIIU (all functionality)	March 2021	March 2021
Pharmacy Stock Control (EMIS)	April 2021	April 2021
Doctor's Handover Document (HDS/EDD)	May 2021	12 May 2021
Cheltenham MIIU transition to ED (additional functionality & training)	9 June 2021	9 June 2021
TCLE – replacement lab system (replacing IPS)	23 June 2021	23 June 2021
Gloucester Emergency Department (all functionality)	7 July 2021	7 July 2021

Sepsis documentation	22 Sept 2021	22 Sept 2021
EMM (Electronic Medicines Management)	Oct 2021	Oct 2021
Upgrade of Sunrise EPR	30 Nov 2021	01 Dec 2021
Clinical Data Storage Platform	23 February 2022	
Clinical documentation (ward rounds & clerking)	23 February 2022	
Nursing documentation (flowsheets & tissue donation referral)	23 February 2022	
Order Communications (theatres & outpatients expansion)	TBC	
Electronic Prescribing & Medicines Administration (known as ePMA)	2022 - dates being rescoped	

3. EPR Project Summaries and Status Updates

This section provides the latest status on EPR projects currently reporting through the EPR Programme Delivery Group.

3.1 EPR General Improvements

The redesigned ED safety checklist went live on 8th February. This was improved following feedback from clinical staff and poor completion rates. It is now easier for nursing teams to access, use and follow.

3.2 Clinical Documentation moving to EPR on 23rd February

We are going live with our next phase of documentation on Sunrise EPR on 23 February 2022. This impacts all clinical staff working in **adult inpatient areas**, documenting in medical notes and providing clinical support. This includes:

- A new batch of inpatient nursing documents and flowsheets, meaning that the majority of nursing notes on ward areas will now be entirely electronic.
- Clerking and ward round notes for Doctors.
- Even more letters and documents available through External Documents.

The documents are:

- Clerking documents
- Post Take Ward Round

- Ward Round Note
- Clinical Review note - this replaces when you would write on a continuation sheet
- Tissue Donation Referral Form

Flowsheets are:

- 24-hour fluid balance chart
- Stool record
- Food record chart
- Central Venous Catheter Care
- Subcutaneous Butterfly Insertion
- Inpatient Peripheral Cannula
- Midline IV Catheter Care Plan

At the same time, more clinical information is being made accessible through EPR. The implementation of a new clinical data storage platform will make letters and documents accessible from the External Documents tab in Sunrise.

- Current Infoflex letters
- Discharge summaries (PDF versions)
- eTrauma documents
- Endoscopy reports
- Ophthalmology documents

3.3 Conclusions

The implementation of electronic systems provides even more opportunities to improve patient safety, provide accountability, but also to realise cash and quality benefits. Since launching Sunrise EPR we have worked hard with finance and quality teams to ensure that the wider benefits of introducing digital systems are understood.

4. Digital Programme Office

This section provides updates on the delivery of projects from within the Digital Programme Management Office (PMO).

Key issues to note:

- The New Teleworker Solution project has completed and closed.
- The Mindray Bedside Monitoring – DCC project has completed and closed.
- The order for Office 2016 licenses has been placed

4.1 Areas of concern and mitigating actions

SQL Migration & Windows 2003 Upgrade
Completion of this programme of work has been delayed as a result of slippage and the reduction in scope of other projects, together with interdependencies with other projects and supplier availability. A re-planning exercise is underway to ensure that there is a schedule for the migration/upgrade of the remaining servers and that this timetable aligns with the current cyber mitigation in place.

Windows 7 Dependant Applications Eradication
Completion of this programme of work has been delayed as a result of slippage and the reduction in scope of other projects, together with the availability of supplier and Trust resource. An additional 12 months of Extended Security Updates has been put in place to ensure that the continuing cyber risk is mitigated whilst removal of Win7 is completed. A re-planning exercise is underway to ensure that there is a schedule for the removal/upgrade of the remaining devices.

Wilson Health Centre NEW GP Surgery
Delay of the site construction element, the availability of BT equipment and changes to the scope of the project have necessitated a revised PID and amended costs. Formal amendments to the PID are awaited from the CCG, together with clarification of costs from CITS. New dates have been requested from the Practices to enable the delivery to be re-planned to align with construction completion and equipment installation.

4.2 Conclusion

The majority of our projects are progressing according to plan. We have put a number of measures in place over the course of the last twelve months to ensure that projects receive adequate scrutiny, progress in a predictable and accountable fashion and deliver products that are able to realise their forecast benefits.

5. Countywide IT Service (CITS)

A monthly performance report from Countywide IT Services (CITS) is submitted to Digital Care Delivery Group.

6. Cyber Security

This section highlights cybersecurity activity for the reporting period (December 2021) in relation to risk mitigation, current controls and ongoing work to protect Gloucestershire Healthcare Community information assets.

- December patching addressed 30 vulnerabilities (1 critical) within 14 days
- PrintNightmare patch rollout continues but has yet to reach 100% across ICS
- We are onboarding AV and Firewall logs into Splunk
- We are onboarding 38 servers into Sophos from Trend Micro

7. Information Governance

This section provides updates and assurance on the Information Governance Framework in operation within the trust to ensure the senior team is regularly briefed on Information Governance issues and the broader Information Governance agenda.

Data Security and Protection (DSP)Toolkit 2021/2022 requirement update

Cyber security related assertions and the requirement for 95% of all staff to have completed the annual IG refresher training continue to be the focus of work over the next reporting period to establish action planning ahead of June 2022 submission.

Current snapshot of compliance illustrates the training requirement challenge – for which a detailed action plan is being followed in order to meet 95% target by June 2022.

GHT compliance is static during this reporting period at 84%. A joint action plan and workstream has been initiated between IG and Human Resources to action.

Training Competency Compliance Report 31 December 2021

Training Competency: NHS|CSTF|Information Governance and Data Security - 1 Year|

Compliance Rate Highlight key:	
Less than 95%	95% and above

Breakdown by Division

Gloucestershire Hospitals

	Compliance
GHT Total	**84%**
Corporate Division	87%
Diagnostic & Specialty Division	88%
Medicine Division	83%
Non-Division	74%
Surgery Division	85%
Women & Children Division	73%

Gloucestershire Managed Services

Gloucestershire Managed Services	**76%**

-Ends-

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT
Quality and Performance Committee, 23 February 2022

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

Items rated Red

Item	Rationale for rating	Actions/Outcome
None.		

Items rated Amber

Item	Rationale for rating	Actions/Outcome
Quality and Performance Report	Key points to note: • Unscheduled care continued to experience significant challenges. • Planned care was performing well. • The Trust had not met the Cancer 2 week-wait target due to the emergence of the Omicron variant, however performance had recovered in February. • The number of patients medically optimised for discharge (MOFD) continued to be challenging; domiciliary and care home capacity was significantly reduced due to workforce challenges. • National and regional focus remained on improving ambulance handover times and timely discharges from hospitals. • The Trust was reviewing patient flow across the organisation and throughout the community to ensure its response to ambulance performance was timely and appropriate. The Trust sought regulatory clearance to accept patients for corridor care in order to meet national expectations. • The Committee received assurance that each reported 12-hour breach was subject to a full Root Cause Analysis (RCA). • The number of Category 2 pressure ulcers had reduced this month, however unstable pressure ulcers had increased. • PALS contacts continued to increase. Recruitment plans were in place to address capacity issues. • Friends and Family Test responses had reduced this month, particularly related to Outpatients. Emergency Department feedback continued to improve. The Committee expressed concern around gaps in sepsis and dementia data; assurance was provided that compliance in these areas would improve following the implementation of an electronic monitoring system. ***Health Inequalities*** The Committee was encouraged by the good presentation. Within planned care, there were no obvious disparities resulting from characteristics; the largest contributors to Did Not Attend (DNA) rates related to ward deprivation. The Elective Recovery Board continued to monitor this key issue regularly, with additional review required on postcodes. ***No Criteria to Reside*** The Committee continued to see much work in trying to reduce the numbers of patients with no criteria to reside however full assurance of the effectiveness of both internal and systems controls was not possible. Future committee meeting will continue to focus on those actions for the Trust to take to reduce internal delays. ***Planned Care***	12-hour breaches would be flagged within the report for future meetings, with detailed breakdowns of times and a review of risk scores to ensure an accurate position was reflected. The MOFD escalation process to ensure sufficient capacity across the system was described, however no additional capacity was reported at the time of the meeting. Additional assurance was sought on management of pressure tissue damage and falls. A report would be produced for April. There would be a board development session in March to discuss health inequalities. A continued focus on the prioritisation of patients and any local enhancements to the national process would be reported back to the Committee.

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.

	The Committee was assured that the Trust was at 70% performance, which was within the top three Trusts in the region for referral to treatment times. Trauma and orthopaedics and ophthalmology remained specialties with the longest waiting times. The Committee received assurance on the range of actions in place to reduce waiting lists, including weekend working and continued risk assessment and review of patients.	
Ockenden Report	• The maternity incentive scheme was currently paused; however, funding had been confirmed and all areas would be reviewed once the scheme was restarted. • The Committee was assured by the Perinatal Quality Surveillance Model report. • The Committee received assurance on the actions in place to improve staffing levels. • The Committee noted the Healthcare Safety Investigation Branch (HSIB) cases, and raised concern about how the Trust was understanding communication needs for patients. Assurance was provided that a communication plan was in development to show patients that the Trust had listened and made changes.	None.
Serious Incident Reports	One new never event had been declared, related to a wrong route medication error. The investigation was underway and had been discussed with CQC. The Committee was advised that a number of the incidents reflected operational pressures and staffing levels across the organisation.	Additional assurance was requested in relation to how the Trust was minimising non-clinical ward moves.
Patient Property Update	The Committee was assured that the policy was developed, currently out to consultation and that there was executive oversight.	The policy and action plan following the Internal Audit would be received in March.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Quality Account Priorities	National guidance had indicated that no external audit was required for the Quality Account, with no separate Quality Report required, and no requirement for a Governor indicator.	The Committee supported the priorities for 2022-23 as set out in the report, noting that Governors would be asked their views.
Risk Register	The Committee was assured by the management of key risks on the register, noting that the orthopaedic mortality risk related to fractured neck of femurs had been reduced. Assurance was provided that sepsis mortality risks were within normal range through current quarterly monitoring.	None

Items not Rated			
CQC update	ICS update	CCG update	Governor comments
Impact on Board Assurance Framework (BAF)			
The Board Assurance Framework was under review, and risks linked to Quality would be discussed at future Committee meetings.			

Gloucestershire Hospitals NHS Foundation Trust

KEY ISSUES AND ASSURANCE REPORT Finance and Digital Committee, 24 February 2022		
The Committee fulfilled its role as defined within its terms of reference. The reports received by the Committee and the levels of assurance are set out below. Minutes of the meeting are available.		
Items rated Red		
Item	**Rationale for rating**	**Actions/Outcome**
Capital Programme Report	Some assurance was provided that invoicing and receipting delays had contributed to the current position. The Committee was concerned around the viability of meeting the high level of expenditure in the balance of the year.	A deep dive into the capital programme would take place, with a view to assessing project delivery capacity and reasonability of expenditure phasing plans and projections.
Items rated Amber		
Item	**Rationale for rating**	**Actions/Outcome**
ICS Update	***Financial Principles*** The Committee was overall supportive of the financial framework, and received assurance that individual organisations would retain responsibility and autonomy whilst working within the system to contribute towards a single savings schedule and investment principles. ***SOF Oversight and Assurance*** The oversight framework focused on three key elements: differentiation, subsidiarity, and robust information flows and financial reporting. The Committee noted that the framework would focus on working as a system to build oversight and collective responsibility. The level of bureaucracy associated with the requirements was a concern and needed to be considered.	Future iterations of ICS documents would need to be considered in more detail. Additional clarity around the language within the documents would be provided to ensure individual organisation autonomy and responsibility was clear.
Financial Performance Report	Key points to note: • The Trust was reporting a year-to-date surplus of £271k, which was on plan. • The forecast outturn showed a mitigated surplus of £0.4m; a range of actions has been established to close the gap by the end of the year and achieve the reported breakeven position. • Month 10 reported a £133k deficit in month, which was on plan for the month. A small deficit each month for the year was planned in order to reduce the surplus gap. • Key drivers behind the current position continued to be workforce constraints. • Over delivery of elective recovery continued. • Investment opportunities continued to be explored to maximise patient care, replace ageing equipment and support staff wellbeing. The Committee was fully assured by the rigorous and robust analysis and monitoring of financial performance.	Proposals to support staff wellbeing would be discussed at Board.
Draft Operational/Financial Plan	Good progress had been made on financial and operational assumptions. Discussions were underway with system partners to review the pathway for medically fit for discharge patients. The Trust continued to focus on restoring and recovering the elective programme.	An update would be provided at Board in March, with delegated approval of the final Plan to the Committee.
Community Diagnostic Centre: Lead Provider Model	The Committee supported the recommendation for GHFT to be the NHS Lead Provider for the Gloucestershire Community Diagnostic Centre. The Committee considered the key risk related to the potential	Further work was required to confirm recurrent revenue costs and future allocations to

	ceasing of national funding for community diagnostic centres in 2024.	Gloucestershire.
Items Rated Green		
Item	**Rationale for rating**	**Actions/Outcome**
Financial Sustainability Update	The Committee was encouraged by the progress that had been made and was assured by the report.	None.
Digital and EPR Programme Report	The Committee was assured by the positive progress made.	None.
Proposed New Ledger	The Committee was fully supportive of the draft business case and draft tender specification.	None.
Finance Risk Register	The Committee was fully assured by the management of key finance risks.	None.
Digital Risk Register	The Committee was fully assured by the management of key digital risks.	None.
Items not Rated		
None.		
Investments		

Case	Comments	Approval	Actions

Impact on Board Assurance Framework (BAF)
The Board Assurance Framework was under review, and risks linked to Finance and Digital would be discussed at future Committee meetings. A full review of the Cyber risk would be incorporated into the revised BAF.

Gloucestershire Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD – February 2022

From People and OD Committee – Alison Moon, **Non-Executive Director (in place of Balvinder Heran)**

This report describes the business conducted at the **People and OD Committee** held **22 February 2022**, indicating the NED challenges made and the assurances received and residual concerns and/or gaps in assurance.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Matters arising	Sustainable workforce update – divisional workforce planning has been paused because of lack of Human Resources Business Partners (HRBP) resource. Action now taken to enable Business Planning Lead to resume in post.	Ongoing fragility in the HRBP team with gaps due to sickness and maternity leave. This has an impact on the capacity for robust workforce planning at divisional level	Recruitment for cover at HRBP level is in train. Plan is clear and realistic over time. Workforce planning to be a regular item at future Committee meetings – workplan to be updated	Plan in place, but not yet stable owing to recruitment challenges.
Workforce performance dashboard	Broader more holistic approach to workforce performance reporting is to be explored Vacancies and turnover Vacancy – increased largely due to increased establishment in Medicine Division. Turnover – increased and requires improvement.	What do we know of medical staff vacancies? Hear a lot about exit interviews, but more interested in 'itchy feet' – what is planned for this?	Agreed to bring back medical vacancy hot spot / high risk areas Reasons for leaving to be analysed in detail to inform early interventions such as itchy feet/stay conversations.	Correlation of workforce performance with patient events and incidents.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Sickness absence – on track to achieve long term target, excluding Covid sickness	Request for early reflections from Director and Deputy Director for People (DfP and DDfP) on whether the Trust is an outlier in terms of performance.	No concern about the Trust being an outlier. Systems now in place and plans for further improvement of these to increase confidence in figures being reported.	
	Mandatory training	What's causing the biggest risk?	Response relates to IG – Analysis shows that training required across the Trust which makes targeted intervention more difficult. Education team to work with HRBP's for targeted approach to improve compliance in each Division	Risk that the Trust is not awarded the Data Security & Protection Toolkit by 30/6/2022
Risk register	Risk register being reviewed	Assurance requested that the Workforce Risk Register is considered as part of the business of Risk Management Group (RMG).	Confirmed that RMG considers workforce risks.	
	Focus on Vaccination as Condition of Deployment (VCOD) – added to Risk Register in November.		Assurance given that national guidance is being followed.	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
	Risk score then increased in January once the detailed data sets reflecting vaccination compliance of the workforce was fully known. However, change of direction by Government requires risk rating to be adjusted down from 16.			
ICS update	Recruitment to ICB executive roles completed in the last week			Failure to recruit to ICB Director of People, OD and Engagement
	OD Working Group – verbal update, significant progress in collaboration on leadership development, EDI and the launch of a Wellbeing Line (Mental Health Hub)		Reassurance received that the Director for People will actively engage across the system	
Sustainable workforce	Five Year Workforce plan submitted in November 2021. Specific diversity focus (model employer target) with divisions. In support of this the number of International 135 nurses recruited, trained and supported in 2021/2022	What is the confidence that known pipeline plans meet the demand in 2022/23 and beyond?	Workforce planning is a key focus and underway through the Operating Planning Process (OPP) , with collaborative working across the P&OD function, key stakeholders across the Trust and across the wider ICS	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
		What correlation takes place regarding placement experience of students and other clinical area data?	Confirmation that evaluations of student experiences is included in review of clinical areas.	
	Good achievements in apprenticeships, with 315 on programme across 43 different standards.			
	Several strands of work involving Work Experience / Careers Awareness: medical career Q&A sessions held December and January – 150 attendees. Band 4 apprenticeship careers and engagement officer due to start in post in			
Staff survey	Raw data presented with final report to be published 30 March. Findings will be mapped against the national People Promise. 50% response rate (1% higher than last year).	Do we know how this compares with others? Are there any immediate remedial actions needed with regards to safety?	Benchmarking available on publication. Data being analysed, nothing to report at this point.	Update on detail, including benchmarking to be shared at next meeting.

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Health and safety	Performance - predicted to meet year 1 target on: sharps safety, risk assessment completion and slips and trips. Manual handling incidents, violence and aggression incidents and quarterly workplace inspection are off target.	Concerns raised over increases in violence and aggression. Assurance sought that this is on the risk register. Questions about action being taken to address issues.	H&S team are working with EDI team to develop actions where violence and aggression is related to protected characteristics. New Violence and Aggression action plan – reports to Trust H&S Committee.	Increase in violence and aggression will be added to Workforce Risk Register. Committee to receive assurance on deliverability and impact of the action plan at next meeting.
Resourcing	Agency spend is above target – nurse agency spend is £7.9m against target of £3.8m.			
	Winter Bank bonus payment launched in January – resulted in increased fill rate - 25% increase in Registered Nurse and 15% for HCAs.	Effectiveness of bonus payment. Retention - do we understand where and why people are leaving to help inform the recruitment plans?	Assurance received related to increased shift fill rate. Fixed timescale of incentive scheme noted and assurance on sustainability requested	Correlation of costs associated with bonus payment and reduction in agency spend at ward / department level to understand the impact of the incentive. Evaluation to be undertaken and shared with future Committee meeting.
	Continued focus on recruitment. 103 international nurses arrived since April 2021 and a further 14 arriving before end of March.	Ensuring known planned numbers of overseas cohorts will meet the RN vacancy demands	Workforce planning will give clarity on demand and supply needs	

Item	Report/Key Points	Challenges	Assurance	Residual Issues / Gaps in Controls or Assurance
Gender Pay Gap	As at 31 March 2021 in the Trust Annual Report - • The mean pay for men is 28.5% higher than for women (28.6% in 2020). • The median pay for men is 23.4% higher than for women (19.8% in 2020)	Do we understand the gap?	The gap is largely the consequence of nationally driven terms and conditions and Clinical Excellence Awards (CEAs). CEAs will be replaced in the near future, and equality has been a part of the drive for this.	Recommendation that this goes to Board as in previous years.
Stonewall Index	Stonewall Index position shared, which demonstrates the extent to which the Trust creates an inclusive environment for LGBTQ staff. Info is under embargo – will be shared in full following next meeting. Learning from the process to be incorporated into EDI Strategy.	Can we learn from other organisations such GCHQ? Does the Trust wish to do another submission in August 22?	DfP to review and recommend next steps to Committee.	
Committee Workplan	Agreed to refresh of plan – action for Director for People and Chair of Committee			
Audit & Assurance	Overpayments Policy under review as a result of the Counter fraud Audit	Staff Side have raised concerns about financial hardship for staff when they are asked to pay back overpayments in very tight deadlines	DDfP has oversight of the audit recommendation and the review of the Policy with the Head of Shared Services in the first instance	

Alison Moon
Non-Executive Director, People and OD Committee (in place of Balvinder Heran, Chair of PODC)
22 February 2022